SIGNS AND VOICES IN PSYCHOTHERAPY

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Signs (e.g., words, gestures, tokens, pictures) point to something besides themselves and are observable. Using signs, events can reproduce themselves (in part) across time and space. Signs change meaning each time they are used, but they also accumulate meanings from each use. Voices are active subdivisions (or collectivities) of people, internalized agents representing people, and events formed from traces of previous experience. People can be understood as communities of voices. Most theoretical approaches to psychotherapy recognize some forms of multivoicedness. Multiple voices may represent depth of resources and flexibility or fragmentation and dissociation, depending on the strength of the meaning bridges between the voices, which are constructed of signs. This article reviews research findings and problems that led me to my interest in signs and voices, and gives psychotherapy case examples of sign-mediated assimilation of problematic voices into the client's community of voices.

Psychotherapy is a laboratory as well as a treatment (Greenberg, 1991; Kvale, 1997; Thompson, 1987). It offers a more intimate access to human experience than does almost any other arena. As Len Horowitz (1994) pointed out, psychotherapy researchers have the truly privileged position of working with people who "open their hearts and, in a spirit of trust and optimism, reveal what is most private and personal" (p. 18). I think that from studying psychotherapy we can draw concepts and understandings about human thoughts, feelings, communication, and relationships that have a far wider application.

The phenomena with which psychotherapy researchers are most concerned, particularly significant psychological change, are not rare or unfamiliar. They occur in our offices every day—or at least on good days. Consequently, in psychotherapy research, our search is not so much for new discoveries as for clear ways to understand what we have already seen and heard.

I'll begin by outlining some simple but, I think, powerful ideas I am currently researching. The ideas are not original. I say this not from modesty, but from a theoretical position that will become clear shortly. As you read, many of you will recog-

nize your own ideas or ideas borrowed from others you know. But even if the ideas have been expressed before, they are new for me. I will begin by introducing these important ideas. Then I will offer a retrospective, to show you how I got here, before I return to my newer interests.

The powerful ideas are *sign* and *voice* (Leiman, 1992, 1994, 1997; Honos-Webb & Stiles, 1998; Stiles, 1997b). Much of the work I am doing in this area is qualitative, and part of the retrospective will be aimed at showing why I find myself relying increasingly on qualitative data.

SIGNS

Sign is a very general concept; examples include words, gestures, tokens, pictures, and stories. Signs represent reality. They point to something besides themselves. They also are part of reality. They are tangible and observable. Psychotherapy is conducted almost entirely as sign-mediated communication.

Signs are a means by which events reproduce themselves across time and place. For example, events that occurred previously in my laboratory and in other laboratories and in other talks and conversations are being reproduced here and now—in part and in flavor—as you read the words I have written. I and this journal are vectors carrying the signs that are reproducing those events.

How do signs convey the effects of events? Signs carry the experience of one person to another. The fundamental phenomenon is illustrated by my telling you about something I did or thought and you having some aspects of my experience, as you are doing right now. Put another way, we are sharing an experience, mediated by signs.

We can say that the experience carried by a sign is the sign's meaning. But in speaking of meaning, it is important not to suppose that sign meanings are fixed. The meaning to the speaker is never exactly the same as the meaning to the hearer. And each sign's meaning changes continually, reflecting the experience of each speaker and the audience and context in which the sign is used.

Signs accumulate these meanings. Each use adds another layer. That is, the meaning changes on each use, but the sign also retains the meaning of previous uses. For example, the next time you speak of signs or voices, there will be a bit of my experience tucked in. In this way, signs convey not only the experience of the speaker but also something of the experience of previous speakers who have used those signs. The quality of accumulating meaning was described by Bakhtin (e.g., 1981), and is sometimes called the historicity of signs. The many layers of meaning need not be consciously understood by the speakers. Thus, clients and therapists can, and normally do, say far more than they know. As Roy Hattersley (1991/1976), a British politician and author said, writing about a conversation with author John Braine: "I remember him explaining to me the true message and real moral of *Room at the Top* and discovering how much better was the novel I had read than the one he had written" (p. 120).

Thus, we live in an ocean of signs—words and images and objects that were created by other people and convey other people's experience. Much of our experience is distilled from other people's experience and passed to us by signs. And not just by words. Gestures and facial expressions can speak volumes. Red stop signs without the word stop still tell us to stop. A wealth of cultural meaning is conveyed by simple household objects; contrast, for example, the meaning of a knife and fork

with the meaning of chopsticks. Even natural objects, such as the sun and the moon, have acquired manifold meanings by being invested with other people's experiences.[1]

VOICES

The other powerful idea is voice. An emerging understanding considers people not as separate, unitary individuals, but rather as mosaics or communities of different voices. This understanding encompasses the possibility of internal conversations, and the observation that people's statements or other actions often contradict each other. Each of us seems to carry many voices, representing people, ideas, or events that we've encountered or that have been passed to us by signs. These include voices of our parents, our friends, our therapists, our favorite authors, our goals and ambitions, and our fears and resentments.

Some voices, such as belief systems, psychological theories, or group identities, may transcend individuals, so that the same voice speaks within many of us. For example, to some degree all members of the Society for Psychotherapy Research can speak for the society.

By the same token, most of what we say and think comes from other people. This is what I had in mind when I said that virtually none of what I'm saying here is original. Most of it comes from other people's voices in me, passed to me by signs.

As discussed in the closing plenary session at the 1997 SPR meeting in Geilo, Norway, many theoretical orientations describe psychotherapy clients as bringing multiple, often conflicting perspectives to treatment (Benjamin, 1997; Elliott & Greenberg, 1997; Fonagy, 1997; Hermans, 1997; Stiles et al., 1997). Internal multiplicity is represented, for example, (a) in such cognitive-behavioral concepts as automatic thoughts, intrusive thoughts, self talk, and self statements, (b) in such psychodynamic concepts as internal objects, introjects, and states of mind, and (c) in the humanistic focus on contradictory aspects of self and unrealized potentials. Multiple internal voices are central in dialogue accounts of the self, and in archetypal psychology, and they may be dramatically apparent in dissociative phenomena and borderline states. Multiple "I" positions are deliberately used in the service of therapy and personal growth, in the facilitation of reflective thinking, in the analysis of reciprocal role procedures in cognitive analytic therapy, and in empty chair and two chair work in gestalt and process-experiential therapy (see Stiles, 1997a, for illustrative references).

Multiple voices within people can represent depth of resources and flexibility, or they can represent fragmentation and dissociation. The difference is the strength of the meaning bridges—the sign-mediated links between the voices. (The term "meaning bridge" was used in a related sense by Rice & Saperia, 1984). In many psychopathological conditions, meaning bridges are weak or absent; internal communication is painful, poor, or, in the extreme, nonexistent. Movement between self states tends to be abrupt and discontinuous. Some voices may be warded off and silent.

The concepts of active voices and meaning-accumulating signs can help to overcome the misleading notion, promoted by library and computer metaphors, that in-

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[1]At this point, the talk was illustrated by a cartoon (Koren, 1979) in which objects in a park-like setting bore printed signs indicating their metaphoric meaning. For example, a hill was labeled "metaphor for aspiration," a bird was labeled "metaphor for lyricism," a rock was labeled "metaphor for stability," a fence was labeled "metaphor for limits," and a path was labeled "metaphor for the possible."

formation in people is passive (Stiles, 1997b). I'm suggesting that there is a formal similarity between interpersonal communication and intrapersonal communication. Both are mediated by signs, and both become easier, smoother, and less painful as understanding grows, that is, as the signs become more meaningful. We can say that the meaning bridges grow stronger. In successful therapy, this is something that happens both between therapist and client and within clients by the exchange of signs. I'll return to this theme later.

THE EQUIVALENCE PARADOX

First, however, I will review some of my own history in psychotherapy research, to show how I became interested in signs and voices. To a large extent, this retrospective is a story of frustrations.

When I entered psychotherapy research, I found it on the horns of the dilemma that David Shapiro, Robert Elliott, and I have called the equivalence paradox—the apparently equivalent effectiveness of different therapies in contrast to the apparent nonequivalence of their processes (Elliott, Stiles, & Shapiro, 1993; Shapiro, 1995; Stiles, 1982; Stiles, Shapiro, & Elliott, 1986). The equivalent effectiveness is often described (notably by Luborsky, Singer, & Luborsky, 1975) in terms of the verdict of the Dodo in the nineteenth century children's story of *Alice's Adventures in Wonderland* regarding the winner of a race in which the competitors ran around in a circle: "*Everybody* has won and *all* must have prizes" (Carroll, 1946/1865, p. 28; italics in original). This venerable null result cannot really be true, of course; no two things are exactly alike in psychology or psychotherapy (Meehl, 1978). Nevertheless, more than 60 years after it was first quoted to describe the similar outcomes of different psychotherapies (Rosenzweig, 1936), the Dodo's verdict remains a plausible summary. Effect sizes (ES) found in meta-analyses (see Lambert & Bergin, 1994; Wampold et al., 1997) show that psychotherapy is substantially better than no psychotherapy (mean ES = .82) and somewhat better than a placebo (mean ES = .48), and the placebos have done better than no therapy (mean ES = .42). But the small-to-negligible differences found among the bona fide therapies suggest that they are more or less equivalent (.00 < ES < .21).

My starting point was on the other horn of the dilemma—the nonequivalence of the process. I spent several years building on work by Jerry Goodman (Goodman & Dooley, 1976), to develop a classification of verbal response modes. Each utterance—roughly, each simple sentence or independent clause—can be classified into one of eight modes following theoretical principles, including source of experience and frame of reference (Stiles, 1979, 1992a). For example, therapist self-disclosures and advisements (directives) concern the therapist's experience, whereas therapist's questions and interpretations concern the client's experience. Interpretations put the client's experience into the therapist's frame of reference, as Rogers (1951) emphasized, whereas reflections express the client's experience in the client's own frame of reference (see Table 1).

Coding what therapists of contrasting schools actually did yielded clear evidence of technical nonequivalence (Stiles, 1979; see Table 1). Importantly, the differences corresponded to the theories. Client-centered therapists used verbal response modes that were in the client's frame of reference—reflections and acknowledgments. Gestalt therapists, who were instructed by Perls (1969) to stay in the now and not listen to "the content of the bullshit the patient produces" (p. 53), used modes that were in

TABLE 1. Mean Percentage of Therapist Utterances in Client-Centered, Gestalt, and Psychoanalytic Therapy

		Theoretical approach		
Principles	*Verbal response mode*	Client-centered	Gestalt	Psychoanalytic
Using therapist's frame of reference				
Concerning therapist's experience				
Disclosure		1.9	4.8*	1.9
Advisement		0.6	36.7*	2.8
Concerning client's experience				
Question		2.7	19.9*	12.2*
Interpretation		0.4	26.2*	48.7*
Using client's frame of reference				
Concerning therapist's experience				
Edification		1.9*	0.2	2.1
Confirmation		0.2*	0.0	0.2
Concerning client's experience				
Acknowledgment		46.1*	5.2	17.9*
Reflection		45.4*	3.7	9.9*
Coder disagreement		0.6	0.2	0.3
Total		100.0	100.0	100.0

Note. Based on transcripts of therapy conducted by leading proponents of their respective theoretical approaches. Adapted from Stiles (1979). Principles for coding verbal response mode intent, including frame of reference and source of experience are explained in Stiles (1992).
*Theoretically prescribed modes.

their own frame of reference, such as advisements and disclosures. Psychoanalytic therapists, instructed by Freud (1913/1958) to be like a mirror, used modes from both frames of reference, but restricted themselves to modes that concerned the client's experience—questions, interpretations, acknowledgments, and reflections—avoiding those that would have revealed or imposed their own experience. Similar demonstrations of large, theoretically consistent differences have been made in many other studies of contrasting therapies, using a variety of coding systems and treatments (e.g., Brunik & Schroeder, 1979; DeRubeis, Hollon, Evans, & Bemis, 1982; Elliott et al., 1987; Hill, O'Grady, & Elkin, 1992; Hill, Thames, & Rardin, 1979; Startup & Shapiro, 1993; Stiles, Shapiro, & Firth-Cozens, 1988; Strupp, 1955, 1957).[2] The nonequivalence of process is at least as robust as the equivalence of outcomes.

DISABUSE OF THE DRUG METAPHOR

The systematic differences among treatments seem consistent with understanding alternative psychotherapies in terms of the drug metaphor (Stiles & Shapiro, 1989, 1994; cf. Yeaton & Sechrest, 1981). Each therapy specifies a set of supposedly active psychological or interpersonal ingredients, analogous to a drug's chemical ingredients, which can be coded in the therapist behavior.

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[2] When we coded client speech using the same response modes coding system, however, we found that the clients used similar profiles of modes regardless of what school their therapist adhered to (Stiles & Sultan, 1979; Stiles, Shapiro, & Firth-Cozens, 1988). Mainly the clients used disclosures.

Are the theoretically specified interventions really the active ingredients? A reasonable person might suppose that this could be tested straightforwardly. If interpretation, for example, is an active ingredient, then clients who get more interpretations should do better than those who receive fewer, and interpretations should be correlated with outcome across clients. That is, according to the more is better drug metaphor logic, by coding the process and correlating process components with outcomes, investigators should be able to tell which are the active ingredients (indicated by positive correlations), and which are flavors and fillers (indicated by null correlations). This more is better characterization is, of course, an oversimplification of the effects of actual pharmacological agents (which typically have optimal levels, curvilinear dose-response curves, or more complex relations to outcomes), but it has been powerful and pervasive in psychotherapy research (Stiles & Shapiro, 1989).

I spent ten years and a good deal of several governments' money exploring this logic. I now think it is misleading, for reasons I will discuss shortly. Empirically, outcome was not reliably correlated with the theoretically important process components, at least not with in-session behaviors that can be classified and counted. For example, we coded the verbal response mode of each therapist and client utterance in half of the sessions delivered in the first Sheffield Psychotherapy Project, a clinical trial of brief therapies for depression (Shapiro & Firth, 1987), including over a third of a million utterances (Stiles et al., 1988). We selected as process measures the percentages of theoretically-important verbal response modes—therapist interpretations, questions, exploratory reflections, general advisements, and client disclosures—which together accounted for a large proportion of what therapists and clients did in these sessions. None showed any hint of correlating with improvement on standard outcome measures. We analyzed these data in many ways, with the same null results (Stiles & Shapiro, 1994).

Of course, not every process-outcome study has had such uniformly null results. Investigators have reported significant correlations with some measures, though most have not been consistent across studies. The biggest exception is the alliance, which I'll return to later. What we don't find is the pattern one would expect from the drug metaphor logic—strong process-outcome correlations for theoretically important ingredients and weak or negligible correlations for the supposed flavors and fillers.

In retrospect, we can see that the null process-outcome correlations are the equivalence paradox writ small. If the different treatments, with their huge process differences, have equivalent outcomes, then it's not so surprising that particular treatments varying in particular process components also have equivalent outcomes. Of course, one could argue from the drug metaphor that we simply haven't considered the true active ingredients yet. This argument implies, however, that the theories and clinical intuition are wrong about what is important in the process.

RESPONSIVENESS

I now think that the problem was not the choice of measures but rather the statistical logic. The drug metaphor reasoning overlooks, or at least oversimplifies, the dynamic relations between process and outcome. This dynamic relation can be described as responsiveness (Stiles, Honos-Webb, & Surko, 1998). Responsiveness refers to behavior that is affected by emerging context, particularly including client requirements. For example, therapists are being responsive when they assign a client to a treatment based on the presenting problems, design a homework assignment taking into

account a client's abilities and circumstances, or rephrase an explanation that a client seemed not to understand the first time.

Appropriate responsiveness in therapy means responding to emerging context in a way that advances the goals of treatment. Clients differ in their requirements for each process component, and these requirements may change from moment to moment. Therapists try to respond appropriately to these requirements. They're not perfect, of course, but I suggest that they do far better than the random (noncontingent) emission of techniques implicit in the process-outcome correlation logic.

Responsiveness can occur on a time scale as long as months (e.g., treatment selection and planning) or as small as a few tens or hundreds of milliseconds. To illustrate the latter, in a qualitative Comprehensive Process Analysis of insight events, we found that therapists made adjustments in the course of giving interpretations, in response to client's ongoing reactions (Elliott et al., 1994). For example, a therapist might begin an interpretation and then pause before proceeding, to provide support when the client seemed to have trouble tolerating the emotional pain.

To the extent that therapists adjust their interventions to indications of client's changing requirements, outcome is reciprocally affecting process. In such a feedback system, small fluctuations can be amplified, leading to a cascade of effects that is unpredictable in advance. For example, remarking on some small nonverbal behavior may trigger a productive line of work and send the session off in some unexpected direction. The relations among variables in such a system are likely to be complex or chaotic, rather than linear (Barton, 1994; Gleick, 1987).

If therapists respond appropriately to client requirements for a particular process component (e.g., interpretations), then each client will tend to get the optimum amount at the optimum time. It wouldn't help to get more or less. If a component were always delivered at an optimum level, outcome would tend to be the same across clients insofar as it depended on that component. The level of the process component might vary across clients, but it would not predict outcome unless, by coincidence, client requirements happened to predict outcome. That is, important therapeutic ingredients may be uncorrelated with outcome (Stiles, 1988, 1994, 1996; Stiles & Shapiro, 1989, 1994).

Responsiveness can even produce negative correlations of important process components with outcome. For example, assume that focus on negative self-image is an important component in cognitive therapy of depression. However, client requirements for this component vary. Some clients respond quickly to such a focus and require very little, whereas others require a great deal of this focus, perhaps because their self image was more negative to begin with, or more resistant to change. Suppose that therapists are appropriately responsive, but imperfectly. That is, the needier clients tend to get more of this focus, but not quite enough, so their outcomes are relatively worse. As a consequence, focus on negative self image will be negatively correlated with outcome across clients, even though, as we assumed, it is an important component in the therapy. Parallel examples can be constructed for most process components. Reviewers seeing reports of such negative or null correlations are likely to conclude, mistakenly, that focus on negative self image is useless or harmful.

If essential ingredients may be uncorrelated or negatively correlated with outcome, then, conversely, a null correlation does not imply that a process component is ineffective or useless. Note that this is not a measurement problem. This problem with the process-outcome correlation logic holds even for perfect measures of key ingredients.

By similar reasoning, responsiveness can account for the failure of important client characteristics to correlate with outcome (Stiles, Honos-Webb, & Surko, 1998). For example, in data drawn from the Second Sheffield Psychotherapy Project, which was also a clinical trial of brief therapies for depression (Shapiro et al., 1994), we found evidence that therapists conducting manualized treatments delivered process components responsively, depending on client interpersonal styles (Hardy, Stiles, Barkham, & Startup, 1998). Clients were classified as overinvolved in relationships, as underinvolved in relationships, or as balanced in their involvement, on the basis of pretreatment measures. Plausibly, therapists used substantially more affective and relationship-oriented interventions with clients who had an overinvolved interpersonal style than with other clients. In some conditions, they also tended to use more cognitive interventions with clients who had an underinvolved interpersonal style. But, despite receiving these systematically different mixes of interventions, the clients with these different interpersonal styles had roughly equivalent outcomes. A responsiveness interpretation is that the different interventions represented appropriate responsiveness to differing client requirements, so that all groups benefited more or less optimally from their treatment.

The correlation logic implicitly assumes that process components are delivered ballistically, that is, at some predetermined level, or at least randomly with respect to the client requirements. A therapy session actually conducted in this way would be incoherent and absurd. Even formal treatment manuals recommend responsiveness, rather than ballistic use of techniques. For example, the last three of five considerations for selecting targets and techniques offered in the manual for cognitive therapy of depression (Beck, Rush, Shaw, & Emery, 1979) specify responsiveness.

3. The therapist should attempt to gear his approach to the patient's level of sophistication, personal style, and typical coping techniques.
4. The relative urgency and severity of the various problems and symptoms may dictate the priorities; that is, which problem(s) to deal with first.
5. A certain amount of "trial and error" is usually necessary. The patient should be told: "We have a number of approaches that have been shown to be successful for various problems. We may have to try out several before we find the one that really fits you. Thus, if one method is not particularly helpful, it will provide us with valuable information regarding which method is likely to succeed" (p. 169).

IS THE ALLIANCE AN EXCEPTION?

Despite its logical problems, the drug metaphor is kept going by findings that outcome does correlate reliably with some process measures, most notably the client-therapist alliance. For example, in a study of the alliance in the Second Sheffield Psychotherapy Project, we replicated what many others have found—that stronger alliances were moderately associated with better outcomes on some scales (Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998).

The usual account of such findings has alliance as a common factor across treatments. To me, this seems accurate but a little misleading, because it suggests the alliance is a process component like interpretation or focus on negative self-image. The alliance, however, is not an intervention or a technique. A therapist can't decide to use more alliance in a session in the way he or she can decide to use more interpretations.

Instead, the alliance is an achievement that depends on appropriate responsiveness. That is, a strong alliance reflects the appropriate, mutually responsive use of process components by therapists and clients. A particular class of interventions, such as interpretations or homework suggestions, may sometimes strengthen and sometimes weaken the alliance, depending on the client readiness, the style and timing of the intervention, the setting and circumstances, and adjustments made in response to client ongoing reactions.

Indeed, most of the process indexes that are reliably correlated with outcome seem to be evaluative ratings, such as the alliance, therapist competence, or session impact. Evaluating an interpersonal process seems to involve taking appropriate responsiveness into account (Stiles, Honos-Webb, & Surko, 1998). The alliance-outcome correlations might better be considered as a first step in unpacking the process of outcome rather than as reflecting the contribution of a single process component.

THE ATTRACTIONS OF QUALITATIVE APPROACHES

The failure of the process-outcome correlation logic, and recognizing the importance of responsiveness, pointed me toward qualitative methods (Stiles, 1993). Qualitative observations, in the form of case histories, have always been used to support theories of psychotherapy and psychopathology; this is what we used to call anecdotal evidence and now call narrative research.

In any scientific research, investigators try to simultaneously maximize generality, precision, and realism. Unfortunately, gains in one of these desirable qualities generally entail losses in another one (Levins, 1968). In comparison with hypothesis testing using ratings or verbal coding, the thick descriptions produced by intensive case studies of psychotherapy seem to me to yield gains in realism but a loss of generality.

Narrative discourse (for example, a case history) has advantages for presenting empirical observations of therapy process (Stiles, 1993). Narratives are linguistic. Narratives facilitate empathy with the protagonist, in effect making direct use of our ability to understand the experience of others. Narratives supply the context as part of the story. And narratives can deal with chaos in the technical sense, with human behavior that is like the weather, deterministic but unpredictable in the long term. In short, a narrative understanding incorporates responsiveness.

To summarize my retrospective: I've argued that the drug metaphor process-outcome correlation problem is a product of responsiveness, and that responsiveness can be dealt with in qualitative research.

THE ASSIMILATION MODEL

One alternative to the drug metaphor is the assimilation model (Stiles et al., 1990). Psychotherapy process is typically measured across seconds or minutes, whereas outcome is measured across months or years. Process observations are typically focused on a narrow aspect or topic, whereas outcome is typically considered in relation to the whole person. The assimilation model attempts to reconcile the time scale and scope of process and outcome by identifying particular problematic experiences and tracking them across sessions in the therapy dialogue. In effect, it breaks outcome into smaller pieces and studies how the pieces change.

According to the first formulation of the model (Stiles et al., 1990), in successful therapy the problematic experience is gradually assimilated into a schema. A problematic experience might be a traumatic memory, an unacceptable wish, an overwhelming feeling, or any other idea, attitude, or intention that is threatening or painful to the client. Schema is a broad concept that might be a frame of reference, a way of living, a narrative, a metaphor, or a theme. Consistent with Piaget's (1970) conception, the model suggests that assimilating a problematic experience requires accommodations in existing schemas or the development of new schemas within the therapist–client relationship. In successful therapy, the client schemas change to assimilate the problematic experience. Thus, the formerly problematic experience becomes part of the schema.

More recently, we have formulated the assimilation model in terms of voices (Honos-Webb & Stiles, 1998). In this complementary formulation, the problematic experience is considered to be an active voice within the person. Instead of being considered a passive piece of information, a problematic experience is considered to speak for itself. For example, a traumatic experience has a voice that strives for expression. By speaking and by being heard and understood, that is, by exchanging signs, a problematic voice can gradually build meaning bridges and be assimilated into the community of voices. It can become part of the self.

In either of these formulations, the assimilation model recognizes that the problematic experience changes as therapy proceeds. This change in the client's problem has previously created a problem for process researchers, which we have called the metamorphosis problem (Stiles, 1992b). The client's problem changes form as it develops, so that later versions may not be recognizable from earlier versions, just as a 50-year-old man may not be easily recognizable as the five-year-old boy he once was. Of course, you wouldn't have the problem if you saw him every few weeks. Analogously, the assimilation methodology deals with the metamorphosis problem by longitudinal study of problems and by narrative presentation of results. Briefly, we extract passages dealing with selected problematic topics or themes, and observe how the expressions change from session to session (Stiles, Meshot et al., 1992; Stiles, Morrison et al., 1991).

As a problematic voice is assimilated, it seems to pass through predictable stages or levels, summarized in the Assimilation of Problematic Experiences Scale (APES; Table 2) (Stiles, Morrison et al., 1991). Our current names for the stages are: warded off, unwanted thoughts, vague awareness or emergence, problem statement or clarification, understanding or insight, working through or application, problem solution, and mastery. This scale represents an approximation to what we think are common formal features of the process of change. That is, we hypothesize that in some ways the process of psychological change is similar across cases, even though the problematic experiences may vary a great deal. Clients may enter therapy with problems anywhere along this continuum, and any progress along it could be considered as positive.

Although I have focused on qualitative assimilation research in this article, we have also done quantitative research on the model (Field, Barkham, Shapiro, & Stiles, 1994; Reynolds et al., 1996; Stiles, Barkham, Shapiro, & Firth-Cozens, 1992; Stiles, Shankland, Wright, & Field, 1997a, b). Recently, we developed a marker-driven rating system based on the voices formulation (Honos-Webb, 1998; Honos-Webb, Surko, & Stiles, 1998; Honos-Webb, Surko, Stiles, & Greenberg, in press). This will make it possible to obtain reliable independent ratings of assimilation in passages of therapy.

TABLE 2. Assimilation of Problematic Experiences Scale (APES)

0. *Warded off.* Client is unaware of the problem; the problematic voice is silent. Affect may be minimal, reflecting successful avoidance.
1. *Unwanted thoughts.* Client prefers not to think about the experience. Problematic voices emerge in response to therapist interventions or external circumstances and are suppressed or avoided. Affect involves unfocused negative feelings; their connection with the content may be unclear.
2. *Vague awareness/emergence.* Client is aware of a problematic experience but cannot formulate the problem clearly. Problematic voice emerges into sustained awareness. Affect includes acute psychological pain or panic associated with the problematic material.
3. *Problem statement/clarification.* Content includes a clear statement of a problem—something that can be worked on. Opposing voices are differentiated and can talk about each other. Affect is negative but manageable, not panicky.
4. *Understanding/insight.* The problematic experience is formulated and understood in some way. Voices reach an understanding with each other (a meaning bridge). Affect may be mixed, with some unpleasant recognition but also some pleasant surprise.
5. *Application/working through.* The understanding is used to work on a problem. Voices work together to address problems of living. Affective tone is positive, optimistic.
6. *Problem solution.* Client achieves a successful solution for a specific problem, representing flexible integration of multiple voices. Affect is positive, satisfied.
7. *Mastery.* Client automatically generalizes solutions; voices are integrated, serving as resources in new situations. Affect is positive or neutral (i.e., this is no longer something to get excited about).

We've done quite a few intensive case studies of assimilation in various types of therapy (Honos-Webb, Stiles, Greenberg, & Goldman, 1998, in press; Honos-Webb, Surko, Stiles, & Greenberg, in press; Shapiro, Barkham, Reynolds, Hardy, & Stiles, 1992; Stiles, Meshot, Anderson, & Sloan, 1992; Stiles, Morrison, et al., 1991; Stiles, Shapiro, & Harper, 1994; Stiles, Shapiro, Harper, & Morrison, 1995; Varvin & Stiles, in press). We find assimilation everywhere we look, but of course we would. Such case reports can show others how to look with our eyes and hear with our ears—how to understand psychotherapy as a process of assimilation.

EMERGENCE OF AN UNWANTED VOICE

The remainder of this article is devoted to qualitative examples drawn from two psychotherapy clients we studied, who have given permission for use of their materials in research. The examples are meant to point to the kinds of phenomena we seek to explain with the assimilation model and the concepts of signs and voices, rather than as evidence for particular abstract statements.

The first example is from a 65–session psychoanalytic therapy (Varvin & Stiles, in press). The client, a woman in her late thirties, here called Fatima, was a refugee to Norway from a country in the Middle East. She had been arrested and tortured because she was participating in a political organization. Her husband was arrested at the same time and later tortured to death. At the time of her arrest she was in the last trimester of pregnancy. She was allowed to go to a public hospital to give birth, and while she was there, an escape was arranged for her. While she was living clan-

destinely, her baby daughter died of an unknown disease, probably caused by the torture, maltreatment, and lack of adequate medical care in prison. Fatima eventually made her way to Norway, where she had been living for nine years and working in a health profession. The therapy was conducted in Norwegian and has been translated into English by her Norwegian therapist, Sverre Varvin, who has tried to retain the flavor of her dysfluencies.

Fatima had, to a large extent, mourned the death of her husband, for example by performing grief-rituals on his birthday. However, she had avoided confronting the death of her child. In assimilation terms, the memory was warded off or unwanted. The therapist did not know the details of the birth and death until the story emerged haltingly (and with great psychological pain) in session 21, six sessions after the following episode. In this brief story, told in session 15, she described the death of a 27-week old child in the district where she worked. (This was approximately the age her own child had been when she died.) I present the dialogue in stanza form (Gee, 1986, 1991; McLeod & Balamoutsou, 1996), with lines separated to convey my understanding of importance and emphasis.

> Fatima: *As I mentioned yesterday, for instance,*
> *It was yesterday night.*
> *It was a death* [in the district where she worked].
> *I had great difficulties.*
> *Eh, I was very like, in relation to the other,*
> *And it was a teacher who had lost her child,*
> *And I was at work yesterday,*
> Therapist: *Yes.*
> Fatima: *And then somebody said,*
> *"Can you go and talk with her, because she has lost her child?"*
> *I was* (sniffs) *eh, just like—*
> Th: *Yes.*
> Fatima: *She did not understand*
> *That I was exactly in the same situation.*

Telling this story about the death of someone else's child may have indicated the approaching emergence of the unwanted material. The problematic, unwanted voice seemed to be striving for expression.

When she did tell the story of her child's birth and death in session 21, it emerged gradually, with many long pauses and crying (APES level 2; see Table 2). The immediate trigger was a therapist comment about families. I've included here only the beginning portion of the story's emergence (see Varvin & Stiles, in press, for further dialogue and details).

> Fatima: *Yes, I have been thinking,*
> *If I had my daughter, she would have been 13 years old, and . .* (crying).
> (40-second pause)
> Therapist: *You feel sorrow for her.*
> (90-second pause)
> *Maybe you saw her before your inner eyes,*
> *Your daughter?*
> Fatima: *Eh?*

Th: *Did you see her, your daughter, before you?*
Did you think about her?
(55-second pause; Fatima crying).
You have; . . .
You have not told me how she was,
How you remember her.
(25-second pause; Fatima crying)
It is difficult to remember her?
(Fatima breathes heavily, sniffs).
(110-second pause)
It is painful to cry? eh?
(Fatima sniffs)
(130-second pause)
I don't know if you want to say something of what you think of now?
(20-second pause)

Fatima: *It is like a film which goes* (inaudible).
I have thought about it . . .
(55-second pause)

Th: *When it starts; . . .*
It is OK to just take your time and cry.
(Fatima cries and laughs a little at the same time; Therapist laughs emphatically)
(60-second pause)
Yes, you have many feelings inside yourself now.

Fatima: *Yes.*

This halting disclosure was a breakthrough, which came as surprise for Fatima and for the therapist. At first, the experience was not represented as verbal symbols, but as icons or images; that is, her film-like reexperiencing of the traumatic events can be understood as the emergence into painful but vague awareness of the experiences surrounding the child's birth and death (APES level 2, Table 2). We may say that the voice of the trauma expressed itself using these iconic signs rather than words. The traumatic experiences had apparently been largely unprocessed—warded off or at least unwanted, without meaning bridges to her daily experience, though she had known that they were there. By late in the next session (session 22), however, she could talk more easily about her child's death.

Therapist: *Eh. What happened?*

Fatima: (inaudible) *don't know. It was* (inaudible)
I didn't know anything, eh.
Or it was like the doctor who came and looked at the child,
And he had said afterwards that he knew the child would die,
But they didn't tell me anything because it was,
So I didn't notice anything..

Th: *Yes.*

Fatima: *Was* (inaudible) *so it was a bit,*
When I gave breast,
She had a little problem with breathing and

Th: *Mm.*

Fatima: *And eating.*
   Th: *Mm. Mm.*
Fatima: *But now I think, eh..*
   Th: *Yes, you are thinking?*
Fatima: *No I know it,* (inaudible) *I was one hundred percent sure that it was a
          kind of damage.*
          Or, eh, when I got a bleeding in the prison
          It could have been an infection.
          I was sure I had fever and I didn't get any antibiotics.
          And not the child either, after the birth.
   Th: *Mm.*
Fatima: *And no tests were taken.*
          [I] was only checked by the doctor in that way and,
          and it is like—. I don't know how, eh.
   Th: *Mm.*
Fatima: *I once read about it. Such maltreatment and violence can influence the
          fetus.*

The voice was still emerging here, but more coherently and verbally. In the sessions that followed, she continued to talk about her child's death. She spoke of the pain of not having any pictures of her child. She described not knowing what to do when the milk did not stop. She talked about the name of the child—the name she wanted to give to her daughter, and also a name her parents wanted to give. And she recalled the impossibility of a proper burial (Varvin & Stiles, in press). In assimilation terms, this may be seen as a process of building meaning bridges between the traumatic experiences and the community of voices that was her self, using verbal signs to formulate the problem and work toward understanding (APES levels 3 and 4; see Table 2).

INTRUSION OF A PROBLEMATIC VOICE

A client's different internal voices are sometimes made salient by the intrusion of material that not only expresses distinct material but does so in a distinctive-sounding voice. The following example, drawn from a case that Mikael Leiman and I are working on now, illustrates the intrusion of a distinct-sounding voice. The digital audio files are available on SPR's web site.[3]

The client was a 29-year-old mother of two, here called Debbie, who sought treatment for depression at a clinic in London, England, where she was considered to have borderline characteristics. She was seen for 16 sessions of Cognitive Analytic Therapy (CAT) (Ryle, 1990) as part of a research project on borderline personality disordered clients (Ryle, 1997). She was considered a successful case according to standard measures, as well as in her own and her therapist's judgment.

Debbie's husband of 12 years was alcoholic and had been in and out of the home for several years. He had announced during his last extended visit, three months previously, that from the beginning of their relationship he had never wanted to be

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[3] At this writing, the URL for the SPR web site is http://ted.educ.sfu.ca/society/. The digital audio files, used by permission, are accessible from the abstract of this article (see the journal pages on the web site), and may be played or downloaded.

with her. This, she said, rang true and had precipitated a severe depressive episode. In her first session, she said she could not stand to see him because it reminded her of the rejection. She said she had lost control and physically attacked him the last time he had shown up unannounced. She also said she felt "paranoid" about his mother, who had never approved of the match. The following passage was taken from about eight minutes into the first session. Debbie was explaining that her and her husband's families had known each other since they were children, and that she now felt this part of her life was gone.

Debbie: *And .. you know,*
          I've had this, this fam—, this other family.
          There's my family—
          It's all my family,
          Which always included his family as well—his brother, his sister,
          And it's as though . . . that's gone, y'know.

Therapist: *So, you've lost more than just him.*
             You've lost, sort of, his brothers and sisters—
Debbie: *Yeah, that's what I feel*

Th: *—who were like friends of yours, I mean.*
Debbie: *Well, his sis—*
          I've never,
          I've never really got on well with his mum and his sister.
          Because—
          So that's not so much of a loss as, uh,

          she's won.

          She's finally got what she wanted,
          Which was, she wanted him back.
          And she wanted him away from me, basically.

          That's how I feel.
          Whether that's how she feels,
          but that's how I fe—

          Y'know.
          And this sort of thing's really been getting worse, y'know.
          It's getting more mad, I think.

          And, um, I still keep in touch with his other brother's wife . . .

The emphasized text near the end ("That's how I feel . . .") was spoken in a distinctive voice, louder, more rapidly, in a lower register, and seemingly much more defiantly and angrily than the rather meek voice of the narrator, who was giving background information to the therapist. The defiant, angry voice seemed to intrude abruptly and unexpectedly, triggered perhaps by the discussion of loss or by the thought that her mother-in-law had won. The defiant voice was interrupted in midword. Was this angry voice related to the problems for which Debbie had sought

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treatment? Was it related to Debbie's aggressive outburst against her husband on his last visit? I think so, although at this writing we are still working on the analysis of this case and my understanding is tentative.

It emerged that Debbie had a long-standing pattern of angry outbursts, apparently triggered by signs of rejection. The outbursts were mainly verbal; the physical attack on her husband was unusual and extreme. After the outbursts, which she described as uncontrolled, she would feel rejected and horrible about herself. As the therapist formulated it within a CAT framework, Debbie's outbursts seemed to represent her switching into the complementary rejecting role in a repetitive interpersonal procedure. From a signs-and-voices perspective, the abrupt, painful transitions signal the absence of meaning bridges between the defiant voice and the narrator voice. It's an hypothesis that the louder voice in the passage represented a brief intrusion by Debbie's angry self state.

In therapy, Debbie made great progress in reconciling these aspects of herself. She later reported being surprised and pleased that she could have normal conversations with her husband without losing control. She felt less desperately needy and more assertive. How was this achieved?

The following passage was taken from midway in this process, 25 minutes into session eight. Although we hear only Debbie's narrator voice in this passage, it describes a recent internal conversation with her defiant, rejecting voice. In effect, she was constructing a meaning bridge.

Two days before session eight, Debbie's husband had telephoned her just ten minutes before he was to take their two children to a museum. He said that he couldn't take them because he was going to a boot sale (flea market). Debbie considered this reason utterly inadequate, and a day later she called him back and told him how irresponsible she thought he had been. From her description of this second phone conversation, I imagine that her husband heard the angry, rejecting voice shown as emphasized in the previous passage. But she was less impulsive than in previous episodes, and she did not feel so horrible and rejected afterwards.

Debbie: *Yeah, I mean*
Even with that, sort of that rejecting [self-state] *now,*
When I said [to my husband] *yesterday on the phone—*
I knew that I would feel rejected after I'd said it [told him he'd been irresponsible].
Because . . .
He'll . . .
He'll reject me
Because I'm not going along with what he says.
And I'm not being nice.
And I'm not being, you know . . .
So I did feel like that a little bit.
But then I thought:
No.
I did the right thing.
I can't start feeling bad
Because I'm saying what I think's right.

This internal conversation—one part of herself telling another part that she shouldn't feel bad, because she's doing the right thing—illustrates a sort of reflexivity that we

associate with problem clarification in the assimilation model (APES level 3; Honos-Webb & Stiles, 1998). This was not yet a solution, but it stated the problem in a way that it could be addressed. The exchange of verbal signs was building a meaning bridge that would permit smoother, more modulated, less painful shifts between voices, a step closer to appropriate assertiveness. In other words, the voices were learning to cooperate with each other instead of acting antagonistically.

SUMMARY AND PROSPECTS

Assimilation of problematic experiences, I have suggested, is a common therapeutic process that can be understood in terms of signs and voices. This understanding is compatible with the pervasive responsiveness of human interaction, and may be a way to address the frustrations often encountered in research on the process and outcome of psychotherapy.

I said earlier that the intimate access of psychotherapy to human experience may yield concepts and understandings that have a wider application. The concepts of sign and voice are very general, and the hypothesized similarity of intrapersonal and interpersonal communication points in both directions. Intensive analyses of psychotherapy, such as the case studies of Fatima and Debbie, can yield detailed accounts of how traumatic experiences or dissociated self states may be warded off by, or build meaning bridges with, a dominant community of internal voices. These accounts could then suggest ideas about how marginalized individuals, groups, theories, or ideologies are kept separate or assimilated. Signs and voices can be identified at each level. Whether the process of building meaning bridges is also parallel is a topic for further research.

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Zusammenfassung

Zeichen, das heißt Worte, Gesten, Symbole und Bilder, weisen auf eine dahinter stehende Bedeutung und sind beobachtbar. Unter Nutzung von Zeichen, können sich Ereignisse teilweise über die Zeit und im Raum reproduzieren. Die Zeichen verändern jedesmal ihre Bedeutung, wenn sie benutzt werden, sie bündeln gleichzeitig mit zunehmendem Gebrauch diese Bedeutung. Stimmen wiederum sind aktive Anteile (oder Kollektive) von Menschen, die sich aus den Spuren früherer Erfahrungen formen, sie sind internalisierte Agenten, die andere Menschen und Ereignisse repräsentieren. Man kann Menschen als Kommunität von Stimmen begreifen. Die meisten theoretischen Ansätze innerhalb der Psychotherapie vermuten bestimmte Formen der Vielstimmigkeit. Vielerlei Stimmen können somit die Tiefe von Ressourcen repräsentieren, ebenso Flexibilität oder Fragmentierung und Dissoziation. Dies hängt von der Stärke der Bedeutungsbrücken zwischen verschiedenen Stimmen ab und diese werden wiederum durch Zeichen konstruiert. In diesem Beitrag werden Forschungsbefunde und Forschungsprobleme zusammengefaßt, die mein Interesse an Zeichen und Stimmen erweckten. In der Folge werden einige Fallbeispiele aus der Psychotherapie beschrieben, in denen durch Zeichen mediierte Aufnahmen problematischer Stimmen in die Gemeinschaft der Stimmen eines Klienten dargestellt werden.

Résumé

Des signes (p. ex., des mots, des gestes, des symboles, des images) indiquent quelque chose au delà d'eux-mêmes et sont observables. Par le moyen des signes, des événements peuvent se reproduire eux-mêmes (en partie) à travers le temps et l'espace. Les signes changent de signification à chaque

utilisation, mais ils accumulent aussi des significations de chaque utilisation. Des voix sont des sub-divisions (ou collectivités) actives de personnes, formées par des traces d'expériences préalables—des agents internalisés représentant des personnes et des événements. Des personnes peuvent être com-prises en tant que communautés de voix. La plupart des approches théoriques de la psychothérapic admettent l'une ou l'autre forme de multivocalité. Ces voix multiples peuvent représenter la profondeur des ressources et la flexibilité, ou la fragmentation et la dissociation, en fonction de la force des ponts de signification entre les voix qui se composent de signes. Cet article passe en revue les recherches et les problèmes qui m'ont conduit à m'intéresser aux signes et aux voix, et il donne des exemples de cas avee une assimilation, médiatisée par des signes, de voix problématiques dans la communauté des voix du client.

Resumen

Los signos (v.g., palabras, gestos, emblemas, cuadros) apuntan a algo exterior a sí mismos y son observables. Con el uso de signos, los eventos se pueden (en parte) reproducir a sí mismos a través del tiempo y el espacio. Los signos cambian de significado pero también acumulan significados con el uso. Las voces son un producto de la subdivisión activa de personas (o colectividades), esto es, son trazas de experiencias previas—agentes internalizados representantes de personas y acontecimientos. Las personas pueden ser vistas como comunidades de voces. La mayoría de los enfoques teóricos de la psicoterapia reconoce alguna forma de multivodidad. La multiplicidad de voces puede representar la profundidad y flexibilidad de recursos de que se dispone o bien la fragmentación y la disociación, según la fuerza que tengan los puentes exitentes entre los significados de las voces construídas con los signos. Este artículo pasa revista a los hallazgos y problemas que me llevaron a interesarme en los signos y las voces y proporciona a la psicoterapia la casuística resultante de la similación (por el cliente) de sus voces problemáticas mediadas por los diversos signos dentro de su comunidad de voces.