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Assimilation, Reflexivity, and Therapist Responsiveness in Group Psychotherapy for Social Phobia: A Case Study

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Abstract

Objective: This case study examined reflexivity and the assimilation of problematic experiences, especially its progress within and between the Assimilation of Problematic Experiences Scale (APES) Stages 2 to 3, in group psychotherapy for social phobia.

Method: The data consisted of all of one client's turns expressing the two voices of her main problematic experience in 12 sessions, and all replies by the therapist in direct connection to them. The client's utterances were rated on the APES.

Results: A detailed analysis of 13 conversational passages revealed that progress in assimilation happened only when the client took a reflexive stance towards her inner experience or outer actions. There were a few instances when she took a reflexive stance, but no progress in assimilation could be noted. A qualitative analysis of three conversational episodes showed how therapist responsiveness facilitated the client's increased reflexivity and progress in assimilation.

Conclusions: Reflexivity appears to be a necessary condition for progress in assimilation both at APES Stages 2 and 3, but the model should recognize that reflexivity can appear in diverse forms and at different levels. Therapist responsiveness and sensitivity to the client's assimilation process is crucial for a successful transition from Stage 2 to Stage 3.

Keywords: assimilation, reflexivity, social phobia, group psychotherapy, case study.

Assimilation, Reflexivity, and Therapist responsiveness in Group Psychotherapy for Social Phobia: A Case Study

Despite the common diagnostic criteria for social phobia included in DSM-IV, such as an intense and irrational fear of embarrassment, humiliation, or scrutiny by others in social situations (American Psychiatric Association, 1994), the category of "social phobia" refers to a heterogeneous group of individuals who may differ in a number of dimensions (Hofmann, Heinrichs, & Moscovitch, 2004). Taking such individual variability—which is not restricted to this diagnostic category alone—into account is a challenge for therapists. This is especially true in structured methods of group psychotherapy for particular target categories. One important difference between clients is their readiness to take a reflective stance on their problems and experiences. This calls for sensitivity and responsiveness towards the individual client's ways of processing his or her problematic experiences and inclination to appreciate and benefit from the therapist's interventions (Leiman & Stiles, 2001; Stiles, Honos-Webb, & Surko, 1998).

The Concept of Reflexivity

One of the qualities in which clients differ is in their capacity to assume a self-reflexive stance, a positioning seen as central to progress in psychotherapy (see Levitt, Butler, & Hill, 2006; Rennie, 1992, 2000, 2004). In this case study, we address these issues by examining how, in short-term group psychotherapy for clients presenting with

social phobia, the therapist's responsiveness, or lack of it, contributed to, or hindered, one client's increasing reflexivity, and how this related to progress in the assimilation of her problematic experiences (Stiles et al., 1991; Stiles, 2001, 2002, 2011).

The current case study is part of a larger research project on therapeutic change processes and their variations in cognitive-constructive group psychotherapy for social phobia (Penttinen & Wahlström, 2013; Penttinen, Wahlström & Kuusinen, 2013). In the treatment model applied, increased reflexivity is seen as a central element of therapeutic change. Self-reflexive examination is presumed to have a number of effects for the client: It enhances his or her ability to connect diverse experiences within the self, helps gain a sense that the self can regulate these experiences, and reassures that the disturbing experiences do not threaten the self's sense of coherence (Toskala & Hartikainen, 2005).

The concept of reflexivity is manifold and has been used in psychotherapy research more or less synonymously with such concepts as metacognition, agency, reflectivity, self-monitoring, recursiveness, and self-consciousness (Dimaggio & Lysaker, 2010; Rennie, 1992). Rennie refers to Lawson (1985), who describes reflexivity as turning back on oneself, a form of self-awareness. In Rennie's (2004) definition, reflexivity is taken to mean the formation of intentions within self-awareness which results from turning one's attention to oneself. Reflexivity has also been paralleled with the notion of employing a metaposition. According to Hermans (2004), a well-developed metaposition allows one to stand above the ongoing stream of perception. In other words, the person takes the perspective of an author watching his or her voiced positions and how they function as actors in specific circumstances. As a result of such an increased level of self-awareness, the person is able to strengthen his or her capacity for seeing

relevant connections in life experiences. Hermans (2004) emphasizes that a metaposition is always connected to one or more internal or external positions (e.g., one represented by the psychotherapist), which are actualized at a particular moment and in a particular situation. Accordingly, the meta-position is a dialogical phenomenon, including both the outer dialogue with the therapist and the client's internal dialogue. This also implies that, depending on time and situation, different metapositions can emerge.

From our reading of the literature and the data from this study we contend that different levels of reflexivity can be observed in therapeutic discourse. The first level, forming a basis for assuming a reflexive stance, is achieved when a person turns onto the self and recognizes his or her own internal processes, such as feelings and thoughts. On the second level, such a turning onto the self may allow the person to address and eventually analyze his or her interpretations based on these processes. Reflexivity on the first level can be defined as an observable utterance in the therapeutic discourse where the client takes an observational stance towards her own experiences or internal processes (e.g., "then I get this feeling of uncertainty"), and on the second level as an utterance where he or she indicates making observations on her own way of interpreting her experiences (e.g., "then this feeling of uncertainty makes me think that everybody else is critical of me"). Taking such a metaobservation stance expresses, at least implicitly, an understanding of people having their own personal perspectives, differing from the speaker's image of those perspectives.

The Assimilation of Problematic Experiences Model

In this study we used the Assimilation of Problematic Experiences model to assess therapeutic change. The model is a theory of psychological change that depicts the self as a community of internal voices, composed of traces of the person's experiences (Honos-Webb et al., 1999; Stiles et al., 1991; Stiles, 2001, 2002, 2011). These internal voices may embody other people's activities, events, or any other interlinked complex set of experiences (Mosher & Stiles, 2009; Stiles, 2011). External persons, especially therapists, may sometimes act as real-world representatives of inner voices. In a healthy, functioning community, voices are easily accessed and can be called upon as needed. Voices are considered problematic when they represent foreign, discrepant, or traumatic experiences (Brinegar, Salvi, & Stiles, 2008).

The assimilation model strives to depict how a problematic voice becomes accepted and integrated into the dominant community of voices. Assimilation is hypothesized to proceed according to an eight-level sequence described in the Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1991; Stiles, 2001; Honos-Webb & Stiles, 1998). Problematic or nondominant voices are more or less rejected by the community. In the extreme, problematic voices may be denied awareness or avoided (APES Stages 0 or 1), in which case the therapeutic work entails bringing the voice into awareness (Honos-Webb et. al., 1999). Theoretically, as an unwanted voice emerges into awareness, a voice that opposes it is called forth from the dominant community of voices (Honos-Webb & Stiles, 1998). At Stage 2 (vague awareness), the client acknowledges the problematic experiences and describes distressing associated thoughts but cannot formulate the problem clearly. At Stage 3 (problem statement/clarification), the client is able to state the problem in words and/or give

expression to both the nondominant and the dominant voice. Then, at Stage 4 (understanding/insight), with the development of new understandings, both the dominant and problematic voices change and accommodate each other, and are understood to develop so-called meaning bridges between them. Potentially, this enables the client to progress to the higher assimilation levels.

The transition from Stage 3 to Stage 4 is seen as central to the therapeutic change process, and reaching Stage 4 is considered to be the minimum criterion for a good therapy outcome. Hence, a considerable amount of research has been devoted to that transition (Brinegar, Salvi, & Stiles, 2008; Brinegar, Salvi, Greenberg, & Stiles, 2006; Detert, Llewlyn, Hardy, Barkham, & Stiles, 2006). Much less consideration has been given to the transition from Stage 2 to Stage 3, which is the interest of our study. In the assimilation model, reflexivity is given as one marker of Stage 3 (Honos-Webb, Stiles, & Greenberg, 2003). Theoretically, it is a well-founded notion that for the client to become aware of the dialogical processes between different parts of the self, a required criterion for reaching Stage 3 (problem statement/clarification) is second-level reflexivity (as defined above). Then again, some previous research indicates reflexivity appearing already at Stage 2 (vague awareness). Gonçalves et al. (2014) showed that low APES levels (< 4) were associated with so-called low innovative moment (IM) levels, including reflection. In Leiman's (2012) metamodel of the psychotherapy process, which is presented as a modification of the APES scale, the notion of an observer position is given a central place. In Leiman's reading of the assimilation model, an observational stance is reached already at Stages 2 (vague awareness) and 3 (problem formulation), which then creates the potential for Stage 4 (insight).

The assimilation model does not, however, elaborate on the definition of reflexivity and within research on the model there is limited investigation into the development of reflexivity. Our supposition is that first-level reflexivity (as defined above) needs to be generated already at Stage 2 for a transition to Stage 3 to be possible. We would not expect reflexivity in this sense to be present at the outset of Stage 2 or to be a defining feature of that stage, but we are asking how the processing of problematic experiences in Stage 2 paves the way for a transition to Stage 3. Should reflexivity as a marker of Stage 3 be explicated as presenting the kind of metaobservational stance outlined above as a feature of second-level reflexivity? In addition, should turning onto oneself be seen as an important goal for therapeutic work with clients entering therapy at Stage 2? The main feature of this stage is that the client feels badly but has only a vague sense of why. Reaching a clearer formulation of the problem (Stage 3) would seem to ask for an increased emotional preparedness to look at those bad feelings as parts of the self.

Progress in Assimilation and Therapist Responsiveness

Research shows that the assimilation process does not progress in a fixed or systematic manner; rather, there can be regressions to earlier levels alongside sudden gains (Honos-Webb, Stiles, & Greenberg, 2003). According to Caro Gabalda and Stiles (2013), the causes of setbacks in assimilation appear theoretically and clinically sensible, and can be seen as expected consequences of active therapist interventions, often characteristic of directive therapies. Stiles, Honos-Webb, and Surko (1998) already showed that the therapist's responsiveness and sensitivity to the client's readiness to

utilize the interventions used is vital for the therapeutic change process. In line with this, Leiman and Stiles (2001) have proposed that the dialogical space in which the positions of therapist and client appropriately meet, and in a manner that advances the client's self-awareness, could be defined in terms of the Vygotskian concept of a zone of proximal development (ZPD). The therapeutic ZPD can be understood as a region between the client's present APES level and the level that the client can achieve in collaboration with the therapist. Thus, the therapist's responsiveness to the client's ZPD is thought to be essential in a successful therapeutic process (Caro Gabalda & Stiles, 2013), and therapy is most likely to be effective when working within the therapeutic ZPD (Ribeiro et al., 2014).

In spite of the theoretical significance of reflexivity, empirical studies examining its meaning and specific connection to the assimilation are scarce. Research particularly on the progress of assimilation within Stages 2 and 3 or on the transition from Stage 2 to Stage 3 is very rare, with certain exceptions (e.g. Caro Gabalda, Stiles & Ruiz, 2015; Gonçalves et al, 2014; Meystre, Kramer, De Roten, Despland & Stiles, 2014). Accordingly, in this case study we asked how, for one participant in a therapy group, progress in assimilation at Stage 2 and if progressing to Stage 3 was connected to increasing reflexivity, and how the connection between the two could be seen in the context of a semistructured model of group psychotherapy. The group format did restrict the degree of customization the therapist could achieve for each client's therapeutic ZPD. Hence we expected to find both matches and mismatches in client–therapist positions, in other words, a variation in therapist responsiveness, even in successful cases. We looked at more and less successful therapeutic actions, and asked how these functioned in respect

to enhancing reflexivity and assimilation of problematic experiences within this particular group therapy setting.

Method

Participants

Miia (a pseudonym) was chosen from among our original 17 participants from two therapy groups (n = 10 and n = 7). The two groups were carried out in two subsequent years, one group at a time. In this naturalistic study setting, all clients referred themselves for treatment in response to an announcement in a local newspaper. All clients met the DSM-IV (American Psychiatric Association, 1994) diagnostic criteria for social phobia and gave informed consent for participation in the study. The therapy group in which Miia participated had seven members, and they were all females. Miia was an interesting case, because her particular management strategy for social anxiety was to withdraw from other people, which made the group format of treatment challenging for her. Miia was also an informative subject, because she spoke enough in the group conversations to allow for a detailed analysis, which was not the case with all the clients. These were the grounds for choosing her as the client-participant of this case study.

Miia was a woman in her forties who presented with social phobia related especially to performance situations. She had dreamed of a career as a violinist when she was younger, but she eventually pursued another line of work. At the time of therapy, she played the violin in an orchestra as a hobby, which included regular rehearsals and

performances. Miia was single, childless, and lived with her elderly mother, whom she took care of.

The therapist was a male Ph.D. in his fifties, a licensed and experienced psychotherapist. He had developed the particular treatment model used here.

Treatment model

The treatment model applied in the present study was developed at the University of Jyväskylä Psychotherapy Training and Research Centre (Finland). It is a cognitive-constructive, short-term form of group psychotherapy for socially phobic patients. The treatment rationale is based on constructive views, and thus it differs from traditional forms of cognitive psychotherapy. The constructive perspective emphasizes the operation of tacit (unconscious) ordering processes, the complexity of human experience, and the merits of a developmental, process-focused approach to knowing (Mahoney, 1995). Based on an understanding of persons as active subjects organizing their experiences of themselves and their world (Toskala & Hartikainen, 2005), the treatment model highlights the exploration of the individual meanings given by clients to their problematic experiences. Accordingly, the development of client reflexivity is seen as an essential element of the treatment model; one of the therapist's essential goals was to increase the clients' ability to reflect on their inner states and individual ways of experiencing and interpreting these experiences.

The therapy was time-limited, consisting of 12 weekly two-hour sessions. Five therapeutic strategies based on the aforementioned cognitive-constructive model of the constitution of problematic experience and on the therapeutic development of reflexivity

were adopted for the group treatment. The clients were given brief written material concerning the strategy to be used before the particular sessions in question. The first strategy (Sessions 2 and 3) was to recognize the internal, mental process—such as feelings, thoughts, bodily sensations, images—related to the problematic experience of each individual participant. This was accomplished by processing situations in which social anxiety was experienced. Reformulation, the second strategy (Sessions 4 and 5), included reconstruction of the problem on the basis of the individual's own inner process. At this point, both the client and therapist concentrated on the way in which the problem was constructed and what was most essential in the problematic experience, including possible explanations for it. In the third strategy (Sessions 6 and 7), the idea was to reconstruct an alternative relation to the individual's problematic experience. The goal was a more permissive and accepting attitude towards oneself and towards one's own inner experience, which would enable the integration of the problematic experience with the self.

The fourth strategy (Sessions 8 and 9) was to explore and clarify how the problematic social phobic experience appears in present adulthood attachment relations. With the fifth strategy (Sessions 10 and 11), the group contemplated the problematic experience in each client's early attachments to parents and other significant adults. Clients recalled significant experiences from their childhood and youth to which they had an emotional connection.

The treatment could be characterized as individual therapy offered in a group setting, because the clients were invited in turns to deal with their feelings and experiences related to the issues in question, mainly in dialogue with the therapist.

Occasionally the clients did comment on each other's talking in the group. There was also a psychoeducational component in every meeting, in which the therapist clarified the strategy in question and outlined the clients' experiences related to it, making a summary of them on a flipchart.

Data

The data consisted of all of the client-participant Miia's turns expressing the voices of her main problematic experience in 12 sessions, all videotaped and transcribed, along with all replies by the therapist in direct connection to them. In all, these constituted 25 pages (out of 42 pages in total—all of Miia's turns in the discussion). All analyses were made from the original Finnish transcripts. Extracts from the data have been translated into English for presentation in this article.

Analysis

The analysis consisted of three parts. The first part followed the steps of assimilation analysis (Honos-Webb et al., 2003). Two particular voices were identified in Miia's conversational turns related to her problematic experience with social anxiety, which involved feelings of inferiority, indifference, and a need for support from others. The voices reflected Miia's efforts to cope with her social anxiety by showing seeming autonomy and self-sufficiency, a typical pattern for people with social phobia. All passages of speech relevant to the expression of the voices were extracted from the text. In these passages she spoke about her feelings of inferiority and indifference, her need for support, and her efforts to manage with those feelings. Twenty-five such passages were identified.

Voices can be recognized by their content, their verbal and vocal characteristics, and also by the dialogical patterns that they establish towards the other mental states, for example, by their response or attitude towards the other voices in that same individual (Osatuke et al., 2004). In this study, the dimensions used in distinguishing the two voices were partly taken from Osatuke, Stiles, Barkham, Hardy, and Shapiro (2011), also depending on the evidence available in the transcript. The first author distinguished the two voices by their content (what the voice talked about), intentionality (the voice's apparent reason for speaking), affect (specific emotions associated with the voice), and triggering characteristics (contextual events that seemed to elicit the expression of the voice). The two voices were named and characterized as follows:

The Detracting Voice (dominant): "I am unworthy. I must not imagine that I would matter to anyone, and I have to manage on my own."

The Needy Voice (nondominant): "I am worthy of love. I want to be accepted as I am, including my sensitive side and idiosyncrasies. I need support and approval from others. It's okay to have my needs met."

How Miia assimilated these voices throughout the therapy process was assessed by the first author and two students majoring in psychology. This assessment included APES ratings of all 25 conversational passages in which Miia processed her problematic experience as expressed by the voices.

As a second part of the analysis, we concentrated specifically on a sequence of 13 consecutive passages where the assimilation process was mainly at APES Stages 2 (vague awareness/emergence) and 3 (problem statement/clarification), with two exceptions where Stage 4 was reached. The length of the passages varied from 15 to 106 lines.

Progress in assimilation within and from Stage 2 to Stage 3 was found in passages from Sessions 4 to 7. After that, from Session 8 onwards, Miia mainly processed her problematic experience at APES Stage 4 or higher. There was, however, one regression to Stage 2 in a later session.

In this second part of the analysis, performed jointly by the three authors, two questions were asked in regard to each of the 13 passages:

(1) Does the assimilation process progress in this particular passage?

An affirmative answer to this question included both progress within the APES stage as well as progression to a higher APES stage. Progress within a stage was defined as processing which moved towards the next stage of assimilation without fulfilling the criteria of the next stage in the APES scale.

(2) Is the client taking a reflexive stance in this particular passage?

The criteria for a reflexive stance was that the client turned onto the self in her speech, recognizing her own inner processes and analyzing the representations based on these processes. For an affirmative answer to Question 2 it was sufficient that the first part of the criteria, turning onto the self (i.e., first-level reflexivity) could be recognized in her speech.

On the basis of the aforementioned observations, in the third part of the analysis the first and the second author performed a detailed consensual qualitative analysis of how the therapist's interventions in three representative instances the therapist's responsiveness facilitated or failed to facilitate the assimilation process of the client and her growing reflexivity. We focused especially on the therapist's role, focusing on how he tried to help the client to take a reflexive stance. We also focused on which voices were

addressed by the therapist and how these particular voices responded to the therapist's attention.

Reliability

As a reliability check for the assimilation analysis, the assimilation levels for the client's two voices were determined by the first author and independently two additional judges: two master's students psychology working in tandem. The students familiarized themselves with the literature on assimilation analysis and were supervised by the first author. The students met with her every two weeks for six months to discuss the method and the data. It was during this six-month period that the first author and the students conducted the analysis. The intraclass correlations coefficient (ICC), for all 25 passages, between judges was 0.874, signifying excellent agreement (see Fleiss, 1981).

As a credibility check for the rating of the 13 passages concerning the assimilation process and reflexivity, the three authors separately answered Questions 1 and 2 from above for each passage. Then, in a consensus meeting, all ratings were discussed. The ratings are presented in Table 1. For the ratings of whether the client showed reflexivity 9 out of 13 were unanimous. For the ratings of whether the passage showed progress in assimilation, only 5 out of 13 were unanimous. This greater discrepancy was mainly due to differences in the definition of progress: whether it should be understood as movement to the next stage of assimilation or as progress within a stage. In the consensus meeting, the latter definition was adopted. After this, the raters had no difficulty in agreeing on the final ratings when they jointly reviewed all the passages for which they had earlier shown discrepancies. The final ratings were reached consensually.

[insert Table 1 about here]

For the third part of the analysis, the first two authors looked at the contributions of the therapist to the client's progress in assimilation and increasing reflexivity (or the lack thereof). Detailed accounts of three conversational episodes are included in this article. The inclusion of extracts from the original data, although translated into English, gives the reader the possibility to appraise the trustworthiness of the analysis.

Results

Assimilation of problematic experiences

Miia's problematic experience of social anxiety took its expression in the restricted assimilation of two voices. One dominant voice, the Detracting Voice, defended against and aimed to exclude a nondominant and problematic one, the Needy Voice. The Needy Voice conveyed Miia's wish to be accepted as well as to receive support and approval from others, even when perceived as being weak and sensitive. When using this voice, she expressed that she wanted to feel that she belonged with other people and that someone would take care of her. The Needy Voice was problematic because it represented a part of Miia's self that was different from the dominant community represented by the Detracting Voice, which conveyed her feelings of unworthiness. Miia's solution for these difficult feelings of unworthiness had led to her trying to manage on her own, which also reflected her Detracting Voice. The Needy Voice expressed Miia's feelings of loneliness

and sometimes even her experiences of being abandoned, when her Detracting Voice dominated the internal community.

Miia's assimilation of the two voices was rated at APES Stage 2 in Session 2, and it gradually progressed to APES Stage 6 by Session 11 (see Figure 1), and was rated as Stages 6 and 5 in the last two sessions. In Sessions 4 to 7, she worked towards a clearer statement of her problematic experiences, and then, from Session 8 onwards where the assimilation level was mainly on Stage 4 or higher, the dominant and the nondominant voices built meaning bridges and started to understand each other. She could see the connection between her neediness and her detracting attitude towards herself as grounded in her mother's dismissive stance and expressed her belief that she could only be accepted by others as highly competent.

[insert Figure 1 about here]

In the second part of this section we show how taking a reflexive stance was connected to progress in assimilation from vague awareness (Stage 2) to clarification of the problem (Stage 3). In the third part we present selected extracts from the conversations in the therapy sessions in order to show in detail how the dialogue between the therapist either hindered or allowed for reflexivity and progress in assimilation to occur within Stage 2 and during the transition from Stage 2 to Stage 3.

Reflexivity and progress in assimilation

To assess the connection between reflexivity and progress in assimilation, we looked at the 13 passages from Sessions 4 to 8 in which Miia expressed her Detracting and Needy voices while mainly at Stages 2 or 3. We did not include the first appearance of the voices at Stage 2 in Session 2, because the actual processing of them did not start until Session 4, nor the one drawback from Stage 4 to Stage 2 in a later session (see Figure 1). Looking at the selected sequence in Sessions 4 to 8, it is noteworthy that Miia reached Stage 3 by Passage 3, from Session 5 (see Table 1; the numbering of the passages corresponds to those in Figure 1), but regressed to Stage 2 in Passage 4 from Session 5 and stayed there during the next three passages (Passages 5, 6, and 7 from Session 5).

Table 1 shows whether each of the 13 passages included reflexivity on the part of the client and/or progress in assimilation. As mentioned in the method section, both a movement towards higher assimilation within a stage and a transition to the next stage were rated as progress. In 10 of the passages, reflexivity and progress in assimilation either were both present or were both lacking concurrently. This was the case for 8 of the 11 passages were the level of assimilation was at APES Stages 2 or 3. There were three (3) exceptions: Passages 9, 11, and 13. In these, Miia took a reflexive stance towards the issues at hand, but the assimilation process did not progress. In these passages, Miia's processing was at Stage 2 (Passage 11) and Stage 3 (Passages 9 and 13)**.** There were no passages (0) in which the assimilation process progressed but no reflexivity was shown.

Therapist-client positions and therapeutic change

The three episodes from the therapeutic dialogue between the therapist and Miia that we consider below were chosen in order to show different approaches taken by the therapist

to promote Miia's readiness to take a reflexive stance, as well as her responses to them.

Episode 1 is from Session 4, in which the clients' task was to contemplate why they experienced tension in social situations or what particular factors made the experiences so problematic for them. In the passage below (Passage 2 in Table 1), it is Miia's turn to consider the issue in question. Here she is at Stage 2 (vague awareness), and the problem is not yet clearly defined. In this and all subsequent passages, utterances identified as representing the Detracting Voice are marked with (DV) at the end of the sentence and those representing the Needy Voice are marked with (NV). Utterances showing reflexivity are written in bold.

Miia: I would like to belong to a totally different kind of group, to which I don't belong (NV).

Therapist: Mm-m.

Miia: A kind of a little better crowd (NV).

Therapist: Mm.

Miia: A crowd of more intelligent and capable people, like one would really feel that here I belong (NV), and then one always realizes that I don't belong here because they know much more (DV), and when somebody says something…

Therapist: Mm.

Miia: …they quickly understand what he says. I still ponder things too much on my own.

Therapist: Mm-m, mm. M-hm.

Miia: Well.

At the opening of the passage, Miia in her Needy Voice told about her wish to belong to a "different kind of group," a group of people she considered to better than she

herself was. The intentionality of the Needy Voice was apparent in the expression “like one would really feel that here I belong.” Immediately after that, the Detracting Voice reminded her how she always realizes that she does not belong, because those others know and understand so much more. The therapist reflected on this as follows:

Therapist: So that is connected to these kinds of demands that are unconditional, strict, and severe. It’s not just a kind of creative wish that it would be nice to grow in this or that respect, but it’s as you, as you really, you define even your basic quality as a human being through such things. And that is an endless path. There is no end. Because when you would be there in the other, the better crowd, there would be upon it yet another crowd, and you would have to aspire for it and so on.

Miia: Yeah, but one couldn’t get there (DV).

Therapist: Mm.

Miia: And not to the previous one either (DV).

Therapist: Mm. OK, that’s why you are anxious or feel distressing anxiety, when you, in your own opinion, don’t meet these kinds of standards and these kinds of very strict, absolute standards. OK.

The therapist in his response commented on how Miia, when talking about others as “better” and “more intelligent,” expresses unconditional and severe demands on herself. He highlighted his point of view by saying that Miia even defines her quality as a human being in this way. The therapist accentuated the futility of such an endeavor by saying how it is an endless path of always wanting to be in better and better crowds. In this way, the therapist articulated and challenged the way of thinking represented by Miia’s Detracting Voice. It is noteworthy that the therapist in no way, however, addressed

the actual wish of her Needy Voice to "really" belong to a group of people.

As can be seen, Miia did not comment at all on the perspective offered by the therapist. She only responded by saying "but one couldn't get there," a statement that represented her Detracting Voice. The therapist's confrontation of the severity of Miia's Detracting Voice did not help Miia to achieve a reflexive position. She stayed in a nonreflexive stance, experiencing herself as unworthy, not fitting into "the better group of people". The confrontation appeared to work for the therapist as a conclusion about Miia's particular way of relating to social situations, but it did not help Miia to recognize the demands stemming from the Detracting Voice. Nor did it lead to progress in the assimilation process; she remained at APES Stage 2.

In the episode 2, taken from Session 5 (Passage 3 in Table 1), Miia describes her feelings of being rejected and worthless and eventually makes a problem formulation. When talking about "coming to a standstill," Miia refers to an expression that the therapist had used earlier when encouraging clients to adopt a reflexive, observational position in problematic situations:

Miia: Well, I could, considering my coming to a standstill… I was wondering here by myself about it. Well, I thought like this that if one starts to, well, think about the situation and tries then in that way somehow to get over it, **then at least I feel like that, that I should then feel that I am an accepted person**, **and the kind that I could hold that, that I am somehow a proper person, and… (NV)**

Therapist: Yeah.

Miia: …somehow good (NV). **But if I feel as I feel, that I'm a little bit odd and strange in people's opinion, and that if I were to die then no one would even notice it**

for the next six months that I'm dead (DV), and like that, then there is not really any kind of support where one would get strength then. Then, well, to get rid of this kind of, because…

Therapist: Aha.

Miia: …nevertheless **this anxiety is based on a kind of, I guess, that one feels that one is not an accepted person**.

Miia stated that her social anxiety is based on her experience of not being approved by others. She reflexively recognized her Needy Voice, but in the demanding manner ("I should then feel that I am an accepted person"). Then Miia expressed her wish "that I could hold that I am somehow a proper person and somehow good," conveyed by her Needy Voice, now lacking the former demanding manner. Here the dominant and the nondominant voices are almost talking to each other, sharing each other's points of view: The former takes the approval of others as a condition (that cannot be reached), while the latter sees it as a wish. Then Miia continued by describing her feelings of being "a little bit odd and strange in people's opinion, and that if I were to die then no one would even notice it for the next six months," which represented the Detracting Voice's feelings of unworthiness, the reason why Miia thought one should manage without needing others. Miia's assimilation reached Stage 3 as she formulated her problem by recognizing her painful feeling that was now understood by both voices: "This anxiety is based on a kind of, I guess, that one feels that one is not an accepted person." The problem, at this point, was formulated from the point of view of the Detracting Voice expressing the thought that she is not accepted.

Then she continued as follows:

Miia: And then when one goes to that kind of, even to a pleasant situation, well, well **then, there comes this kind of thought that one is in the wrong place and it would be better that one wouldn't be there, and maybe even better that one wouldn't even exist, that one would have died already as a baby (DV), then one would have, well. So these kinds of feelings I have. So one feels that it's terribly hard to struggle then against that kind of feeling. That it, it's kind of natural, so it just comes.**

Therapist: Mm-m

Miia: And it's, if it's this kind of special… In just the kind of ordinary grey situations I manage, but if there's even a little of that kind of, more lively and more interesting, and that kind of where one would like to be along (NV), well then, **one feels how boring and unpleasant a person one is, and that kind which people would rather like to move aside so that they would have more fun (DV).**

Therapist: A-haa

Miia: Or I don't know if that's it, but anyway **this is how I feel on my part**.

Therapist: Yeah, that sounds terribly sad.

Miia: Well, it is.

Therapist: Mm.

Miia: **But that is how I feel**.

Here it is noteworthy that Miia further described, without any interruption or questioning by the therapist, the Detracting Voice's side of the experience, especially the experience of being a little bit odd and weird and, because of this, not approved of by others. The therapist was empathic to Miia, mainly listening, but saying finally how sad it sounded when Miia described her experience and feelings. Miia accepted this formulation

and actually used the word “sadness” many times in later therapy sessions when describing her feeling in the Detracting Voice. She had not used that word in earlier sessions. Through these descriptions and by giving words to her feelings, in this passage Miia reached a reflexive stance as she turned her attention towards her own way of experiencing and recognized her painful feelings. This particular reflexivity was an instance of first-level reflexivity.

The last conversational episode we present (Passage 8 in Table 1) is from Session 6. Here Miia continued dealing with her sense of being ignored as she and the therapist talked about Miia’s experience that other people despised her. Miia was telling how she lived, surrounded by people who judged and disapproved of her. Here she is referring to the therapist’s former psychoeducational talk, where he had emphasized the clients’ possibilities to form an alternative, less troublesome relation to their own problematic experience.

Miia: **But I think like this, that if one all the time lives in that kind of negative atmosphere… (DV)**

Therapist: Mm.

Miia: …**that you are being disapproved of, evaluated, and people are that kind of negative (DV), then it’s terribly hard to start to think in that way.** You really have to make an effort that you try to think that it isn’t so anyway, that I’m not that kind of what that one implies, but if one then would live in that kind of atmosphere, that one is being approved of, and so then…(NV)

T: Mm.

Miia: …then it would seem that it’s much easier to experience oneself that, oh, I’m quite

that kind of decent person. (NV)

Therapist: Mm.

Miia: And I'm not so bad and guilty as…(NV)

Therapist: M-hm.

Miia: …or in a blaming atmosphere.

Therapist: Yeah.

Miia: I don't know.

Therapist: But how do you, Miia, think? Isn't partly this atmosphere of blame, isn't it maybe partly, however, something that we ourselves construe?

Miia: Well, it could be so also, that one construes that…

Therapist: Yes.

Miia: …one is being blamed, though one isn't.

Therapist: Yes, we, we have a kind of sensitivity to notice these kinds of things then, if we have inside this kind of, have a negative relation to ourselves.

Miia: Mm.

Therapist: So then we kind of think that those others also, when I'm in this way in relation to, I don't approve of myself, others don't either approve of me. And you don't know what those other people are in relation to you.

Miia: Mm.

Here Miia's Detracting Voice expressed that being despised by other people made her feel herself to be an insignificant person. The therapist responded to this, inviting Miia to adopt a second-level reflexive stance, by implying that it was primarily Miia herself who was despising herself, not other people, and that she herself interpreted how

other people related to her. However, he formulated his comment as a question and in a softened mode by using the inclusive word *we* (e.g., "something that we ourselves construe"). Miia responded to this by admitting that this could be true, but she did not yet apply the idea directly to herself. She stated more generally: "One construes that one is being blamed though one isn't." The therapist continued to gently offer Miia a reflexive stance by talking about our "sensitivity to notice these kinds of things." It is noteworthy that he did not ask about Miia's possible actual experiences of being despised, but right away offered the idea of it being a subjective interpretation.

As the conversation went on, the therapist brought up alternative ways in which other people might relate to Miia. When Miia considered these alternative positive ways, the Needy Voice could emerge:

Therapist: They (other people) have a very, as I said, they have surely very different kinds of attitudes towards you, as towards anyone of us any other person has.

Miia: Mm. **But still I think so, that when you have met sometimes some person, whom you have, who has been that kind of a person whom you… (NV)**

Therapist: Mm.

Miia: …**yourself appreciate…(NV)**

Therapist: Yeah.

Miia: …**then that person has treated you quite as…(NV)**

Therapist: Mm.

Miia: …**you would be somehow nice, and kind of, like personal, and like that kind of person who can be approved…(NV)**

Therapist: Mm.

Miia: …**then it immediately feels like that you would have enough strength to do whatsoever after that.(NV)**

Therapist: That's right.

Miia: For a while…

Therapist: Yeah, yeah.

Miia: …after that kind of encounter.

Therapist: Yeah, yeah, yeah, yeah. So you are kind of talking about that, that you have a kind of an enormous, this, this kind of hunger for encounter.

Miia: **Apparently I need some approval…(NV)**

Therapist: Mm.

Miia: …**and this kind of friendly treating…(NV)**

Therapist: Mm.

Miia: …**that**…

Therapist: Mm.

Miia: …and kind of just like that, that it comes kind of spontaneously, that I see that it comes from, came from that person quite really truly, and then these kind of a little bit stranger people, who probably…

Therapist: Yeah.

Miia: …don't know, that **there is like a need to be approved of (NV)**, that they just approve just like that, straight away.

Miia's Needy Voice emerged as she thought of situations in which she had felt approval. She described how meaningful these kinds of encounters had been for her, and how afterwards she had felt she had enough strength to do anything. After this, the

therapist responded to Miia's Needy Voice. He reflected and commented with empathy on Miia's hunger for meeting with other people. At this point, working within Miia's therapeutic ZPD, the therapist offered reflexivity on the first level. Miia could benefit from this intervention and then defined her problematic experience more clearly, and in her own words; it was all about her need for other people's approval. Here Miia became aware of her need for support as a problematic voice in her community of internal voices, and the occurrence of the problematic voice was more visible in this passage. Her dominant Detracting Voice could not approve of this need, since it contradicted the voice's conviction that she was unworthy. Now Miia was able to formulate and express this need aloud, after the therapist had reflected on it. At this point, Miia reached APES Stage 3 again and now more firmly. Except for two regressions to Stage 2, she now started to process her difficulties on APES Stage 3 and higher (see Figure 1).

Discussion

In this study, we looked at how progress in assimilation was connected to increasing reflexivity in the case of one client with social phobia who participated in short-term, semistructured group therapy. We also had a special interest in the contribution of the therapist's actions to the change process, keeping in mind that the group format puts restrictions on the degree to which the therapist can customize his or her interventions.

From the point of view of assimilation, this was a successful case in which the client progressed from APES Stage 2 to Stage 6 during the course of the treatment. A

detailed analysis of all passages in the therapy conversations where she mainly processed her problematic experiences at Stages 2 to 3, before reaching a more stable level of assimilation at Stage 4 or higher, revealed that progress in assimilation happened only when the client took a reflexive stance towards her inner experiences or outer actions. There were a few instances in which she took a reflexive stance, but no progress in assimilation could be noted. Thus, in the sense of taking an observational position in respect to the self, reflexivity appears to be a necessary condition for progress in assimilation at those stages. This finding supports the claim that the client's reflexivity is generally a central factor in successful therapy (Rennie, 2004; Toskala & Hartikainen, 2005) The finding by Goncalves et al. (2014) that innovative moments identified as reflection occurred in both good and poor outcome cases indicates though that occurrence of reflexivity in the client's utterances is not sufficient to enhance assimilation beyond APES Stage 3.

It should be noted, however, that in the particular case of this study, the close connection between increased reflexivity and progress in assimilation could be attributed to the structure and the strategy of the treatment model. In the model the development of client reflexivity was seen as an essential active element of the intervention strategy. It is possible that the emergence of client reflexivity already at stage 2 happened because it was targeted at by the therapist, and would not appear in some other therapeutic modality. This is a question that we cannot answer in this study.

We looked in detail at three episodes of exchanges between the client and the therapist. In the first one, in which the client was at APES Stage 2, the therapist offered a formulation of her problematic experience which was relevant to the intention of her

dominant voice, but did not in any way address the feelings behind the dominant voice or her nondominant, problematic voice. This did not lead to any increase in reflexivity or to progress in assimilation. In the second episode, the client herself formulated in an experiential way her dominant self-detracting voice, especially its feelings of unworthiness. The therapist responded by listening empathically and expressing his sympathetic reaction. This appeared to help the client adopt a new emotional relationship to her dominant voice and to formulate her problematic experience in a manner that allowed the nondominant voice to also be heard. In the third episode, the therapist, in a rather confronting but simultaneously softened mode, pointed to the significance of the client's own construction of her problematic experience. This led the client to formulate her nondominant voice more vividly and to take a reflexive stance towards the discrepancy between the two voices.

When considering these episodes, one can notice the importance of the therapist's responsiveness (Stiles, Honos-Webb, & Surko, 1998) and sensitivity to the client's readiness to receive his or her perspective. When the therapist incorrectly evaluated the client's ability to accept the point of view that was offered, as happened in the first episode, the assimilation process did not proceed. This was a clear example of working outside the client's therapeutic zone of proximal development (ZPD; Leiman & Stiles, 2001; Ribeiro et al., 2014), in which premature exposure to the therapist's conclusion, meant to increase the client's reflexivity, can actually be counterproductive. It is possible that such a mismatch can happen more easily at Stage 2, where the client is aware of the problem but cannot formulate it clearly or reflect on it. Accordingly, this presents a special challenge to therapists in terms of how they receive the material that the client is

offering at this particular assimilation stage.

At this early assimilation stage, when directly prompting the client to take a reflexive stance is premature, what the client actually needs is empathy. In the second episode, simply naming a feeling turned out to be productive. Expressing empathy is indeed important and has been recognized in many theories. For example, in the process-experiental approach (Greenberg, Rice & Elliot, 1993) empathic understanding serves to enhance the client-therapist relationship, to offer prizing and support to the client, and to underline emerging issues. According to Toskala and Hartikainen (2005) construing a new meaning is easier when emotionally charged experiences are activated. In our case, however, showing empathy alone led only to temporary progress from Stage 2 to Stage 3. Advancing to Stage 3 in a more stable way took place after more work on clarification and reconstruction had been done, as shown in the third episode. To enable the client to move from Stage 2 to Stages 3 and 4, it was important that the therapist and the client shared the expression of all the voices, both the dominant and the nondominant, problematic ones. Tikkanen, Stiles, and Leiman (2013) also stated that an observer position allows a flexible exchange between the perspectives of self and other. Their findings demonstrated the parallel development of intrapersonal and interpersonal empathy, the former being significant in our case. Our results seem to support Kramer and Meystre's (2010) observation that taking sides is not helpful for the client. They suggested that supporting marginal voices unilaterally, without supporting the other communities of voices, does not encourage assimilation but tends to trigger only the specific voice. Brinegar et al. (2006) and Osatuke et al. (2007) also observed that the therapist has to honor and reflect all voices.

According to Georgaca (2001), the encouragement of a reflexive position entails the danger that this might silence and dominate the other voices. This would produce an essentially monological self, in which all other positions would be voiced through and mediated by an overarching observer. Georgaca suggests that therapy should perhaps aim not at the replacement of a variety of "I"s with an overviewing reflexive I, but at an interplay between all of these positions, including the reflexive I, in a fluent narrative of self. On the basis of our study, we agree with this view and emphasize the importance of timing in encouraging clients' reflexivity. In addition, the reflexive or observational stance should not be seen as a goal in and of itself, but as one alternative stance that can be adaptively adopted when needed.

The processes of reflexivity and of assimilation at Stages 2 to 3 seemed to appear largely at the same time and alongside one another, although there were a few exceptions. These exceptions appeared in three passages where Miia showed reflexivity, but the assimilation process did not appreciably progress. In one of these three passages, the client was at Stage 2. This is an interesting phenomenon, because reflexivity has been identified as one marker of Stage 3 (problem statement/clarification; Honos-Webb, Stiles, & Greenberg, 2003). In our study, the client had reached Stage 3 earlier, so this can be seen as a temporary regression. Then again, as the definition of reflexivity in the APES model is not detailedit could not be fully compared with our definition. One explanation for our finding could be that the client's first-level reflexivity, that is, taking an observational stance and turning onto the self and recognizing one's own inner processes, might actually be a requirement for him or her to be able to form a clarification of the problem and to move to Stage 3. This would mean that a client may be able to be

reflexive even if she is still at Stage 2 or on her way to Stage 3. Indeed, assimilation is considered as a continuum, and intermediate levels are allowed. For example, 2.5 represents a level of assimilation halfway between vague awareness/emergence (2.0) and problem statement/clarification (3.0). This notion is in line with Leiman's (2012) metamodel of the psychotherapy process, in which an observational stance is regarded as being reached throughout the progression within and between APES Stages 2 and 3 (vague awareness and problem formulation, respectively).

It has been observed that although formulations that lead to building a meaning bridge are frequently offered by therapists, clients often find accurate expressions themselves (Stiles, 2011). This was also evident in our case: The client formulated the final problem statements herself, and the therapist's earlier formulation, although in accord with the client's statements, was not helpful for her assimilation process. This aligns with Rennie's (2000) findings that clients actively lead therapeutic interactions in order to pursue their own goals for the session, often implicitly and without the therapist being aware of it. As Rennie (2007, p. 56) states: "It is reassuring to learn that the clients in good relationships evidently take from the therapist what is useful and transform or ignore the rest, in a spirit of goodwill." Also in our case, although the therapist made an important contribution to the change process, it was eventually the client who relentlessly brought her central issues into the therapeutic conversation, thus giving the therapist a chance to notice them, even after he had initially failed to do that.

There are some relevant aspects of the group treatment format that need to be addressed. Since several clients participate in the group, it restricts the degree to which the therapist can customize his or her actions to the clients' individual therapeutic needs

and readiness to benefit from therapeutic interventions. In addition, there are time limitations, because each client has less time to express his or her issues, and the therapist has less time to pay attention to each individual client. This may put limits on how sensitive the therapist can be in regard to different clients, even though the group format, as was the case in this study, allows for each client to have his or her own interaction time with the therapist.

On the other hand, the group format offers the therapist the possibility for some crucial interventions that are not available in individual therapy. For example, the therapist may use one particular client to illustrate a specific occurrence of an essential issue for the rest of the group. This seemed to happen in episode 1 where the therapist defined the demands that Miia set upon herself as unconditional and too strict. Using Miia as an example, he pointed out a theme common to all the group members, but this then precluded showing sensitivity towards her Needy Voice. Nonetheless, observing how others' issues are dealt with gives group members the opportunity to take a reflexive stance towards their own problematic experiences and how they relate to them.

Our primary conclusion from this case study is that client reflexivity plays a crucial role in the assimilation of problematic experiences, building from problem awareness, through clarification, to understanding and insight based on the emergence of meaning bridges between internal voices. We feel that reflexivity should be given an even more central role in the assimilation model than is the case at present, and conclude that it would be useful to take into account the diversity of the concept, as we have done by specifying the two levels of reflexivity. This would be a suggestion for further research. Second, we noticed the importance of finding a match between the therapist's actions and

the client's stage of assimilation, especially in terms of showing empathic acceptance before working on clarification and understanding. Third, we conclude that the group format of psychotherapy presents some particular challenges to the customization of therapist actions to the clients' process of individual change.

While we recognize the limitations put on conclusions and generalizations derived from a single qualitative case study, and from data based on a limited amount of conversational passages, we look forward to further intensive studies of the moment-by-moment change processes in psychotherapy. In particular, we would welcome further examination of the interrelationship between reflexivity and assimilation, especially in different modalities of psychotherapy and with clients presenting with different problems.

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