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An assimilation analysis of clinician-assisted emotional disclosure therapy with survivors of intimate partner sexual assault

LINDSAY M. ORCHOWSKI, BRIAN D. UHLIN, DANIELLE R. PROBST, KATIE M. EDWARDS, & TIMOTHY ANDERSON

Department of Psychology, Ohio University, Athens, Ohio, USA

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Abstract
This study examined clinician-assisted emotional disclosure therapy among college women with a history of intimate partner sexual assault. Assimilation analysis, a method for tracking client movement in psychotherapy, was used to document changes in dominant and submissive voices during clients’ disclosure of the trauma. Self-blame, traditional gender-role assumptions, and internalized rape myth ideology emerged as prominent themes in clients’ formations of problem statements. The two case studies presented illustrate the difficulty in clearly formulating experiences of intimate partner sexual assault as problematic, integrating submissive and dominant voices and empowering adaptive voices that speak for the well-being and self-assertion of the individual. Implications for psychotherapy with survivors of intimate partner sexual assault are discussed.

Keywords: process research; qualitative research methods; trauma; emotion in therapy

By way of a protective mechanism against constant fear and hypervigilance, individuals tend to underestimate their overall risk for experiencing a sexual assault (Nurius, 2000). Commonly referred to as the “just world belief” (Janoff-Bulman, 1992), individuals tend to believe that good things will happen to good people and bad things will happen to bad people. Thus, when a woman who believed “it could never happen to me” experiences intimate partner sexual assault, a host of world beliefs concerning personal safety and trust are challenged (Resick & Schnicke, 1996). Searching for a way to understand such an incongruent life event, survivors of sexual victimization may distort the experience by shifting blame onto themselves (e.g., “If this happened to me, I must be a bad person” or “I was unclear, I provoked this”), altering the meaning of the trauma (e.g., “It wasn’t a big deal”), or denying that the assault occurred (Weaver & Pye, 2004). Individuals may also overaccommodate following the assault, altering their worldview in ways that prevent interpersonal intimacy (e.g., “No one will ever understand”), decreases trust (e.g., “No man can be trusted”), or increases fear (e.g., “I am not safe anywhere”; Resick & Schnicke, 1996). Processing the event may be complicated by negative social reactions from others (Fillipas & Ullman, 2001) or an existing avoidant coping style (McCann, Sakheim, & Abrahamson, 1988).

Because survivors of sexual violence must necessarily draw upon existing social ideologies to understand their experience (Lea & Auburn, 2001), rape myth ideology may illegitimate the survivor’s trauma or increase feelings of self-blame (Mason, Riger, & Foley, 2004). Burt (1980) defined rape myths as “prejudicial, stereotyped or false beliefs about rape, rape survivors, and rapists” (p. 217). Examples of rape myths include “Women ask for it,” “Rapists are sex-starved, insane, or both,” “In reality, women are almost never raped by their boyfriends,” and “If a woman doesn’t physically fight back, you can’t really say that it was rape” (Payne, Lonsway, & Fitzgerald, 1999). Rape myth acceptance is correlated with victim blame (Peterson & Muehlenhard, 2004), not labeling assault experiences as rape (Mason et al., 2004), and acceptance of interpersonal violence and adversarial sexual beliefs (Burt, 1980). Rape myths likely are intensified for survivors of intimate partner assault, if feelings of confusion and self-blame are linked with social status of the survivor’s relationship to the perpetrator and further complicate the social circumstances leading up to the assault.
Although the experience of intimate partner sexual assault is no less common or serious than stranger rape (see Temple, Weston, Rodriguez, & Marshall, 2007), the experience may be so schema incongruent that the survivor may not conceptualize the experience as rape, instead internalizing a host of invalidating interpretations of the assault (Gidyicz & Layman, 1996). Further, because intimate partner sexual assault is often underreported and stranger rape is conceptualized as “real rape” (Koss, 1985), survivors of acquaintance assault may face disbelief and stigma when seeking support from friends, family members, or health care providers (Filipas & Ullman, 2001).

### Trauma Narratives

Trauma narratives are often distinctly different in content and coherence than narratives constructed to explain typical autobiographical memories (Brewin, Dangleish, & Joseph, 1996). As a distinct window of experience in which an individual endures intense and unusual stress, narratives of traumatic events are frequently more vivid, sensory in nature, and unintentionally evoked compared with other forms of memory (Brewin et al., 1996). Trauma narratives may be characterized by unavailable memories (i.e., dissociation), distorted cognitions (i.e., faulty thinking), or fragmented and incomplete recollection of the experience (Halligan, Michael, Clark, & Ehlers, 2003). Increases in the content and organization of trauma narratives are frequently correlated with decreases in the individual’s symptomatology (Pennebaker, 1999). It is suggested that the telling of one’s story produces a structural change and systematic reorganization of a memory, such that the experience of trauma becomes less isolated and the feelings associated with it less intense, thus transforming the fragmented narrative into a more deliberately accessible, integrated, and sequential story (White & Epston, 1990). Increases in the coherence and structure of a narrative are believed to reflect the process by which an individual directly reconstructs incompatible memories and corrects conflicting interpretations of an event (Resick & Schnicke, 1996).

However, when constructing a narrative, individuals are restricted to the pool of “linguistic resources” from which members of a society construct and render their actions intelligible (Lea & Auburn, 2001). The role of language and societal messages in shaping an individual’s conceptualization of an event is especially relevant when considering the experiences of sexual trauma survivors. As Lea and Auburn note, “Rape is not contained in the events themselves but in the descriptions used to account for an event” (p. 13). Rape myth ideologies are represented within the linguistic formulations provided by the dominant social domain. Hence, sexual trauma survivors are left to understand and describe sexual victimization through a language influenced by rape myth ideology. Similar to how an individual’s subjective experience is inextricable from the larger social context in which it exists, an individual cannot tell a story that is free from the ideology in which it was produced (Hermans, 1999). It is, therefore, within this social discourse that a narrative can be explored.

Whereas there is substantial theory and research identifying rape myths and their social implications, research has yet to consider how internalized cultural messages contribute to an individual’s interpretation of sexual trauma. Based on the aforementioned theories and research on rape myths, survivors of intimate partner sexual assault are likely to internalize cultural beliefs that women should be submissive to a partner’s sexual requests, precluding them from understanding their experience as a clear transgression of autonomy. Because of the complex array of intrapersonal dynamics associated with intimate partner sexual assault and the lack of in-depth examination of the role of rape myth ideology in survivors’ abilities to process the event, we believed that the assimilation model (Stiles et al., 1990) might be a useful method for conceptualizing survivors’ attempts to make sense of sexual trauma.

### Assimilation of Problematic Experiences

The assimilation of problematic experiences model (APES) is an approach to understanding beneficial change in psychotherapy by describing progress in terms of a client’s ability to assimilate difficult or problematic experiences into newly formed or existing schemata (Stiles, 2002). A basic assumption of this model is that problematic experiences have a tendency to be warded off or kept away from conscious reflection in an attempt to avoid conflicting interpretations of the experience and further unpleasant emotions (Williams, Stiles, & Shapiro, 1999). The APES model theorizes that the voices of problematic experiences, which tend to begin at the lowest stage of being warded off, will emerge through the process of therapy in a step-by-step fashion. The client ideally moves to a stage at which he or she has assimilated the voices of the experience into the dialogical self and has essentially “mastered” the experience (see Table I).

Assimilation research increasingly has used the notion of the dialogical self to elaborate how individuals make meaning of a wide variety of APES problematic experiences (Hermans & Kempen, 1993). Dialogical self theory suggests that the self
Table I. Assimilation of Problematic Experiences Scale

0. Warded off/dissociated: Client is unaware of the problem; the problem is silent or dissociated. Affect may be minimal, reflecting successful avoidance.

1. Unwanted thoughts/active avoidance: Client prefers not to think about the experience. Problems emerge in response to therapist interventions or external circumstances and are suppressed or avoided. Affect is intensely negative but episodic and unfocused; the connection with the content may be unclear.

2. Vague awareness/emergence: Client is aware of a problematic experience but cannot formulate the problem clearly. The problem 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. The client can take alternative or opposing perspectives with respect to the problems. Affect is negative but manageable, not panicky.

4. Understanding/insight: The problematic experience is formulated and understood in some way. An understanding is reached that incorporates or gives access to the problematic experience (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, considering implications and ramifications. Client seeks to apply the understanding in daily living. Affective tone is positive, optimistic.

6. Resourcefulness/problem solution: The formerly problematic experience has become a resource, used for solving problems. The formerly problematic experience can be drawn upon and used flexibly. Affect is positive, satisfied.

7. Integration/mastery: Client automatically generalizes solutions. The formerly problematic experience is fully integrated, serving as resources in new situations. Affect is positive or neutral (i.e., this is no longer something to get excited about).

Note. The Assimilation of Problematic Experiences Scale table was obtained with permission for use in publication by William B. Stiles.

can be more realistically understood as a dynamic community of voices rather than as a monolithic, unified whole, as the conventional, modernist, Cartesian notion of the self suggests (Hermans, 2002; Honos-Webb & Stiles, 1998; Stiles, 1999a). Part of the utility of this approach is that it recognizes that intrapersonal complexity is a natural occurrence that can lead to a richer experience of the self rather than an experience that is inherently pathological in its disruption of self-unity. In fact, from this perspective, one of the goals of therapy can be seen as the development of a more flexible acceptance of one’s self as being composed of several different voices (sometimes called self-positions) coexisting together in order to allow for a more open and productive communication between these voices (Honos-Webb & Stiles, 1998; Stiles, 1999b). As Honos-Webb and Stiles (1998) explain, the voices in the assimilation model can be used to represent key constructs of change in other theoretical models. For example, voices can be understood as the automatic thoughts that are expected to change in cognitive therapy. Beck (1995) describes the change process in cognitive therapy as one in which the client comes to identify maladaptive thoughts, question the nature, meaning, and effects of these thoughts, and then replace them with more adaptive ones. Similarly, the assimilation model identifies the client’s process of identifying voices that were previously warded off, and creating new meanings and ultimately replacing voice dynamics that perpetuate symptoms. A key element of the assimilation model not explicitly emphasized in cognitive therapy is the notion that some voices may be suppressing the emergence of adaptive voices that already exist. In this way, the assimilation model considers change not so much in terms of replacing one voice with another but rather as a change in the dynamics among these voices.

Voices can also be understood as schemas, which was the construct used in the initial formulation of the assimilation model (Stiles et al., 1990). From this perspective, the assimilation model shares commonalities with configurational analysis, another system of tracking change in psychotherapy (Horowitz, 1979, 2005). In particular, this approach also considers how multiple intrapersonal and interpersonal schemas must interact and compromise in order to manage stress and conflict. As with the assimilation model, making sense of traumatic experiences involves multiple, often contradictory schemas that must somehow be negotiated in a working-through process (Horowitz & Eells, 1997).

Survivors of intimate partner sexual assault may have a particularly difficult time allowing the trauma to be fully processed in conscious awareness. The dialogical self approach may be especially useful when considering how various, sometimes conflicting, social internalizations play a role in a person’s ability to make meaning from experiences of sexual trauma. For example, women may wish to maintain many of the positive representations of their intimate partner, even when he has violated her trust by sexual perpetration. At the same time, attempts to articulate feelings of violation may be downplayed or dismissed, as a result of society’s broader ascription to rape myth ideology (see Filipas & Ullman, 2001). Culturally sanctioned “rape myths” (Burt, 1980), along with traditional gender-role expectations, could be meaningfully understood as internalizations of cultural voices, which influence the dialogical process of coping with sexual trauma. In terms of theory building, understanding how sexual assault experiences are assimilated might be facilitated...
through closer examination of the various self positions in this dialogical process.

Continuity benevolence assumptions (CBAs) are recognized as those internalized assumptions about the basic continuity of the self, benevolence in the world, and one’s inherent right to participate in and be a recipient of that benevolence (Glick Brinegar, Salvi, Stiles, & Greenberg, 2006; Honos-Webb & Stiles, 1998; Humphreys, Rubin, Knudson, & Stiles, 2005; Stiles, 1999a, 1999b). After a trauma such as sexual assault, these CBAs are typically shattered (see Janoff-Bulman, 1992). As research has shown, the extent to which such world beliefs are shattered is associated with increased distress and psycho-pathology (Temple et al., 2007).

We hypothesize that any or all of the potential internalizations mentioned previously (e.g., rape myth ideology, traditional gender-role beliefs) may play a role in suppressing CBA voices. Our focus on sexual assault by intimate partners should be particularly useful in understanding how CBA voices might be disrupted as well as how their reemergence might signal progress in the assimilation process. In theory, the reemergence of the CBA voices in treatment after a sexual assault should provide the client with the strength to speak up against mistreatment, an increased appreciation for personal autonomy, and other therapeutic improvements.

**Purpose of the Current Study**

The problematic experiences of sexual assault present a unique challenge for therapeutic work. The current study adds to existing research utilizing the assimilation model by examining the process of women’s disclosure of intimate partner sexual assault in the context of short-term clinician-assisted emotional disclosure therapy. An assimilation analysis was utilized to identify and track the dynamics of voices that emerged over the course of the therapy. Based on existing research, several specific hypotheses were explored:

**Hypothesis 1:** Women’s voiced ascription to rape myth ideology and gender-role expectations would influence the degree to which women are able to formulate a problem statement and integrate the traumatic experience as indicated on the APES scale.

**Hypothesis 2:** The context of the relationship to the perpetrator would influence the degree to which women are able to integrate the traumatic experience.

**Hypothesis 3:** The reemergence of the CBA voice would be associated with women’s ability to explore, question, or challenge prior ascription to rape myth ideology or gender-role expectations.

Two cases representing varying relationships to the perpetrator were specifically selected in order to explore Hypothesis 2.

**Method**

**Participants**

These data come from a larger study assessing the effectiveness of short-term clinician-assisted emotional disclosure therapy (see Anderson, Guajardo, Luthra, & Edwards, in press). A sample of 670 undergraduate women from a medium-sized midwestern university were screened to participate in the current study. Women completed the Sexual Experiences Survey (SES; Koss & Oros, 1982), which assesses past sexual experiences along a variety of behaviorally specific dimensions, and the Outcome Questionnaire–45 (OQ-45; Lambert et al., 1996), a general symptom questionnaire. Scores of 59 or below on the OQ-45 are considered to be in the functional range for female college students (Lambert et al., 1996). Inclusion criteria in the study included (1) endorsing experiences of sexual coercion (i.e., authority, continual arguments, and pressure were used to coerce sexual intercourse) or rape (i.e., threats of force or physical force were used to coerce oral, anal, or vaginal intercourse) on the SES; and (2) reporting a total score of 59 or above on the OQ-45. Sixty-five women (9.7%) met the criteria to participate in the psychotherapy study. Of these, 28 agreed to participate (43%). No further data were collected from women who declined to participate following the screening. All participants completed consent forms indicating the voluntary nature of participation before enrollment in the study. Fifteen women were randomly assigned to the treatment group (53.5%) and 13 to the non-treatment control group (46.5%). On average, women were 19.3 years old and the vast majority of the sample self-identified as Caucasian (85.7%).

For the purpose of the current study, audiotapes of the therapy sessions for the women who were randomly assigned to the treatment group were screened. Only women reporting experiences of intimate partner sexual assault were considered for analysis in the current study, resulting in a sample of five participants. The sessions with each client were transcribed and reviewed. Two clients with the most diverse assault experiences were selected for inclusion in the current analyses in order to depict
variations in how the APES model can be applied in work with survivors of intimate partner sexual assault (i.e., Hypothesis 2). Clients who participated in the study were assigned to one of five therapists, and the two clients selected for the current analyses were assigned to different therapists.

**Treatment Paradigm**

Clinician-assisted emotional disclosure (CAED; Anderson, Keefe, Lumley, Elliott, & Carson, 2001), adapted from emotion-focused therapy (EFT; Greenberg et al., 1993), allows clients to select any negative, stressful, or traumatic experience to disclose and explore. In the present study, participants were specifically encouraged to disclose emotions related to their experiences of sexual trauma. The treatment protocol included four sessions administered within a 4-week period, similar to the experimental protocol used for emotional disclosure while narrating a stressful life event (e.g., Pennebaker, 1999). A fundamental component of change within experiential-based treatment paradigms such as CAED is encouraging clients to link internal reactions associated with narrating an event to the external facts and meanings associated with the memory (Angus, Lewin, Bouffard, & Rotondi-Trevisan, 2004). Of note, in a meta-analytic review, Smyth (1998) documents that the experimental protocol used for emotional disclosure of a stressful event evidences improvement in negative affect, as well as sustained health, and physiological benefits up to 7 months posttreatment.

In our protocol, the CAED treatment adapted two of six EFT (Greenberg et al., 1993) treatment modules into a brief protocol format. The two modules included (1) systematic evocative unfolding (e.g., “unfolding”) and (2) emotional focusing (e.g., examining moment-by-moment emotional experiences). In systematic evocative unfolding, clients are encouraged to identify markers of problematic emotions within the trauma narrative, re-engage the experience to the extent that they are comfortable, and develop associations between their internal sensations and external memory of the past event (Eliot, Watson, Goldman, & Greenberg, 2004; Greenberg et al., 1993). Similarly, in emotional focusing, clients are encouraged to attend to the moment-by-moment emotional experience by remaining attuned to shifts in internal experience. This process includes the following subtasks: (1) identifying an emotional marker; (2) attending to the emotional experience; and (3) elaborating on feelings in order to foster a shift in feelings or emotional release (see description of EFT by Greenberg et al., 1993).

Although these therapeutic activities can be utilized to examine a range of problematic experiences, in our study these techniques centered on exposure-based narration of the client’s emotional experience at the time of the assault. Specifically, therapists aimed to balance systematic evocative unfolding and emotional focusing by shifting the focus of dialogue to both elaborate on the felt sense of moments within the narrative (e.g., emotional focusing) and encouraging the client to expand on the emotional structure of the narrative (e.g., systematic evocative unfolding).

Numerous researchers document that the process of telling of one’s story produces a structural change and systematic reorganization of a memory, such that the experience of trauma becomes less isolated and the feelings associated with it less intense, thus transforming the fragmented narrative into a more deliberately accessible, integrated, and sequential story (White & Epston, 1990). Thus, increases in the coherence and structure of a narrative is believed to reflect the method by which an individual processes the experience (i.e., prolonged exposure) and directly reconstructs incompatible memories and conflicting interpretations of the event (Resick & Schnicke, 1996). Trauma narratives that are longer, more detailed, coherent, and structurally organized are predictive of a more positive therapy outcome (van Minnen, Wessel, Dijkstra, & Roelofs, 2002).

**Therapist Training**

Therapists for this study included five female graduate student clinicians from a medium-sized midwestern university in their mid-20s to early 30s. Four of the therapists self-identified as Caucasian and one self-identified as Asian American. Graduate student clinicians volunteered to participate and were supervised by a licensed psychologist. None of the clinicians had specific training in the CAED protocol before the study. Intensive training was conducted over a series of 2 days and included didactic instruction on the administration of CAED as well as role-play practice utilizing scripts of sexual assault experiences. Before commencing the study, each clinician completed at least one supervised training case. Participants in the training case were recruited from the pool of participants who did not meet the inclusion criteria for the study. The purpose of the training case was explained to the participants before the onset of the experience, and all participants were provided with resources for local counseling and psychological services.

**Investigators**

Each of the five authors served as both reviewers of the therapy content and discussants in the assimilation analysis process. Three of the authors are
members of a laboratory that researches correlates of violence against women and prevention of sexual victimization, and two of the authors are members of a laboratory that researches psychotherapy process and outcome. Lindsay Marie Orchowski is a graduate student in clinical psychology in her mid-20s. Brian D. Uhlin is a graduate student in clinical psychology in his early 30s. Danielle R. Probst and Katie M. Edward are both clinical psychology graduate students in their mid-20s. Timothy Anderson is a clinical psychology professor in his mid-40s and has extensive experience with psychotherapy research.

Procedure

Assimilation of Problematic Experiences Scale
The assimilation model utilizes a scale that tracks changes in dialogical voices and their dynamics within the dialogical self over time (see Table I). For the purpose of the current study, the research team followed the four steps described by Stiles and Angus (2001)Stiles and Angus (2001a) common procedure in previous applications of the assimilation model.

Step 1: Familiarization and indexing. Each of the five authors read all therapy transcripts for the five participants who endorsed experiences of intimate-partner sexual violence (20 therapy sessions total). The first goal was to identify voices that appeared relevant to the ways in which clients were conceptualizing their unwanted sexual experiences. Particular attention was paid to identifying rape myths and conceptualizing them in terms of voices within the dialogical self. Other beliefs and attitudes, including traditional gender-role beliefs that appeared to be relevant to the clients’ conceptualizations, were also identified. The notes from these initial readings were catalogued together session by session in order to determine converging and diverging observations between authors.

Step 2: Identifying and choosing themes. After cataloging initial observations, it was found that all five authors identified similar themes in the majority of sessions. After discussion of the identified themes, consensus was reached, through discussion, with regard to the most important themes involved in therapeutic change. Given that the therapies of five clients were being considered, it was important to note which themes were common to most or all of the clients and which were unique to individual clients. Five major themes were found to be present in at least three of the clients—rape myths, traditional gender-role beliefs, attribution of blame, CBAs, and emergence of negative feelings—and are discussed next. Themes unique to an individual’s process of change are discussed as necessary later in the Results section.

Rape myths: All of the participants expressed having beliefs about the nature of sexual behavior in the context of a relationship that fit our aforementioned definition of rape myths (i.e., Hypothesis 1; see Burt, 1980). Some of these rape myths appeared to be accepted without question, whereas others seemed to be in question or even challenged but continued to influence the client’s thoughts and feelings about the unwanted event.

Traditional gender-role beliefs: The emergence of rape myths appeared to manifest within broader contexts of traditional gender-role beliefs (i.e., Hypothesis 1). For example, several clients discussed the assault experience in the context of stereotypical social and cultural hierarchies between men and women that position women as subordinate and submissive to their male partners (e.g., Blood & Wolfe, 1960). Each client had her own unique constellation of such beliefs, and the level of ascription to conventional gender-role beliefs played a key role in the process of making sense out of their experience.

Attribution of blame: Although the acceptability of self-blame for a sexual assault was conceptualized to fall under the broad category of rape myths, the question of where to place blame for the event, and how much blame to place, appeared to be an ongoing intrapersonal struggle for all of the participants (i.e., Hypothesis 1). At some point in their sessions, each client expressed some form of confusion or ambivalence concerning whether or not to attribute blame to herself for the problematic experience. The process of questioning and rejecting self-blame was viewed as a fundamental goal for therapy with survivors of sexual assault.

CBAs: Also emerging in each of the clients, to varying degrees, were attempts at self-assertion and the rejection of self-blame and self-damaging beliefs associated with the negative event (i.e., Hypothesis 3). Each client varied in her ability to consciously identify a desire for self-empowerment and challenge the other voices that were suppressing self-assertion. We were specifically interested in how the emergence of self-empowerment was associated with the relationship to the perpetrator of the assault (i.e., Hypothesis 2).
Emergence of negative feelings: Through the course of emotional disclosure, most clients tended to express increasing amounts of negative feelings toward the perpetrator and/or negative general affect (i.e., Hypothesis 3). It is important to note that each client began the therapy with different levels of awareness of their negative feelings associated with the event. We, therefore, attempted to identify where pretherapy processing of the event had brought the clients in terms of their emotional self-awareness. Some clients appeared to minimize their negative feelings using terms such as “annoyance” and “frustration,” whereas other used strong words such as “anger” or even “hatred.” We explored specifically how women’s voicing of negative feelings was associated with their current relationship to the perpetrator (i.e., Hypothesis 2).

Step 3: Selecting passages. Whereas all five authors participated in both individual and collaborative analyses of each of the sessions, each author was assigned to one of the five clients in order to select the appropriate passages that were most representative of observed process and change. Next, all five authors reviewed the selected passages taken from all five clients to determine agreement about their relevance and representativeness.

Step 4: Describing the process of assimilation. The final step of the analysis involved each author individually identifying important voices as they emerged in the transcripts, with particular focus placed on identifying CBA voices, those voices that appeared to be suppressing CBA voices, and how the dynamics of these voices changed or failed to change throughout the course of therapy. The goal of the analysis was to bring to light the client’s own self-understanding and how it was changing, as presented in the transcripts. With the exception of the theoretical assumptions already mentioned, we attempted to avoid interpretation that extended beyond what data presented in the transcripts.

This process was then repeated with the five authors together, reading through each transcript line by line in order to reach agreement concerning the conceptualization of the voices and where the client fell on the APES measure. Throughout the course of this process, there was substantial agreement among the authors with regard to the majority of conceptualizations. The few disagreements that emerged were resolved through discussion. It should be noted that the high level of rater agreement was likely due to the extensive discussion before beginning the APES analysis concerning how the important constructs being used (i.e., rape myth ideology, self-blame, traditional gender-role ideology) would be defined and how each author understands both the process of therapeutic change and what it means for an individual to be presenting to therapy with issues concerning a sexual assault.

During this process, the CBA voices were assigned a number on the APES scale for each session. When there was a significant change from one stage on the scale to another within the course of one session, the transcript section was noted. Significant changes in the assimilation process were sometimes observed to be taking place in between sessions, presumably as clients had further time to reflect on and process the emotional disclosure experienced in the session itself. Throughout this process, we attempted to describe how meaning bridges seemed to be forming between the CBA and other voices. According to the metaphor of the “meaning bridge,” progress in psychotherapy is commonly accompanied by differing voices learning to find common meaning and importance in material that was previously incompatible (Glick Brinegar et al., 2006).

We also examined those voices that appeared to be suppressing the CBA voices, using the APES scale, to determine whether they could be understood as being “assimilated” into the dialogical self community. Initially, this proved to be problematic, because it appeared that assimilation of previously warded-off CBA voices necessitated the rejection of certain internalized messages, particularly those identified as rape myths. To maintain the assumption that conflicting voices are all assimilated in successful therapy, we decided to consider rape myths not as voices themselves but rather as internalizations that are being spoken by a dominant cultural voice. According to this conceptualization, such voices are not silenced or rejected through therapeutic change but rather begin to reflect different meanings over time. Despite choosing this working metaphor for the purpose of our analysis, we still believe that the conceptualization of how to treat internalizations of oppressive cultural messages warrants further elaboration from assimilation model researchers.

Results

Assimilation Analysis 1: “Kim”

During the treatment, Kim remained in a relationship with the man who had perpetrated the sexually aggressive act against her. As the analysis suggests, Kim demonstrated relatively little movement along the APES scale over the course of the four sessions. It is important to note that Kim’s experience of intimate partner sexual assault was, reportedly, an
isolated event, although she feared a subsequent assault.

**Session 1**
The primary problematic voice identified early in the therapy was Kim’s present anger at her boyfriend. This voice can be understood as a CBA voice in that it represents Kim’s personal self-affirming reaction against an abusive and demeaning experience. Despite the obvious presence of this anger, throughout the session, the CBA voice of Kim’s self-affirmation was either minimized or warded off completely. For example, Kim’s first mention that she was “frustrated and upset” by the experience of intimate partner sexual assault was quickly downplayed with the following qualification:

Kim: It was just my boyfriend and it wasn’t … I don’t know … I guess I thought it wasn’t that big of a deal, because it wasn’t the first time and unless something extreme happened it wouldn’t have been the last time … so hey, what’s another time? … I guess I was more frustrated than anything.

Importantly, two themes in the prior statement are repeated throughout the therapy. First, Kim continually referred to her emotion at the time of the assault as “frustrated,” which we came to see as a warding off of more intense feelings of anger at being forced to have sexual intercourse with her partner. Further, when Kim’s therapist attempted to deepen her emotional experience of the frustration through evocative unfolding, she tended to minimize and ward off the importance of her emotions. Her manner of expressing frustration typically was tentative, guarded, and with little trust that her emotions might be valid. Second, her belief that the assault was not “that big of a deal” because it occurred with her boyfriend, rather than a stranger, is a good example of a “rape myth.” Here, the expression of more intense emotions like anger and rage is suppressed by an internalized cultural voice stating that the event, when perpetrated by an intimate partner, is not rape. This internalized cultural message repeatedly emerged in Kim’s explanations of merely being “frustrated.” For example, she explained that it “hasn’t had as much effect on me as it would with a stranger.” Later, she expanded, illustrating how feelings of self-blame work against her ability to be in touch with primary adaptive anger:

Kim: So, I think, like, I would have made it awkward if I was like no, just get off me like he was a complete stranger or something. It would have offended him and then it would have made me feel extremely uncomfortable.

Here, Kim seems to equate actively resisting an unwanted sexual advance by her partner to treating her boyfriend as if he was a stranger. It is possible that Kim’s reaction is a reflection of an internalization of the traditional gender-role expectation that women should be submissive to men in sexual encounters. Kim’s reaction also illustrates her internalization of the rape myth that unwanted sexual experiences are not perpetrated by individuals who women know and trust.

Kim’s veiled acceptance of the unwanted sexual experience allowed her to view it as less problematic. For example, Kim suggested that she would have felt worse if she had fought harder to resist the assault. She later confronted her boyfriend about the assault and described this conversation as “awkward.” Although she stated that their discussion had “fixed” the relational rupture that resulted from the unwanted sexual experience, she also revealed that she was still concerned that another assault may occur:

Kim: But it’s still that it has happened before, so I’m kind of worried it will happen again, with like college and if we drink or something like that, then it is liable to happen again. So, I don’t know. I don’t know how to explain it really.

Despite Kim’s ambivalence about the aftereffects of confronting her partner about the experience, the angry and frightened CBA voice remains present in the dialogical dynamics, but in a latent, rather than articulated, form.

At times, Kim acknowledged more intense, primary adaptive emotions, using language like “mad” and “aggravated,” but these moments were brief and her wording was quickly downplayed to “annoyed” and “frustrated.” Of particular note was that Kim asserted that she was frustrated specifically because her boyfriend did not listen or pay attention to her verbal resistance. By focusing on the interpersonal communication as the primary object of her frustration, it seems that Kim was able to avoid recognizing her feelings of anger associated with the assault itself.

The usefulness of the dialogical self model can be seen in this initial presentation as a result of the emergence of visibly conflicting self positions. The acceptance of rape myths and the self-position of a person who is reluctant to create conflict in a relationship appeared to be warding off CBA voices of anger and protest. The position of the CBA voice in the first session was, therefore, coded as moving between Stage 0 and Stage 1 because of Kim’s inability to consciously express anger toward her
boyfriend without either downplaying or rationalizing that emotion.

Session 2
The second session began with what appeared to be some recognition from Kim that the problematic experience had, in fact, been warded off before coming to her first session. Here the direct conflict between two voices is illustrated:

Kim: I put it in the past and it happened and I know it happened, but I didn’t think about it. So it’s just been something that I’ve thought about a whole lot more in the past days since we talked about it, so . . .

Therapist: And how are you feeling about that?

Kim: I’m not sure. It doesn’t upset me because I know that for the most part on my end I’ve done what I can to solve it and corrected it and things, and realized that it is in the past and something that we did talk about and fix. So it’s hard since I’m thinking about it because I did tell myself I wanted to put it in the past.

Kim’s fearful self-position appeared to suppress her unresolved feelings about the assault by putting it “in the past.” Whereas utilizing avoidance coping strategies immediately following a traumatic event may help an individual gain a sense of control, approach-oriented coping strategies are associated with better long-term adjustment (Frazier, Mortensen, & Steward, 2005). Her experience in the first session appeared to have stirred the CBA voices of anger and concern for her future well-being, potentially indicating to Kim that putting the event in the past does not equate to fully processing and resolving the problematic experience.

Expressions of anger in the second session were followed by confusion about whether or not she actually did desire to put the assault in the past. Kim initially claimed that she and her boyfriend had “fixed” the problem, without further clarification of what this meant. Kim also recognized that she felt somewhat depressed when thinking about the event. There appeared to be some “rapid crossfire” between expressions of more negative affect, a return to her “frustration” characterization of her response, and then back to an expression of her desire to put it in the past. Her description of how the experience had recently been affecting her daily life reflected these conflicted dynamics, as can be seen in the following statement:

Kim: It will just pop into my head or I’ll think about . . . having to meet today and think about what we’re going to talk about, and then I’ll end up thinking about what we’re going to talk about. I think about it and then I start thinking about the conversation that me and my boyfriend had and . . . then I, in my head, make it better, like it’s not something to be upset about now, and since we talked about it and things like that . . . but it’s just when I’m not busy doing something or when I start thinking about things I have to do today, and things like that, it just somehow pops into my head and I start thinking about it longer.

This is the first of several utterances indicating that discussing the assault in the context of therapy had brought Kim’s problematic feelings, as well as memories of the assault, into greater awareness. In fact, Kim noted that the assault had not consciously bothered her for some time. Shortly after making this statement, Kim described what may be some mild dissociation associated with memories of the assault:

Kim: I ended up blocking out everything else that was going on, I was sitting in my room . . . my phone was ringing and I didn’t even realize it until it rang a couple of times but I end up just blocking everything else out and just sitting and thinking about some aspect that relates to [the assault].

From the point of view of the assimilation model, Kim’s expressions of confusion, and the symptomatic distress associated with it, can be conceptualized as attempts to make sense of the assault and resolve conflicting emotions. However, Kim was not given an opportunity in this session to pursue the task of processing her current feelings of conflict any further. Rather, the therapist quickly jumped from discussion of her recent struggles to the manualized imperative to spend the session focusing on the emotional experience at the time of the assault. In a rather abrupt manner, the therapist interrupted the flow of Kim’s discourse concerning these attempts at meaning making:

Therapist: Would you be ready to go back and then do what we did last time. And work on the emotions . . .

Kim: Uh huh.

Therapist: Go back into it and look at the scene and kind of retell the story once again . . . and I’m going to probably interrupt you a little bit more, and maybe umm . . . have you look at certain units with a little more . . . sort of focus.
The remainder of the session is focused on the emotional disclosure intervention in which Kim is directed to recreate in the present the sexual assault and is encouraged by the therapist to stay with the emotions she experiences as they arise in vivo.

It did appear that Kim recognized the assault as a problem but was still not clear in articulating exactly how the assault was problematic. The problem was not consciously recognized and clarified as an expression of the CBA voice’s desires for anger and protest. Namely, Kim did not express a need to have her boyfriend recognize her anger and hurt to the extent that she could be assured that such an event will not happen again. For this reason, Kim’s CBA voice remained at Stage 1 in this session, with some limited movement toward Stage 2, which was ultimately warded off by the end of the session.

**Session 3**
Kim began Session 3 by recognizing that, after the previous session, her thinking about the event had become more emotional. However, Kim also expressed a sense of confusion about feeling more emotional about the assault, yet also desiring to avoid thinking about the experience. For example, the following exchange occurred between Kim and the therapist at the beginning of Session 3:

Therapist: So, when you left last week, how did you feel, how did the evening go?

Kim: Umm, it went pretty well, I was just really busy with everything, so I kinda tried to keep my mind off of it. And I noticed that last time, in between [the two sessions]; I thought about it a lot. I know walking, walking home after the session last week, it was a little bit more emotional and more in depth than just thinking about something and it popping into your head and then leaving, and then not thinking about it again. Umm... and then, it was on and off, both Monday and Tuesday, but not really in depth like how it was last week.

At this point, the therapist engaged Kim in the emotional disclosure protocol. It is unclear whether there was a connection between Kim’s effort to “not think” about the assault and the fact that her emotional experience of the assault was becoming more intense. Importantly, it was noted that instead of exploring Kim’s conflicting emotions, the therapist attempted to engage Kim in discussing her feelings at the time of the assault. At the end of the third session, Kim revealed that it had been difficult for her to go through the emotional disclosure process but that she felt more able to do so. Although she was able to discuss the experience more easily, there was no indication that she was beginning to challenge the suppression of her CBA voice on any conscious level. Kim, therefore, remained at APES Stage 1, with again some limited movement toward Stage 2.

**Session 4**
In Session 4, Kim reported that she had experienced some degree of cathartic release from the emotional reexperiencing over the course of the therapy. Despite this apparent benefit, it was difficult to clearly determine the current state of her CBA voice and those that were suppressing it, because Kim described her experience of catharsis as feeling more able to leave the experience in the past. As such, during this session, Kim remained at APES Stage 1, with, again, some limited movement toward Stage 2. There was no further discussion about how she felt toward her boyfriend currently, whether she had recognized and accepted her anger toward him as justified or whether she had come to feel confident that a future assault would not occur.

In addition, Kim returned in this session to a conceptualization of the event as “confusion” between her and her boyfriend. On the one hand, she gave indications that he was aware that she did not want to have sex. On the other hand, Kim again downplayed her ascription of responsibility to him for forcing her engagement in unwanted sexual activity by speculating about whether or not she had protested sufficiently or sent clear enough messages. Following the emotional reexperiencing in this session, the therapist attempts to challenge Kim’s conceptualization of the event:

Therapist: Really, it may just have been, oh well, he didn’t get it, and we talked about it and it’s fine now. Maybe it is as simple as that. Maybe it also... on the other hand, there is more to it, you know? Maybe it was more hurtful than that, and maybe you’re not reexperiencing, maybe you’re kind of holding back from reexperiencing the full blow of the emotions from back then because it, it was worse than just a misunderstanding.

Kim: Mmm hmm.

Therapist: Umm... you know, maybe on some level he did ignore pretty clear, nonverbal information and did not respect your wish, and maybe it’s not that easy to say it’s okay. You know, maybe there’s more hurt that you’re not ready to experience.

Kim: Mmm hmm.
The session followed this pattern of the therapist making different suggestions about how and why Kim may be holding back from recognizing the depth of her hurt and anger regarding the assault. Kim offered no other verbal response to the therapist’s interpretations and appeared to disengage with the therapist at the onset of the dialogue. This was taken as further evidence that Kim was continuing to look for ways to put the event in the past, without attending to the protests of her CBA voices.

The final minutes of Session 4 focused on Kim’s description of her experience of the therapy. Her utterances appeared to reflect both a difficulty integrating the therapist’s interpretations and her need to ward off the problematic emotions by putting the assault in the past.

Therapist: What are you taking from this, our four meetings . . . in general?

Kim: I know what I’m feeling and pay attention to it more because, after talking so much about my feelings I have in the past 2 weeks noticed my feelings more than I have before. And kind of realized the things I’m thinking. So, probably that just, I think I have come to terms with it a little bit more with being able to talk about it and how I was feeling. And then knowing how to deal with a situation if it happens again.

Therapist: Mmm hmm.

Kim: And be able to deal with it right away and everything like that . . . so . . . I think it’s helped a lot, with even future experiences, and it may be not necessarily the same thing, but . . . it shouldn’t happen in a way that is awkward or something along those terms that I’m just not comfortable with.

Certainly, Kim’s report that she felt more self-efficacy in dealing with potential future events should not be underemphasized, nor should her reports of experiencing some emotional relief as a result of the therapy. However, as it can be seen in some of these final selections, there was little coherence displayed in how Kim conceptualized the assault and no evidence of her accepting the anger and outrage of her CBA voice.

The realization that Kim was harmed and had a right to be angry still appeared to be warded off, even after lengthy interpretations by the therapist explaining that she believes Kim may be using avoidance to cope with her anger surrounding the assault. It is important to note that Kim began the first session with a rating of Stage 0 on the APES scale, indicating that her CBA voice had become completely warded off by a submissive, nonconfrontational self-position as well as internalized rape myths. At the close of therapy, Kim remained at APES Stage 1, with some limited movement toward Stage 2.

**Assimilation Analysis 2: “Sarah”**

In contrast to Kim, Sarah showed rather marked movement in the assimilation process over the course of therapy. As discussed later, the differences between these two cases reflect the importance of recognizing a person’s readiness, resources, and ability to face the emotionally painful elements of a traumatic event. Further, differences in the two therapists’ approaches to the manualized treatment may have also contributed to the relative differences between the two cases.

Sarah’s case is described in terms of the important dialogical voices identified and their dynamics as well as her questioning of how rape myths and conventional gender-role ideology have kept her CBA voice suppressed. Sarah’s conceptualization of how the problematic experience will influence her future romantic relationships is also delineated. The primary foci of analysis are the first two sessions of therapy because these exemplify the most dramatic changes in the assimilation process.

**Session 1**

In Sarah’s first session, she discusses multiple sexual victimization experiences that were perpetrated by her ex-boyfriend. Several voices were identified that appeared to be suppressing the voices of her anger, her own empowerment, and sense of autonomy in relationships with men. Whereas Kim’s manifest suppressing voices were reflective of more obvious cultural rape myths (i.e., “Rape is perpetrated by strangers”), Sarah’s suppressing voices appeared as internalizations of traditional gender-role ideology, in which women are expected to be sexually available to men. One of the most marked differences between the two cases is that Sarah had ended her relationship with the perpetrator of the assault before the onset of therapy. Nonetheless, it is striking how the internalizations from this important relationship remained with her well after the relationship ended and are easily conceptualized as part of her dialogical self.

Sarah described to the therapist an ongoing interpersonal dynamic in her relationship in which she felt pressured to justify her wishes to not engage in sexual intercourse. Sarah explained that, although she did not feel ready to engage in sexual intercourse with her boyfriend, she also worried that not meeting her partner’s requests may jeopardize the
relationship. Specifically, she worried that her boyfriend may cheat on her. Moreover, Sarah's boyfriend also directly communicated to her that he believed it was unfair and hurtful toward him to refuse to engage in sexual intercourse. Sarah noted that she was unsuccessful in justifying her desires and felt guilty for her self-assertion. For example, she noted that she felt "silly" and "immature" for feeling that she was not ready to have sexual intercourse. Thus, we perceived Sarah's feelings about her boyfriend's behavior to be ambivalent at the onset of therapy:

Sarah: He's like, you can't expect me to just, say okay, and then quit sleeping together ... I'm like, I don't know why not. I'm like, we were together for almost a year, and I didn't sleep with you. So what's, what's the difference now? Let me figure out if I really want this or not. And he said that ... he just kept telling me that it wasn't fair for him. I asked why and he said I was just silly and I was being ridiculous.

Despite Sarah's self-assertion, the assumption that she was expected to meet her partner's sexual needs in spite of her own reservations was bolstered by stereotypical messages that she had received from her family about how women are expected to act toward men. She described these generalized expectations about gender roles as follows:

Sarah: I've just been so used to it. I watched it with my grandpa ... he just kind of reigned over my grandma ... telling her what to do ... and you know you're going to do this, you're going to have this ready when I need it and all that ... And, so I was kind of used to that aspect of it, and then with my dad ... that was easy for me, because my boyfriend was so much like my dad.

Sarah’s ability to articulate these internalized messages and express her ambivalence about them in the first session suggested that she came to the therapy already moving toward Stage 2 in the assimilation model. Specifically, she reflected a vague awareness that there was something wrong with her boyfriend’s actions toward her but was unsure how to understand the experience. She appeared uncertain about how seriously to take her CBA voice or what role it should play in her understanding of herself in relation to others.

In the first half of this session, Sarah also struggled with self-blame for the unwanted sexual experience. She questioned whether she could have prevented the assault if she would have resisted more forcefully.

These utterances are strikingly similar to Kim's questioning of whether she had sufficiently communicated her desire to not have sexual intercourse:

Sarah: And I just didn't know what to say at the time. And I felt like I wasn't being clear, like I wasn't being clear enough to make him understand, and a lot of times I felt like my reason wasn't valid. Like he would say, you can't expect me, you've been sleeping with me for so long you can't expect me to stop; it got to where that would make sense to me. It got to where the stuff he would say, I would put value on, like I would try to understand.

Although Sarah recognized that her boyfriend's use of force was inappropriate, she described the event with a high level of self-blame, placing fault on herself for not more forcefully resisting. Sarah’s own description of the origins of the internalization of her boyfriend's voice and its suppression of her CBA voices is also present in this session. The self-blame typical of this dynamic is seen again later in this session:

Sarah: I just feel like I should have known better than to put myself in that position.

Therapist: Well, it is not like you did or didn't do anything to put yourself in that position.

When Sarah engaged in this dialogue of self-blame, the therapist consistently challenged such voices and gently questioned what Sarah’s CBA voices were telling her. As this sequence progressed, Sarah’s uncertain tone of voice began giving way to an angrier tone. A voice emerged that was not ambivalent in ascribing blame to herself or her boyfriend for the assault. Sarah became clearer in ascribing blame to her boyfriend for not respecting her desires. This subtle shift from ambivalence to anger was commonly accompanied or preceded by utterances from the therapist that were gently bolstering Sarah's CBA voices. In addition to this shift, the following segment also displays Sarah's own awareness of how her internalizations from her parents play into the dynamics of the situation at hand:

Sarah: I had all this pressure from my parents; I had all this pressure from him. I just didn't know how to handle it, so I just stepped away.

Therapist: And where are you in the whole thing?

Sarah: Just in the middle it always seemed like, I didn't know if I was making my boyfriend happy I
wasn’t making my parents happy . . . Even my dad, up until I got my boyfriend, and then my boyfriend was the person that I was attached to outside of my dad, and so, they were pretty important.

Therapist: Yeah, very important. He was a very important person in your life.

Sarah: I mean that’s been my whole thing all through high school. I haven’t wanted to disappoint my dad, and then it turns into, my boyfriend is my dad, and then I never want to disappoint him.

The remainder of the first session was spent exploring Sarah’s feelings about others’ expectations of her and where her own desires fit into a life that was focused on the expectations of others. Sarah was able to recognize that, in fact, she was unclear about her desires in life and what would make her happy. There was further recognition that the voices of her desires had become lost in the sea of others’ voices. Therefore, we positioned Sarah’s CBA voice as moving from Stage 2 toward Stage 3 on the APES scale by the end of the first session.

Importantly, the prior discussion represents a significant disjuncture from the study protocol, which focused primarily on emotional disclosure of the assault. However, in this session the therapist made virtually no attempt to utilize the emotional reexperiencing protocol, which would encourage Sarah to think back to the time of one of the assaults. Although the therapist asked about some details of the events as well as the emotions Sarah was experiencing, this quickly returned to a discussion about how Sarah was feeling now or how these experiences continued to affect her in the present. It was clear in this first session that Sarah felt comfortable discussing her current emotional experiences. The therapist also appeared to get a sense that making that present experience the focus of the session would be most beneficial, even though this would diverge from the treatment protocol.

Session 2
The second session began with a report from Sarah that indicated the substantial impact of the first session.

Therapist: So you feel better after thinking about it all?

Sarah: Yeah, actually I have. With what we went through I thought I’m going to be in the worst mood for the rest of the weekend because I’m going to be thinking about this and it’s going to be horrible, and I’m going to cry, and it’s going to be intense . . . But after I had got beyond the emotional, where I’m crying, and still upset, I can be a little more logical about it and I just feel like I hadn’t really thought about it . . . Like, I felt that at the time I wasn’t being reasonable, like I was the one that was being not reasonable about it, and that he was the one that was making all the sense.

Therapist: So you’re saying now, upon reflection, you realize that wasn’t the way it really was?

Sarah: Right. And now I know better. Now I know that I’m not crazy and at the time I wasn’t being . . . just some little girl who didn’t know what she was doing, because I was a little girl that didn’t know what she was doing, and I was just really . . .

Therapist: A little girl making big decisions for her own life though.

Sarah: Right, right, definitely!

This rather drastic shift in Sarah’s conceptualization of who was at fault and her role in the events begs the question of whether such a change can occur after only one session. How is it that a deeply held belief about one’s submissive role in a relationship changes almost overnight? A dialogical self perspective seems to offer a potential answer to this question of sudden gains. As seen in the first session, Sarah’s CBA voices were clearly manifest, only subdued and put into conflict by several suppressive voices. It appeared meaningful to interpret this shift in Sarah’s ability to recognize her angry feelings as the beginnings of the CBA voice emerging with more strength and influence over how Sarah felt about the experience. Shortly after Sarah’s explanation of how the first session had impacted her conceptualization of the assault, the therapist made a point of introducing the emotional reexperiencing. Her own conceptualization of what they had done in the first session adequately describes how the first session had deviated from the manualized protocol:

Therapist: Last time we talked about some broader things. I think that for the purposes of the session what I was going to ask you to try to do with this session, if you’d be willing to . . . We’re trying to concentrate, if you can think of, maybe one of the times, that were more salient in your mind, that you recall it happening, him wanting to and you not wanting to . . .
Sarah’s process of emotional reexperiencing presented some initial confusion as to whether or not there were some warded-off CBA voices associated with her conceptualization of the assaults. Following her recounts of two instances of sexual assault by her boyfriend and an explanation that the events were exacerbated by her discoveries that he had been cheating on her, Sarah offers the following conceptualization:

Sarah: I feel like I’m not giving you enough because I don’t really think that the physical act was what, was the biggest problem for me. I think, emotionally I felt more abused than physically. And I don’t, abuse is a strong word, and I don’t think it wasn’t that, but I just feel like, emotionally he hurt me, more than he ever could physically.

Therapist: It almost sounds like you were feeling like sex was more important than you.

Sarah: Mm, uh, yeah (laughs). That definitely . . . and, last week, I don’t know, I don’t remember if I told you, but when he went to college it felt like all we did was have sex, and I . . . that was one of the arguments that I had, that you know, having sex with me was way more important than being with me, than just, you know, getting to see me for an hour. And I, I didn’t feel like he should put that above me. Because I was there before the sex was.

At first glance, it may appear that Sarah was warding off the feelings associated with physical abuse. On further inspection, it can be inferred that she was actually attempting to situate the sexual assault in the broader context of her boyfriend’s tendencies toward abuse and his lack of concern for her desires, feelings, and well-being. Unlike Kim, who generally treated the assault as an isolated incident in her relationship, Sarah attempted to make sense of the assaults within the context of an abusive relationship. We conceptualized this as a more complex emergence of the CBA voice, attempting to treat the experience as a whole and identifying the emotional aspect of the abuse as harmful.

Rather than return to the emotional reexperiencing protocol, as Kim’s therapist had, Sarah’s therapist picked up on the larger interpersonal context of the assault and gently encouraged Sarah to express her emotions about the relationship and relationships with men in general. Although this was a clear deviation from the treatment protocol, the therapist takes Sarah through a much more productive emotional disclosure process than would have happened had she strictly adhered to the manual.

Sarah’s laughter at this point in the discourse again draws attention to dialogical dynamics. Sarah was expressing the natural CBA voice with confidence, articulation, and a clear sense of what she really desired in a relationship. It was speculated that despite the well-developed state of the CBA voice, this point in the session may have been one of the first times Sarah had disclosed such self-assertions to another person, particularly a person of authority, who was able to validate them. The realization that her CBA voice was legitimate can be viewed as an insight or an “Aha!” experience that may reasonably bring about the experience of laughter. It was designated that at this point Sarah began to move
from Stage 3 to Stage 4 of the assimilation model. Specifically, Sarah not only appeared to have insight into the fact that her own desires had been suppressed and invalidated but also demonstrated insight into the process of how the internalized messages regarding women’s roles in relationships brought about this suppression.

The remainder of the second session was spent on a similar dialogue; however, near the end of the session, the therapist returned briefly to Sarah’s experience of the assaults, questioning why it was difficult for her to remember details of the events. Specifically, the therapist inquired whether Sarah was processing her emotional response to the events. The language used plainly reflects the process of the therapist ensuring that Sarah does not have lingering feelings that have been warded off. Sarah was able to discuss in more detail some of the unwanted sexual occurrences with more fluidity. She explained that during these events she found herself numb, not wanting to feel or experience what was happening. The therapist normalized this reaction as a common response to a traumatic event. Although the treatment protocol implied that further attempts should have been made to help Sarah reexperience the events in more vivid detail, the therapist accepted Sarah’s reports that she was not actively avoiding memories of the assaults.

**Sessions 3 and 4**

Because Sarah’s major movement on the APES scale took place between the beginning of the first and second sessions, these final two sessions are presented together. Details have also been omitted, because their content included a significant amount of identifying information. The process of Sessions 3 and 4 was conceptualized as serving to strengthen and crystallize the insights in the first two sessions and to encourage future growth and help seeking.

The third session begins with an expression by Sarah of how surprised she had been by the impact of the first two sessions:

Sarah: It’s kind of helped to prioritize ... made me realize that hey ... you know, it’s not all that bad, and I need to figure out what I need before I can make anybody else happy.

Therapist: So make yourself happy and figure out what you really want before ...

Sarah: And this is an odd thing for, it’s really weird, I thought, oh one session, this is going to do nothing ... and then I was like, wow! (laughing)

In these remaining two sessions, the therapist refrained from engaging Sarah in emotional reexperiencing of the assaults. Rather, the therapist encouraged Sarah to explore the themes of internalized pressure from others that were identified in the first and second sessions. This exploration further elucidates the power and extent to which internalizations of traditional gender-role beliefs were suppressing Sarah’s CBA voice. Sarah’s internalized suppressive voices came not only from her family and boyfriend but also from her school, her boyfriend’s family, and even members of the town in which she grew up. It was also discovered how manipulative and punitive Sarah’s father could be and how his behavior clearly prevented her from having her own voice in the context of the family. Importantly, Sarah explained how having an objective listener who was completely removed from her social network helped to bring about the emergence of her own genuine feelings and desires.

By the fourth session, Sarah clearly articulated her understanding of how and why she has never been able to determine what she desires for her own life. As she mentions, these brief sessions allowed her a space to begin to identify what she does not want in her relationships with others, particularly with men. She discussed her desire to get more geographical distance from her family in order to learn more about her own desires. She was also able to identify differences between the unhealthy friendships that she had in high school and the healthier, more supportive ones that she had developed in college. In this session, Sarah also began to report on behavioral changes that she had witnessed since the onset of therapy. In particular, she reported feeling that she could ignore attempts from her ex-boyfriend to reinitiate the relationship. In addition, Sarah reported having disclosed to her mother that she had been coming to the therapy sessions and had some serious issues with her family relationships that she wanted to address. In contrast to the ambivalence seen in Kim’s presentation, Sarah’s anger toward both her boyfriend and the people whom she identified as sending her negative messages about herself was consistent and direct throughout the sessions.

We positioned Sarah’s CBA voice at Stage 4 by the end of the fourth session. Notably, the rapid and
drastic emergence of this voice in the first and second sessions was met by Sarah with excitement and enthusiasm. This reinforced our belief that Sarah came into the therapy already moving toward Stage 2 in the assimilation model, as movement from Stage 1 to Stage 2 generally reflects increases in stress and anxiety that were not witnessed in Sarah’s self-reports. Further, the validation and encouragement from the therapist seemed to create an ideal context for the emergence of Sarah’s sense of autonomy and agency. Given that internalized rape myth ideology and conventional gender-role beliefs played a significant role in suppressing the CBA voices of both Sarah and Kim, we believed the direct challenging of cultural messages in Sarah’s voices of both Sarah and Kim, we believed the direct challenging of cultural messages in Sarah’s therapy sessions played a substantial role in fostering her sense of empowerment within the brief therapy. The remainder of the therapy appeared to bolster the presence of the CBA voice and its role as an important voice in the self and helped Sarah realize that she would require more work in the future to establish the CBA voice as a dominant, guiding voice in her dialogical self.

Discussion
The two cases discussed in this analysis offer distinctly different presentations of movement on the APES scale over the course of four sessions of emotional-disclosure therapy (see Table II). These cases were selected for the current analysis specifically because of the survivors’ differing decisions to remain in relationships with the perpetrators of the assault (i.e., Hypothesis 2). The primary goal of the current study was to illustrate the unique dynamics of each of these cases in order to offer clinicians potential insights into both barriers and facilitators in the emergence and growth of CBA voices within the dialogical self. The APES model and exploration of CBA voices were used to describe changes in dominant and submissive voices as they related to the clients’ emotional disclosure of experiences of sexual victimization (i.e., Hypothesis 3). Themes of defining one’s personal autonomy, well-being, equality, and self-assertiveness were identified in both clients’ therapy dialogues. These therapy experiences highlight how broader cultural constructions may impact a survivor’s ability to make meaning of a traumatic event (i.e., Hypothesis 1). More specifically, constructions such as traditional gender-role beliefs and internalized rape myth ideology may impact a survivor’s ability to formulate a problem statement by suppressing the adaptive emotion of anger. Because survivors must necessarily draw on existing ideologies (i.e., rape myths) to explain their experiences, it is possible that while the language of a narrative may be consistent with experiences of sexual victimization, the narrator may not label the experience as such.

The most qualitatively meaningful change in affect was often witnessed when the therapist or client directly challenged oppressive societal messages about traditional gender roles or violence against women, thereby allowing for the emergence and acceptance of voices that can easily be categorized with the CBA construct. Whereas growth in psychotherapy is a function of numerous factors, we identified three levels of difference in these cases that may be particularly useful for clinicians working with survivors of intimate partner sexual assault. These include (1) the survivor’s relationship status with the perpetrator, (2) the client’s readiness for CBA voices to emerge, and (3) the therapist’s approach to implementing a manualized treatment paradigm, which may preclude exploration of broader sociocultural themes.

At the onset of the study, Kim was still in a relationship with the perpetrator of the assault, whereas Sarah had since ended her relationship with the perpetrator. Kim’s need to maintain a positive internalized image of her boyfriend made it difficult for her to question and experience a full range of emotional reactions to the assault. Sarah’s distance from the relationship afforded her a broader perspective on her emotional experiences and her relationships with men in general. It is important to mention that these clients’ decisions to stay in or leave the relationship were likely affected by other

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important themes. For example, research suggests that adherence to rape myth ideology, traditional notions of gender, and self-blame are all predictive of women’s decisions to remain in abusive relationships (Truman-Schram, Cann, Calhoun, & Vanwallendaal, 2000). As demonstrated by these narratives, it seems as though Kim, who was still in a relationship with the perpetrator, possessed greater adherence to rape myths and blamed herself more than Sarah, who left the perpetrator. Women’s decisions to stay or leave may influence their ability to formulate a problem statement and further progress through the APES stages. These themes underscore the importance of carefully evaluating the current state of the relationship (and variables related to this state) when clients initiate psychotherapy. How much emotional distance exists between the client and the perpetrator and how the client feels about the perpetrator’s current role in his or her life should be assessed. The therapist’s willingness to acknowledge the perpetrator as a significant figure in the client’s life was identified as a vital difference between the therapies. Specifically, the verbal recognition and validation by Sarah’s therapist of the importance of her relationship with the perpetrator contrasted with the response of Kim’s therapist, who seemed to pay little attention to that relationship. It is important to recognize that survivors of intimate partner sexual assault may desire to maintain some positive representations of their partner, especially in light of qualitative research suggesting that most college women who experience sexual assault do not acknowledge their experiences as abuse (Gidycz & Layman, 1996). Thus, the significance of an individual’s relationship to the perpetrator of an assault should not be underestimated within therapy.

In Sarah’s case, recognition of the importance of the relationship may have facilitated the formation of a meaning bridge between the submissive voice’s desire to view herself as a good girlfriend and the competing CBA desire for an egalitarian relationship. Osatuke et al. (2007) point to the importance of collectivist versus individualistic value judgments in understanding the dynamics of submissive and dominant voices. These authors argue that many women may be taught that maintaining relationships and family solidarity takes precedence over the assertion of individual desires. The therapist’s recognition of the importance of Sarah’s relationship with her ex-boyfriend and her family may have validated the voice that wished to prize relationships and solidarity to them, while also encouraging her to explore her individual autonomy. Here, Sarah began to recognize that satisfying relationships could involve taking care of other’s needs, while not sacrificing her own.

The therapists’ contrasting focus on the client’s relationship to the perpetrator and social contexts seemed to reflect a broader difference between the two therapists’ approaches to executing the manualized protocol. Given that therapists often draw from varying levels of training and expertise when implementing a manualized therapeutic technique, these stylistic differences further highlight the importance of considering therapists’ own awareness and “location” within larger cultural dialogues when fluidly implementing treatment paradigms. For example, in both cases, there were attempts to discuss the client’s feelings toward the perpetrator on a broader level. However, Kim’s therapist continually redirected her to the emotional reexperiencing of the traumatic event itself, allowing her little, if any, opportunity to explore her conflicting emotions regarding the context of her relationship or of how she felt about her role in the relationship. As was learned from Sarah’s case, a more complete emotional reexperiencing appears to require emotional experiencing of all feelings related to not only the event but to its larger relational and sociocultural context as well. Specifically, exploring how a broader social context impacts an individual’s ability to make meaning of an experience may be especially relevant for trauma survivors. For example, clients may need to experience anger toward sources of rape myths and misplaced self-blame and guilt (Mason et al., 2004). In terms of systematic evocative unfolding, it might be useful if the clinician remains attuned to how emotions are situated by aspects of the traumatic event that evoke rape myths as well block CBA voices. In regard to EFT, greater attention to differentiating rape myths from core beliefs about the meaning of relationships (and the desire to maintain interpersonal contact) might serve as a useful prologue to confrontation of rape myth voices through two-chair technique.

These findings are reflective of ongoing discussion of the administrations of manualized treatment protocols. Evidence has been presented suggesting that strict adherence to manuals may not enhance outcome, and in some circumstances may actually hinder creativity in the therapy process (Anderson, Ogles, & Weiss, 1999; Strupp & Anderson, 1997). Here, we witnessed that Kim’s therapy reflected what has been called a “ballistic” use of manualized treatment (Stiles, Honos-Webb, & Surko, 1998). In the therapist’s attempt to stay true to the protocol, the client was consistently bombarded by intervention acts that missed the emotional experiences of the client as well as the full context of her experience. The strict focus on the re-experiencing exercise frequently prevented connections between past and current meaning, thus making the formation of meaning bridges difficult, if
not impossible. Sarah’s therapy, on the other hand, deviated from the stated protocol to the extent that it allowed her to address the fuller context of her pain. It was clearly seen throughout the sessions that Sarah was more emotionally charged and engaged and expressed a full range of anger toward her boyfriend, not only for the assault but also for his disrespect toward her and habitual disregard for her feelings. In places where the manual would have diverted attention away from emerging meaning bridges, Sarah’s therapist regularly treated the protocol with a degree of creative flexibility that allowed such connections to manifest.

The assimilation model proved to be a meaningful and rewarding method for qualitatively evaluating change for the clients in this study. It is suggested that exploration of the dialogical dynamics using this method would be useful for both researchers and clinicians working with trauma survivors. In orienting a treatment plan, the therapist can listen closely for CBA voices and what they are trying to say. It is also important to understand how ready the client is to begin to explore them.

The current study suggests that established psychotherapy approaches may be enhanced by attending to the broader relational and sociocultural context surrounding interpersonal trauma and recovery. Indeed, the dialogue and focus of psychotherapy may be drastically altered when working with individuals who are victimized by an acquaintance or romantic partner compared with those victimized by a stranger. Thus, we suggest that a more comprehensive understanding of the healing functions of storytelling in therapy with survivors of sexual victimization may assist clinicians in deconstructing the complexities and subjectivities within rape narratives. We also believe that supplementing current treatment approaches with social constructionist and constructivist theory may provide a more comprehensive framework from which to guide processes of narrative reconstruction.

Some limitations of the current research must be noted. Given the paucity of research examining the processes that influence meaning making and therapeutic change for survivors of sexual assault, investigators in the current study specifically selected clients at varying stages in their relationship to the perpetrator of the assault to elucidate potential differences in the factors that influence an individual’s ability to formulate a problem statement following experiences of sexual victimization. Given that the current analysis only included two survivors of intimate partner sexual assault, the APES model could be utilized to conduct future research examining the complexities of the healing processes among women sexually assaulted by a stranger, family member, or acquaintance. Future studies may also include an expanded array of outcome measures, measures of therapeutic process, as well as outcome questionnaires to better understand why some women declined to participate in the study. Nonetheless, the current study aids in the construction of APES theory and the use of dialogical self by paying specific attention to how important voices may be influenced by larger cultural contexts (e.g., gender role beliefs, rape myths). Future studies are needed that pay more attention to the cultural contexts of important voices across diverse populations.

Currently, feminist scholars advocate for a more comprehensive research agenda that moves beyond individual levels of analysis and affords more attention to the discourses of power and control embedded within dominant social ideology. Thus, just as research must move beyond an elementary portrait of individual rapists and their personalities in order to uncover the dominant ideology that drives and maintains acts of sexual violence, it is also necessary for current therapies to be infused by a conceptualization of trauma that extends beyond the individual’s experience to consider the larger sociocultural constructions of violence against women.

References


Frazier, P. A., Mortensen, H., & Steward, J. (2005). Coping strategies as mediators of the relations among perceived control...


