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EMPIRICAL PAPER

Fluctuation in the assimilation of problematic experiences: A comparison of two contrasting cases of Emotion Focused Therapy

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Abstract
The assimilation model suggests that therapeutic change occurs through a gradual assimilation of problematic experiences. Previous case studies have suggested that both good- and poor-outcome cases exhibit a fluctuating pattern of assimilation progress, characterized by advances and setbacks. Our study examined more closely how this fluctuating pattern is related to symptom change across therapy. We analyzed the longitudinal relations among assimilation ratings, instability (fluctuation) in assimilation ratings, and clinical symptom intensity in two contrasting cases of emotion-focused therapy for depression, one good and one poor outcome. We used the assimilation of problematic experiences scales (APES) to measure assimilation and the outcome- questionnaire (OQ-10) to measure clinical symptom intensity. To assess assimilation instability, we used a fluctuation measure that calculated the amplitude and the frequency of changes in assimilation levels. The results showed that in the good-outcome case, assimilation levels and instability tended to increase and symptom intensity tended to decrease, particularly in the final phase of treatment. In the poor-outcome case, assimilation levels and instability did not change much across sessions.

Keywords: assimilation model; instability; setbacks; therapeutic change process

Clinical or methodological significance of this article: Fluctuation in the assimilation progress seems to be a common feature of therapeutic change. Shifting attention to strands of a problem that are at lower assimilation levels may help to consolidate the assimilation of problematic experiences. For clinicians working at lower assimilation levels, it may be important to consider that the client's zone of proximal development may be more restricted. Therapists should be careful to keep therapeutic tasks focused on parts of the assimilation continuum in which the client is able to progress.

Introduction

According to the assimilation model (Stiles, 2011; Stiles et al., 1990), therapeutic change occurs when previously avoided problematic experiences are accepted and assimilated into the self. Although the theory proposes a regular sequence of stages of change, in practice, this process often appears discontinuous and irregular. This instability has been studied through the analysis of moment-to-moment setbacks and advances in assimilation progress (Caro Gabalda, 2006; Mendes et al., 2016). Previous studies have consistently suggested that instability is a normal and important part of therapeutic change (Basto, Stiles, Bento, et al., 2018; Detert et al., 2006; Knobloch et al., 2001; Osatuke,

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Glick, et al., 2005). The aim of the current study was to examine the relation between instability in assimilation progress and the evolution of symptom intensity, measured at each session in two contrasting cases of emotion focused therapy (EFT) for depression, one with a good outcome and one with a poor outcome.

The Assimilation Model

The assimilation model (Stiles, 2001, 2011; Stiles et al., 1990) suggests that therapeutic change occurs when previously avoided experiences are accepted and assimilated into the self. The assimilation model is an explanatory theory, not a treatment theory (Stiles, 2020; Stiles et al., 2015); it does not prescribe particular interventions or treatment approaches. Instead, it seeks to explain psychological change in any sort of psychotherapy, including EFT.

The model conceptualizes the self as composed of multiple internal *voices* (Dimaggio & Stiles, 2007) that are interlinked, forming an organized, stable structure called a community of voices (Honos-Webb & Stiles, 1998; Honos-Webb, Surko, et al., 1999). These voices represent traces of previous experiences (Osatuke, Humphreys, et al., 2005) that may be activated whenever present experiences resemble previous past experiences (Caro Gabalda, 2014; Caro Gabalda & Stiles, 2009). Sometimes the stability of this community is threatened by incongruent, problematic voices (Honos-Webb & Stiles, 1998) representing experiences that are rejected because their integration would significantly change the organization of the self (Osatuke & Stiles, 2006). The conflict between the problematic voices – which try to respond whenever they are addressed – and the dominant voices from the self – which try to prevent this intrusion – generates psychological distress (Basto et al., 2017; Stiles et al., 2004). Conversely, the inaccessibility of those problematic experiences tends to impoverish the self, making it less able to deal effectively with life situations in which the experiences might be relevant (Caro Gabalda, 2007; Humphreys et al., 2005). This may generate clinical problems and emotional suffering.

According to assimilation model, psychotherapy may facilitate the development of connections between the problematic voices and the voices from the dominant community of voices. Through the therapeutic dialogue, the voices create mutual understandings, which are called *meaning bridges* (Honos-Webb, Surko, et al., 1999; Stiles, 2011; Stiles & Brinegar, 2007). Through the creation of mutual understandings between voices, conflict diminishes and the previously rejected voice is integrated in the community, working as a resource for future life experiences.

The assimilation process can be assessed by the Assimilation of Problematic Experiences Scale (APES; Caro Gabalda & Stiles, 2009; Stiles, 1999). The APES is composed of eight levels, or stages, and describes the changes in the relation between problematic voices and dominant voices, or equivalently, between the traces of a problematic experience and the usual self. As summarized in Table I, APES levels range from dissociation of the problematic voice at APES level 0, to a full integration of the no-longer-problematic voice into the community, at APES level 7.

Statistical studies (Basto, Stiles, Rijo, et al., 2018; Detert et al., 2006) and intensive case studies involving a variety of therapeutic approaches (Brinegar et al., 2008; Caro Gabalda, 2007; Honos-Webb et al., 2003; Knobloch et al., 2001; Leiman & Stiles, 2001; Osatuke, Glick, et al., 2005; Osatuke, Humphreys, et al., 2005) have empirically supported the model's assumptions. First, in successful cases, the main problematic voices progress through the APES continuum. Second, good-outcome cases (conventionally assessed, using change on symptom intensity measures) tend to reach higher APES levels than poor-outcome cases. Although the main problematic voices in conventionally defined poor-outcome cases may progress to some degree in APES terms, they tend to remain below APES level 4 (the understanding/insight stage), whereas the problems in good-outcome cases usually reach at least APES level 4 (e.g., Caro Gabalda, 2007; Detert et al., 2006). That is, APES 4 seems to be a cutting point for distinguishing conventionally-defined good from poor-outcome cases (Caro Gabalda, 2006, 2007; Detert et al., 2006).

Instability in Assimilation Progress

Although in good-outcome cases APES levels tended to increase during therapy, researchers who have analyzed assimilation progress more carefully have observed a fluctuating, sawtoothed pattern of progress, with frequent setbacks alternating with the advances within the broader pattern APES progress (Caro Gabalda, 2006; Caro Gabalda & Stiles, 2013; Detert et al., 2006; Knobloch et al., 2001; Mendes et al., 2016; Osatuke, Glick, et al., 2005). In these studies, a setback was defined as a decrease of at least one APES level from one passage to the next (Caro Gabalda & Stiles, 2013). Setbacks seem to be a common feature of the assimilation process across different therapeutic approaches in both good- and poor-outcome cases (Caro Gabalda, 2006; Caro Gabalda & Stiles, 2013; Detert et al., 2006; Knobloch et al., 2001; Leiman & Stiles,

Table I. Assimilation of problematic experiences scale (adapted from Caro Gabalda & Stiles, 2009).

Apes level	Cognitive content	Emotional content
0. Warded off/ Dissociated	Content is unformed; client is unaware of the problem.	Distress may be minimal, reflecting successful avoidance.
1. Unwanted thoughts/ Active avoidance	Content includes distressing thoughts. Client prefers not to think about it.	Strong negative feelings.
2. Awareness/ Emergence	Client acknowledges his problematic experience and describes the distressing thoughts, but cannot formulate the problem clearly.	Feelings include acute psychological pain or panic.
3. Problem statement/ Clarification	Includes a clear statement of a problem, that is, something that could be worked on.	Feelings are mainly negative but manageable, not panicky.
4. Understanding/ Insight	The problematic experience is placed into a schema, formulated, understood, with clear connective links (meaning bridge).	There may mixed feelings with some unpleasant recognitions, but also with curiosity or even pleasant surprise.
5. Application/Working through	The understanding is used to work on a problem, so there are specific problem-solving efforts.	Affective tone is positive and optimistic.
6. Resource/Problem solution	Client achieves a solution for a specific problem. As the problem recedes, feelings become more neutral.	Feelings are positive, satisfied, proud of accomplishment.
7. Integration/Mastery	Client successfully uses solutions in new situations, automatically.	Feelings are neutral because problem is no longer a problem.

2001; Mendes et al., 2016; Osatuke, Humphreys, et al., 2005).

Theoretical developments arising from the setbacks research suggest that the fluctuating, saw-toothed pattern of APES progress reflects moment-to-moment switching among *strands* of a problematic theme (Caro Gabalda & Stiles, 2013, 2018). Theoretically, each problematic theme derives from a number of interrelated past experiences. The traces of these similar or linked experiences comprise multiple *strands* of the problem. The strands thus represent different aspects of the larger problematic experience, each of which needs to be assimilated. Theoretically, strands of a theme are interlinked and tend to become assimilated to a similar degree under normal circumstances. However, during active work in therapy, some strands of a problematic theme may be assimilated faster than others. To bring the strands into synchrony, switching to a less assimilated strand–that is, an APES setback–may sometimes be productive. Thus, rather than being an undesirable phenomenon, setbacks seem to be an important feature of assimilation progress. Previous case studies have shown that both good- and poor-outcome cases exhibit numerous, marked setbacks (Caro Gabalda, 2006; Mendes et al., 2016).

Most of the setbacks observed in the studies conducted so far appear to be due to one of two reasons, both of which involve switching strands. These are (a) exceeding the therapeutic zone of proximal development (TZPD; Leiman & Stiles, 2001; Ribeiro et al., 2016) or (b) the *balance strategy*, that is, balancing advances in one area by drawing attention to a different, relatively problematic strand of the problem (Caro Gabalda & Stiles, 2013; Mendes et al., 2016). The TZPD is the therapeutic working zone within the APES for a problem at a specific point in therapy, analogous to Vygotsky's (1978) concept of the zone of proximal development in children's cognitive growth (see Leiman & Stiles, 2001). Theoretically, if a therapist's proposals or a client's own statements exceed the upper limit of the TZPD, then the client may experience such content as too risky or threatening, hence retreat to another strand of the problem that is at a more comfortable and lower APES level (Caro Gabalda, 2006; Leiman & Stiles, 2001; Osatuke, Glick, et al., 2005). Alternatively, the therapist may use the balance strategy to facilitate the assimilation of less-assimilated strands of the by directing the client's attention to material that is at a lower APES level after the client has achieved higher APES levels in another strand. Thus, in balance strategy setbacks, the client *follows* the therapist's proposal to shift to a lower-APES strand, whereas in exceeding the TZPD setbacks, the client *fails to follow* the therapist's proposal to advance to a higher APES level. Most of the research distinguishing these two types of setbacks has been conducted on cases treated by a directive cognitive therapy called linguistic therapy of evaluation (Caro Gabalda & Stiles, 2018). In one study of setbacks in EFT, however, Mendes et al. (2016) identified a third type of setback, which they called *exceeding the TZPD induced by the client*. In this type of setback, the client's own productions, rather than the therapist's proposals, lead to feeling threatened, thus exceeding the TZPD.

Instability due to alternating setbacks and advances is not a bad sign. On the contrary, a study of a good-outcome case (Basto, Stiles, Bento, et al.,

2018) showed a direct association between fluctuations and the APES level; that is, instability increased as degree of assimilation rose across sessions. On the other hand, there were no significant associations between instability in the assimilation process and outcome (clinical symptom intensity) either within sessions or between adjacent sessions. Instability was assessed by calculating the amplitude and frequency of setbacks using a fluctuation measure designed specifically to assess nonstationary phenomena in short time-series (Schiepek & Strunk, 2010). Since that statistical analysis considered only linear associations, it remains possible that there are systematic relations between instability in assimilation and symptom intensity that are not linear. We decided to explore this and other possible explanations for such results by contrasting this good-outcome case with a poor-outcome case treated within the same therapeutic model and the same therapist.

Aims of This Study

This study aimed to analyze the relation between assimilation level, instability in the assimilation process, and outcome (clinical symptom intensity) in two contrasting cases: one good and one poor outcome. We explored how assimilation and symptom intensity evolved longitudinally across therapy in the two cases, noting similarities and differences in their pathway. Thus, our interest was in how instability in the assimilation pattern is related to psychotherapeutic outcome at a session-by-session level. We also did a qualitative analysis to examine the detailed fit of case observations to the theoretical account, and we report relevant dialogue from each case.

This was a theory-building case study (Stiles, 2009). We used both quantitative and qualitative observations on these cases to assess the theoretical account. In such studies, observations that are contrary to or go beyond theoretical expectations suggest that the theory needs modification or elaboration.

Method

Clients

The two clients were drawn from the Emotion Focused Therapy (EFT) arm of the ISMAI Depression Study (Salgado, 2019), a randomized clinical trial that compared the efficacy of EFT and Cognitive-Behavior Therapy (CBT) in the treatment of clients diagnosed with mild or moderate major depressive disorder (MDD).

The good-outcome case, Alice (a pseudonym), was a single 26-year old woman who lived with her parents. At intake she was employed. During therapy she became unemployed, but she started a new job at the final phase of treatment. Her main problems were related with her difficulty in expressing her needs because she feared that others would reject her. Across therapy, gradually, she was able to overcome this fear, and express her needs more assertively. She took important life decisions, like she decided to live with her boyfriend. Alice's case was the focus of a previous study (Basto, Stiles, Bento, et al., 2018), reviewed earlier.

The poor-outcome case, Afonso (a pseudonym), was a single 24-year old man, a college student, who lived with his mother. Afonso's main problem concerned his difficulty in recognizing and expressing his feelings. Across therapy, this difficulty became more evident, and Afonso struggled and even avoided therapeutic tasks that focused in negative emotions. His difficulty remained an issue after therapy termination.

Before the beginning of therapy, a complete description of the clinical trial and the research, which involved the video recording of sessions, was given to both clients. Both gave informed consent to have their data transcribed and analyzed for the clinical trial and for further process-outcome studies.

Therapy

Alice and Afonso were treated by the same therapist, who was a 31-year old female clinical psychologist with 8 years of experience in clinical practice and 1 year of experience in EFT.

EFT is an empirically validated humanistic therapy (Elliott et al., 2004; Greenberg, 2002; Greenberg & Watson, 2006). This therapeutic model views emotions as the key element in human experience, contributing to an adaptive or a maladaptive functioning of the individual. The main therapeutic goal is to change maladaptive emotional processing (Pos & Greenberg, 2007). Specific markers that signal maladaptive emotional processing point towards matching interventions of transforming the core emotional schema into more adaptive emotional responses and new meanings (Pos & Greenberg, 2007).

Measures

Beck depression inventory-II (BDI-II). The BDI-II (translated into Portuguese from Beck, Steer, &

Table II. Pre-test and post-test from the two cases.

	Questionnaires	Pre-test	Last Session	1 Year follow-up
Alice (good outcome)	BDI-II	29	1	12
	OQ-45.2	86	39	51
	OQ-10	21	7	10
Afonso (poor outcome)	BDI-II	23	16	5
	OQ-45.2	83	80	54
	OQ-10	27	22	18

Note: BDI-II = Beck Depression Inventory (translated into Portuguese from Beck, Steer, & Brown, 1996 by Coelho et al., 2002); OQ-45.2 = Outcome Questionnaire (Lambert et al., 1996; Machado & Fassnacht, 2015) is a 45 item self-report questionnaire designed to assess psychotherapy outcome (a total score higher than 63 is considered within clinical range); HDRS = Hamilton Depression Questionnaire (Hamilton, 1960) is a clinician depression assessment scale (a total score higher than 9 is considered within clinical range); OQ-10 = Outcome Questionnaire-10 (Lambert et al., 1998).

Brown, 1996 by Coelho et al., 2002) is self-report questionnaire designed to assess the intensity of depressive symptoms. It is composed by 21 items that can be scored from 0 to 3 points. BDI-II total scores can range from 0 to 63. Higher total scores mean more intense depressive symptoms. The cut-off point for Portuguese population is 13 The Cronbach's Alpha was 0.89 (Coelho et al., 2002).

Outcome questionnaire-10 (OQ-10). The OQ-10 (Lambert et al., 1998) is a 10-item self-report inventory designed to assess psychotherapy outcome over sort periods of time. Each item is scored on a scale ranging from 0 to 4 and the total score goes from 0 to 40. Achieving higher scores suggests a poorer mental health functionality. Concerning the Portuguese population (Basto et al., 2017), based on the ISMAI Depression study sample (N = 64; Salgado, 2019), the internal consistency was of .88 (Cronbach's Alpha) and the test-retest reliability was of .74 over a 1-week interval.

Assimilation of problematic experiences scale (APES; Caro Gabalda & Stiles, 2009; Stiles et al., 1992). The APES is a rating scale applied to session discourse, interviews, or other material. It measures the current level of assimilation of the problematic experience under consideration. As shown in Table I, the APES has eight levels, numbered from 0 to 7. The levels are considered as anchor points on a continuum, and intermediate ratings (e.g., 1.5, 3.4) are allowed.

Procedure

Case selection. Both clients met the clinical trial's inclusion and exclusion criteria, which required a diagnosis of MDD assessed using the Structural Clinical Interview for the DSM-IV-TR (First et al., 1997, 2002). The exclusion criteria included being currently on medication or another form of psychological treatment; or currently or previously diagnosed with one of the following DSM–IV Axis I disorders: panic, substance abuse, psychotic, bipolar, or eating disorder; or one of the following DSM–IV Axis II disorders: borderline, antisocial, narcissistic, or schizotypal; or being at high risk of suicide.

After being admitted into the clinical trial, the clients were randomly assigned to a treatment condition (EFT or CBT) and to a therapist. For the current study, our design called for us to study EFT and to select a good-outcome case and a poor-outcome case (defined using criteria specified by Jacobson & Truax, 1991) who had been treated by same therapist. The latter requirement aimed to reduce effects of therapist differences. In the clinical trial from which the cases were selected, only the early cases in the series were fully transcribed. For convenience, we decided to select from this pool. Alice and Afonso were the first complete cases to be transcribed that met our criteria.

Alice met the two conditions specified by Jacobson and Truax (1991) for reliable and clinically significant improvement according to the Beck Depression Inventory-II scores (BDI-II; Beck et al. 1996; Table II). Specifically, her scores decreased from above to below the cutoff of 13 (cutoff point dividing clinical from non-clinical population for the ISMAI Depression Study sample), and the amount of change from pre to post-test was greater than the Reliable Change Index (RCI), an amount unlikely to have been due to chance (7.75 for the ISMAI Depression Study, sample) (Table II). She remained asymptomatic 1 year after post-test (Table II).

Afonso's BDI-II scores decreased from pre- to post-test, but he did not achieve a non-clinical score by the last session (session 16). At the 1-year follow-up, however, he was asymptomatic (Table II). Thus, although he met our criteria for failure to overcome his depression during therapy, his treatment should not be considered as a complete failure.

Treatment and assessment procedure. The clients received their treatment in the psychotherapeutic lab at Maia University Institute. Both clients attended all 16 sessions specified in the ISMAI Depression Study therapeutic protocol. Sessions were videotaped, except session 2 in Afonso's case, due to technical problems.

The OQ-10 was administered immediately before each of the 16 sessions of each case.

Data preparation. All sessions of each case (except Afonso's session 2, which was not recorded) were transcribed verbatim following procedures described by Mergenthaler and Stinson (1992). These transcripts were analyzed and rated on the APES following the procedures described in previous assimilation studies (e.g., Honos-Webb et al., 2003; Stiles et al., 1992; Stiles & Angus, 2001).

APES raters and training. The four APES raters were all specializing in clinical psychology: a PhD psychologist, a PhD student, a Master's degree psychologist and a Master's student. All raters, except the master student, had had previous experience in applying the APES. Each case was analyzed by a team of two raters. Before rating the material, the raters participated in training that lasted approximately four months. During training, raters met every week at least for two hours. The first part of training involved reading and discussing journal articles and rating manuals. Then, raters were given therapy sessions (not from this study) to rate. Initially, the ratings were made in group and afterwards individually, to establish reliability. The raters were considered reliable after achieving a level of inter-rater reliability between each other characterized as good by Cicchetti (1994): *Intraclass Correlation Coefficient* (*ICC*) $[2,1] \geq .60$.

Assimilation analysis and APES reliability. The assimilation analysis followed the four phases described by Stiles and Angus (2001), (1) familiarization, (2) topic selection, (3) excerpting, and (4) describing the process of assimilation (APES rating and interpretation). First, all sessions of each case were read multiple times by each of the assigned raters independently, and the recurring issues were identified. The raters independently identified the clients' problematic themes and their dominant and the problematic voices. Then, by consensual judgment, the most central themes were selected, based on their clinical salience (e.g., high proportion of time spent in therapeutic sessions), and the problematic and dominant voices were characterized. Technically, themes are defined by the content of the dialogue and are thus observable in recordings or transcripts. Theoretically, voices are aggregations of traces of experiences that are active and agentic parts of the person (Stiles, 2009); they are not observed directly, but are inferred from attitudes expressed in the person's talk and other behavior.

After identifying and characterizing the themes and voices, raters selected excerpts from the transcripts where the themes emerged. Then, the APES was applied to these excerpts independently by each rater, who split each excerpt into passages and rated the APES level in each passage. The passage, typically several sentences in length, was the unit of analysis for the APES ratings; it is defined as a stretch of discourse delineated by a change in the topic of the conversation or by markers of changes in APES level (see Honos-Webb et al., 2003; Honos-Webb, Lani, et al., 1999; see the Results for examples of excerpts and passages). The raters distinguished 554 passages in the excerpts from Alice's transcripts and 681 passages in the excerpts from Afonso's transcripts. Disagreements were solved by consensus between each pair of judges (see Hill et al., 2005). The interrater reliability before consensus was calculated using the intraclass correlation coefficient (ICC; Shrout & Fliess, 1979). In the Alice's case the interrater reliability was $ICC(2, 2) = .97$. In the Afonso's case the interrater reliability was $ICC\ (2, 2) = .84$. In both cases this reliability was considered good ($\geq .60$ [Cicchetti, 1994]).

The dominant voice in Alice's case was labeled as "fear of being rejected;" she presented a submissive relational pattern across a variety of interpersonal contexts. This submissive pattern seemed to reflect a strong fear of being rejected by others. The problematic voice was labeled as "I have the right to express myself and be accepted" since it represented experiences related to the client's need to express her needs and rights. These dominant and problematic voices were the same in each of the two themes that were selected in Alice's case.

Alice major theme was "fear of being rejected and abandoned" that reflected the submissive interpersonal pattern in different contexts of her life: work, relationships with family and boyfriend. This theme evolved positively across therapy: Alice was able to make important life decisions, taking into account her own needs and diminishing her concern about having others' approval. At the final phase of therapy, she decided to live together with her boyfriend, despite what her parents thought about this.

Alice's other selected theme was "hurt towards her father." This theme involved unfinished business with her father. This theme appeared briefly in the initial session and then again only in the final phase of therapy. Apparently, Alice did not feel prepared to deal with this theme until the final phase of therapy. In the last session, Alice was able to understand important aspects of this problem, which helped her move on with her life.

In Afonso's case, the dominant voice was labeled "I need to be strong." Afonso showed in varied intra- and interpersonal contexts the need to present himself as a strong man, who does not depend on others and never feels vulnerable. The problematic voice, "I am vulnerable," represented experiences related with the need to express his

emotions, vulnerability and need to be loved and protected by others. In Afonso's case too, the same dominant and problematic voices were expressed in the themes we selected, which were "difficulty in accessing his emotional experiences," "resentment towards his parents," and "social anxiety."

The theme "difficulty in accessing his emotional experiences" was the most frequent. It concerned his difficulty in feeling emotions and how this impaired his life. Throughout therapy, Afonso avoided being in contact with painful aspects of a variety of intra- and interpersonal experiences. In the theme "resentment towards his parents," Afonso expressed the hurt associated with feeling neglected by his parents, especially during his childhood. This was a very painful issue, and Afonso avoided dealing with it throughout his therapy. Finally, the theme "social anxiety" was linked with difficulties in coping with new social situations. Although Afonso frequently tried to hide his social difficulties, in some moments he was able to express them.

Fluctuation intensity index. Instability in assimilation progress was assessed by a fluctuation intensity index (F) which reflects the amplitude and the frequency of changes throughout time (see formula below). Fluctuation intensity was calculated to quantify the session-by-session amount of instability in the assimilation process, as described by Schiepek & Strunk, 2010. This measure was calculated within a data-window moving over the time-series. The data window used in this time-series was the session. All measurement points within the window were aggregated into periods defined by a change in the trend of the assimilation pattern: increasing, decreasing, or no change. We used the absolute numbers (not considering if it was a positive or negative trend). The difference between the x values was calculated and then divided by the duration of the period (number of data points within the period). Each of these results was summed. To normalize the values, a maximum amount of change was calculated (greatest possible fluctuation) within the minimum period possible. Then, the sum of the obtained differences was divided by the greatest possible fluctuation within the moving window to obtain a normalized fluctuation intensity 0<F<1:

$$F = \frac{\sum_{i=1}^{1} \frac{Y_i}{n_{k+1} + n_{k_0}}}{s(m-1)}$$

Where $y_i = |x_{nk} + 1 - x_{nkj}$, x_n = nth session score, k = points of return (changes in slope in the data sequence), i = periods between points of return, I = total number of such periods within the window, m = number of measurement points within a moving window, m–1 = number of intervals between all measurement points of a window, $s = x_{max} - x_{min}$ with x_{min} smallest value of the scale, x_{max} = largest value of the scale.

Results

First, we present the progression of symptom intensity, assimilation and fluctuation across Alice's and Afonso's treatments. As we did not have the results from session 2 in Afonso's case, we decided to exclude the results from session 2 of both cases. Second, we present a qualitative description of the assimilation progress and its instability using representative clinic vignettes of each case.

Overall means and standard deviations of the three variables in the two cases are presented in Table III.

Symptom Intensity Changes

As shown in Figure 1, both cases begun with similar levels of symptom intensity (OQ-10 scores), but from session 3 to the end of therapy, they evolved differently. Alice showed a strong decrease from session 3 to session 5 and then an increase from 6 to session 10 (except from session 7 to session 8, where there was a slight decrease). From session 10 until the last session, symptom intensity progressively decreased (more pronouncedly from session 12 to session 13). Although non-linear, in Alice's case there was an overall progressive decrease in symptom intensity across her treatment. In contrast, although Afonso's showed some variation across sessions, there was no substantial positive or negative trend across therapy.

Assimilation

Alice and Afonso each had two or three different themes; however, we decided to combine them and present the overall results of the assimilation progress in each case (gathering themes), because the voices were the same in the different themes within each case. That is, we judged that, in each case, the identified themes represented different manifestations of the same problem. Figure 2 shows the assimilation progress across therapy in both cases, where the APES level of each session was computed as the mean of the APES levels in all rated passages in that session.

As Figure 2 shows, Alice reached higher APES levels than did Afonso, and mean levels higher than APES 4 were achieved in three of her later sessions.

Table III. Symptom intensity, assimilation and fluctuation in Alice and Afonso's cases.

		Alice's case (good-outcome)	Afonso's case (poor-outcome)
Symptom intensity (OQ-10)	Mean	13.8	23.06
	Standard deviation	5.26	2.15
Assimilation (APES)	Mean	3.15	1.49
	Standard deviation	.90	.26
Fluctuation (F)	Mean	.09	.08
	Standard Deviation	.02	.02

Afonso's mean assimilation levels did not exceed APES 4 in any of his sessions. In Alice's case, we also observed a more unstable pattern in mean assimilation levels during the final phase of therapy (sessions 10-16), with marked increases and decreases in the assimilation levels between sessions. In Afonso's case, assimilation progress was more stable, with only slight increases and decreases in the mean assimilation levels between sessions.

Figures 3 and 4 show the passage-by-passage assimilation progress in the Alice and Afonso cases, respectively. Figure 3 shows that in Alice's early sessions APES 2 and 3 were the most frequent levels. However, even during this initial phase, APES 4 started to appear in a few passages. Then, from the middle to the final phase of therapy, higher APES levels become progressively more frequent.

In Afonso's case (Figure 4), we observed that low assimilation levels were maintained across therapy, with ratings ranging from APES level 0 to APES level 3.

Fluctuation

Figure 5 shows that Alice's and Afonso's fluctuation intensity evolved very similarly from session 1 to session 11 but the two cases had different trajectories at the final phase of therapy. From session 12 to the final session, in Alice's case, there was a gradual increase in the fluctuation measure. In Afonso's case there was a decrease from session 12 to session 14 and then a recovery in the last two sessions.

Descriptive Qualitative Analysis of Assimilation and its Instability

In this section, we present four excerpts that illustrate the patterns of instability we observed in the cases of Alice and Afonso. The excerpts were translated into English from the original Portuguese by the first author. Our characterizations of each excerpt's themes and of the dominant and problematic voices

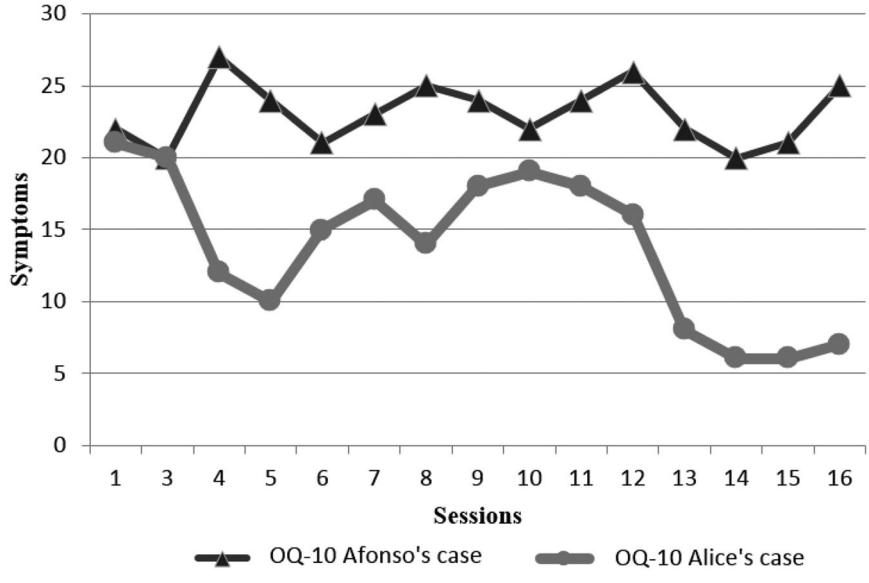

Figure 1. Evolution of symptom intensity across therapy in Alice's and Afonso's case.

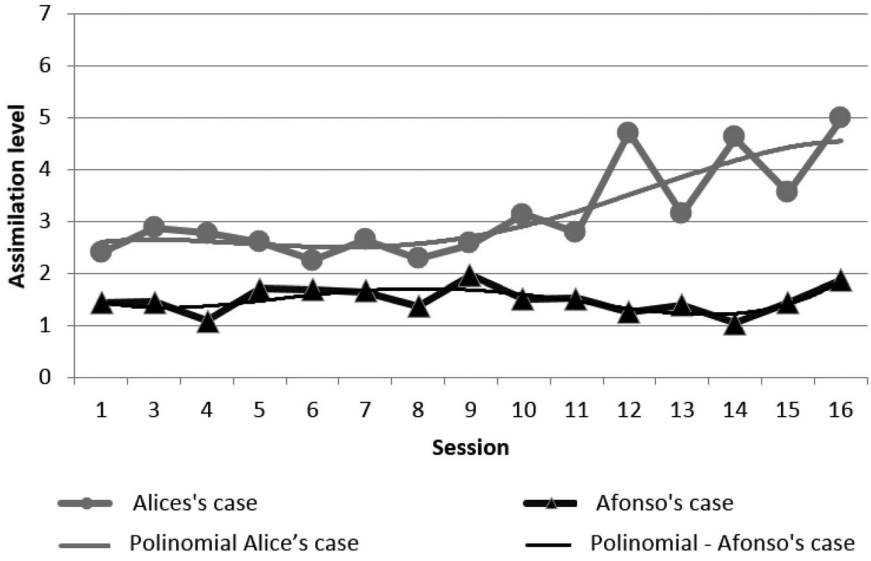

Figure 2. Evolution of assimilation (mean values per session) across therapy in Alice's and Afonso's cases.

are presented in subheadings. Square brackets are used to delimit rated passages.

Alice (good outcome case). In the initial phase of therapy, negative feelings were predominant. Alice felt stuck and confused about expressing her needs to important people in her life, probably, because giving voice to what she wanted could mean disapproval and rejection from others. The entitlement of the problematic voice "I have the right to express myself and be accepted" was not much expressed in the beginning of therapy, but progressively became more salient. Alice's sense of vulnerability along with an anticipated rejection from others, the conflict between "wants" and "shoulds," interleaved with the progress towards the entitlement of the problematic voice seemed responsible for the alternation between APES level 2 and APES level 3. The setbacks in the initial phase of therapy were small in amplitude.

The following excerpt from session 2 illustrates how Alice's assimilation level fluctuated modestly in the initial phase of therapy. Alice was explaining how she felt sad and disappointed because her boyfriend did not desire to marry her, but at the same time, she wondered if her need to marry was being influenced by external pressure, especially from her parents.

Excerpt 1. Dominant Voice:
fear of being rejected; Problematic voice: I have the right to express myself and be accepted; Theme: fear of being rejected and abandoned.

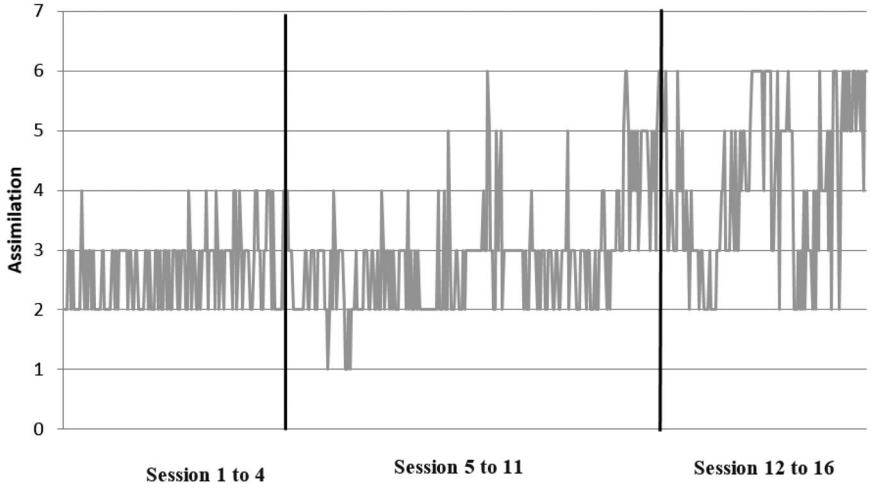

Figure 3. Assimilation process across sessions (554 passages) in the Alice case.

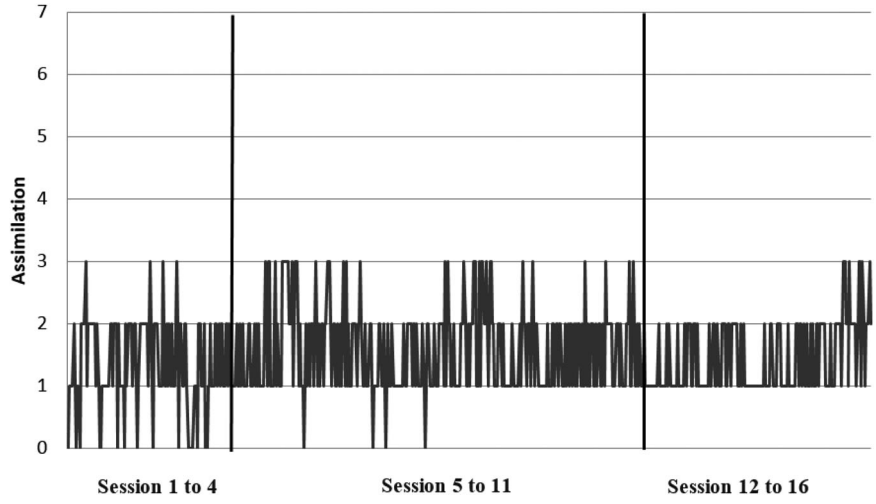

Figure 4. Assimilation process across sessions (681 passages) in the Afonso case.

Alice: [We went to his cousin's house to see their wedding photos. As I was watching these photos, I was thinking that I would like to have a very simple ceremony, I wouldn't want anything like that, so strictly organized. I would like to have something that we could identify as ours, our party, our marriage] APES 3 – clarification. [But at the same time, I felt once more, there was this pressure "so when will you decide to marry?" We are always talking about it. During Christmas, we spent a week in Paris and everyone thought he was going to propose. There was pressure from his family, there was pressure from both sides and he felt that pressure.

Therapist: What do you feel about this?

Alice: I feel pressure from my family, and he feels that, and it is complicated to manage this pressure. For example, I never know what to say to my family - he knows this but he says "forget it because I'll not get married" but I didn't have the courage to say this to my parents. For instance, they still do not know that he is atheist. I'll have to choose the best time (laughter) and the best day to - to reveal this (crying) I don't know when and how.

Therapist: Of course.

Alice: They thought he was going to propose (crying). His cousin said "I always thought you would propose to her in this trip" and he said no.**] APES 2 – emergence**

Therapist: **[**How were the two parts of you feeling about these things?

Alice: I was feeling uncomfortable with the situation because I'm feeling this pressure again. They were talking about a delicate issue for us and I already know what his position in relation to the wedding is. He joked with this situation – but he is very shy- and he feels …

Therapist: Always upset.

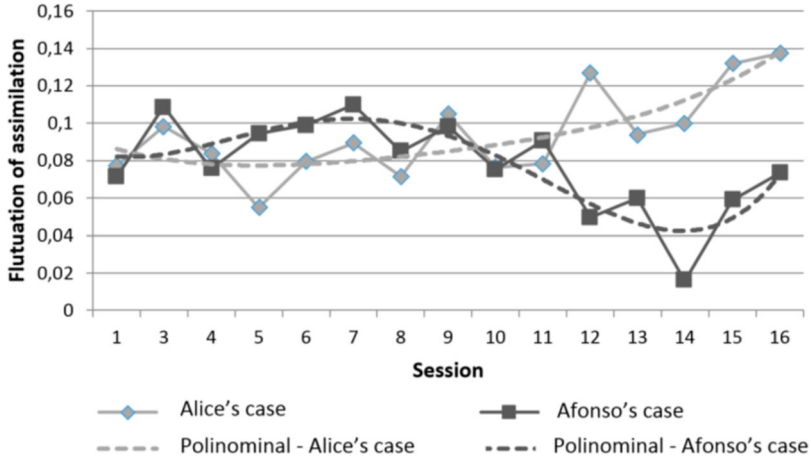

Figure 5. Comparison between Alice's and Afonso's case in terms of the evolution of fluctuation across therapy.

Alice: It is obvious that he feels uncomfortable with this situation, but he remains silent: he won't say anything but then when I went away to the train, he told me "I felt that you are not well" and I wasn't.

Therapist: Of course.

Alice: I felt sad to know that, probably, I will never have a day like that.**] APES 2 – emergence** (session 2)Progressively, Alice was able to assert her needs and make important life decisions that were more congruent with her needs. However, setbacks in assimilation were frequent. Higher assimilation levels were achieved but fluctuation between APES levels became more frequent and pronounced. These setbacks seemed related to Alice's ambivalence as she considered various strands of her problem: deciding and putting in practice important life decisions and, at the same time, feeling a strong fear of being rejected by others.

The following excerpt illustrates the fluctuation pattern in the final phase of therapy. Alice and her therapist were engaged in a therapeutic strategy called "two-chair work," used in EFT to promote the integration of different parts of the self. Specifically, one part of Alice was talking to another part about her decision to live with her boyfriend.

Excerpt 2. Dominant Voice:
fear of being rejected; Problematic voice: I have the right to express myself and be accepted; Theme: fear of being rejected and abandoned.

Therapist: [What do you feel right now?

Alice: I feel stronger

Therapist: Do you feel angry with that part of yourself?

Alice: Yes, I do.

Therapist: Tell her.

Alice: (talking to another part of herself) You need to do what you want, what you need, regardless what other people think. What others think doesn't matter. You need to be independent. Of course, it is frightening to make this decision**] APES 3 - clarification**

Therapist: yes

Alice: **[**But fear is normal, and I need this change and I am not insecure about it. I want to change my life!**] APES 5 - application**

Therapist: **[**What do you need right now Alice?

Alice: I need her to understand me and to be supportive and to not be cruel and accept my decision. This is what I need from her, to accept and to stop criticizing me!

Therapist: What if she doesn't accept it?

Alice: If she doesn't accept - I am going to feel bad about myself, but she has to accept because

Therapist: Tell her, tell her that

Alice: You have to accept, because I'm going to make that decision! I'm going to make that decision and then, after I make that decision, I will forget this and I'm not going to think about it anymore.

Therapist: Because I know what I want.

Alice: Because I know what I want and I'm not thinking about it anymore.

Therapist: I have no doubts.

Alice: I have no doubts and the little strength she has at this moment, that you have right now, it will disappear because I have made my decision, and this is the best for me.**] APES 3 - clarification**

Therapist: **[**How do you feel right now?

Alice: I feel good.

Therapist: Do you feel stronger?

Alice: Yes, Yes. I try not to think about her so much.

Therapist: Uh-huh and what does she wants to respond?

Alice: It's not worth it.

Therapist: Tell her that.

Alice: (to the other part) I've already decided. It is not worth talking to me because I have made my decision and I've already made up my mind whether people accept my decision or not.

Therapist: Uh-huh. How are you feeling right now?

Alice: I am feeling good.

Therapist: By telling her that?

Alice: Yes, I don't care about what she has to tell me.**] APES 5 – application [**because if I go back to that chair these thoughts are going to arise and she will gain strength. This is what I have been doing, to ignore, to not hear! I don't care! Because I know what I want and even though she's trying to change my opinion, to make sure I stay insecure and with doubts.**] APES 4 – insight [**I won't allow, I won't allow! I'm not I'm not going to allow that to happen to my decision and today was important! This day was important! And my decision is final

Therapist: You are at peace.

Alice: Yes, I have found peace within myself regarding this.**] APES 5 – application** (session 14)

Afonso (poor-outcome case). Afonso began therapy aiming to cope with his emotional experiences. He felt that not being able to experience emotions was the main cause of his depressive symptoms. He linked this difficulty with feeling neglected during his childhood due to the conflictual relationship between his parents. This cognitive understanding about his problem showed some level of contact with the problematic voice of vulnerability. However, throughout therapy, Afonso avoided dealing with negative emotions, not allowing a

complete connection with the problematic experience. In the initial phase of therapy, Afonso remained at lower assimilation levels, APES levels 0, 1 and 2. Fluctuation, was modest but frequent (Figure 4).

The following excerpt illustrates Afonso's APES fluctuation in the initial phase of therapy. In it, Afonso was talking about his difficulties in acknowledging, recognizing and expressing his emotions and how this is related with earlier childhood experiences.

Excerpt 3. Dominant Voice:
I need to be strong; Problematic voice: I am vulnerable; Theme: difficulty in accessing his emotional experiences.

Therapist: [You woke up this morning feeling a little bit …

Afonso: It can also be related with smoking and taking coffee first thing in the morning … It may not help … It may have something to do with that.] (APES 0 - Warded off)

Therapist: [You have said that this uncomfortable sensation is not new

Afonso: Yes. I think I get more stress up or worried when family issues emerge and ah - these are situations that I can hardly change or solve but which normally I am asked to deal with.

Therapist: To solve

Afonso: To solve, to decide, or to make changes.**] (APES 2 - emergence). [**This is something that has been happening for many years … For 15, 16 years 16. I have watched to those quarrels at night and … usually the quarrels were always at night. That affected me … I felt sad at that time, so what I did was to lock myself to somehow make me stronger.

Therapist: Ok, you felt sad, worn.

Afonso: I was not going to deal with that. What was going on and probably I blocked myself. I don't know. Probably I'm blocked and maybe now I'm feeling the consequences of this in other aspects of my life.

Therapist: Other relationships

Afonso: In other relationships, exactly. I made this block and since then I am not able to cry**] (APES 2- emergence)** (session 1)In the final phase of therapy, Afonso's avoidance of the problematic voice became more frequent (shown by lower APES levels), and changes between assimilation levels were less frequent. That is, fluctuation became even more restricted, especially in session 14. It seemed that Afonso was less available to explore and access his problematic experience of vulnerability. This could indicate increased rigidity in community of voices with a consequent decrease in the dialogue between the community voices and the problematic voice. Several times, Afonso's therapist tried to promote a connection with the problematic voice, but Afonso avoided it, changing the topic of the conversation or not answering the therapist's questions. The following excerpt illustrates this pattern. Afonso and his therapist were reflecting upon what Afonso felt about the conflicting relationship between his parents:

Excerpt 4. Dominant Voice:
I need to be strong; Problematic voice: I am vulnerable; Theme: resentment towards his parents.

Afonso: [I don't push too hard and I dońt bother him (talking about his father) because he said that it is not worth neither me nor my mother pushing him … but he has problems with my mom because … When I was living with my mother in Switzerland, she had to provide me … . And then she said she would settle accounts with him, but it creates this sort of thing. I mean, my mother is a teacher, with a low income and then she sees my father, an engineer, earning a good salary … and she doesn't understand how this happens.] (APES 1- Avoidance)

Therapist: **[**How are you feeling with all of this?

Afonso: No, also my mother can make some financial savings and my father is unable to do this … Isn't this strange?**] (APES 1 - Avoidance)**

Therapist: **[**and how do you feel? Concerning these two things?

Afonso: hm: I, I enjoyed visiting the Netherlands. They are very organized, very civilized too and they earn well. Things are more expensive but, it seemed like a good place to work**] (APES 1-Avoidance)** (Session 14)

Discussion

As expected, the good- and poor-outcome cases presented different paths of evolution in symptom intensity, assimilation level, and fluctuation in assimilation level (Basto, Stiles, Rijo, et al., 2018; Caro Gabalda, 2006; Mendes et al., 2016). The differences were pronounced in the final phase of the therapeutic process.

The two cases began with very similar symptom intensity levels, but whereas Alice showed a significant (albeit non-linear) decrease in symptom intensity from the beginning until the end of therapy, Afonso showed little improvement (Figure 1). Regarding the evolution of assimilation, Alice began therapy with higher assimilation levels than Afonso, and she made substantial progress, whereas Afonso maintained relatively low levels of assimilation across sessions (Figure 2). The contrasting evolution of assimilation between the two cases could have been influenced by the initial difference in assimilation levels. Nevertheless, these observations

add support to the theoretical suggestion that progress through the assimilation continuum and achieving higher assimilation levels are associated with conventionally-measured therapeutic success (Basto, Stiles, Rijo, et al., 2018; Caro Gabalda, 2006, 2007; Detert et al., 2006; Stiles, 2011). A hypothesis that could explain this association between higher assimilation levels and conventionally-measured therapeutic success is that achieving higher assimilation levels during a therapeutic session may be in itself an in-session outcome of important affective / emotional, cognitive and behavioral micro changes that are occurring within and across sessions (Llewelyn et al., 2016). These micro changes may be signals of the emergence of a significant clinical change process that could result in the decrease of clinical symptoms and, consequently in a positive therapeutic outcome. As in the previous studies, the good-outcome case achieved assimilation levels at or above APES 4, whereas the poor-outcome case stayed below APES 4. At the intra-session level, the fluctuating, sawtoothed pattern of APES progress that has been reported by other investigators (e.g., Caro Gabalda, 2006; Mendes et al., 2016) was evident in both cases (Figures 3 and 4).

The main difference in fluctuation between the two cases occurred late in therapy. Intra-session fluctuation was greater in Alice's case, but only from the middle to the final phase of therapy, where some passages reached APES levels 5 and 6 (see Figure 3). This suggests that while Alice had achieved an understanding of some strands of her problematic experience and was applying it successfully in her life, other strands were still working their way through APES levels 2 and 3, even in the final phase of therapy (cf. Caro Gabalda & Stiles, 2018). As her attention switched (either following therapist process directions, as in chairwork, or of her own accord), the APES ratings fluctuated. The large fluctuations can thus be interpreted as showing work on a problem with strands that are widely separated. To put it another way, the high degree of fluctuation can be interpreted as a side effect of productive therapeutic work.

The qualitative analysis of Alice's case showed how the gradual integration of the problematic voice, "I have the right to express myself and be accepted," into Alice's community of voices gave her the strength to make important life decisions. Yet, making these decisions was a major challenge to her dominant voice, "fear of being rejected." This ambivalence between fear of others' rejection and her need to make her own decisions no matter what others would think had many ramifications in her life. Dealing with each of these contributing strands seemed to underlie the fluctuating pattern in her assimilation progress (cf. Ribeiro et al., 2016).

In Afonso's case, both the assimilation and the fluctuation levels remained much the same throughout his therapy, except for a modest decrease in fluctuation from session 11 to session 14. Based on the qualitative analysis of this case, it appeared that Afonso became progressively less responsive and collaborative across treatment. His dominant voice, "I need to be strong," became more rigid, resulting in a strong avoidance of his problematic voice, "I am vulnerable." It seems relevant that Afonso began treatment with his problematic voice in the range of APES level 1, avoidance (see Figure 2). As a result, the sort of active interventions that were helpful for Alice might have exceeded Afonson's TZPD and induced resistance, so that he could not follow the therapist's proposals. In theoretical terms, the TZPD of his main themes were initially lower than Alice's, and they may have become more restricted if the interventions made him resistant. Qualitatively, the reduced fluctuation seemed to reflect reluctance to explore additional strands of his problematic themes. In effect, he avoided work on his problematic experience. This rigidity appears to have hindered the progression in assimilation and compromised the therapeutic change process. The slight uptick in fluctuation (Figure 4) and perhaps in symptomatic distress (Figure 1) at the end of Afonso's therapy could be a hint of a last-minute slight reversal of this pattern (note that at low assimilation levels, between APES 0 and 2, increases in assimilation are associated with *increases* in symptomatic distress as clients begin to face their problems; Basto et al., 2017; Stiles et al., 2004).

The results from this study seem to be congruent with previous results suggesting that fluctuation in the assimilation progress is a common, indeed integral feature of therapeutic change (Caro Gabalda, 2006; Mendes et al., 2016). For example, directing attention to strands of a problem that are at lower assimilation levels by therapists employing the balance strategy may help to consolidate the assimilation of problematic experiences (Caro Gabalda, 2006). The sawtoothed assimilation pattern may indicate not only that the client is capable of achieving higher assimilation levels but also that less assimilated aspects of the problem are being worked through.

Although both Alice and Afonso were treated with EFT, this theory-building case study was framed and conducted in terms of assimilation theory, not EFT theory. The juxtaposition offers an opportunity to comment on relations of concepts in the two theories. In assimilation theory, any encounter of the self with a conflicting or problematic experience or voice is

presumed to produce some dysphoric emotion (see Basto, Stiles, Bento, et al., 2018; Stiles et al., 2004; cf. Greenberg, 2002, 2008). Thus, for practical purposes, addressing the conflict is also addressing the emotion. Assimilation can be fostered by an exchange of experience, a coming to terms, between conflicting voices (Stiles, 2011). This process is well illustrated in EFT chairwork, in which the therapist directs and facilitates expression and dialogue by and between different parts (voices) of the client, representing, for example, internal representations of significant others, unmet needs, or alternative ways of being in the world. Evidence of assimilation of a problematic voice can be seen in the softening that occurs as clients' opposing perspectives come to terms, that is, as they find shared ways to understand and live with each other, mediated by the signs they exchange in the therapeutic dialogue.

Clinically, the case of Alice showed how increasing fluctuation can reflect active therapeutic work, as some strands of a problem may advance more quickly and attention shifts to those left behind. Even though Alice made significant progress, the large fluctuation in APES scores in the final sessions suggested that more work remained to be done on lagging strands. We hope that Alice continued to consolidate her gains after the treatment ended.

The case of Afonso showed how low or decreasing fluctuation can reflect stalled progress. For clinicians working at lower assimilation levels, it may be important to consider that the client's TZPD may be more restricted, with a lower upper limit. Exceeding the client's TZPD may have an undesirable effect on the therapeutic change process, resulting in a rigidity and in a decreased dialogue between the dominant and the problematic voices (Stiles et al., 2016). Theoretically, therapists would be well advised to keep therapeutic tasks focused within the TZPD on the assimilation continuum, where the client is capable of progress, to avoid forcing the client beyond working zone for the focal problem.

Although these two cases had contrasting OQ-10-measured outcomes, they are not necessarily representative of good- and poor-outcome clients generally; clients may succeed or fail in many ways. As another limitation, one of the raters in each team was aware of the client's outcome status, so we cannot rule out bias in that rater's passage-level judgments. On the other hand, the other rater was not aware of it, and the interrater reliability was strong. Neither had access to the results of the session-level outcome measures.

No two case studies by themselves warrant confident generalization. At best, according to the theory-building case study strategy (Stiles, 2009), case studies offer small increments of confidence in the theory, sometimes with pointers toward theoretical elaborations regarding mechanisms that may underlie therapeutic success. Our results were theoretically informative, but further case studies are needed to see if these patterns are repeated or if new patterns appear.

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