

APPLICATION OF THE ASSIMILATION MODEL IN THE CONTEXT OF FAMILY THERAPY: A CASE STUDY*

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ABSTRACT: In this case study the aim was to apply the APES (Assimilation of Problematic Experiences Scale) model to the analysis of the family therapeutic treatment process. This was done as a qualitative methodological triangulation in a case of the family of a 10-year old psychotic boy. The study suggests that assimilation model is suitable for many kinds of data in analyzing family therapeutic treatment processes, makes the change more comprehensible, and yields information about the effectiveness of experiential family therapy techniques.

KEY WORDS: reflecting team; experiential techniques; assimilation analysis; narratives in family therapy research.

Where therapeutic change is studied as the evolution of meanings and change in existing meanings, a variety of approaches can be employed in analyzing the therapeutic process. Heritage (1984) has discussed the possibilities of the ethnomethodological tradition in analyzing institutional conversations. A wide spectrum of ethnographic

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*The Nordic Academy for Advanced Study (NORFA) and The Finnish Academy made it possible for the first author to learn about the assimilation model. Our thanks to them. We also thank Professor William B. Stiles for his kind permission to use his table to present the course and contents of the APES.

studies has been published in the field of family therapy (Laird, 1994; Newfield, Kuehl, Joanning, & Quinn, 1990; Sells, Smith, Coe, Yoshioka, & Robbins, 1994; Smith, Sells, & Clevenger, 1994; Smith, Jenkins, & Sells, 1995; Todd, Joanning, Enders, Mutchler, & Thomas, 1990). In the study of family therapy conversations as transcribed texts, conversation analysis (Gale & Newfield, 1992; Stamp, 1991), discourse analysis (Aronsson & Cederborg, 1996; Wahlstrom, 1992), and textual analysis (Kogan & Gale, 1997) have been used. In the study of individual psychotherapies narrative analysis (Angus & Hardtke, 1994; McLeod & Balamoutsou, 1997; Rennie, 1994), metaphor analysis (Angus & Rennie, 1988, 1989), and assimilation analysis (Stiles, Elliott, Llewellyn, Firth-Cozens, Margison, Shapiro, & Hardy, 1990; Stiles, Morrison, Haw, Harper, Shapiro, & Firth-Cozens, 1991; Stiles, Meshot, Anderson, & Sloan, 1992; Stiles, 1996) also have been employed.

Assimilation of problematic experiences (APES) is a model which describes the process of semantic change during the therapy process. The model is designed for empirical research, and its purpose is to break the general therapeutic outcome down into smaller domains (as seen through the assimilation of different problematic experiences). Thus each aspect of therapeutic change can be studied case-specifically, separately, and longitudinally, i.e., contextually (Rosnow & Georgoudi, 1986).

The analysis proceeds from the recognition of the problematic experience with closed ends. The aim is to find the course of the evolution of the therapeutic process by taking one specific problematic experience at a time. To do this the researcher has to go through the data in order to recognize the first hints of the emerging problematic experience. Here the research method is empathy, which is usual in qualitative research (Stiles, 1993).

A central concept in assimilation analysis is the problematic experience, which can be considered "as a memory, wish, feeling, idea, or attitude that is threatening or painful to the client" (Stiles, 1996, p. 1). The process of assimilation passes through certain predictable stages. As the result the meaning of the problematic experience changes as it is assimilated into a schema. The schema is a concept taken from Piaget's individual cognitive psychology, but Stiles (1996) uses the concept in a broad sense. Thus a schema may be considered "as a frame of reference, way of living, narrative, metaphor, or theme" (1996, p. 1). Stiles is also ready to broaden the concept of schema in this context to accommodate the bakhtinian idea of voices or a com-

munity of voices within a person. These conceptual extensions also are useful for the purposes of family therapy research.

Outside the scope of the assimilation model is the concept of "narrative" or "narrative account". Angus and Hardtke (1994) defined three different types of narratives relevant in the field of psychotherapy: 1) narratives or stories, which refer to the description of events or individual stories which clients tell during psychotherapy; 2) "the narrative", which refers to the overall perspective of an individual's life in which events are placed in a temporal sequence and are meaningfully organized along a set of intrapersonal and interpersonal themes; and 3) narrative processes, which refer to the processes or strategies in which clients and therapists engage during psychotherapy in order to give meaning to the client's experiences.

Family sculpture is both a diagnostic and therapeutic tool which spatially and concretely visualizes the relational patterns within the family (Simon, Stierlin, & Wynne, 1985, p. 134). This family therapeutic technique is a traditional tool. Through the process of assimilation this nonverbal approach can be studied in the narrative context of therapy. This also allows us to see the narrative nature of the assimilation process.

The course of assimilation process contains eight stages from (0) warded off to (1) unwanted thoughts, (2) vague awareness/emergence, (3) problem statement/clarification, (4) understanding/insight, (5) application/working through, (6) problem solution, and, finally, (7) mastery (Stiles, 1996; Stiles et al., 1992). A summary of the psychological and emotional contents according to Stiles is presented in Table 1. The course of the assimilation process is defined from the client's viewpoint, and the therapeutic interaction is more or less in the background.

As a result of the assimilation process, the formerly problematic experience is no longer threatening or anxiety arousing; the client has achieved adaptive ways of dealing with it, and the relationship with the experience is now mostly neutral.

The assimilation model has mostly been applied to the analysis of individual psychotherapies (Stiles et al., 1990, 1991, 1992; Stiles, 1996), and the data available have consisted of transcriptions of therapeutic conversations. Attempts in the other fields of psychotherapy have not been reported.

In the present study we applied the assimilation model as a pilot study to analyze a family therapeutic treatment process with the emphasis on a single problematic experience. This experience was as-

TABLE 1
Assimilation of Problematic Experiences Scale (APES)

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- 0. Warded off.* Content is unformed; client is unaware of the problem. An experience is considered warded off if there is evidence of actively avoiding emotionally disturbing topics (e.g., immediately changing subject raised by the therapist). Affect may be minimal at level 0, reflecting successful avoidance; vague negative affect (especially anxiety) is associated with levels 0.1 to 0.9.
- 1. Unwanted thoughts.* Content reflects emergence of thoughts associated with discomfort. Client prefers not to think about it; topics are raised by therapist or external circumstances. Affect is often more salient than the content and involves strong negative feelings—anxiety, fear, anger, sadness. Despite the feelings' intensity, they may be unfocused and their connection with the content may be unclear. Levels 1.1 to 1.9 reflect increasingly stronger affect and less successful avoidance.
- 2. Vague awareness/emergence.* Client acknowledges the existence of a problematic experience, and describes uncomfortable associated thoughts, but cannot formulate the problem clearly. Affect includes acute psychological pain or panic associated with the problematic thoughts and experiences. Levels 2.1 to 2.9 reflect increasing clarity of the experience's content and decreasing intensity and diffusion of affect.
- 3. Problem statement/clarification.* Content includes a clear statement of a problem— something that could be worked on. Affect is negative but manageable, not panicky. Levels 3.1 to 3.9 reflect active, focused working toward understanding the problematic experience.
- 4. Understanding/insight.* The problematic experience is placed into a schema, formulated, understood, with clear connective links. Affect may be mixed, with some unpleasant recognitions, but with curiosity or even pleasant surprise of the "aha" sort. Levels 4.1 to 4.9 reflect progressively greater clarity or generality of the understanding, usually associated with increasingly positive (or decreasingly negative) affect.
- 5. Application/working through.* The understanding is used to work on a problem; there is reference to specific problem-solving efforts, though without complete success. Client may describe considering alternatives or systematically selecting courses of action. Affective tone is positive, businesslike, optimistic. Levels 5.1 to 5.9 reflect tangible progress toward solutions of problems in daily living.
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TABLE 1 (*Continued*)

6. *Problem solution.* Client achieves a successful solution for a specific problem. Affect is positive, satisfied, proud of accomplishment. Levels 6.1 to 6.9 reflect generalizing the solution to other problems and building the solutions into usual or habitual patterns of behavior. As the problem recedes, affect becomes more neutral.

7. *Mastery.* Client successfully uses solutions in new situations; this generalizing is largely automatic, not salient. Affect is positive when the topic is raised, but otherwise neutral (i.e., this is no longer something to get excited about).

Source: Stiles, 1996, by permission

sumed to be important from the point of view of psychological differentiation and individuation. The central questions were as follows: 1) Is it possible to use assimilation analysis to study family therapeutic change with case materials consisting of health care documents and just one therapy session as transcribed conversation? 2) What kind of results are produced by this kind of analysis? Could it yield any new ideas for understanding the meaning of experiential family therapy techniques and therapeutic enactment?

METHOD

The Subject of the Study and Therapeutic Approach

The family described in this report had participated in a follow-up study carried out in two child-psychiatric units (Laitila, 1994). The family consists of middle-aged parents and two children: 10-year-old son and a 20-year-old daughter (at the time of the treatment process). (The family was the same as that described by Laitila, Aaltonen, Piilinen, & Rasanen, 1996.) The reasons for their seeking professional help were the hallucinations experienced by the son and his withdrawn behavior. The team (a child psychiatrist and a psychologist) met the family six times during a three-month period in different compositions. In addition to this, a certain amount of phone calls, and correspondence took place.

The therapeutic approach was the open reflecting setting. This is an applied form of the reflecting-team approach (Andersen, 1987; Friedman, 1995) in which no technical, experience-isolating equipment—e.g. a one-way screen—is used in the context of the therapeutic

tic work (Aaltonen, Vartiainen, Kalliokoski, & Riikonen, 1994). However in the third session the central method of working was the family sculpture. This choice was made as the patient's sister was participating in the therapy process for the first time in the third session, and the therapeutic team found it useful to try something different in order to obtain new perspectives on the situation.

Materials

The materials of the case study consisted of 1) the follow-up study materials (a semi-structured telephone interview), 2) written records of the child-psychiatric treatment process, and 3) a videotape. The videotape was transcribed and filed as a textfile with the case records. Thus we had various kinds of documentary case materials appropriate to qualitative case studies (Hamel, Dufour, & Fortin, 1991; Stiles, 1993). The materials met the quality control requirements of qualitative research (Stiles, 1993), and offered a possibility for realizing methodological triangulation. According to the APES (Stiles, 1996) the ideal situation would be to have complete recordings and transcripts of a whole course of therapy, but that was not possible in this case, and this imposes a limitation for the generalisability of the analysis. The relevant data are described in more detail in the results section.

Analysis

The analysis proceeded from the recognition of the significant problematic experience by looking backward and forward in the case materials. At first we searched for the problem statement in which the family members for the first time during the therapy process gave a narrative account of a specific problematic experience. (Originally we thought that this would meet the criteria for stage 3 of the assimilation model.) This narrative account contained the theme of the analysis, i.e., it referred to an attitude that was expressed repeatedly during the treatment process (Stiles et al., 1991). According to Angus and Hardtke's (1994) definition this narrative account could be both "narrative" and "the narrative". Our viewpoint was to emphasize the role of the verbal account as the carrier of meaning in this specific case. Thus this account is closer to the idea of "the narrative".

After this the aim was to recognize the evolution of this one topic during the therapy process. The aim was to see if the different stages

of the assimilation process could be seen through case materials of this kind. For the sake of clarity we present the results not in the order of the analysis but in chronological order.

RESULTS

Symptoms and the Beginning of the Therapy (Stages 0 to 2)

The neurologist referred the boy for child psychiatric consultation because his accounts of hallucinations and absent minded presence could not be understood merely as epileptic seizures. As the explanation connected with epilepsy was not validated, the symptomatic behaviour became irrational and inexplicable to the parents. As the symptoms continued to prevail the parents became increasingly distressed and anxious. Their level of functioning as parents decreased, and they became more and more panic-stricken and helpless. They also tried to make sense of their son's behaviour by recourse to different explanations regarding the side-effects of medication, of illness, and of their own over-protectiveness. The family was in crisis.

The events before and right at the beginning of the treatment can be seen as unwanted thoughts (stage 1) and vague awareness/emergence (stage 2) stages. The warded-off stage (stage 0) was before the emergence of all the symptoms, as the symptoms and symptomatic behaviour were already part of the failure of adaptive defenses. The threat/possibility of sister's leaving home, and the deaths of two relatives re-activated the question of differentiation, separation, and independence.

The Experiential Nonverbal Technique Assisting Assimilation (Stages 3 to 4)

In the family therapy session with the family therapy training group the family members each made a family sculpture of her or his own. The big sister located all the family members in a closed circle, physically close to each other. In the sculptures provided by the other family members, the distances became even smaller, and nearness and touching increased. There was one exception in that the son received a different instruction for his sculpture, i.e., to do it in such a way that he felt good in it. He located the family members near each other in a small half circle, and he himself was smiling and leaning backward on the other family members. Afterwards the

team applied the reflecting team approach. The family members had the opportunity to listen first to the reflecting team of six members and then to the two therapists conversing with each other about the sculptures.

These repeated sculptures acted as a nonverbal multivoiced conversation in which each family member had the chance to describe her or his personal view of the family situation. Each member also had her or his concrete personal voice after the reflecting team in the joint conversation. This situation in which the different sculptures were on equal terms with each other, without the expert version of the team, made it possible to compare them, and to look at the differences, i.e., to start the internal dialogues. This was in direct contradiction to the beginning of the session when family members were reading the agreement governing the videotaping. On that occasion the patient was jointly seen as virtually analphabetic, unable to understand the contents of the agreement. Clearly, his sculpture was very surprising, as his father nominated it as the most creative one.

In this particular treatment process the family sculpture technique functioned phase-specifically. What previously had been fragments of explanations and understanding non-verbally acquired their first coherent expression. The sculptures represented the condensation of problem statement/clarification (stage 3) and understanding/insight (stage 4) stages of the assimilation process (with the exception of the son's sculpture which already contained elements of a problem solution (stage 7) in it).

As the process of sculpture is in itself nonverbal, it is hard to specify the course of the process, or the internal dialogue. What we saw was the product and the outcome. In this single session the outer dialogue was captured through transcripts. One specific example of this was how the father defined the family as "a closed one" using the Finnish expression "sulkeutunut" which also has the connotations like "withdrawn", "reserved" or "uncommunicative".

This element of conversation was the first sign of a change toward interactional and systemic understanding within the family. The explanations before had all been more disease-oriented. Even though the phrase "sulkeutunut" is problem-oriented, it carries some connotations or voices in it which suggest that the meaning shared by the family members gradually becomes more polysemic and ambiguous. This allowed us to see the polydimensionality of the experience of family members (Stiles, 1993).

The Significant Problematic Experience (Stages 4 to 5)

The next narrative account of the significant problematic experience was not provided by the family before the fifth session. This was the second session after the session in which the family sculpture technique had been employed.

When the parents got married and had their first child they were living in another part of the country. Their apartment was too small for a family with a baby. The father went back to his native district to see what possibilities for employment he could find. He received a good offer, and decided for the family that they should move. He moved first, and the mother with the baby followed him in a couple of months. To move was self-evident and easy for the father, but very difficult for the mother because she had to give up the best job she had ever had. The mother's attitude was still of nostalgia 20 years later. The meaning of this move was different for each parent: for the father it was an example of his agency, and of the fact that he was able to arrange well-being for his family; for the mother it was an example of her subjugated underdog position as far as the decisions about the family's future were concerned.

In the context of therapy this narrative appeared after the most acute crisis was over. It contained the meaning of why differentiation and independence can be problematic and even dangerous: if family members are left to make decision independently, this may cause long-lasting difficulties for other members. Thus the narrative the parents told was representative of the problematic nature of differentiation and independence. It also makes it possible to understand why the mother opposed the father's efforts to make some age-relevant demands on their son: she could not be certain if the father's actions were for the good of their son.

According to the assimilation model (Stiles, 1996), this could be seen as the problem statement/clarification stage, as it presented a clear statement of the problem. (This is exactly what we did in the beginning of the analysis.) There are however some critical reasons why this is not self-evident. First, the affect of the joint process of discussing this experience was not negative (as the APES suggests), but the atmosphere was relaxed and open according to the documents. The subject was no longer a taboo. Second, it seems that "the problematic experience was placed into a schema, formulated, understood, with clear connective links" (Stiles, 1996) which refers to understanding/insight (Stage 4). The mother's nostalgic attitude sug-

gests that she was gradually able to mourn her lost opportunity while still yearning for it. This indicates more the application/working through stage 5. The couple also deal openly with the fear of quarreling with each other. Third, the parents report that their mutual problems have been in the background, and that after their son was born these problems became connected with him and his epilepsy.

Thus it seems justified to claim that the parents were able to provide the problem statement and clarification after they themselves had acquired some measure of understanding of its meaning. The psychological process had, however moved on from stage 3 so that already during the "sculpture session" the boy partly reached the "problem solution" and his parents also had quite clear insight and were jointly working through the previously taboo-like issues of the family's past. The psychological differentiation was a threat as long as the parents could only look at it through the problematic experience. The question facing this case study was now: what was the origin of the assimilation process in the case of this particular experience, and how far did the change go according to the APES?

The Course of Assimilation and Therapeutic Change (Stages 6 to 7)

Both the behavioural indicators and the attitude of the parents at the end of the treatment process suggested that the family had reached the problem solution phase (stage 6). The son was able to act independently, his symptoms vanished, he had friends who visited him at home, and the parents had the energy to take care of themselves, too. In the follow-up interview, 18 month later, the mother revealed that her daughter had got engaged, and the son's development had continued well. It seems justified to conclude that the therapeutic assimilation had reached mastery (stage 7) in relation to this one specific problematic experience. The family also had reached a new level of differentiation which allowed more independence and separation, reflecting on the previously undealt issues of the past, as well as differences of opinion.

DISCUSSION

As a model for understanding family therapeutic change the assimilation model is challenging. The effectiveness of experiential

techniques is easier to understand, as the model helps us to see how a condensed psychological process is included in a single family sculpture. The sculpture technique helps to bring forth previously unstated issues, and gives some form to formerly disorganized fragments of experience. Some of this could also be applied to the psychological process of therapeutic enactment (Minuchin & Fishman, 1981).

Ricoeur (1991) has emphasized two forms of narrative understanding: first-order narrative understanding which emphasizes the prenarrative quality of human experience, and second-order narrative understanding, which has more to do with concepts and verbal language. All symptoms first represent something irrational which does not yet have any full verbal meaning, and second, the people involved (and on many occasions together with the therapy team) try to find some meaning in them. The experiential techniques are something more. They are used in the therapeutic context intentionally with the aim of making a joint effort to reach a unique contextualized understanding of what is going on. This intentionality marks the difference between symptomatic behaviour and nonverbal therapy techniques.

As the family therapy session is an interactional social situation it also brings to light new possibilities for understanding. In each sculpture the author makes some of her or his ideas public. These sculptures represent private prenarrative experience (Ricoeur, 1991) which is made public in the context of therapy (Harre, 1983). The audience here is the rest of the family and the therapy team. This, according to Harre (1983), serves the formation of individuality, which seemed to be a problem in this family.

The assimilation model is challenging methodologically. Our materials were closer to health care documents than the transcribed sessions which have been the more usual data in assimilation studies, and transcripts from only one session were included. There is a danger that this could lead to the use of the phases of the assimilation process as fixed categories of interpretation or repertoires of interpretation, and thus to predictable results. In the context of this case study it seems that the APES served the opposite purpose. Each therapy process always contains a vast amount of nonverbal information which cannot be transcribed. Here this was emphasized because of the nonverbal technique. Thus we tried to take advantage of the assimilation model and to see the interconnected phases of the assimilation process through all the various materials that were available for us.

This seems to mean that the process of assimilation is available

for recognition, but the search process, or the "trial, error, and success" of the therapeutic process cannot be specified in the same way as with verbatim materials.

In the process of doing this kind of analysis the role of therapeutic interaction is purposefully excluded (the descriptive documental materials even emphasize this view in this article). This may lead to the therapeutic process being seen as something very technical where the role of the therapist(s) is simply to deliver some kind of correct input to which the family responds by reaching a new level of functioning or a new attitude toward some problematic experience, or the family reaches the state of family homeostasis which had been threatened by a new life situation. This would suggest that psychotherapy is more related to technical expertise than to human interaction. It would also be against the principles of qualitative research to assume linear causality in therapeutic interaction (Stiles, 1993). Our previous article (Laitila et al., 1996) showed that the therapeutic system, therapeutic interaction, and verbal reflections of the team and the training group were the site of the change as much as the nuclear family. To look at the process of the family is thus a more or less artificial choice: the researcher's position is one where it is possible to choose what is the emphasis, and this is also a position of power. Neither of these two pictures of the family is a perfect description or account.

Methodological triangulation helps to shift the emphasis, and to look at the same materials differentially. In the present case study this validated the change process, showed how the assimilation proceeded through the entire course of therapy, gave information about the power of the family sculpture technique, and proved the assimilation model to be a valid method of analysis in family therapy research as elsewhere.

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