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Testing the Integrative Psychotherapy Model: An Integration of Psychoanalysis, Cognitive-Behaviorism, and Humanism

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Walden University
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Abstract

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by

Lindsay Parsons-Sterious

MA, Eastern University, 2001

BA, Millersville University, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The integrated psychotherapy model (IPM) is an insight-oriented, integrative therapeutic approach that weaves psychoanalytic, cognitive-behavioral, and humanistic approaches into a treatment methodology. This model is new and untested; therefore, its therapeutic effectiveness is unknown. The purpose of this study was to measure the treatment effectiveness of IPM using Bell's Object Relations and Reality Testing Inventory, the Constructive Thinking Inventory, and the Working Alliance Inventory. Participants in the study included 19 undergraduate psychology students volunteering for extra credit and 11 clients of counseling psychology graduate students. This quasi-experimental, pretest-posttest, nonequivalent group study involved 9 sessions of IPM for the treatment group and 9 classes in a general psychology course for the comparison group. An analysis of covariance using the pre-post testing of object relations and reality testing, productive and unproductive thinking, and working alliance measured changes in these constructs and determined the therapeutic effectiveness of IPM. Results revealed that there were no differences between the experimental and comparison groups. Although no significant differences were demonstrated when comparing pre and post testing, this study demonstrated that 9 sessions of IPM did not harm those who underwent the treatment; this finding is positive given the need for further research to potentially validate the IPM as a new and effective integrative model for psychotherapy. It is recommended that a similar study be repeated with more seasoned IPM therapists, a longer treatment period, and the focus of change on client symptoms.

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Chapter 1: Introduction to the Study

Introduction

The practice of psychotherapy is a melding of art and science. Practitioners constantly use decision making to choose interventions to best alleviate a client's symptom presentation and to engage longer-term changes within the client's relational world (Magnavita, Critchfield, & Castonguay, 2010). When a client presents with complaints about a depressed mood and problems within his or her relationships, a practitioner chooses to conceptualize that client's symptom and relational concerns based on a theory or set of theories and begins to use techniques and interventions to alleviate depressive symptoms and to transform relational dynamics.

A cognitive behavioral approach could be used to address some of the negative thoughts often demonstrated in individuals with depression. A more relational approach (interpersonal, object relations, client-centered) could be used to identify relational issues that are fueling other problems (author, year). A psychoanalytic approach could be used to uncover unconscious motivations that may keep a client in unhealthy relationships as an attempt to resolve unhealthy relationships from the past (McWilliams, 2004). There are many possible approaches to take when conceptualizing and developing a plan for helping clients who seek psychotherapy to alleviate the discomfort in his or her life.

Balancing the art and science aspects of the therapeutic encounter has been an ongoing challenge in the field of counseling and clinical psychology. The push for empirically validated treatments (EVTs) is called upon in the field, yet the application of these treatments does not exist among practitioners (Steir, Losta, & Christensen, 2007).

According to Steir et al. (2007), 23% of doctoral level psychologists reportedly use EVTs 75% to 100% of the time, while 17% use EVTs 25% to 50% of the time and another 17% use EVTs seldom or never. The largest percentage of practitioners (41%) in the study of Steir et al. (2007) did not identify whether they used EVTs, which means the treatment method being used by a significant number of doctoral-level psychologists in this study is largely unknown. If 41% of doctoral level psychologists from Steir's study failed to report whether they use EVTs is added to the 17% of practitioners who seldom or never use EVTs, a majority, or 58%, of practitioners are admitting to working with client's seeking help from psychotherapeutic intervention; however, it is unclear what modality, methodology, and help techniques are being used to render help to psychotherapy clients.

If the additional 17% of practitioners who use EVTs 25% to 50% of the time are added to the aforementioned 58%, 75% of practitioners who worked with clients in Steir's study did not inform what methodology he or she used to aide psychotherapy clients 50% of the time or less. Steir's research results highlight the practitioner-science gap. The practitioner-science gap is that which occurs between scientific research related to counseling and clinical psychology and the clinical practice of psychotherapeutics (Mumma, 2014). When practitioners fail to use ETVs and do not report the theories and corresponding techniques being used to help psychotherapy clients, it becomes difficult, if not impossible, to measure what is effective for psychotherapy clients and why. According to Consoli and Jester (2005), about 75% of practitioners are identified as eclectic or integrative, while few programs offer specific training for psychotherapy integration. Lampropoulos and Dixon (2007) surveyed 29 pre-doctoral training programs

in psychotherapy integration and indicated that such training only partially exists. Those who responded to the survey reported that they had training in at least four theoretical orientations (33%), while a smaller percentage of programs (15%) offer student training in only two theoretical orientations (author, year). Fifty-four percent of those surveyed reported that the training program mandated training in more than one theoretical orientation: “33% reported mandatory training in all five theories, 17% in three theories, and 4% in two theories” (Lampropoulos & Dixon, 2007, p. 192).

The need for EVT approaches is significant given the dynamic needs of those who seek psychotherapeutic intervention (Steir et al., 2007). Up to 75% of all practitioners work from either an eclectic or integrative orientation, and few programs of study offer specific training on psychotherapy integration; therefore, it might be assumed that a large percentage of those who integrate are self-taught. Lampropoulos and Dixon (2007) reported that many who claim to use an integrative theory are self-taught, which can lead to a potential lack of empirical support for how they are working with clients. These questions and concerns further highlight the need for researchers to validate integrative methodologies and training on integrative approaches (Boswell, Castonguay, & Pincus, 2009).

The validation of integrative psychotherapies and training programs that equip practitioners to integrate is essential to bring to light how practitioners are working with psychotherapy clients. Duncan (2002) purported that it is more effective to measure a modality’s effectiveness when comparing treatment and non-treatment groups given that inter-treatment comparisons have not supported any one modality over another.

Regardless of an individual's stance on the push for EVT's (Steir et al., 2007) or a person's support for finding a treatment modality's effectiveness by comparing treatment and non-treatment groups (Duncan, 2002), the propensity of practitioners who claim theoretical integration and eclecticism as their theoretical orientation (Lampropoulos & Dixon 2007) highlights a need for validated and/or supported integration in the field. A move toward the validation of integrative modalities could have implications for the training, education, and practice of clinical and counseling psychology (Boswell et al., 2009).

There are several social benefits to identifying effective integrative therapy models. Sound and valid integrative models used by trained professionals can create a fiscally responsible relationship between those administering therapeutic services, the individuals seeking such services, and third party reimbursement companies (Duncan, 2002). Improvements in the quality of care could include a comprehensive approach that meets the dynamic needs of those who seek treatment while ensuring the approach being used to promote health and stability actually does so (Tan, 2008). Finally, using comprehensive modalities that combine theory and technique from past practices in the field of psychology may both deepen and broaden "our understanding of the particular complexities characterizing processes and outcomes of effective integrative psychotherapies, in turn feeding back to further enhance integrative theory construction and clinical practice (Anchin, 2008, p. 19). When researchers are aware and able to study the application of integrative therapies, practitioners in the field are better able to use findings from research to modify, enhance, and perfect integrative theory and technique.

Background of the Problem

The focus of this study was to test the treatment effectiveness of the integrative psychotherapy model (IPM; White, 2002). Counselors and clinical psychologists benefit from therapeutic modalities that result in lasting change. Several faculty members in the counseling psychology department at Eastern University worked to develop an integrative approach that promotes lasting characterological change; the integrative psychotherapy model was born after nearly a decade. The IPM weaves psychoanalytic, cognitive-behavioral, and humanistic theory and techniques together into a methodological approach that results in lasting characterological change (White, 2002). Prior to testing the IPM's ability to result in lasting change, its initial treatment effectiveness must be empirically supported. The IPM is untested and, therefore, its treatment effectiveness is purely testimonial. For any treatment modality to be used by psychologists, it is imperative that it be tested and supported using a sound scientific methodology.

Statement of the Problem

The process of psychoanalysis has existed for over 100 years. Currently, psychoanalysis is still practiced in its original form, as well as in modern forms (Leary, 2007; Renik, 2006). Both humanism and cognitive therapy have been rooted in the fields of clinical and counseling psychology for the past 66 (Duncan, 2002; Rogers 1942; Rogers, 1951) and 48 years respectively (Butler, Chapman, Forman, & Beck, 2006; McEvoy & Nathan, 2007). The IPM has not yet been tested. Although it is based on

theories that have been tested in the field, the theoretical application of these techniques in clinical practice are held to a different standard and therefore should be tested. All treatment modalities should have founded treatment effectiveness. In the current study, the researcher sought to measure the effectiveness of the IPM.

Purpose of the Study

Most practicing psychologists graduate from counseling and clinical graduate programs and use an integrative approach in their practice (Boswell et al., 2009; Boswell et al., 2010; Consoli & Jester, 2005). Few graduate programs offer training on the integration of theory and technique (Consoli & Jester, 2005; Lampropoulos & Dixon, 2007), which leaves little room for monitoring and measuring empirically-validated treatments. The researcher examined the pre-post assessment of three theoretical prongs of the IPM: object relations, cognitive behavioral, and humanistic. Additionally, the researcher compared the pre-post testing results of the treatment and comparison groups; this comparison was used to determine the overall effectiveness of the IPM as an integrative psychotherapy model. Measuring the effectiveness of the IPM could add an empirically founded integrative therapy model to the field, which allows for practitioners who borrow from integrative theory to use this model in their own therapeutic applications.

Theoretical Framework of the Study

Psychoanalysis

Psychoanalytic theory is known for its conception of the unconscious. Although Freud was not the first to theorize about the unconscious, he popularized the term in the

field of psychological practice and everyday life (Lothane, 2006). Freud's (1953, 1955) conceptualization of the mind was divided into layers of consciousness and unconsciousness (Shevrin, 1998). Within these layers are degrees of consciousness, including the conscious, preconscious, and unconscious (Shevrin, 1998). Each layer delves deeper into the unknown of an individual's' psyche. The developers of the IPM borrowed from Freud's conceptualization to understand the complexity of thoughts feelings, behaviors, view-of-self, and view-of-others at the various levels of consciousness (White, 2002).

Cognitive Theory

Cognitive theory and therapy are most known due to Beck's conceptualization of schema (Beck, 1991; Calvete, Estévez, Arroyabe, & Ruiz, 2005). According to cognitive theory, each individual has a template for how he or she experiences him or herself, others, and the world. This template has firm boundaries; however, it is not fixed, and it is used to determine how that individual filters information to confirm beliefs about him or herself and others. Nix (2001) and White (2002) used Beck's conceptualization to understand an individual's view-of-self and view-of-others at the various levels of consciousness (see Figure 1).

Humanism

The IPM model includes a free-flowing, client-centered approach as the individual tells his or her life story. The therapist listens to track and reflect the client's thoughts, feelings, and behaviors at the preconscious level of awareness. The therapist can then attune to the client's stories using accurate empathy and tracking (Kahn &

Rachman, 2000). These attunement and empathy skills are borrowed from the humanistic perspective (Rogers, 2007). Through the therapeutic relationship, the client and therapist can form a healthy attachment and implement change strategies that elicit long-term, characterological change.

Integrative Psychotherapy Model

The IPM is a therapy model that integrates humanism, cognitive behaviorism, and object relations with the goal of reframing deep beliefs about the self, others, and the world and thus transforming a client's character. According to Blatt, Auerback, and Levy (1997), the goal of psychotherapy is to uncover and understand the distorted self and object representations, and to use the therapy to recreate and shape new patterns for viewing oneself and others. Over time and through the therapeutic relationship, patterns of thoughts, feelings, and behaviors are uncovered at all levels of consciousness (White, 2002). When global beliefs about the self and others are identified, the therapist uses a reframing technique to elicit change (White, 2002). The therapeutic reframe is key to the IPM model. It is a technique that shifts the perspective of an individual's view-of-self. This technique does not replace the old view-of-self with a new one; rather, it lends a new perspective to how the original view-of-self was set in place and opens the opportunity to entertain other possible views-of-self (White, 2002).

Freud addressed how early influences shape and foster the superego's development (Hyttinen, 2002), and these influences become internalized during adulthood. However, at one point, they were parental and environmental persuasions that served to guide, nurture, and frustrate the developing child (Hyttinen, 2002). Beck (1991)

agreed that early influences contribute to and foster an individual's development; Beck focused on how these experiences and influences aide in the cognitive and schema development of the individual (Calvete et al., 2005). Freud and Beck agreed that personality dynamics form through repeated experiences which can shape an individual's view-of-self. A view-of-self is a perceptual understanding that fuels patterns of affect, behavior, and cognition. It is pertinent to outline how an individual's view-of-self impacts character development.

When demands in the environment exceed an individual's ability to make appropriate accommodations, this can result in maladaptive, cognitive-affective structures which can eventually lead to psychopathology (Blatt et al., 1997). Profound and inappropriate demands can warp or even halt the development of self-agency, self-coherence, and self-continuity (Stern, 1985). These constructs (self-agency, self-coherence, and self-continuity) comprise an individual's core sense of self and must develop. If these constructs fail to develop, psychopathology will result (Stern, 1985). In the case of severe psychopathology such as psychosis, one or more of these self constructs is missing or is severely underdeveloped (Stern, 1985). Furthermore, severe and early frustrations can result in rigid and inflexible patterns of affect, behavior, and cognitions, similar to the inflexibility demonstrated in individuals with personality disorders (Johnson, 1994).

Less severe frustrations manifest themselves in personality nuances known as character styles (Johnson, 1994). Johnson (1994) extrapolated from the cognitive-behavioral conceptualization of schema to develop a conception of character styles. Each

character style has a set of affective, behavioral, and cognitive patterns that are germane to that character style. Furthermore, each character style has a basic view-of-self, view-of-others and view of the world.

Upon reviewing the various views-of-self, views-of-others, and views of the world, it may seem harsh, dismal, and even depressing to the affected individual. These deep views-of-self, others, and the world are formed around deficits in attunement, engagement, and attachment (Stern, 2000; White, 1984). In the midst of these deficits, infants and children learn to self-regulate and adapt their self-presentation to influence others' responses to them (Higgins, 1996). Therefore, the deep and typically negative aspects of an individual's view-of-self must be reframed into a more acceptable and seemingly less needy state.

Representations of deep views-of-self, others, and the world are the aspects of an individual that prompt productivity in life. McWilliams (1994) stated: "What we [psychoanalyst's] end up calling defenses in mature adults begin as more global, inevitable, healthy, adaptive ways of experiencing the world" (p. 96). It is when defenses become overused or insufficient that techniques to uncover, reframe, and restructure deep views-of-self are warranted (Greenberger & Padesky, 1995). Although these representations of deep views-of-self serve an adaptive purpose, they also frustrate the individual's needs from being met.

Like the early experiences that initially shape and influence behavior, therapeutic experiences attempt to reroute maladaptive behavioral patterns into healthier ones for relating. Therapeutic strategies such as reframing an individual's deep view-of-self serve

to bring into awareness the view-of-self that drives behavioral, affective, and cognitive responses. This raising of awareness begins to reshape the individual's character and creates new patterns for relating.

Research Questions and Hypotheses

In this study, the researcher sought to measure the effectiveness of the IPM by using pretesting and post-testing with participants who either received the IPM treatment (treatment group), or with those who received a series of classes in a general psychology course (comparison group). The treatment group consisted of volunteer clients who agreed to participate in the study. Graduate level students being trained in the IPM applied the treatment; such an arrangement allowed for treatment adherence and the consistent monitoring of client safety. The comparison group consisted of undergraduate students enrolled in a general psychology course; these students volunteered to participate in the study for extra credit in the course. Both the treatment and comparison groups completed pretesting of object relations and reality testing, productive and unproductive thinking, and working alliance prior to the beginning of either a course of the IPM treatment or their general psychology course. The same testing was repeated nine sessions or classes later. An analysis of covariance was used to track differences between the two groups and pointed to the IPM's effectiveness or lack thereof.

The following research questions and hypotheses were developed given the existing research on integrative psychotherapies, object relations, constructive thinking, and working alliance. A more detailed outline of the study's methodology is provided in Chapter 3.

1. What effect does the application of the IPM have on a treatment group participant's object relations, as measured by Bell's Object Relations and Reality Testing Inventory (BORRTI); how does this effect compare to those who do not receive the IPM, but rather receive a series of classes in general psychology?

$H_0$1: There will be no difference in object relations, as measured by the BORRTI, between those participants who receive an application of the IPM and those who take a series of classes in a general psychology course.

$H_1$1: There will be a difference in object relations, as measured by the BORRTI, between those participants who receive an application of the IPM and those who take a series of classes in a general psychology course.

2. As measured by the Constructive Thinking Inventory (CTI), what influence does an application of the IPM have on a participant's constructive thinking? Does this influence compare to the participants who attended a series of classes in a general psychology course?

$H_0$2: There will be no difference in constructive thinking, as measured by the CTI, between those participants who receive an application of the IPM and those who take a series of classes in a general psychology course.

$H_1$2: There will be a difference in constructive thinking, as measured by the CTI, between those participants who receive an application of the IPM and those who take a series of classes in a general psychology course.

3. What effect does the application of the IPM have on therapeutic alliance, as measured by the Working Alliance Inventory (WAI) (client form); does this effect compare to that of the participants who attended a series of classes in a general psychology course?

$H_0$3: There will be no difference in therapeutic alliance, as measured by the WAI, between those participants who receive an application of the IPM and those who take a series of classes in a general psychology class.

$H_1$3: There will be a difference in therapeutic alliance, as measured by the WAI, between those participants who receive an application of the IPM and those who take a series of classes in a general psychology class.

Definition of Terms

Character style: A constellation of personality traits that govern relatively consistent patterns of thinking, feeling, behaving, and relating (Johnson, 1994).

Cognitive behaviorism: The theoretical orientation that integrates theory and technique on thinking and behavior patterns to understand and alter thinking and behaving styles (Beck et al., 1979).

Cognitive reframe: A therapeutic intervention that aims to offer an alternative view of thinking about a situation or view-of-self. This alternative view does not replace the original thought; however, it does seek to offer an alternative explanation for the original thought (White, 2002).

Conscious: Patterns of thinking, behaving, and feeling that are within the awareness of an individual (McWilliams, 2004).

Constructive thinking: An individual's ability to approach and solve everyday problems with relative ease (Epstein, 1992).

Eclecticism: Pooling techniques from various paradigms within the field of psychology to best meet the immediate needs of a client in the moment of therapy (Norcross & Goldfried, 2005).

Ego dystonic: Patterns of thinking, behaving, feeling, and views-of-self, others, and the world that are unconscious and out of the immediate awareness of the client (Josephs, 1995).

Ego syntonic: Patterns of thinking, behaving, feeling, and views-of-self, others, and the world that are conscious and within the immediate awareness of the client (Josephs, 1995).

Empirically validated treatment: Modalities and approaches to treatment that are effective using the scientific method (Steir et al., 2007).

Humanism: The theoretical orientation developed by Rogers (1949) that values and exercises empathy, unconditional positive regard towards a client, and genuineness from the therapist as techniques that foster change in the therapeutic process.

Integrative: The weaving together of theories and techniques that span the waves of psychology to develop a new and comprehensive fabric for which to conceptualize a case and guide therapeutic endeavors (Norcross & Goldfried, 2005).

Integrative psychotherapy model: A therapeutic model that weaves psychoanalytic, cognitive behavioral, and humanistic theory and technique into a comprehensive approach that focuses on characterological change (White, 2002).

Interpretation: A technique born out of the analytic tradition of psychotherapy that offers new and unconscious information and gently brings to light information that was originally outside of the client's awareness (Jones, 2000).

Object relations: A theory born out of the analytic tradition of psychology; it differentiates itself from analysis by its proclamation that the ethos of human motivation is found in the pursuit of human relations and connections (Fairbairn, 1952).

Pattern analysis: The therapeutic technique that links together three or more stories that share similar dynamics to highlight repetitions in thinking, behaving, or feeling in a client's life (White, 2002).

Schema: A cognitive template for thinking about oneself, others, and the world (Young, 2005).

Therapeutic alliance: The connection established between a therapist and client in a psychotherapeutic relationship (Principe, Marci, Glick, & Ablon, 2006).

Tracking and reflecting: A therapeutic technique that uses attentive listening and empathic attunement to accurately communicate the feeling and content of a client's story (White, 2002).

Unconscious: Information in an individual's psyche that is outside of his or her awareness (McWilliams, 2004).

Significance of the Study

Studying the treatment effectiveness of any modality has the potential to increase treatment effectiveness and quality of care. Such studies broaden the availability of effective treatment modalities. Testing the treatment effectiveness of the IPM may

provide opportunities for future researchers to determine what is or is not effective about the IPM. If the IPM is found to make a positive difference in a client's object relations, constructive thinking, and the therapeutic alliance, psychologists can claim another empirically validated treatment modality. If practitioners prefer to use theoretical and technique integration, IPM can serve as an empirically validated guide for those who may not have been specifically trained on integration. Validating the IPM may improve the overall quality of treatment for clients, thus helping them to become and remain healthy.

Assumptions and Limitations

In this study, the researcher assumed the existence of the unconscious, and that the conceptualizations of personality and schema articulated by Beck (1991) do in fact exist. Although these constructs cannot be verified, behavioral science has collected evidence through research and literature that substantiates and allows for such assumptions (Blanton & Stapel, 2008; Calvete et al., 2005; Johnson, 1994; Leone, 2008; Ruys, Spears, Gordijn, & de Vries, 2007; Turner, Rose, & Cooper, 2005). Because the IPM is an insight-oriented model of therapy, it may be too stimulating for the severely mentally ill. Modifications of the IPM could be used to establish and maintain a client's stability; however, the IPM in its original form may not be fitting for clients who are actively psychotic or for those who are sensitive to decompensation.

Another limitation of this study was the treatment integrity of the IPM therapists-in-training. In an attempt to accommodate for this limitation, only the data gathered from therapists-in-training who earned a passing grade (83% and above) as assessed by his/her field training instructor were included in the study. The therapists-in-training who applied

the IMP to the treatment group were systematically trained in the IPM's use throughout the course of the treatment application. As a requirement in their graduate level techniques course, the individuals acquired several skills outlined in the courses syllabus and grading rubrics. Please see Appendices A and B through E for copies of the course syllabus and coordinating grading rubrics. The utilization of therapists-in-training was also limiting, as these students were learning how to develop a therapeutic relationship and conduct therapy and were thus less developed in gauging the nuances of therapy.

Summary

Because upwards of 75% of practitioners claim integration as their theoretical orientation (Consoli & Jester, 2005), there is a need in the field for integrative treatments that are scientifically sound (Boswell, Castonguay, & Pincus, 2009; Tan, 2008). Few universities and training programs teach empirically validated integrative modalities (Consoli & Jester); therefore, researchers must test the effectiveness of integrative approaches in preparation for appropriately training and equipping practitioners to use the most effective modalities.

In this study, the researcher aimed to test the effectiveness of the IPM, a model that integrates psychoanalysis, cognitive behaviorism, and humanism with the aim of transforming an individual's character. In this chapter, the researcher provided an overview of the current study's goals to use therapists-in-training at Eastern University to conduct pre/post testing on clients who either received a course of the IMP or received a series of classes in a general psychology course. In Chapter 2, the researcher reviews and summarizes the most current research related to the IPM, as well as that which is related

to the theory and techniques that the IPM uses to create its model. In Chapter 3, the researcher describes the objectives of the study and outlines the methodological approach used to measure the IPM's effectiveness. In Chapter 4, the researcher reviews the statistical findings of this study. Finally, Chapter 5 summarizes the study and makes recommendations for future research related to studying the IPM.

Chapter 2: Literature Review

Introduction

The field of psychology has been evolving since its original birth from philosophy. The waves in psychology flow from psychoanalysis to behaviorism, humanism/existentialism to cognitive behaviorism, and integration to multiculturalism. Integrative psychology incorporates the best of all prior theoretical quests. The integrative movement in psychology borrows from various theories to generate hybrid theories and techniques. Blending existing theories and techniques bridges the barriers between theoretical orientations, increases the opportunity for holistic healing, increases the possibility of a well-rounded case formulation, and decreases the likelihood of haphazard eclecticism (Norcross & Goldfried, 2005).

The IPM is an integrative model that includes three theoretical orientations and creates a cohesive model for case conceptualization and therapeutic practice. White (2002), one the developers of the IPM, proposed that the model is a foundational base on which to train master's level practitioners. Providing an integrative foundation for practicing psychotherapy allows practitioners to develop his or her personal style of practice. The IPM is comprehensive, integrative, and designed to be a foundation for psychotherapy practice (White, 2002). According to Consoli and Jester (2005):

> Training in psychotherapy integration has not yet received the attention it deserves. One possible explanation is the fact that the vast majority of the current leaders in the psychotherapy integration movement were trained in one specific

> orientation and evolved their own integrative stance after their primary training. (p. 359)

Because the integrative psychotherapy movement is in its infancy, most practitioners who use the approach learn how to integrate it through trial and error after formal training. A lack of training programs on how to formulate and formalize integrative psychotherapeutic practice puts practitioners at a disadvantage and encourages individual experimentation to develop.

In the literature review, the researcher summarizes the seminal and current research in psychotherapy integration, reviews the theories and techniques that the IPM integrates, and describes the IPM as an integrative training model. The IPM integrates psychoanalytic, cognitive-behavioral, and humanistic approaches to conceptualize and work towards symptom reduction and character transformation.

Literature Search Strategy

The literature used for this review was derived from books on character styles, cognitive therapy, developmental psychoanalysis, integrative psychotherapy, integrating spirituality, psychoanalytic theory and technique, schemas, and schema therapy. The articles used for this literature review were peer-reviewed and retrieved through databases such as Academic Search Premier, Mental Measurements Yearbook, PsycARTICLES, and PsycINFO. The researcher used several local university libraries to obtain literature for this chapter. The articles range in date from 1984 to 2010. The search terms used to locate these articles included the following: *client-centered technique, client-centered theory, clinical training, cognitive-behavioral technique, cognitive-*

behavioral theory, character style, eclecticism, future of psychotherapy, integration, integrative psychotherapy, integrative techniques, psychoanalysis, psychoanalytic technique, schema, schema therapy, and *treatment outcomes*.

Overview of Psychotherapy Integration

The integrative movement was established nearly 24 years ago and is still growing today (Norcross & Goldfried, 2005). The Society for the Exploration of Psychotherapy Integration (SEPI) was founded in 1983 (Magnavita & Carlson, 2003; Norcross & Goldfried). Over the last 15 years, the integrative movement has gained interest in the field and has continued growing since (Magnavita & Carlson, 2003). Jensen, Bergin, and Greaves (1990) reported that up to 75% of practitioners practice from an eclectic or integrative theoretical orientation; however, there are few psychotherapy programs that offer specific training on integrative psychotherapy (Consoli & Jester, 2005).

Consoli and Jester (2005) are two of the leaders encouraging the transformation of how integrative psychotherapy is taught. There are several pioneers in the field of psychotherapeutics who inspired the transformation of the training of integrative psychotherapy. Fernandez-Alvarez (1992), Jurgen Kriz (1985), Frey (1972), Patterson (1966), and London (1964) began developing concepts which Consoli and Jester (2005) used later to teach integrative psychotherapy theory. Consoli and Jester (2005) highlighted the importance of transforming the process of teaching psychotherapy theory so as to:

> Move the student beyond the dualistic thinking of good versus evil, right versus wrong, to a new intellectual stance that can tolerate ambiguity and understand personal and social truths as moderately contextual and tentative…to redress reductionism and invite students to explore the role of authority and habits in settling issues. (p. 366)

The ultimate goal of the process is to help students adopt a both/and versus the historical either/or stance when learning about theory. The goal is to blend the commonalities and strengths that span theories and techniques versus pitting one against another; such a stance allows for critical thinking and openness to integration.

There are several disadvantages associated with training programs that only teach one theory and its corresponding techniques for psychotherapy. Feldman and Powel (1992) discussed the disadvantages of training programs using only one theoretical orientation (as cited in Norcross & Goldfried, 2005). Practitioners who are not trained on how to integrate theory and practice generally enter the real world of therapeutic practice and haphazardly use techniques with no true integration and rationale. Such practices do not help the client; instead, they are created in the moment based on a practitioner's subjective ideas. Haphazard eclecticism also fails to have a method for integration and thus cannot be studied and measured for effectiveness. As practitioners are trained and graduate into the fields of counseling and clinical psychology, developing their integrative style, the need for quality management becomes evident (Feist, 2006). With few training programs that emphasize methodological integration, practitioners are left to create their own integrative styles (Feist, 2006).

Roughly 90% of therapeutic outcomes are due to factors such as client resources; a client's sense of hope, faith, and expectancy in the therapeutic process; and other extra therapeutic factors (Beutler et al., 1987; Sperry, Carlson, & Kjos, 2003). Despite the empirical data to support which factors influence positive therapeutic outcomes, training programs and outcomes research tend to focus on teaching and measuring the effectiveness of techniques. Embracing and effectively teaching psychotherapy integration is a healthy alternative that may clarify how therapy is taught and its effectiveness measured. Differential therapeutics is the study of how to match a particular client with a specific therapy (Frances, Clarkin, & Perry, 1984). Rather than fitting a particular client with an existing theory and technique of therapy, the approach should be transformed to fit the needs of a particular client; this is the essence of integration. Magnavita and Carlson (2003) stated that using differential therapeutics allows the practitioner to custom fit theories and techniques to best meet the needs of the client, and delivers a more collaborative and streamline tactic to best serve the client.

Therapists who create their own integrative practices tend to borrow from three theoretical trends within the field of psychology: psychodynamic, cognitive behavioral, and humanistic (Moursund & Erskine, 2004). Therapists borrowing conceptions from the psychodynamic camp identify with neo-Freudianism, object relations, or self psychology. Identifying with these concepts tends toward an appreciation of personality constructs driven by long-standing emotional and relational patterns (Moursund & Erskine, 2004). The focus of therapy is on bringing to awareness such patterns of emoting and relating, rather than merely focusing on and redirecting maladaptive behaviors.

Cognitive behaviorism is a favored approach by many because it satisfies the demands of managed care companies and empirical science (Moursund & Erskine, 2004). Cognitive behavioral techniques are measurable and quantifiable and can therefore be measured for effectiveness. Cognitive behavioral techniques are gleaned from rational emotive and cognitive therapy to shed light on maladaptive cognitive and behavioral patterns. Regardless of the theory or technique used, practitioners and empirical researchers recognize the importance of empathy and therapeutic relationships in a therapeutic encounter (Boswell et al., 2010; Miller, Duncan, Sorrell, & Brown, 2005).

There are three main approaches to integration. Magnavita and Carlson (2003) claimed that the three approaches to integration include finding common factors across various therapeutic practices, technical eclecticism, and theoretical integration. Practitioners who integrate using the common factors method do not necessarily subscribe to any theoretical orientation or particular technique. These practitioners seek to determine the common practices that span various theories and techniques and borrow from those common threads to practice therapy (Magnavita & Carlson, 2003). For example, the technique of confrontation spans many theoretical orientations and corresponding techniques. Confrontation in psychoanalysis occurs when the therapist confronts a client with an interpretation that provides meaning for unconscious wishes, desires, and conflicts (McWilliams, 2004). In cognitive behaviorism, a therapist may confront the incongruence between a client's thoughts and behaviors. In humanistic theory and therapy, the therapist may confront the client with inconsistencies in the false and true self (Rogers, 1951). Regardless of the rationale for confrontation, the technique

spans various theoretical orientations and provides common factors for therapeutic practice.

Technical eclecticism uses theory, research, and experience to guide how and when certain therapeutic techniques are applied with a particular client (Magnavita & Carlson, 2003). Theoretical integration aims to weave theories together to create a sound framework for psychotherapeutic practice. Theoretical integration creates hybrid theories that serve as a firmer foundation when compared to that of any one theory (Magnavita & Carlson).

Some practitioners warn against theoretical integration. Lazarus (2005) made a case against theoretical integration stating that it had the potential to become a haphazard combination of theories with no true rationale or reasoning. Lazarus (2005) promoted the notion of adhering to one particular theoretical orientation and "one may then borrow, purchase, pilfer, and import methods and techniques (not theories) from diverse sources so as to harness their specific power" (p. 150). Despite the pleas for integration and the warning against its potential downfalls, the evolution of psychology and psychotherapy continues through the birth of integrative psychotherapy models.

Short-Term Restructuring Psychotherapy

Short-term restructuring psychotherapy was created as an integrative model of psychotherapy for treating individuals diagnosed with a personality disorder (Magnavita & Carlson, 2003). According to the researchers, several biopsychosocial factors such as biological, interpersonal, intrapersonal, social, and systemic culminate in the development of a personality disorder. Developing a model for treatment that caters to

these factors is necessary for treatment. Given the diversity of developmental factors and treatment needs, an integrative approach is necessary for an integrative model used to treat personality disorders.

The first step in the treatment process is the assessment of the client. Determining the client's fitness for short versus long-term psychotherapy is essential. Assessing where the client falls on the neurotic–borderline–psychotic spectrum can guide in the assessment process. According to Magnavita and Carlson (2003): "A key determination in the assessment is whether the client's defensive system serves to protect him or her from intimacy and closeness or there is attachment disturbance" (p. 278). Clients who are assessed as being in the neurotic-borderline range are more fit for short-term restructuring psychotherapy. Clients who reside in the borderline-psychotic range are more fit for a supportive and longer-term psychotherapy approach. Short-term restructuring psychotherapy (STRP) uses Malan's (1979) concept of the triangle of person to conceptualize the nature of a client's past, present, and therapeutic relationships. Understanding a client's interpersonal relating tracks his or her patterns of doing so. The triangle of person (Malan, 1979) conceptualizes a client's anxieties and cognitive and behavioral responses to identified anxieties. Tracking the individual's anxieties and fears, while noting his or her cognitive and behavioral responses to the identified fears, brings intrapersonal insight into the individual's awareness in an attempt to begin the restructuring process (Magnavita & Carlson, 2003). Magnavita and Carlson also stated that the outcome's research for the integrative STRP model is not well documented;

however, it is consistent with the outcome's research comparing no-treatment to treatment (Perry, Banon, & Ianni, 1999).

Integrative Cognitive Therapy for Depression

Integrative cognitive therapy for depression was developed in response to some noted shortcomings evidenced in previously conducted cognitive therapy studies. Castonguay et al. (2004) investigated the stylistic nuances of therapeutic techniques and the recovery rates of clients in previous cognitive therapy trails. The researcher noted that empathic failures were met with stricter adherence to treatment manual protocols. Further research called for an investigation of injecting tenets from humanism to tend to empathic failures in the midst of cognitive therapy clinical trials. Castonguay et al. (2004) sought to investigate whether the integration of humanistic techniques serves as reparative and complimentary to such cognitive approaches.

Castonguay et al. (2004) compared the depression levels of participants either placed in treatment groups receiving integrative cognitive therapy (ICT) or on a waitlist (WL). All participants met the criteria for Major Depressive Disorder according the Diagnostic and Statistical Manual for Mental Disorders (2001), and scored at least a 20 on the Beck Depression Inventory (BDI). Individuals diagnosed with a comorbid mental illness, including substance abuse/dependence, were ruled out of the study. In total, there were 11 participants in the ICT group and 10 participants in the WL group. Pre/post correlations of the BDI scores, Hamilton Depression Rating Scale (HDRS) scores, and Global Assessment of Functioning Scale (GAF) scores indicated significant differences at the $p < .001$ level on all three measures in the ICT group. Correlations for the WL group

showed differences in the pre/post comparisons significant at the $p < .05$ level. A further analysis of the data used an analysis of covariance (ANCOVA) for each dependent measure (BDI, HDRS, GAF), and found the ICT group to be favored as efficacious with effect sizes of 1.91 (BDI), 1.72 (HDRS), and .91 (GAF).

After the application of the first wave of treatments, some of the individuals originally assigned to the WL control group asked to be treated using the ICT model. Findings from the therapeutic application of ICT to the WL group were similar to those of the original ICT group. Such findings indicated that the integration of humanistic and empathic techniques with cognitive therapy has positive treatment outcomes when using pre/post depression and global assessment of functioning measures. Due to the small sample size in the first and second wave of treatment applications, findings should be interpreted with caution. The need for further research using a larger sample size may yield more accurate results; such findings err on the side of integration.

Schema Focused Therapy

Jeffery Young developed schema focused therapy (SFT) in 1994. Young developed SFT in response to several unsuccessfully treated individuals using a more cognitive approach (Bamber, 2004). The researcher became curious about the difference between individuals who responded to cognitive therapy and those who did not. Young coined the concept of early maladaptive schemas (EMSs) and compared them to Beck's (1991) concept of schemas: "Early maladaptive schemas are broad pervasive themes or patterns regarding oneself and one's relationships that are dysfunctional to a significant degree…" (Bamber, 2004, p. 425). While Beck's (1991) concept of schema is seen as a

more malleable, cognitive framework for experiencing oneself, others, and the world (Beck, 1991), EMSs are schemas that develop early in life and are inflexible beliefs referencing an individual's self-worth, self agency, and social desirability (Beck, 1991; Young, 2003).

Schema focused therapy is appropriate for individuals who have complex cases, EMSs, and a chronicity of symptoms that have been resistant to other forms of treatment (Bamber 2004; Young, 2005). The process of SFT begins with assessing an individual's adaptive and maladaptive schemas, which can be done using the Young Schema Questionnaire (Young, 2001).

Specific constellations of schemas can formulate a mode (Young, 2003), which can be developed through early and repeated experiences with caregivers (Young, 2005). Schema focused therapy invites the client to give a title to the schema modes; more negative modes are not permitted to have a positive name (Bamber, 2004).

In the initial phases of therapy, the client is asked to use imagery and dialogues, allowing their internalized modes interact with one another (Bamber, 2004; Young, 2005). The goal of this technique is to develop a heighted sense of how each mode functions within the individual. Furthermore, learning to transition from one mode to another with ease is a sign of personality integration, a goal of SFT (Bamber, 2004). Once the client's modes are known, understood, and used in imagery techniques, the therapy progresses to working with cognitive techniques, behavioral techniques, and eventually emotional regulation skills (Young, 2005). The three main goals of the therapy

are to simultaneously develop healthy bonding with others, develop emotional regulation, promote schema mode change, and encourage individuation (Young, 2005).

Because SFT is in its infancy, it has yet to be supported as an evidenced based practice (Bamber, 2004; Young, 2005). Most of the researchers studying SFT use case studies which may be considered anecdotal. There is a need for the study of SFT in a more controlled and clinical setting.

The Theoretical Foundations of Integrative Psychotherapy Model

The Integrative psychotherapy model (IPM) is a theoretical integration of psychoanalysis, cognitive behaviorism, and humanism. For the past decade, several professors in the Graduate Counseling Psychology program at Eastern University have been developing the IPM. Borrowing theoretical concepts and techniques from psychoanalysis, cognitive behaviorism, and humanism, the IPM serves as a methodical model and foundation for psychotherapeutic practice (White, 2002).

Psychoanalysis. Sigmund Freud is known as the father of psychoanalysis. With a background in neurology, Freud tried to conceptualize his developments in psychology within the framework of neurology (Fancher, 1973). His goal was to find the neurology of thoughts, feelings, and behavior to better understand personality and psychological functioning (Wallerstein, 2003). His efforts were stunted by the boundaries of technology when he attempted to track the neurology of fantasy (Fancher, 1973). Given the current advances in technology, it is plausible that Freud's attempt to track psychological functioning though neurology was accurate (Reppen, 2006). His efforts to understand personality and psychological functioning were not in vain; the limitations in technology

inspired him to develop the theory of psychoanalysis. From this, he developed theoretical concepts that are still widely accepted in current psychotherapeutic practices (Wallerstein, 2003).

Several concepts from psychoanalysis and theories born out of psychoanalysis are integrated into the framework of the IMP. Psychoanalytic developmental psychology is a broad term that includes the analytic offspring object relations, ego psychology, and self-psychology (Johnson, 1994). All of these theories conceptualize the development of the psyche within a relational context. Drive theory postulates that the root of human behavior lies in biological drives and sexual energy, and these forces fuel human behavior. Object relations theory individuates from drive theory and postulates that the root of human motivation and behavior is in the need for and the seeking of relationships (White, 1984). White proposed that "humanity cannot truly be understood apart from understanding which seeks to view people as they exist in relationship to others" (p. 286). The object relations theory lays the foundation for the case conceptualization in the IPM. The analytic concepts of transference, countertransference, the unconscious, and defensive functioning are concepts borrowed from analytic theory and integrated into the IPM. Corresponding techniques to work with such concepts including interpretation are used in the IPM.

Object relations. According to modern psychology, Melanie Klein and D. W. Winnicott are often named as the founders of the object relations school of analytic thought. In this theory, early interactions with caregivers create mental introjects that shape one's relational interactions (Klein, 1946, 1994). Object relations theory assumes

certain aspects of the human condition. For example, infants are born into a complete state of dependence on the caregiver. The quality and consistency of early relationships is essential for the healthy development of the psyche. Caregivers who offer optimal attunement and engagement to the infants' needs foster the development of conscious attachment (Blatt et al., 1997; Stern, 1985, 2000). Around the age of two years, the child develops a sense of separateness from the caregiver; this process is called separation individuation (Blatt et al., 1997). This psychological process is used to support evidence of a developing mental representation and an intrapersonal world (Blatt et al., 1997; Stern, 1985). The absence of separation may indicate the development of psychopathology, thus the anxious clinging of the child to the caregiver so as to maintain self and object constancy; without such clinging, the child would psychologically cease to exist (Stern, 1985).

Attunement, engagement, and attachment lay the foundation for the development and formation of mental representations (Blatt et al., 1997). Within the first two months of life, the demands of the infant are primitive and geared towards the basic needs for food, shelter, and love. As time progresses, the needs and demands of the infant grow more complex. This increasing complexity leaves more room for a caregiver to fail to meet the demands of the infant. The lack of seamless attunement, engagement, and attachment coupled with the instinctual reaction to idealize the caregiver protects the survival instinct and becomes the relational nuance that shapes and influences the developing view-of-self (Stern, 1985, 2000). Repeated patterns of relating in the budding infant-caregiver relationship are interpreted and internalized into a view-of-self and a

view-of-other. Furthermore, these patterns in relating become the dynamics that shape patterns for affectivity, behavior, and cognition (Blatt et al., 1997).

Transference and countertransference. According to White (2002), transference and countertransference are:

> A foundational tenet of psychodynamic psychotherapy holds that past experiences in early childhood are a determinant of adult personality so a goal of therapy is to understand the meanings of past events that have shaped the present patterns of thought, emotion, and behavior that bring a client to the therapist's office. (p. 10)

This phenomenon is the essence of transference. Transference occurs in everyday situations (Berk & Anderson, 2000); however, therapy provides the opportunity to explore the phenomenon further. The client will naturally displace past relational drama onto the therapist, and the client expects the therapist to react in a similar fashion to past objects (Berk & Anderson, 2000). At any time during the therapeutic encounter, the therapist can become experienced as an important figure from the client's past (White, 2002). In addition, the therapist can have thoughts and feelings about a client that are provoked by his or her relational dynamics. This is the essence of countertransference. The goal for the therapeutic interaction is using both transference and countertransference information to gain a deeper understanding of the client's relational dynamics. Countertransference has previously been frowned upon in the research community, and has been viewed as a hindrance to the therapeutic process; however, it is now viewed as natural, necessary, and essential to the productive progression of any therapeutic

encounter (Clarkson & Nuttall, 2000). According to the analytic tradition, transference resolution is the road to health.

Unconscious. Freud was not the first to develop an understanding of the unconscious; however, he did take the notion of the unconscious and created a theory to understand human motivation (Freud, 1953). Through this theory, he articulated that the unconscious is critical to the motivation of human behavior. Prior to Freud's interpretations of the unconscious, theorists believed that the unconscious was a reservoir of past experiences waiting to be activated (Hunt, 1993). According to Hunt, Freud took a different and more dynamic approach to understanding the unconscious:

> He envisioned the mind as having three levels of functioning: the conscious, the preconscious, and the unconscious. The last was the largest and the most influential part; far from being a warehouse of inactive material, it was an area of highly active and powerful primitive drives and forbidden wishes that constantly generate pressure on the conscious mind, in disguised or altered form, thereby motivating and determining behavior. (p. 185)

Defense mechanisms. Behaviors motivated by unconscious materials are manifested in defense mechanisms and therapeutic encounters. Defense mechanisms are unconscious protectors of the ego that attempt to satisfy impulses and negotiate between what is wished for and the reality of what truly is (McWilliams, 1994; McWilliams, 1999). Repression is the unconscious burying of traumatic events. These buried memories and events, although out of awareness, influence overt behavior. Freud stated that the path to healing is the uncovering of repressed material, bringing it into conscious

awareness (Freud, 1953). Displacement is another defense mechanism which serves to shift affect from one object to another. Displacement occurs in the therapeutic encounter as transference; it also occurs in dreams.

Interpretation. The notion of health is sought by bringing the unconscious into consciousness (Freud, 1953). This is done through the technique of interpretation. Interpretation is bringing unconscious material into the awareness of an individual through making the unknown known or offering insight into the awareness of an individual's intrapersonal and interpersonal world (McWilliams, 2004).

Cognitive behaviorism. Aaron Beck is a medical doctor with a specialty in psychiatry. Beck was trained in the psychoanalytic tradition; however, he grew tired of believing that the process of change needed to be a long and painful one. During the 1970s, Beck developed a cognitively, problem-focused approach for aiding clients in recovery. Beck is now commonly associated with Cognitive-behavioral Therapy (CBT). Cognitive-behavioral therapy proposes that the personality is a cognitive template that guides an individual's thoughts and fuels his or her affective and behavioral reactions (Beck & Weishaar, 1989). The IPM borrows the cognitive behavioral concepts of schema, core beliefs, and automatic thoughts to understand a client's intrapersonal and interpersonal world (White, 2002).

Schema. Schemas are cognitive templates that serve as a filter for incoming information (Rector, Segal, & Gemar, 1998; Robins & Hayes, 1993). Schemas direct patterns of thinking about oneself and others while also guiding information processing and governing behavior (White, 2002). Schemas interpret, shape, reinforce, focus

attention, and activate memories (Rector et al., 1998). Interpersonal schemas are created and shaped by past relationships (Robins & Hayes, 1993). Schemas function much like a screen filtering all incoming information, and therefore can serve to guide future cognitive, affective, behavioral, and relational patterns (Blatt et al., 1997; Rector et al., 1998; Robins & Hayes, 1993). Interpersonal schemas are templates that shape, maintain, and reinforce patterns for interpersonal relating (Robins & Hayes, 1993). For example, individuals who themselves in the same kind of destructive relationship are acting out their interpersonal schemata. According to Robins and Hayes (1993):

> All humans have an innate need, beginning in infancy, to attach themselves to significant adults. Patterns of attachment behavior are influenced by the responses of those significant adults to the infant and form the basis of the interpersonal schemata that influence the individual's relationships later in life. (p. 211)

Schemas are formed in reaction to environmental triggers and persuasions (Blatt et al., 1997). Over time, an individual's needs and demands from the environment grow more complex, and thus schemas must accommodate for increasingly complex needs and environmental persuasions. The result is more highly developed cognitive-affective structures (Blatt et al., 1997). In general, schemas (cognitive templates for filtering incoming information) are driven by core beliefs (global beliefs and blanket statements) about the self, others, and the world. Judith Beck (1998) stated that: "schemas act as templates for the appraisal of experience. Individuals begin to process information in a way that is consistent with these negative beliefs, readily incorporating data that confirm the core belief but discounting, ignoring, or disregarding contradictory data" (p. 174).

Core beliefs. Core beliefs are global statements about oneself, others, and the world (Beck, 1991); they are cognitions that guide an individual's relational dynamics, view-of-self, view-of-others, and view-of-world. Cognitive-behaviorism does not assume the existence of the unconscious; rather, core beliefs are found at the lowest point of consciousness where information is non-conscious and is merely out of the individual's awareness (Beck, 1998). Through the process of therapy, such non-conscious information can be known and altered during the therapeutic process. The middle layer of awareness is the assumptive level (Beck, 1998). This level of awareness harbors the individual's guidelines and rules for living and the assumptions about the self, others, and the world (Millon, 1999). This is the level where compensatory strategies are discovered. These can be compared to Anna Freud's conceptualization of defenses. Compensatory strategies are tactics used to create a sense of internal stability. Core beliefs trigger internal dissonance, while compensatory strategies offer a false sense of resolve. For example, a core belief that an individual is empty at the schema level may be compensated through repeated acts of acquiring material goods to compensate for a lack of internal satisfaction.

Automatic thoughts. At the highest level of consciousness are an individual's automatic thoughts. These are reflexive cognitions driven by an individual's schema. Automatic thoughts are also referred to as "self-talk," a cognitive script that is influenced by one's schema. According to cognitive-behaviorism, psychopathology arises from maladaptive information processing (Beck, 1991). Compensatory strategies that are either over or underdeveloped protect and preserve dysfunctional thinking. The cognitive model demonstrates that all psychological disturbances involve distorted thinking that

influences mood and behavior. The goal of therapy is to evaluate and modify thinking to influence these factors. Lasting improvements aim to identify and alter underlying dysfunctional beliefs (Beck, 1998).

Humanism. Rogers (1949) developed Person-Centered Therapy (PCT). There are several tenets within PCT including honoring the actualizing potential of an individual, being genuine with a client, using empathic attunement to understand, and working towards congruence between the client's ideal self and real self (Rogers, 1956). Past researchers have postulated that psychopathology arises from the incongruence between the perceived expectations of oneself (ideal self) and the actual view of oneself (real self). Individuals develop defenses to protect him/herself from being fully aware of the gap between the ideal and real self (Rogers, 1956).

It is the therapist's role to fully accept the client in a non-judgmental interaction to encourage the individual to talk more freely and deeply about the differences between the real and ideal self (Rogers, 1949). The goal of therapy is to use unconditional positive regard, acceptance, and empathy to soften one's defenses and promote self acceptance: "It appears that when the person comes to see himself as the perceiving, organizing agent, than the reorganization of perception and consequent change in patterns of reaction take place" (Rogers, 1947, p. 361). The IPM borrows the concepts of using empathy to soften defenses to reveal gaps between a real self and a wished-for view-of-self (White, 2002).

Empathy. Empathy is a phenomenon and a skill whereby an individual is able to emotionally transport themself into the viewpoint of another individual without having lived the same experience (Rogers, 1959). Empathy is the capacity to attune to another

and share an emotional experience. Curiosity in the field of psychology has led to researchers asking questions about the phenomenon of empathy in an attempt to understand it (Miville, Carlozzi, Gushue, Schara, & Ueda, 2006). Researchers have delineated that empathy is a complex cognitive, emotional, and social experience that requires one to be able to engage in "perspective-taking, the spontaneous ability to adopt the viewpoint of others" (Miville et al., 2006). Individuals who are highly developed in their own emotional experience are more likely to remain grounded in their ability to be present and emotionally available to another individual (Miville et al., 2006).

Real self and ideal self. Uncovering the internal discrepancies between the manner a client presents to others in the world and the manner in which a client wishes to present in the world involves attuned listening and a non-judgmental stance towards anything a client may share during the therapy relationship (Rogers, 1947). According to Rogers (1947; 1949; 1956; 1959), the more accepting a therapist is toward a client, the more freely a client can begin to share his or her story with less reservation. Being able to share emotional experiences that feel threatening with a therapist who has demonstrated an accepting and non-judgmental stance can offer a corrective emotional experience (Goldfried & Davila, 2005). A corrective emotional experience allows the client to reconnect with his or her real self while exploring the wished-for ideal self (Goldfried & Davila, 2005). Outside of the context of a safe and secure therapeutic relationship, a client may feel too threatened to explore the gaps between how and who one is versus how and who one wishes to be (Rogers, 1992). Psychological health is experienced when

the gap between the real self and the ideal self becomes less of a gap and more congruent (Rogers, 1947; 1992).

Integrative Psychotherapy Model

The IPM weaves theory and techniques from psychoanalysis, cognitive-behaviorism, and person-centered therapy to conceptualize one's personality structure and to work towards characterological change. The IPM borrows the analytic conceptualizations of the object relations, transference and countertransference, the unconscious, defense mechanisms, and the technique of interpretation. The concepts of the levels of consciousness, the conception of schema, core beliefs, and the technique of cognitive reframe are borrowed from cognitive-behavioral tradition. The importance of empathy and creating a safe therapeutic relationship to fully explore a client's perception of self is borrowed from person-centered therapy. These theoretical concepts weave together to form a comprehensive model for case conceptualization and a methodology for therapeutic interaction that aims to rework and reframe a client's view-of-self and interpersonal relationships.

Case Conceptualization

Morris (2003) reviewed a meta model for theories of psychotherapy to define the underlying constructs of a theory and its corresponding techniques. The researcher broke the concept for analysis into two distinct processes: one for case conceptualization and one for treatment application. Case conceptualization begins with an assumption about the precursors of dysfunction. Dysfunctional personal characteristics develop from these originators and are played out resulting in psychological problems. For example,

according to psychodynamic theory, early childhood experiences (origins) can result in unconscious conflicts and fixations (dysfunctional personal characteristics). Individuals attempt to cope with such dysfunction by developing and using defense mechanisms (process for playing out dysfunction), which result in symptoms that mask and mimic unresolved unconscious conflict (psychological problems) (Morris, 2003).

According to the IPM, the theoretical conceptualization for pathology is born from repeated deficits in early relational experiences (White, 2002). Object relations theorist and experimental developmental psychoanalyst Daniel Stern highlighted the importance of attunement, engagement, and attachment in the infant-caregiver relationship (Blatt et al., 1997; Stern, 1985, 2000). Because perfect attunement, engagement, and attachment do not exist, gaps in attunement, engagement, and attachment are interpreted by the infant and shape the view-of-self. When demands in the environment exceed one's ability to accommodate appropriately, this can result in maladaptive cognitive-affective structures which can lead to psychopathology (Blatt et al., 1997). Profound and inappropriate demands can warp or even halt the development of self-agency, self-coherence, and self-continuity (Stern, 1985). These constructs (self-agency, self-coherence, and self-continuity) comprise one's core sense of self and must develop or psychopathology will result. In the case of severe psychopathology, similar to psychosis, one or more of these self constructs is missing or severely underdeveloped (Stern, 1985). Furthermore, severe and early frustrations can result in rigid and inflexible patterns of affect, behavior, and cognitions, much like the inflexibility demonstrated in individuals with personality disorders (Johnson, 1994).

Less severe frustrations manifest themselves in personality nuances which are known as character styles (Johnson, 1994). Johnson extrapolated from the cognitive-behavioral conceptualization of schema to develop his conception of character styles. Each character style has a set of affective, behavioral, and cognitive patterns that are germane to that character style. Furthermore, each character style has a basic view-of-self, view-of-others, and view of the world.

According to Stern (1985), around the age of three years old the toddler and caregiver work together to create a narrative self. This narrative self is the aspect of the self that begins to collect a working history and cohesive story for his or her life. The narrative self is developed when the family system begins to create a story and a "shared history together [which] provides a framework for each individual family member to understand and integrate shared events into their own individual life stories" (Bohanek, Marin, Fivush, & Duke, 2006, p. 39). The development of the narrative self and collaboration between family members creates the history of the child's experience. With the assistance of the caregiver, a child is able to create a cohesive story and assign the story emotional meaning (Stern, 2000). In the following section, the current researcher provides ten character styles and offers an etiological background for their development.

Schizoid. The schizoid experience includes frustration in the early stages of attachment and attunement (Hendrix, 1992; Johnson, 1994). As a result of unattuned parents who are experienced as harsh, cold, and distant, and/or overbearing, smothering, and over-involved, the needs of the infant are buried (Hendrix, 1992; Johnson, 1994). There is an assumption that the caregiver will not attend appropriately if the needs are

expressed, and therefore the child disassociates from them and carries on as if without needs (Johnson, 1994). The view-of-self becomes “I am alien; I am alone; and I have no right to exist” (Johnson, 1994). The schizoid character cannot live with this dismal view-of-self, and therefore a defended re-representation of the deeper view-of-self presents as one who is overly intellectual or even spiritual (Johnson, 1994). Adopting this more acceptable presentation to the world keeps the harsh views-of-self at bay and explains this individual’s inherent detachment to others. Others are viewed as powerful, rejecting, and threatening (Johnson, 1994). The world is seen in a similar light as being dangerous and harsh; these views (of self, others, and the world) stem from early experiences of unattuned caregivers.

Paranoid. The paranoid experience is that of overpowering and humiliating parents who usually condemn and disconfirm the child’s reality (McWilliams, 1994). The individual with a paranoid character style is always on guard to defend against being attacked and humiliated (McWilliams, 1994). Others are experienced as threatening, sneaky, and malicious (McWilliams, 1994). An individual with a paranoid character style views the world as dangerous, which causes the individual to be defensive, often feeling suspicious of others and on-guard at all times. Underneath this harsh view of others and the world, the paranoid character views themself as vulnerable, powerless, and impotent (McWilliams, 1994). On a more conscious level, a character style of this sort may present as a vindicator for the weak and an advocate for others (McWilliams, 1994).

Schizoid-avoidant. An individual with a schizoid-avoidant character style has a major fear of being rejected by others. Early experiences include feeling criticized and

rejected by an important other, typically the caregiver (Hendrix, 1992). Others are viewed as critical, uncaring, uninterested, and rejecting (Hendrix, 1992; Johnson, 1994). The world is seen as risky with the potential to reject, which causes the style to manifest itself in behaviors of blending in, withholding, withdrawing. However, the individual will still have a conscious desire for closeness (Hendrix, 1992; Johnson, 1994; McWilliams, 1999). The view-of-self for a schizoid-avoidant character style is "I am different, I don't fit, I am unlikable, and I am inadequate."

Psychopathic. An individual who develops a psychopathic character style views others as either predators or prey. In response to this dog-eat-dog mentality, this character style causes the individual to work ferociously to prevent being exploited by others and to prevent being viewed as weak (McWilliams, 1994). In the effort to avoid being exploited and being viewed as weak, the psychopathic character style will attack and exploit others (McWilliams, 1994). Underneath the layer of defensive predacious behaviors, this character style causes the individual to view the self as weak, a victim, and impotent (McWilliams, 1994). The compensatory self presents as infallible, omnipotent, and grandiose (McWilliams, 1994). There are developmental factors influencing this type of character style that "point to the probability of a biological substrate for the higher levels of affective and predatory aggression" (McWilliams, 1994, p.152). In addition, the early experiences of an individual with this character type are laden with the chaos of harsh discipline and over indulgence (McWilliams, 1994).

Depressive. Depressive character styles are riddled with a pessimistic outlook on life. Early experiences include loss and discouraged mourning (Johnson, 1994). An

individual with a depressive character style fears being abandoned and disappointed by others (Johnson, 1994). A depressive view of others is abandoning, neglecting, and good (Hendrix, 1992), while the self is viewed as bad, hopeless, helpless, and guilty. In every day interactions, an individual with a depressive character style could be seen as reserved, compassionate, and good (Johnson, 1994).

Symbiotic. The symbiotic character is also referred to as the dependent character style. The view-of-self for a symbiotic character is incomplete and unable (Young, Klosko, & Weishaar, 2003). Due to a deep belief about the self as lacking the defensive behavior, the individual will cling in an attempt to find completeness (Johnson, 1994). Others are viewed as more powerful, strong, and abandoning (Johnson, 1994). The illusion of the other as powerful draws the symbiotic character to connection, and the fear that the other will abandon prompts the symbiotic to cling (Gabbard, 1994). The world is experienced as cold and lonely. At the conscious level, the symbiotic character presents as helpful while experiencing others as needy and in need of the symbiotic (Johnson, 1994). This character style is shaped by either premature separation with a caregiver or a caregiver's repeated blocking of the child's desire to individuate (Gabbard, 1994; Johnson, 1994).

Narcissistic. The early child-caregiver experiences that shape a narcissistic character style can be varied. There are several child-caregiver dynamics that predispose a child to present as superior, special, admirable, and worthy of approval (Johnson, 1994; Young et al., 2003). Narcissistically oriented parents can use the child to mirror and meet the unmet needs of the caregiver (Johnson, 1994; McWilliams, 1994). Cold, critical, and

hostile parents can deprive a child of the normal need for mirroring which results in the child's unquenchable need for mirroring from the world (Johnson, 1994). Caregivers who praise and adore the child through over-mirroring, even when positive feedback should be withheld, can result in an attitude of entitlement of praise from others (Johnson, 1994). In general, a narcissistic character is competitive and achieving; these overt behaviors overcome a view-of-self stating: "I am empty, I am ashamed, and I am inadequate" (Hendrix, 1992; Johnson, 1994; McWilliams, 1994; McWilliams, 1999). Others are viewed as powerful and worthy of being idealized or devalued (Hendrix, 1992; McWilliams, 1994). The individual with this character style will view the world as competitive (Hendrix, 1992).

Masochistic. Caregivers who are abusive, critical, or detached can shape a masochistic character style (Johnson, 1994; McWilliams, 1994). Within a masochistic character, a suffering-care link develops into a pattern of relating (McWilliams, 1994). For example, a child learns to suffer in order to receive care from others; the view-of-self is defeated, weak, and dependent, while the view-of-others is critical, abusive, and controlling (Johnson, 1994). With the view-of-the-world as unsafe, the masochistic character dreams of feeling freedom is tethered to a pattern of behavior that is self-defeating and keeps the individual in bondage (Hendrix, 1992; Johnson, 1994).

Obsessive-compulsive. The obsessive-compulsive character style is also known as the disciplined child. This character style lacks spontaneity and displays of emotion (Gabbard, 1994; Johnson, 1994; McWilliams, 1994; McWilliams, 1999). The individual often presents as rule-bound, self-righteous, frugal, cautious, and judgmental (Johnson,

1994). Underneath the surface, the obsessive-compulsive character views the self as defective, bad, and rejectable, while others are seen as demanding, condemning, unpredictable, and rejecting (Johnson, 1994; McWilliams, 1994). The world is experienced as chaotic, and the obsessive-compulsive character overcomes the buried view-of-self, others, and the world by being organized, beyond blame, striving for perfection, and in control (Gabbard, 1994; McWilliams, 1994). Early environmental experiences that shape this character style include chaotic or controlling caregivers, or rigid, moralistic, and controlling parenting styles (Johnson, 1994; McWilliams, 1994).

Histrionic. The histrionic experience is shaped by early relationships where clear power differentials are present (Johnson, 1994; McWilliams, 1994). It is common that some kind of abuse, usually sexual exploitation, occurs in these situations (Johnson, 1994). Caregivers of a histrionic character are experienced as cold and competitive, and send messages that love is contingent on one's physical presentation (Johnson, 1994; McWilliams, 1994). This message manifests itself in an individual who presents as someone who is exciting, interesting, cute, bubbly, attractive, captivating, and entertaining (McWilliams, 1994). Underneath this superficial surface is an anxiety-ridden individual who fears being viewed as insignificant, inadequate, and guilty (Gabbard, 1994; Johnson, 1994; McWilliams, 1994). Others are viewed as powerful, seductive, desirable, and frightening simultaneously (McWilliams, 1994). The world is viewed as performance-based and rife with seduction, which is enticing and revolting at the same time (Gabbard, 1994). Histrionic characters fear being ignored or being seen as boring;

therefore, their behavior manifests as fun and bubbly to captivate others, yet superficial to avoid being found out (Gabbard, 1994; Johnson, 1994).

The various views of self, views of others, and views of the world may seem harsh, dismal, and depressing; these deep views-of-self, others, and the world are formed around deficits in attunement, engagement, and attachment (Stern, 2000; White, 1984). In the midst of these deficits, infants and children learn to self-regulate and adapt their self-presentation to influence others' responses to them (Higgins, 1996). Therefore, the deep and usually negative aspects of one's view-of-self must be reframed into a more acceptable and seemingly less needy state.

Representations of deep views-of-self, others, and the world can also prompt productivity in life. It is when defenses become overused or insufficient that techniques to uncover, reframe, and restructure deep views-of-self are warranted (Greenberger & Padesky, 1995). Although these representations of deep views-of-self serve an adaptive purpose, they also frustrate the individual's needs from being met.

Treatment Application: Integrative Psychotherapy Model

The process for treatment application begins with identifying specific interventions that will resolve and revise the personality characteristics of the client and list specific treatment goals. Breaking the treatment application process into three distinct subsections differentiates interventions from goals, and how these factors influence a client. In psychodynamic terms, the interventions used are interpretation, free association, transference resolution, working with resistance, and dream work. These techniques are used to bring unconscious conflicts into consciousness, thus giving the client insight. The

treatment goals include symptom reduction and personality reorganization, so as to increase the client's ability to love and work more freely (Morris, 2003).

Like the early experiences that initially shape and influence behavior, therapeutic experiences are used to reroute maladaptive behavioral patterns into healthier patterns of relating. Therapeutic strategies such as tracking and reflecting one's deep view-of-self serve to bring into awareness the view-of-self that drives behavioral, affective, and cognitive responses. This raising of awareness begins to reshape the character style and creates new patterns for relating. Therapeutic interventions can aim to compensate for these gaps through therapeutic attunement, engagement, and attachment. In the process of therapy, the client can disclose these memories and engage in the process of self-revelation with the therapist. The therapist can then attune to the client's stories using accurate empathy and tracking (Kahn & Rachman, 2000). Through the therapeutic relationship, the client and therapist can form a healthy attachment. According to Blatt et al. (1997), if psychotherapy involves distortions of object and self-representation and childhood attachments in normal development result in the formation of mature interpersonal schemas, then constructive interactions between patient and therapist should facilitate revisions of impaired or distorted representations of self and object and lead to the development of more integrated and mature objects and self-schemas. Stern (1985) prompted therapists to "roam with the patient across the ages and through the domains of senses of self" (p. 257). Allowing the client to roam freely through the memory of experience allows the therapist the opportunity to join the client and attune to the stories that construct this history. In the IPM, the client begins the session and does his/her best

to put all thoughts into words. The challenge of the therapeutic relationship is the transference pull from the client. The client may expect and even set up scenarios for the therapist to enact the dance of the client's interpersonal drama (Robbins & Hayes, 1993). The role of the therapist is to remain engaged with the client, but to not participate in repetitions of the client's past drama. Helping the client to understand these patterns will help to communicate an unconditional acceptance of the client (Kahn & Rachman, 2000; Robbins & Hayes, 1993). This improves the quality of attachment in the therapeutic relationship. However, changes in self-perception and self-conception are not met without resistance (Markus & Nurius, 1986); in fact, individuals set up situations that reinforce their view-of-self and will avoid situations that may communicate a different message about the self (Markus & Nurius, 1986). Despite an individual's resistance to a shift in his or her view-of-self, Marcus and Nurius (1986) purported that much research supports that "the self-concept is highly, perhaps infinitely, malleable" (p. 964). McWilliams (1994) agreed, although the researcher also stated that character cannot be changed, only modified. Again, the IPM uses the analytic constructs of the unconscious, transference, and transference resolution to understand and conceptualize a case.

The therapeutic reframe is a technique that shifts the perspective of one's view-of-self. This technique does not replace the old view-of-self with a new view of self; rather, it lends a new perspective as to how the original view-of-self was set in place. It also allows for the opportunity to entertain other, more positive views-of-self. There are multiple therapeutic benefits to the therapeutic reframe. Adopting a new view-of-self helps the client to empathize with the seemingly immature cognitions, behaviors, and

emotions that are part of the old view-of-self (Johnson, 1994). This empathy and self-acceptance can prompt more positive patterns for relating (Johnson, 1994). The reframe also has other positive effects on the client, including the fact that the therapeutic relationship is usually strengthened (Johnson, 1994).

The goal of treatment becomes identifying automatic thoughts, cognitive assumptions, compensatory strategies, and eventual cognitive restructuring (Millon, 1999; White, 2002). The target of change is the client's deep core beliefs and schema (White, 2002). Several therapeutic techniques aid in the process of cognitive restructuring. Cognitive-behavioral therapists value building rapport with the client, honoring a collaborative client-therapist relationship, educating the client, "collecting data, testing hypothesis, and summarizing" (Beck, 1995 p. 9). See Figure 1 for a visual model of the IPM (borrowed with permission from White, 2002).

White (2002) has outlined a conceptual model for integrating psychoanalytic, cognitive behavioral, and humanistic theory and techniques into the IPM in her doctoral dissertation. The IPM is untested; testing the IPM provided an opportunity for the field of clinical and counseling psychology to potentially add an empirically validated treatment to its repertoire. Chapter 3 offers an outline of the first step in validating the IPM. Chapters 4 and 5 report on the findings of this study and offer suggestions for future research.

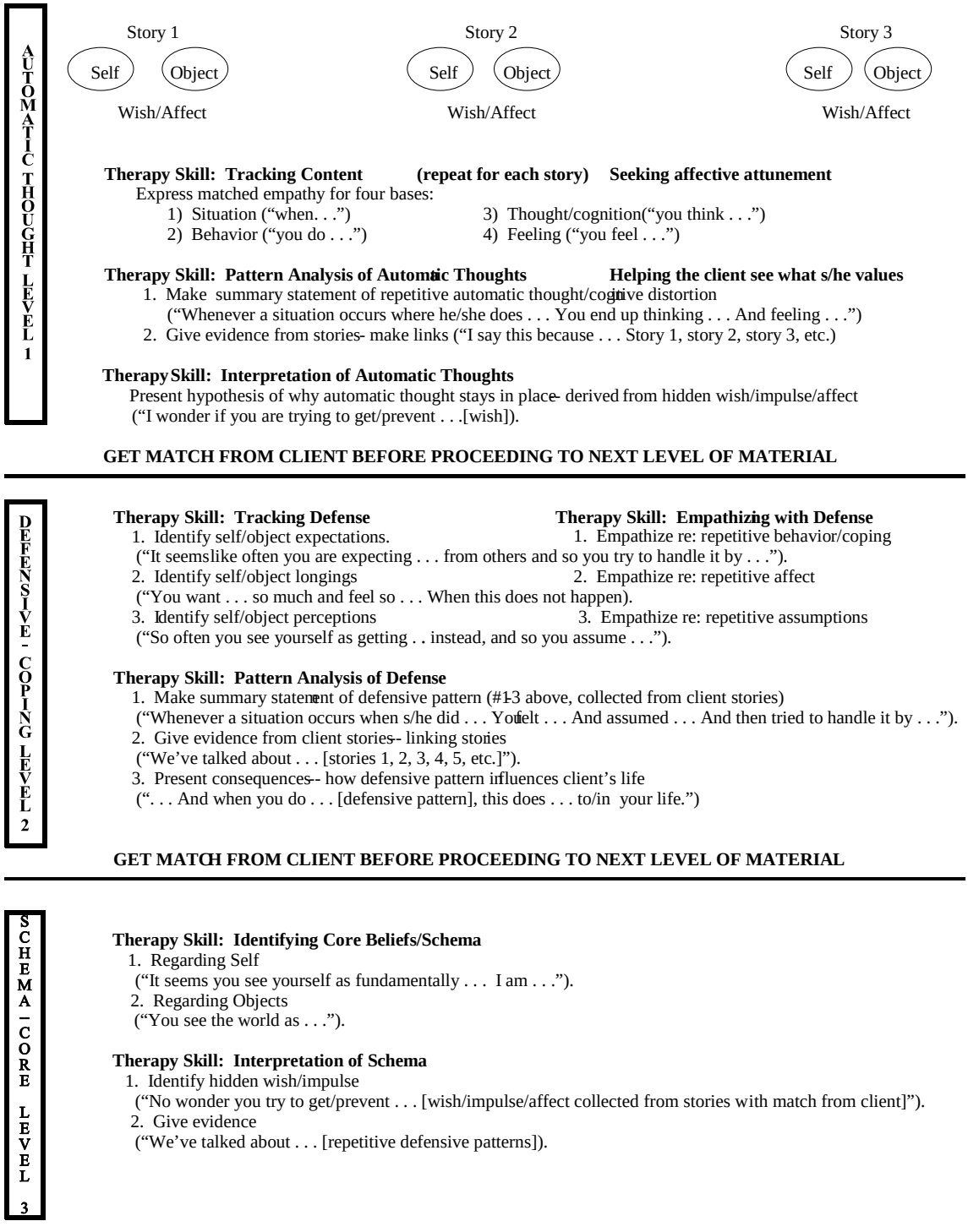

Figure 1. Integrated intervention guide.

Chapter 3: Research Method

Introduction

In Chapter 3, the researcher outlines this study's design and methodology. The researcher describes the purpose of the study, research design and approach, setting and sample, instrumentation, data analysis, and ethical considerations. This study, measuring the treatment effectiveness of the IPM, is justified given the existing research on other integrative psychotherapy models. In this chapter, the researcher reviews the research design and demographics of the participants in both the treatment and control groups. An overview of the instrumentation used to measure the IPM's effectiveness is included. Finally, overviews of the data analysis used to calculate the statistical effectiveness and ethical considerations are included.

Purpose of the Study

The purpose of this study was to measure the effectiveness of the IPM. The IPM is an untested, insight-oriented psychotherapy model. The demands from managed care companies and science call upon the standard for empirically validated treatments. Although the three theoretical foundations of the IPM are not new to the field of psychotherapy, the manner in which the model weaves techniques from each theory is novel and untested. In order to measure the effectiveness of the IPM, the researcher used tools that measure what it seeks to integrate into its cohesive model for psychotherapeutic practice. The IPM conceptualizes a case from an object relations perspective, which was born out of the psychoanalytic tradition. This model focuses on the client's view-of-self and view-of-others, which are concepts borrowed from the object relations and client-

centered approach. The IPM is used to identify and reframe schema frameworks and core beliefs, concepts borrowed from cognitive-behaviorism. The IPM includes empathy to create a holding environment for the client to explore his or her defensive structure and reshape his or her object relations, tenets in the humanistic-/client-centered and psychoanalytic approaches. Given the integrative nature of the IPM, it is feasible to use tools that measure the three theoretical foundations of the model. Bell's (1995) BORRTI was used to measure an individual's object relations and to assess for potential confounds such as poor reality testing and psychosis. The CTI was used to measure an individual's view-of-self and others and how his or her view-of-self and others influences behaviors (Epstein, 2001). The WAI (client form) was used to measure perception in the therapeutic bond throughout the therapeutic encounter (Horvath & Greenberg, 1994).

Research Design and Approach

In this study, the researcher sought to gain a better understanding of how an individual's object relations, thinking patterns, and perceived working alliance was influenced by an application of the IPM. The design included a within and between groups comparison of the following pre-post measures: BORRTI (measuring object relations), CTI (measuring constructive thinking), and the WAI (measuring working alliance).

According to the basic hierarchy of research design, a one-group (e.g., treatment group) pretest-posttest design is less desirable when compared to designs that include a control, comparison, or contrast group (Campbell & Stanley, 1963). Campbell and Stanley (1963) and Cook and Campbell (1979) presented the one-group pretest-posttest

design to illustrate a variety of classic threats to internal validity: history, maturation, testing, and instrumentation. Control, comparison, or contrast groups control for these threats to internal validity.

Without measures to control for threats to internal validity, a researcher cannot begin to rule out what may have contributed to treatment effectiveness. Because random assignment from a common population is not practical and could, perhaps, have some ethical concerns with respect to withholding of treatment, the nonequivalent control group design is a suitable alternative to control for internal validity threats (Campbell & Stanley, 1963; Cook & Campbell, 1979). The fact that the nonequivalent controls are from a benign population further ensures that the difference for the control group between pretest and posttest is not likely due to the effect of unreported treatment, as might be the case for controls clinically equivalent to the treatment group.

The two groups being compared were the treatment and control groups. The treatment group consisted of volunteers who underwent nine sessions of IPM; the IPM therapy was applied by therapists-in-training who were learning how to apply the IPM. Using therapists-in-training allowed for the close monitoring of treatment adherence because the therapists were assessed and graded on their adherence to the IPM. The therapists-in-training were required to audiotape each session that was conducted with the client; the course instructor could have reviewed any of these sessions at any time. For the purposes of the course requirements, the therapists-in-training were required to transcribe and meet specific skills according to the IPM. Sessions 2, 5, and 8 were transcribed and evaluated by the course instructor, a therapist trained in the IPM.

The comparison group did not receive treatment; however, they did participate in nine classes in a general psychology course. Pretesting of the comparison and treatment groups began after the first therapy session, or after the first class of general psychology. Post testing occurred after nine therapy sessions or classes of general psychology. Matching the number of therapy sessions with the classes of general psychology reduced the threat of internal validity and, therefore, reduced the possibility of external factors unduly influencing the results of the study. This quasi-experimental pretest-posttest nonequivalent group design (NEGD) compared the results from the BORRTI, CTI, and WAI prior to the treatment or psychology course application and after. A comparison of the difference within and between groups determined the change effectiveness of the IPM.

An analysis of covariance (ANCOVA) was used to control for initial differences between groups at the time of pretesting. It was used to calculate an accurate measure of differences in object relations, constructive thinking, and working alliance between groups post treatment (Trochim, 2002). About 30 participants were expected in each the comparison and treatment group (total $N = 60$). A total number of $N = 60$ constituted an adequate sample size with power of .8 to detect a posttest medium effect size (i.e., Cohen's $d = .5$) at a .05 alpha level after controlling for a pretest correlated with posttest at .7 (power analysis computations based on Wuensch, n.d.).

Setting and Sample

The participants for this study were individuals who were either seeking mental health counseling at a community mental health center or currently taking a course in

general psychology at Eastern University. Those participants who agreed to undergo nine sessions of the IPM were in the treatment group. Those students who were enrolled in a general psychology course and consented to participate in this study were members of the comparison group. An assessment of demographics noted similarities and differences within and between groups. See Appendix F for the treatment and comparison group demographics survey.

Treatment Group

To best reflect a mental health setting, the participants were permitted to undergo medication treatment under the supervision of a psychiatrist. Clients were not excluded based on the comorbid diagnoses. It is likely that comorbidity exists in real life, as clients rarely present with a single diagnosis. Individuals who participated were not permitted to undergo any other psychological treatment, such as couples/marriage therapy, family therapy, or group therapy. Other forms of psychotherapy were likely to confound the results. The participants were permitted to seek case management assistance if needed. Participants eligible for participation were any nonpsychotic adult aged 18 or older who was seeking individual psychotherapy or who wished to volunteer for nine sessions of the IPM therapy.

Comparison Group

Undergraduate students enrolled in a general psychology course at Eastern University had the opportunity to earn extra credit by participating in this study. Any student enrolled in the general psychology course who was willing was able to participate. Those students who wished to participate were not permitted to undergo any

counseling or psychotherapy if they were placed in the control group. In the brief demographics questionnaire, students were asked if they had undergone any form of counseling or therapy during the course of the semester. Those participants who confirmed participation in any form of counseling or psychotherapy were excluded from the study. Participants in the comparison group were permitted to take psychiatric medication during the course of the study.

Procedures

The therapists-in-training who applied the IPM were practicum and internship students at Eastern University. These students were trained in this integrative approach. As a requirement for graduation, each student was required to complete a 100-hour practicum and a 600-hour internship. During these field-training experiences, students conducted various mental health services including individual therapy. With permission from each internship site and the individual clients, the therapists-in-training administered the pre-assessments to measure the baseline object relations, thinking patterns, and working alliance levels of their clients. Over the course of the IPM therapy, the students were supervised by their course instructors as well as evaluated on their ability to apply the model. Each session was audio-recorded. Throughout the course of the sessions, the students were required to evidence their adherence to the IPM by transcribing three (practicum students) or four (internship students) sessions that demonstrated the skills outlined in the model. These skills are outlined in the course grading rubrics (see Appendices B through E for a copy of the grading rubrics). Students who earned an 83% on each transcript qualified as adhering to the treatment application.

The students who earned less than 83% were not included in the study. Using this supervisory approach ensured that the therapist was adhering to the treatment application.

Both practicum and internship students were applying the IPM with their clients at various internship sites. These sites spanned several cultural components, including rural and suburban, lower and middle socioeconomic status, and the clinics serving clients of various ethnic, educational, and religious backgrounds. Due to the nature of convenience sampling, this study could not ensure cultural equality. An appropriate assessment of the demographic information of the participants was included to ensure the appropriate generalization of results.

Instrumentation

Demographics. A brief questionnaire assessed the demographic information of the participants in both control and comparison groups. This questionnaire assessed for information related to age, gender, ethnicity, and level of education; current (if relevant) psychiatric diagnosis; current (if relevant) psychiatric medications; and involvement in therapy services (See Appendix F).

BORRTI. Bell's Object Relations Inventory (BORRTI) is a personality inventory designed to measure an individual's object relations and reality testing. This inventory has 90 true/false prompts, with 45 items in each subsection assessing the client's object relations and reality testing. There are seven scales on the inventory: four designated to assess alienation, insecure attachment, egocentricity, and social incompetence (object relations scales), and three scales to measure reality distortion, uncertainty of perception, and hallucination and delusions (reality testing scales). A *T*-score of 60 or higher on any

of the subtests deems a clinically significant score and indicates impairment in one's intrapersonal and interpersonal relationships and/or reality testing.

Using Cronbach's Alpha and Spearman Split-half reliability, reliability assessments indicate consistent correlations between individual items and the scale with which they are associated (Bell, 1995). All correlations rated in the good to excellent range; the lowest correlation for both the Cronbach's Alpha and the Spearman Split-half reliability was .78, with the highest correlation at .90 (Bell, 1995). Correlations in this range indicate that the items on the object relations scale and the reality testing scale in fact measure these ego functions.

The theoretical substantiation of the BORRTI was born in response to Bellak and Abrams's (1997) projective measures that aimed to gather similar interpersonal and intrapersonal information. The BORRTI became the quantitative answer to these projective measures. Because of the exhaustive nature of qualitatively gathering information on all ego functions, Bell (1995) chose to focus on object relations and reality testing. A process of factor analysis was used for scale/subscale development and item selection. According to Bell (1995), "the broad nomological network of the BORRTI indicates the instruments importance as a measure individual differences, and also denotes the robustness of the underlying constructs" (p. 32). The BORRTI has been published in many studies with varied subjects ranging from psychopathology, child development, infant attachment, treatment outcomes, health related-issues, clinical and non-clinical personality, and development (Bell, 1995). According to Alpher (1990) the BORRTI is a reliable and valid measure of object relations and reality testing.

CTI. The Constructive Thinking Inventory is a 108-question inventory that assesses patterns of thinking. When taking the CTI, clients are asked to respond to each question using the following a five-point Likert-type scale, 1 (definitely false), 2 (mostly false), 3 (undecided or equally false and true), 4 (mostly true), 5 (definitely true).

Patterns of thinking constructed from one's experiences are divided into nine scales and several subscales. Only the composite scores from the main scales were included in the analysis of data for this study. These main scales include global Constructive Thinking (GCT), Emotional Coping (EC), Behavioral Coping Scale (BC), Personal Superstitious Thinking (PST), Categorical Thinking (CT), Naïve Optimism (NO), and the two remaining main scales measuring for defensiveness towards taking the CTI and a validity scale.

The average range *T* scores attained on the CTI fell between 45 and 50, with high scores ranging from 56 to 65 and low scores range from 35 to 44 (Epstein, 2001). A very high score is above 65 and a very low score is below 35. High scores are interpreted as a sign of positive adaptation on the following scales and their coordinating subscales of the GCT, EC, and BC. Lower scores are interpreted as more desirable on the PST, CT, ET, and NO scales and their coordinating subscales (Epstein, 2001).

The reliability ratings for the main scales are reported to be satisfactory (ranging from .67 to .94); however, some of the reliability ratings for the subscales are lower (ranging from .44 to .86) and should thus be interpreted with caution (Epstein, 2001). Factor analysis studies have supported the factorial validity of five of the six main scales on the CTI (Hoyer, 1983; Epstein, 1992). According to Epstein (2001), "the CTI, with the

exception of the Personal Superstitious Thinking, has strong factorial validity as both the item and subscale level" (p. 23). In addition to factorial validity, multiple studies have correlated the CTI with personality inventories and inventories that measure the client's well-being and have found concurrent validity to be high (Epstein, 2001).

WAI (client form). The Working Alliance Inventory (WAI) (client form) is a 36-item questionnaire that seeks to measure the task, bond, and goal in the therapeutic relationship (Horvath & Greenberg, 1994). Clients rate these scales on a Likert-type scale ranging from one to seven (1 = never, 2 = rarely, 3 = occasionally, 4 = sometimes, 5 = often, 6 = very often, 7 = always). The task scale "refers to the in-therapy activities that form the substance of the therapeutic process" (Horvath & Greenberg, 1994, p. 111). Higher scores on the task scale indicate therapist-client agreement that the focus of therapy is both relevant and effective; this scale also measures the level of mutual investment and responsibility towards the therapy process. The goal scale measures the mutuality of the aim, outcome, and tailored interventions used to attain the desired outcomes of the therapeutic process (Horvath & Greenberg, 1994). The bond scale measures the interpersonal connectedness between the therapist and client (Horvath & Greenberg, 1994). This scale measures the positive interactions of trust in the therapist and therapy, feelings of acceptance by the therapist, and confidence in feeling understood by the therapist (Horvath & Greenberg, 1994). Overall, the WAI measures the perceived therapist empathy in a therapeutic relationship, a factor that is evidenced to be able to predict positive therapeutic outcomes (Horvath & Symonds, 1991).

Given the close relationship of the content rating and Bordin's description of the alliance construct, the WAI is said to have content validity (Horvath, 1994). Correlational comparisons between the WAI and other established alliance measures (California Psychotherapy Alliance Scale, Helping Alliance, and the Vanderbilt scales) all yielded significant correlations (Horvath, 1994). Reliability measures using Cronbach's Alpha ranged from .93 to .84 and determined the entire WAI instrument to have item homogeneity (Horvath, 1994). An analysis of the three subscales on the WAI yielded lower correlations than the overall instrument, however correlations still ranged from .92 to .68 (Horvath, 1994). Test-retest correlations yielded .80 after a three-week stay prior to retesting. All considerations and consistent correlations related to the WAI support this tool as a reliable and valid measure of therapeutic alliance (Horvath, 1994).

Analysis

This study compared the pretest-posttest results from nonequivalent groups. To account for the initial difference between groups, an ANCOVA was used to temper initial differences and more accurately measure true differences (Trochim, 2002). The composite scores for each variable were used to determine the overall significance. The subscale scores could be used secondarily to determine which are of interest and the contributing factors to the overall significance or lack thereof. The research questions and hypotheses below reflect this analysis.

Research Question #1

What effect does an application of the IPM have on a participant's object relations, as measured by Bell's Object Relations and Reality Testing Inventory

(BORRTI); how does this effect compare to those who do not receive the IPM, but do undergo a series of classes in general psychology?

Null hypothesis #1. There will be no difference in object relations as measured by the BORRTI between those participants who receive an application of the IPM and those who take a series of classes in a general psychology course.

Alternative hypothesis #1. There will be a difference in object relations as measured by the BORRTI between those participants who receive an application of the IPM and those who take a series of classes in a general psychology course.

Research Question #2

As measured by the Constructive Thinking Inventory (CTI), what influence does an application of the IPM have on a participant's constructive thinking? Does this influence compare to the participants who attended a series of classes in a general psychology course?

Null hypothesis #2. There will be no difference in constructive thinking as measured by the CTI between those participants who receive an application of the IPM and those who take a series of classes in a general psychology course.

Alternative hypothesis #2. There will be a difference in constructive thinking as measured by the CTI between those participants who receive an application of the IPM and those who take a series of classes in a general psychology course.

Research Question #3

What effect does the application of the IPM have on therapeutic alliance, as measured by the Working Alliance Inventory (WAI) (client form); does this effect

compare to that of the participants who attended a series of classes in a general psychology course?

Null hypothesis #3. There will be no difference in therapeutic alliance as measured by the WAI between those participants who receive an application of the IPM and those who take a series of classes in a general psychology class.

Alternative hypothesis #3. There will be a difference in therapeutic alliance as measured by the WAI between those participants who receive an application of the IPM and those who take a series of classes in a general psychology class.

The BORRTI and CTI were computer scored, while the WAI (client form) was hand scored. The Statistical Package for Social Sciences (SPSS) was used for the data analysis. Composite scores from the BORRTI, CTI, and WAI (client form) were analyzed using an ANCOVA. The ANCOVA viewed the pretest as a covariate to determine differences among the treatment and control groups on the pre/post testing.

Pre-posttest. The process used to analyze the data was a quasi-experimental design using nonequivalent groups. A comparison of pretest/posttest composite scores on the BORRTI, CTI, and WAI determined differences between treatment groups. The independent variable has two levels, the application of the IPM or a general psychology class. The three dependent variables included a client's object relations, constructive thinking, and working alliance before the application of the IPM or general psychology class and after the application of the IPM. The BORRTI, CTI, and WAI provided an interval measure of each client's object relations, constructive thinking, and working alliance. The pre/post comparisons of the BORRTI, CTI and WAI scores measured the

IPM's effectiveness in being able to improve object relations, constructive thinking, and working alliance.

Ethical Considerations

With any kind of therapeutic application there is always some risk involved. There were several measures taken to ensure the safety of the participants in this study. In addition to onsite supervisors, the therapists-in-training had at least two IPM supervisors who monitored therapy adherence and participant safety. All therapy sessions were audio-recorded and a supervisor could review any session to ensure participant safety. The participants had the right to withdraw from therapy and/or the study at any time. The findings of the study were provided to the therapists-in-training and participants upon request. If the results reflected that the IPM was significantly less effective when compared to other treatment outcomes established in the field, the participants had the right to request and receive appropriate and effective treatment.

Participants in the comparison group had the right to withdraw from the study at any time without penalty as well. These participants also had the right to seek therapy at no cost from the counseling center at Eastern University if they so chose.

Chapter 4: Results

Introduction

The purpose of this study was to quantitatively examine whether the IPM was an effective form of treatment when compared to individuals participating in nine general psychology classes. Three measures were used to quantify effectiveness: the BORRTI (measures object relations), the CTI (measures constructive thinking), and WAI (measures therapeutic alliance). Three hypotheses were tested using an ANCOVA to account for the effect of the pretest means. In this chapter, the researcher summarizes the results of these analyses and provides a demographic description of the participants sampled in this study.

Sample Demographics

The data collection portion of this study was conducted at Eastern University. Counselors-in-training dispensed three questionnaires (BORRTI, CTI, and WAI) and a demographics survey to volunteer counselees (treatment group) and volunteer psychology undergraduate students who agreed to fill out the same three questionnaires and demographics survey (comparison group). Of the 40 treatment group and 50 comparison group-informed consents dispensed, 15 treatment group participants and 21 and comparison group participants signed the informed consents and took pretesting packets indicating a willingness to participate in this study. After nine weeks of either IPM or general psychology classes, post testing packets were dispensed to the previously consenting participants in both the treatment and comparison groups. Of the 15 treatment group and 21 comparison group participants, 11 (73%) and 19 (90%) respective

participants fully completed the three measures. Incomplete questionnaire sets were not included in the final data analysis. Table 1 summarizes the demographic makeup of this study's participant pool. The information was analyzed using SPSS. The dependent variables included measures calculating object relations, working alliance, and constructive thinking; either nine sessions of the IPM therapy or nine classes in an undergraduate psychology class served as the independent variables.

Table 1

Demographic Characteristics of the Study Sample (N=11 and N=19)

	Treatment Group		Comparison Group	
Characteristic	N	%	N	%
Gender				
Male	3	27	5	26
Female	8	73	14	74
Age Bracket				
18-20	6	55	17	90
21-30	3	27	1	5
31-40	2	18	1	5
Ethnicity				
African American	1	9	3	16
Asian	1	9	--	--
Caucasian	9	82	16	84
Education				
GED	1	9	--	--
High School diploma	9	82	19	100
Associates Degree	1	9	--	--

The treatment group participants included 27% (three) male participants and 73% (eight) female participants. The comparison group included 26% (five) male participants and 74% (14) female participants. More than one half (55%) of the treatment group participants were between the ages of 18 and 20; 27% and 18% respectively were

between the ages of 21 and 30 and 31-40. The ages of those participants in the comparison group were 18-20 (90%), 21-30 (5%), and 31-40 (5%).

The majority of participants in both groups identified as European American: 82% (treatment group) and 84% (comparison group). The treatment group consisted of 9% who identified as Asian American and 9% as African American. Sixteen percent of those in the comparison group identified as African American. The diversity in both treatment and comparison groups was lacking, as the majority of participants identified as European American. All of the participants in both groups were enrolled in classes at a 4-year university. The educational achievement of the treatment group participants was reported to be 82% having earned a high school diploma, 9% having earned a general equivalency diploma, and 9% having earned an associates' degree. All of the comparison group participants reported earning a high school diploma, while both the treatment and comparison groups were educationally homogeneous and well educated.

Results

There was no difference in object relations, working alliance, and constructive thinking when comparing groups who either underwent nine sessions of the IPM therapy and those who participated in nine classes of an undergraduate psychology course. The mean score differences between the comparison and treatment groups did not achieve a statistically significant difference on any of the factors measured (object relations, therapeutic alliance, and constructive thinking; see Tables 2 and 3). All of the variables were examined for severe skewness and kurtosis, and all proved to be within normal limits. Using the *z* value of 3.29, which is the critical *z* at alpha = .001, all values less

than + 1.5, all *z*-value ratios of skewness to its standard error, and kurtosis to its standard error were considered normal.

Table 2

BORRTI and Subscale Descriptive Statistics for Total Sample, Comparison Group, and Treatment Group

	Total		Comparison		Treatment	
Statistic	Pre	Post	Pre	Post	Pre	Post
BORRTI						
Mean	50.09	49.56	50.32	49.84	49.96	49.39
SD	7.61	7.51	8.40	8.44	7.35	7.15
Min.	37.75	37.50	38.50	37.50	37.75	38.50
Median	50.88	49.50	49.00	47.75	51.50	51.25
Max.	66.25	65.50	66.25	65.50	62.00	60.50
Alienation						
Mean	50.47	48.13	51.91	48.64	49.63	47.84
SD	8.91	7.33	9.28	7.09	8.83	7.64
Min.	33.00	32.00	34.00	37.00	33.00	32.00
Median	52.00	46.50	54.00	48.00	49.00	45.00
Max.	69.00	61.00	69.00	61.00	69.00	61.00
Insecure attachment						
Mean	50.27	48.93	50.46	50.09	50.16	48.26
SD	10.68	10.86	12.25	12.77	10.02	9.91
Min.	30.00	30.00	30.00	30.00	33.00	33.00
Median	49.50	48.50	46.00	50.00	50.00	47.00
Max.	72.00	73.00	72.00	73.00	68.00	71.00
Egocentricity						
Mean	50.37	50.63	48.46	49.91	51.47	51.05
SD	9.31	9.00	9.18	9.77	9.44	8.78
Min.	33.00	36.00	35.00	37.00	33.00	36.00
Median	50.00	49.50	50.00	37.00	42.00	59.00
Max.	67.00	70.00	62.00	70.00	67.00	66.00
Social incompetence						
Mean	49.27	50.53	50.46	50.73	48.58	50.42
SD	10.19	9.95	10.93	9.19	9.97	10.61
Min.	34.00	34.00	34.00	38.00	34.00	34.00
Median	50.00	52.00	54.00	51.00	50.00	52.00
Max.	76.00	78.00	65.00	65.00	76.00	78.00

Table 3

Constructive Thinking Inventory (CTI) and Working Alliance Inventory (WAI) Descriptive Statistics for Total Sample, Comparison Group, and Treatment Group

	Total		Comparison		Treatment	
Statistic	Pre	Post	Pre	Post	Pre	Post
Constructive Thinking Inventory						
Mean	46.73	47.73	45.91	48.82	47.21	47.11
SD	7.35	9.71	8.37	12.16	6.89	8.28
Min.	31.00	25.00	31.00	25.00	37.00	32.00
Median	46.00	51.00	45.00	51.00	47.00	50.00
Max.	62.00	67.00	62.00	67.00	61.00	63.00
Working Alliance Inventory						
Mean	142.73	152.83	150.00	162.73	138.53	147.11
SD	19.40	17.98	18.27	17.87	19.23	15.77
Min.	94.00	121.00	115.00	128.00	94.00	121.00
Median	142.00	152.50	151.00	162.00	139.00	145.00
Max.	186.00	191.00	186.00	191.00	174.00	176.00

The results of the ANCOVA supported the null hypotheses when responding to all three of the null hypotheses. The first null hypothesis stated that there would be no difference in object relations as measured by the BORRTI when comparing those who underwent nine sessions of the IPM and those who took nine classes in general psychology. The second null hypothesis purported that there would be no difference in constructive thinking as measured by the CTI between those who received nine sessions of the IPM and nine classes in general psychology. The third and final null hypothesis assumed that there would be no difference in therapeutic alliance as measured by WAI (client form) between those participants who received an application of the IPM and those who took a series of classes in a general psychology class. An ANCOVA was used to test the adjusted posttest means to ensure for equal error variances. Levene's is not

significant, which validates the assumption of equal error variances. Controlling for pretest, the posttest BORRTI (object relations measure) was not statistically significant, $F(1,27) = 0.009$, $p = .924$, partial eta squared < .001. Controlling for prettest, the posttest WAI (therapeutic alliance measure) and CTI (constructive thinking measure) were not statistically significant, $F(1.27) = 1.195$, $p = .284$, partial eta squared < .042 and $F(1,27) = 3.22$, $p = .084$, partial eta squared < .107, respectively. Each of the statistical analyses produced no statistical significance between those who underwent nine sessions of the IPM therapy and those who attended nine classes in an undergraduate psychology course. The result of the study was a failure to reject the null hypothesis.

Table 4

Adjusted Posttest Means [95% CI] and ANCOVA Results

Variable	Adjusted Posttest Mean [95% CI]				
	Comparison	Treatment	*F*(1, 27)	*P*	η_p^2
BORRTI	49.6 [47.3, 52.0]	49.5 [47.7, 51.3]	0.009	.924	<.001
Alienation	47.7 [44.8, 50.6]	48.4 [46.2, 50.6]	0.148	.704	.005
Insecure attachment	49.9 [46.1, 53.7]	48.4 [45.5, 51.3]	0.458	.505	.017
Egocentricity	51.5 [48.4, 54.6]	50.1 [47.8, 52.5]	0.518	.478	.019
Social incompetence	49.9 [45.6, 54.2]	50.9 [47.6, 54.2]	0.159	.693	.006
Constructive Thinking Inventory	49.6 [45.2, 54.0]	46.7 [43.3, 50.0]	1.195	.284	.042
Working Alliance Inventory	158.4 [150.5, 166.4]	149.6 [143.6, 155.6]	3.221	.084	.107

Note. CI = confidence interval. η_p^2 = partial eta squared, a measure of effect size with .01 a small effect, .06 a medium effect, and .14 a large effect.

Summary

There was no significant difference in object relations, therapeutic alliance, and constructive thinking as measured by the BORRTI, WAI, and CTI, respectively between participants who underwent nine sessions of IPM therapy and those who attended nine classes in an undergraduate psychology course. Therefore, the null hypotheses failed to be rejected.

In Chapter 4, the researcher reported that the methods used in this current study failed to validate the IPM. Although the researcher failed to achieve statistical validation of the IPM, there are several recommendations for future research that could offer improvements to future studies and validation processes. In Chapter 5, the researcher explores potential improvements to the current study for the betterment of future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This study was carried out to test the treatment effectiveness of the IPM. Treatment effectiveness was measured by pre and post testing of therapeutic alliance, object relations, and constructive thinking. The researcher sought to validate the use of the IPM as an effective integrative model for psychotherapeutic treatment. The researcher used the WAI, BORRTI, and the CTI to measure the effectiveness of the IPM. The participants included individuals attending a general psychology course at the undergraduate college level. Participants were either grouped as participating in nine general psychology classes or participants who volunteered to undergo nine sessions of psychotherapy with a therapist-in-training implementing the IPM. All participants were eligible to earn extra credit in their general psychology course. All participants consented to participation and filled out pre and post testing forms using the WAI, BORRTI, and CTI.

Testing the treatment effectiveness of the IPM offers the field of counseling psychology reliable and valid integrative frameworks to direct clinicians on methods of integration to help clients. According to Consoli and Jester (2005), 75% of practitioners identify their therapeutic approach as either eclectic or integrative. According to Lampropoulos and Dixon (2007) and Boswell et al. (2009), there is a lack of master's level training programs that equip practitioners to integrate both theory and technique. Tracking theoretical and practical methods of integration offers practitioners a helpful

framework for practicing from an integrative approach. In this study, the researcher tested the IPM as one of those reliable and valid options.

Interpretation of Findings

The IPM weaves both theory and technique from the psychoanalytic, cognitive behavioral, and humanistic traditions (White, 2002). Moursund and Erskine (2004) reported that integrative therapists tend to borrow from three theoretical orientations when integrating: psychodynamic, cognitive behavioral, and humanistic. Magnavita and Carlson (2003) reviewed several approaches to integration, and two of those approaches included finding common factors that span psychotherapeutic practice and theoretical integration. The IPM includes both integrative approaches in its theoretical and technical framework. The IPM tracks similarities and assimilates commonalities in theory and technique from the psychoanalytic tradition, cognitive behaviorism, and humanism. Both researchers of psychoanalysis (Johnson, 1994) and cognitive behaviorism (Beck, 1995) would concur that an individual's character structure or schema is developed in response to repetitious relational dynamics with important figures in that person's life. The notion that an individual's psychological existence spans levels of awareness is another common element in the IPM. Psychoanalysis purports that every individual has a complex layering of both conscious and unconscious psychological material waiting to be awakened through the therapeutic process (Hunt, 1993). Cognitive behaviorism endorses an individual's layered levels of awareness; however, it does not endorse the notion of the unconscious (Millon, 1999). The humanistic tradition speaks of the classic battle between the ideal and real self, a layered presentation of the wished for self, and the true and more

accurate self (Rogers, 1947). The psychoanalytic, cognitive behavioral, and humanistic traditions agree that individuals protect themselves from undesirable information by engaging in defensive behaviors (psychoanalysis), using compensatory strategies (cognitive behaviorism) and highlighting the ideal self at the expense of the individual's real self (humanism).

The IPM includes theoretical integration when melding the analytic notion of character styles and the cognitive behavioral notion of schemas. Both the analytic and cognitive behavioral traditions theorize about the psychological impact of repeated experiences on an individual's view-of-self, view-of-others, and view-of-the-world. The concepts of character styles (Blatt et al., 1997) and schema (Rector et al., 1998) share theoretical similarities and integrate to shape case conceptualization of the IPM.

The IPM gleans both theory and technique from classic psychology. The theoretical underpinnings of the IPM are not new to the field of counseling psychology. The implementation of the IPM in its unique melding of theory and technique offers a different perspective for the field of psychotherapy. Lampropoulos and Dixon (2005) and Steir et al. (2007) noted the need for more empirically validated integrative models for psychotherapeutic practice. In this study, the researcher explored the validity and reliability of the IPM as a potential integrative option for the field of psychotherapy. The research questions posed in this study were used to track differences in object relations, constructive thinking, and working alliance when comparing participants who either attended nine classes of general psychology or underwent nine sessions of IPM therapy. The researcher did not find statistically significant differences in working alliance,

constructive thinking, or object relations when comparing the treatment and comparison groups.

Limitations of the Study

There were several factors that may have contributed to the lack of significant results in this study, including the decreased participant pool, the use of therapists-in-training, the length of treatment application, the use of practicum versus intern students, negative transference, and measuring changes in client symptom presentation.

Decreased participant pool. According to Lipsey and Wilson (1993), it was suggested to reach a maximum power of .8 and that 30 participants be included in each comparison and treatment group (power analysis computations based on Wuensch (n.d.). A total of *n*=60 (30 in each group) would allow for differences in comparison and treatment groups to be measured beyond chance happenings. Eleven therapists-in-training volunteered to implement the IPM to undergraduate level students seeking therapy. The lack of therapist volunteers limited the treatment group to only 11 participants. Participation in the comparison group was slightly higher, with 19 participants. Although higher than the treatment group, this amount of participants did not meet the desired number. Several of the pre and posttests sets in the comparison group were deemed invalid due to missing data. If these data had been included, it would have invalidated the data sets and skewed the outcome results.

Therapists in training. There are advantages and disadvantages to using therapists-in-training to measure the IPM. Using therapists-in-training allows for measuring treatment adherence, as these therapists were closely assessed and monitored

by instructors. This adherence monitoring approach assured that a standard of treatment adherence was met. Although there is accountability and a strong measure for treatment adherence, this same adherence monitoring approach used therapists learning how to conduct therapy for the first time. Using a more seasoned therapist trained in the IPM would have been the ideal scenario. Given time and monetary constraints, using therapists-in-training was the next best option for the initial testing of the IPM.

Length of treatment application. Those seeking psychotherapeutic treatment typically show improvement in symptom presentation within the initial 26 sessions of treatment. According to Howard et al. (1986), it is ideal to measure psychotherapeutic outcomes within the initial 26 sessions of treatment. Howard cautioned that: "this, of course, does not mean that such patients have achieved maximum treatment benefits. However, …26 sessions might be used as a rational time limit" (p. 163). Magnavita, Critchfield, and Castonguay (2010) addressed concerns related to premature termination and its negative effects on a positive treatment outcome. In this study, the researcher measured changes in therapeutic alliance, cognitive thinking, and object relations after nine sessions of treatment. Past researchers have suggested (Howard et al., 1986) that participants should undergo 17 more sessions to provide the potential opportunity to support changes in alliance, thinking, and object relations. Due to limitations in participant involvement, the researcher used volunteers who were limited to participating for only nine sessions. Ideally, this study would have taken the maximum time recommended (26 sessions) by previous research to note psychotherapeutic transformation.

Practicum students versus interns. The researcher used volunteer practicum level students implementing the IPM with volunteer clients to test the treatment effectiveness of the model. These practicum level practitioners were bound to the requirements of their graduate course in integrative psychotherapy. It was a course requirement to meet with a volunteer student for a total of nine sessions to measure the effectiveness of implementing the IPM for a course grade. It would have been more ideal to use internship level therapists in training who were further along in their graduate studies. However, only one internship level therapist volunteered to have her client undergo pre-post testing and participate in this study. Due to neglecting to properly fill out the post testing assessments, this participant's information had to be excluded from the participant pool. A more ideal scenario would have used a seasoned therapist who was trained in the IPM to measure the effectiveness of the model. Due to time and money limitations, using practicum level therapists in training was the most feasible option for this study.

Negative transference. Negative transference could have influenced the alliance, constructive thinking, and object relation for pre/post testing comparison scores. Given the timing of the post-testing coupled with the therapeutic skills being practiced in the 7-9 sessions of the IPM, it is possible that the clients' transference reaction could have skewed the outcome results of this study (Gelso et al., 2005; 1997). The therapeutic skills being practiced and implemented in the latter part of this study delved into the dystonic view-of-self, others, and the world. Given the defensive level and sometimes negative aspects of these unconscious self and object experiences, a negative transference could

have developed for some participants and influenced the outcome results of the study. Ideally, a measure could have been put into place to account for such an unintended influence. The most ideal research scenario would have lengthened the therapeutic implementation of the IPM to work through the dystonic aspects of the model and then conduct post-testing. This would have reduced or eliminated the potential influence of negative transference on the post-test outcome results.

Measuring changes in client symptom presentation. Comparing the pre-post alliance, thinking, and object relations scores measures the change that takes place within the three theoretical prongs of the IPM. Essentially, this study was an attempt to answer the question: does the IPM influence change within therapeutic alliance, constructive thinking and object relations? It might have been more advantageous to measure the pre-post symptom presentation of the clients who either underwent nine sessions of the IPM or nine undergraduate psychology classes. Tracking differences in symptom presentation might have been a simplified way to measure the potential effectiveness of the IPM. The original idea for this study might have been better reserved for future research.

Recommendations

Adding an empirically validated integrative psychotherapy model to the field of counseling psychology would allow practitioners an opportunity to learn and use a validated integrative model. The field of counseling psychology lacks graduate programs that teach the framework of how a practitioner develops an integrative psychotherapeutic practice. The lack of programs that teach practitioners how to develop integrative psychotherapeutic practices causes them to create a therapist-specific integrative

framework, which leaves the field at a disadvantage to empirically measure the aspects of the psychotherapeutic encounter as efficacious or not. Being able to rely on validated and effective integrative frameworks would offer practitioners the foundation upon which to nuance a personal therapeutic style.

Practitioners who implement inconsistent psychotherapeutic techniques create difficulty in measuring effectiveness within the therapeutic process. Smoyak (2007) wrote about her attempt to research helpful versus harmful psychotherapeutic practices. The researcher interviewed psychiatric nurses who worked with clients in an inpatient setting. Smoyak (2007) was unable to formalize her research project because of the inconsistent interventions used by psychiatric nurses and the inability of nurses to articulate the interventions used with inpatient clients. Such therapist-specific practices leave researchers at a disadvantage to sift through the myriad of psychotherapeutic practices in an attempt to validate them as effective. Lilienfeld (2007) voiced his approach to combatting haphazard and harmful therapies. The researcher called for: “a heightened emphasis on PHTs [potentially harmful therapies]” which “should narrow the scientist-practitioner gap and safeguard mental health consumers against harm” (p. 53).

The purpose of this study was to measure the treatment effectiveness of the IPM. The shortcomings of the study failed to reject the null hypotheses. In other words, the IPM was not effective in promoting changes in therapeutic alliance, constructive thinking, and object relations after nine sessions of IPM. Although there were no significant findings evidencing positive changes in the three theoretical prongs of the IPM, there was also no evidence of an inverse connection between alliance, thinking, and

object relations. Future researchers may conclude that undergoing nine sessions of the IPM does not harm clients in the areas of alliance, constructive thinking, and object relations. The results of this study did not evidence harm in the areas it sought to measure. Although no evidence of positive change occurred in this particular study, there was also no evidence of harm in undergoing the IPM.

Although this current study did not validate the IPM as a model for therapeutic practice, the theoretic underpinnings of the IPM align with those of classic psychological theory, and this warrants continued research to determine whether the IPM is a valid and reliable integrative model for psychotherapeutic practice. Future research should consider the following recommendations.

The researcher could have used volunteer participants who placed themselves into the comparison or experimental groups. The purest of the scientific processes would have participants randomly assigned to either the comparison or experimental groups. Future researchers should consider randomizing the participant pool as a way of attaining a potentially sound scientific methodology.

Using seasoned therapists trained in the IPM could increase the validity of the results of future research seeking to compare pre-post psychotherapeutic changes. Using therapists-in-training assured that the therapists were implementing the IPM; however, these therapists were also learning to implement the IPM as a requirement for their coursework. Using seasoned therapists trained in IPM could offer participants a richer therapeutic encounter given that a seasoned therapist is more likely to be attuned to the dynamic psychotherapeutic experience.

Future researchers might seek a more simplified methodology when measuring psychotherapeutic changes. A pre-post comparison of client symptom presentations could yield a more accurate depiction of change. The focus of interest would shift from measuring changes in the three theoretical prongs of the IPM to measuring pre and post changes in symptom presentation.

The final recommendation for future research would be to increase the number of sessions to evidence psychotherapeutic change. Past research reports that therapeutic change can occur within the initial 26 sessions of therapy (Howard et al., 1986). Future researchers investigating the effectiveness of the IPM should take advantage of this 26-session recommendation and increase the length of therapeutic application.

Implications

The potential social change implications resulting from validating an integrative therapy model are vast. Potential positive contributions to psychology include adding a valid and reliable integrative framework for therapists to use when working with clients. Providing evidence that a psychotherapeutic model prompts positive client change can offer hope and help for those who seek meaningful change from a therapeutic process.

The outcome results of this study did not validate the IPM in a statistically significant manner. The positive social implications resulting from this study are limited. The creed when working with people is always to do no harm. Although the results from this study did not evidence a statistically significant outcome, the findings did not indicate that the IPM resulted in a decline or harm in object relations, constructive thinking, or working alliance. In other words, this study provided preliminary evidence

that when compared to students taking a series of classes in an undergraduate psychology course, the IPM does no harm. Such findings prompt scientific curiosity and invite further research to more thoroughly test the validity of the IPM. Further research could offer the opportunity to fully realize the potential positive social implications of the IPM.

Conclusion

Although statistical significance was not achieved to determine whether the IPM is a valid and reliable form of integrative psychotherapy, this study did not provide evidence that it is a harmful form of treatment. The IPM could still be a valid and reliable form of integrative treatment if supported by future research. It is recommended that future research test the IPM as a viable methodology for prompting characterological transformation. The results of this study do not rule out the IPM as an option for practitioners; rather, the results of this study urge future research to continue the quest for finding reliable and valid integrative psychotherapeutic practices.

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Appendix A: Course Syllabus

THE CAMPOLO COLLEGE OF GRADUATE AND PROFESSIONAL STUDIES AT EASTERN UNIVERSITY

Promoting the Integration of Faith, Reason, and Justice

COURSE SYLLABUS

Course Number and Title: **CNSL625 Practicum in Psychotherapy Integration** (Section 11)
Academic Program(s): Community/Clinical Counseling
School or department: Counseling Psychology
Semester or term: Spring 2009
Meeting time/place: Eagle Learning Center (ELC) 102, Thursdays 4:30-7:00 pm

Instructor: Lindsay Sterious, MA, NCP, LPC
Phone: (xxx) xxx-xxxx
Fax: (xxx) xxx-xxxx
Email: xxxx@xxxxxx.edu
Office hours: by appointment

Teaching Assistant: Beth Rivera, M.A. cell: (xxx) xxx-xxxx xxxx@xxxxx.edu

COURSE DESCRIPTION: This advanced clinical skills course builds upon the foundations of previous theoretical courses and the basic skills introduced in CNSL602. The focus is on forming interventions that enrich the clinical dialogue through integration and application of techniques from across the field of counseling practice. Skills will be demonstrated and practiced in class, and students will conduct a course of psychotherapy with a volunteer client. The course also requires a field placement of 100 hours in an approved clinical setting. A grade of B or better is required.

COURSE OBJECTIVES: Upon successful completion of this course, students will demonstrate competency in:

1. **Therapy Alliance Skills**: as evidenced by students' ability to establish and maintain a positive therapeutic relationship with a practicum or practice client through a course of 9 therapy sessions.

2. **Tracking Skills**: as evidenced by accurate, gender-, cultural- and spiritual-sensitive tracking and

reflecting of client disclosures over the 9-week therapy course.

3. **Empathizing Skills**: as evidenced by accurate reflecting of client affect over the 9-week therapy course.

4. **Insight-Giving Skills**: as evidenced by appropriate interpretations of client wishes and fears over the 9-week therapy course.

5. **Introspection Skills:** as evidenced by written self- and peer-critique of therapy sessions including accurate labeling of therapy dialogues, assessment of impact of interventions with alternatives generated, and reflection upon one's own thoughts, feelings, and reactions elicited by the therapeutic encounter.

6. **Professional Role:** this includes ethical practice with the client such as (but not limited to) informed consent, confidentiality, and appropriate termination. Additionally productive use of feedback will be demonstrated across the transcript assignments, and field work responsibilities completed satisfactorily (as evidenced by at least average ratings by site supervisor).

PA STATE REGULATIONS FOR LPC MET IN THIS CLASS: 4.9-8 and 4.9-9

PREREQUISITES:

CNSL 500 Introduction to Counseling Theory & Practice
CNSL 602 Techniques of Counseling & Psychotherapy
CNSL 609 Personality Dynamics & Psychosocial Assessment

GENERAL COURSE POLICIES:

Teaching Method and Attendance: Eastern University uses the Blackboard Learning Platform as the learning environment for this course. Using your Eastern University username and password, you can access the site for this course at **http://eastern.blackboard.com**.

This course consists of at least 14 hours of instructional time for each credit awarded. Attendance at all scheduled sessions is considered a critical element in the accomplishment of learning outcomes. Furthermore, attendance records are maintained and are essential to comply with government regulations for recipients of financial aid and assistance programs, as well as accreditation standards.

This is an interactive course with in-class practice and feedback from instructors and fellow students as integral to skill attainment. We will be using multiple methods to facilitate skill acquisition, including lecture, discussion, demonstrations, film excerpts, and student role plays. Your attendance is essential to your success in this class. Please contact the instructor in advance if you will be late or unable to attend a class. Students are responsible for missed material and should obtain notes/handouts from a peer if they are absent from class. More than one unexcused absence will result in a half-grade reduction (i.e. A to A-); more than two may result in failure of the course. This includes accumulated lateness. **Please plan your schedule accordingly.**

Smarthinking Tutorial Assistance: The instructor for this course assumes that all students are prepared for the level of instruction appropriate for the course number and placement in the academic program. Students requiring or desiring additional academic support or preparation may utilize the Smarthinking

system. This system of on-line tutorials, including writing assistance, can be accessed directly from the Blackboard course site (use the "Tools" feature).

Student Disability Policy: Students with documented disabilities are encouraged to work with the Cushing Center for Counseling and Academic Support (CCAS): 610-341-5837 to submit a written request for accommodations specific to this course. To receive accommodations, the instructor must receive a written request from CCAS. A student must update accommodations requests with CCAS prior to each academic session.

University Policies: Please note that all university policies pertaining to academic dishonesty, drop/add procedures, and grade appeal apply in this course. These are outlined in the CCGPS Graduate Catalog, and students are expected to be familiar with and follow them. In addition, as professionals in training, students in this class are expected to adhere to standards of ethical behavior and professional demeanor as outlined in the discipline's ethical codes (e.g., ACA, CAPS). Failure to do so can be cause for dismissal from the program.

Emergency and Crisis Information: In the case of an emergency event, we ask that all community members use their best judgment. We also recommend that each member of this community become familiar with emergency procedures. Call Campus Security at 610-341-1737 for emergencies on the St. Davids campus.

Inclement Weather: Decisions to cancel class due to inclement weather will be made by 3:30 p.m. on a weekday and 6:00 a.m. on Saturdays. Use your own judgment regarding travel conditions from your area. If you determine that it is unsafe to travel and the class has not been cancelled, CCGPS or departmental attendance policies will apply. If the University is closed or classes are delayed due to inclement weather, there are two convenient ways for you to stay informed:

- The CCGPS Information Bulletin Board. Please call the voice mail system at 610-225-5055; once you hear "Repartee Messaging System," dial 2834 and the recorded message will begin. (For those making long distance calls, please feel free to dial 1-800-732-7669; at the menu, dial 2834.)
- The Eastern University Website: School closing information can be seen at www.eastern.edu by clicking on "School Closing Info" under the "EU Quick Links" drop-down menu at the top of the page.
- Radio: A radio announcement will be made on KYW news radio, 1060 AM (our school closing number—1207--is listed in Delaware County) and on WARM 103 FM (in Central Pennsylvania).

REQUIRED TEXTS:

Baird, B.N. (2008). ***The internship, practicum, and field placement handbook*** (5th ed). New Jersey: Prentice Hall. **ISBN-10:** 0132238802

Martin, D.G. (2000) ***Counseling and therapy skills*** (2nd ed). Long Grove, IL: Waveland Press. **ISBN-10:** 1577660684

The instructor will post articles/book chapters on Blackboard as a supplement to the textbook readings. These documents can only be used for educational purposes. They may not be downloaded, retained, printed, shared, or modified, except as needed temporarily for specific academic assignments.

RECOMMENDED READINGS:

McMinn, M.R., & Campbell, C.D. (2007). ***Integrative Psychotherapy: Toward a Comprehensive Christian Approach***. Downers Grove, IL: InterVarsity Academic Press. (ISBN# 978-0-8308-2830-2)

Schema charts and information on character styles from CNSL609

EVALUATED LEARNING ACTIVITIES:

1. Field Work

Course Objective Fulfilled: #6
Due: 4/23/09 (Log of hours and completed Site Supervisor Evaluation—both posted on Blackboard)
Grading Value: Pass/Fail (based on required hours completed and at least average scores on Site Supervisor Evaluation). Please note: Students are expected to conduct themselves as professionals at the Practicum placement site. Should the site supervisor indicate the student's progress is unacceptable, Eastern University retains the right to fail the student in this course and withdraw the student from the site.

Description and Parameters: Minimum of 100 hours **at practicum placement site in activities the site supervisor deems appropriate.** One hour of supervision per week **with an on-site supervisor is required. A** Practicum Site Supervisor Evaluation form **must be completed by the site supervisor and submitted at the end of the semester.** Logs **documenting fieldwork activities must be completed, signed by the site supervisor, and submitted at the end of the semester.**

2. **Session #2 Tape and 5 page transcript** (with self-critique labels/comments)
Course Objectives Fulfilled: #1-6
Due: 2/26/09
Grading Value: 20%
Description and Parameters: Students should transcribe one page (each) of the beginning and end of the session. The remaining three continuous pages of transcription should demonstrate the required skills outlined in the grading rubric. This assignment is designed to assess the student's level of skills retained from the pre-requisite skills course, CNSL602. The assignment will be evaluated so the student and the instructor/TA know areas of strength and weakness. Please note: the pacing of skill acquisition varies greatly among students. If you are struggling to demonstrate the pre-requisite skills (or to acquire the new skills), one-on-one tutoring is available. This has proven helpful for students in the past. The instructor will recommend names of tutors who will negotiate a fee with you privately.
Skills assessed: Alliance building (eliciting client disclosure by attending, probes, neutrality), tracking/reflecting and empathizing (4 bases); pattern analysis at the automatic thought level; labeling/self-critique skills (see pp. 5-6 for instructions). Grading rubric posted on Blackboard.

3. **Critique of Peer's Session #3**
Course Objective Fulfilled: #5
Due: 3/12/09 (tape submitted to peer); 3/16/09 (by 10 pm, email feedback to peer with copy to

instructors)
Grading Value: 5%
Description and Parameters: Students will listen to a peer's tape and email feedback (using format to be distributed in class). Grading rubric posted on Blackboard.

4. **Session #5 Tape and 5 page transcript** (with self-critique labels/comments)
Course Objectives Fulfilled: #1-6
Due: 3/26/09
Grading Value: 30%
Description and Parameters: Students should transcribe 5 pages of continuous dialogue that they deem best demonstrates the required skills.
Skills assessed: Previous tape skills, plus self-syntonic interpretation; identifying and empathizing with defenses; labeling/self-critique skills (see pp. 5-6 for instructions). Grading rubric posted on Blackboard.

5. **Critique of Peer's Session #6**
Course Objective Fulfilled: #5
Due: 4/2/09 (tape submitted to peer); 4/6/09 (by 10 pm, email feedback to peer with copy to instructors)
Grading Value: 5%
Description and Parameters: Students will listen to a peer's tape and email feedback (using format to be distributed in class). Grading rubric posted on Blackboard.

6. **Session #8 Tape and 7 page transcript** (with self-critique labels/comments)
Course Objectives Fulfilled: #1-6
Due: 4/16/09
Grading Value: 35%
Description and Parameters: Students should transcribe 7 pages of continuous dialogue that they deem best demonstrates the required skills.
Skills assessed: Previous tapes' skills, plus self-dystonic interpretation; alliance deepening skills; labeling/self-critique skills (see pp. 5-6 for instructions). Grading rubric posted on Blackboard.

7. **Termination session #9** (audiotape only)
Course Objectives Fulfilled: #1-4, 6
Due: 4/23/09
Grading Value: 5%
Description and Parameters: Students will submit tapes of the final session with their practice clients.
Skills assessed: Professional termination skills. Grading rubric posted on Blackboard.

GRADING POLICIES:

1. **Due dates -** It is expected that assignments will be handed in on time. If a legitimate emergency occurs (or a situation with your client) that delays your completion of assignments, you must notify the instructor in advance of the due date and arrange for an extension. Unless prior approval is received, late submissions will result in a 5-point reduction for each day beyond the due date. For this course, an assignment is on time if submitted on the due date at the beginning of class (no later than 15 minutes after class begins). PLEASE NOTE: absence from class does not nullify due dates. If you must miss a class, you are responsible to get the assignment to the instructor by the beginning of class on the due date.

2. **Grading Scale** - The grading scale used in this course follows:

98-100	A+
93-97	A
90-92	A-
88-89	B+
83-87	B
80-82	B-
78-79	C+
73-77	C
70-72	C-
69 and below	F

3. Taping and Transcribing Parameters - **Students will conduct a 9-session course of weekly psychotherapy with a client from the field placement site or from Eastern's undergraduate pool. Permission from the client to tape the sessions is mandatory. Please tape ALL sessions throughout the entire 45-50 minutes of the session, as this is less disruptive to the client, and having the tapes available for review is highly beneficial to your training.**

*****USE 120 MINUTE TAPES to eliminate the need to turn the tape over during the counseling sessions. Any tape that contains a stop and start will not be accepted.**

Students will be evaluated based upon the **entire** (45-50 minute) session for all taped assignments. However, to alleviate the burden of transcribing, students are only required to transcribe part of the session for the assignments (see previous section for amount required for each assignment). Students transcribe at least the minimum requirement for each of the tapes, but are welcome to transcribe more if they believe skills are demonstrated in other parts of the session. Please submit transcripts and the audio tape in a large envelope with your name on the outside as well as on each of the parts of the assignment, including the tape. DO NOT INCLUDE YOUR CLIENT'S NAME ON ANY MATERIALS. **Be sure your tapes are cued to the beginning of the session**.

Transcripts should be typed double-spaced to allow room for your handwritten labeling of the dialogue and for instructor feedback. Use one inch margins and 12 point font. The client's responses should be labeled C1, C2, C3, etc. and your responses should be listed as T1, T2, T3, etc. This numbering provides a quick way to summarize specific examples of skill demonstration. **See exemplar (posted on Blackboard) of the transcribing format.**

PLEASE NOTE: Because we rely heavily on accurate tapes and transcripts of student counseling sessions, any falsification of tapes/transcripts will result in automatic failure of the course. "Falsification" includes, but is not limited to:

- Turning in a tape that does not record an actual counseling session with the client you've indicated you are working with. Recording a session that did not emerge spontaneously (i.e., coaching your client to say things in the session to help you demonstrate required skills). Please note: this is exploitation of the client and is expressly forbidden by the ethics codes of the counseling profession.
- Altering the tape in any fashion, including shutting the tape off and restarting it during the session. If for some reason, the tape is stopped you must use a different tape that is continuous from a different session for assignment credit.
- Failing to transcribe the taped session exactly as recorded. If something is not able to be understood, please indicate this by the phrase: (. . . unclear). One or two instances of a brief phase that is unclear on a transcript are acceptable. If you have more unclear sections of the transcript it will be considered inaudible and the tape will be failed. Client silences should be indicated by the phrase: (long/short silence). Please do not transcribe simple repeated CLIENT expressions, such as "uh" and "like" which

are used as filler and are hard to read unless you feel such expressions help to demonstrate client dynamics. Such THERAPIST'S expressions must be transcribed.

In order to understand the flow of the therapeutic dialogue it is necessary that the audio tape be clear and the transcript accurate. **Please check tapes for audibility before submitting them.** No more than three unclear sections in one transcript will be accepted. If the instructor cannot hear the flow of dialogue between the student and the client(s), the first tape will be returned, ungraded. If another tape is submitted that is not audible, the student will receive a 0 for the assignment.

4. **Self Critique Parameters:** Becoming an effective therapist requires not only sound client assessment and intervention skills but also skills internal to the person of the therapist. The use of self is foundational in the counseling relationship, and thus we are looking for students' capacity for self-awareness, self-critique and openness to feedback. These personal self-reflection skills will be evaluated in self-critiques of your work with your client. **See exemplar (posted on Blackboard) .**

First, typing in bold font immediately after the word or phrase, label the **client's disclosures**:

- Situation (1st base—trigger) - **S**
- Affect (2nd base—feelings) – **A**
- Cognition (3rd base – thoughts) – **C**
  Specify if the cognition reflects:
  - view of self (syntonic or dystonic) – **VOS-S** or **VOS-D**
  - view of others (syntonic or dystonic) – **VOO-S** or **VOS-D**
  - view of the world – **VOW**
- Behavior (4th base--actions taken or forgone) – **B**
- Wished for self/object experience - **WISH**
- Feared self/object experience - **FEAR**
- Match (affirmation of therapist's intervention as on target) - **MATCH**

Second, typing in bold font immediately after the word or phrase, label **your interventions**:

- Open opening (allows client to lead) - **OO**
- Simple probe (e.g., "can you tell me more about that") - **PR**
- Tracking/reflection of situations, affect, behavior or cognitions – **T/R A, B, or C**
- Naked question (off topic or without first acknowledging client's disclosure) - **NQ**
- Clothed question (on topic & first acknowledges client's disclosure) - **CQ**
- Tone or pacing (match or mismatch) – **TONE or PACING**
- Minimal encourager (e.g., "mmm" or "go on") - **ME**
- Neutrality break (validating or challenging the client's views) - **NB**
- Syntonic Pattern Analysis with Evidence – **PA-Syn, Evid**
- Dystonic Pattern Analysis with Evidence – **PA-Dys, Evid**
- Immediacy – **IMMED**
- Syntonic Interpretation (of wish) – **Syn Interp**
- Dystonic Interpretation (of fear) – **Dys Interp**

Third, in bold font just below your interventions (single-spaced), type **self-critique comments**. Comments can include a reflection of what was occurring during the dialogue (including transference/countertransference), discussion of the impact of your interventions, and suggested alternative interventions. (See sample transcript for reference).
Fourth, please fill out a grading rubric on your work, noting where you believe you have accomplished the skill set from the rubric. For example under Tracking and Reflecting Skills on the rubric you might list: T4, T5, T8, T10, T12, etc.

Appendix B: Grading Rubric Session #2

Session #2 Tape/Transcript (5 pages): Alliance Building (eliciting client disclosure by attending, probes; neutrality), Tracking/Reflecting and Empathizing (4 bases), Pattern Analysis at the automatic thought level; labeling/self-critique skills

	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**
Alliance Building Skills: **Eliciting client disclosure**	Student has difficulty establishing a sound working alliance with client due to: **Poor attending skills**: - fails to use silence to encourage client disclosures &/or elaboration (i.e., immediately fills "space") - allows client to talk on and on without appropriately breaking in, thus too much data accumulates to adequately attend to client disclosures - tone/pacing mismatch with client **Poor execution of probes**: - omits open opening - minimal encouragers lacking or overused - questions overused,	Student has difficulty building alliance due to: **Inadequate attending skills**: - does not use silence sufficiently to encourage client disclosure &/or elaboration - occasionally breaks in when client data accumulating, but not often enough to adequately attend to client disclosures - inconsistent tone/pacing match with client **Inadequate execution of probes**: - minimal encouragers lacking or overused - questions overused, "naked" -had trouble closing the session	Student begins building on initial alliance by: **Good attending skills:** language - uses silence sufficiently to encourage client disclosure &/or elaboration - breaks in appropriately when client data accumulates - good tone/pacing match with client **Good execution of probes:** - uses open opening and minimal encouragers to invite client disclosures and elaboration - uses questions sparingly, purposefully (for clarity) and "clothed" with empathy	Student easily builds on initial alliance by: **Consistent and effective attending skills:** - uses silence effectively to encourage client disclosure &/or elaboration - deftly breaks in when client data accumulates - excellent tone/pacing match with client **Consistent and effective execution of probes:** - uses open opening and minimal encouragers to invite client disclosures and elaboration - uses questions sparingly, purposefully (for clarity) and "clothed" with

	"naked" -closed session inappropriately		-closed session but could use help winding session down	empathy -closed session appropriately

INTERVENTION SKILLS GRADING RUBRIC (Practicum, Session #2 Tape, p. 2)

	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**
Tracking/ Reflecting with Empathy Skills: 4 "Bases"	Student shows poor apprehension of client communications—reflections back to client may: - miss major elements of the client's disclosure (situations, cognitions, affect, behavior) - distort the meanings of the client's disclosures (e.g., misunderstands cultural, spiritual or other nuances of the situations client describes, misinterprets one feeling for another, mistakes feelings for thoughts, misperceives client's automatic thoughts and/or mislabels client's behaviors). Rarely obtains "match." Has great difficulty revising reflections when match not given.	Student shows rough apprehension of client communications —reflections back to client may: - miss some elements of the client's disclosure (situations, cognitions, affect, behavior) - be off sometimes in capturing meaning. Occasionally obtains "match." Has difficulty revising reflections when match not given.	Student shows clear apprehension of client communications—reflections back to client are: - usually complete with occasional missed elements (situations, cognitions, affect, behavior - usually accurate in capturing meaning. Usually obtains "match." Some difficulty revising reflection, however, when match is not given.	Student shows clear apprehension of client communications —reflections back to client are: - usually complete with consistent tracking (situations, cognitions, affect, and behavior) - with keen grasp of cultural and spiritual nuances. Frequently obtains "match." Easily revises reflections when match is not given.
	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**

Syntonic Pattern Analysis	Student does not adequately link client stories: - makes no attempts at summarizing pattern - has difficulty identifying psychologically relevant themes for pattern analysis - is off target in summary - gives little or no evidence of pattern - does not obtain match for pattern analysis	Student beginning to link client stories: - attempts to identify psychologically relevant themes for pattern analysis - at times is off target in summary - gives some evidence of pattern - may obtain partial match for pattern analysis	Student effectively links client stories: - effectively identifies psychologically relevant themes for pattern analysis - summary is accurate - usually gives adequate evidence of pattern - usually obtains match for pattern analysis	Student effectively links client stories: - easily identifies psychologically relevant themes for pattern analysis - summary is accurate - gives clear evidence of pattern - frequently obtains match for pattern analysis

INTERVENTION SKILLS GRADING RUBRIC (Practicum, Session #2 Tape, p. 3)

	(0 – 72)	**(73–82)**	**(83 – 92)**	**(93 – 100)**
Harmful Responses to avoid	Numerous harmful responses are present. Therapeutic alliance is in jeopardy due to: - unchecked counter-transference - jumping ahead without match - blatant neutrality breaks (i.e., advice-giving, evaluative remarks, minimization, hostility) - subtle neutrality breaks (i.e., evaluative minimal encouragers like "okay," "yes," "right," "but" or omission of neutral phrases like "in your view," "as you see it"). - inappropriate personal disclosures - handling Christian issues in a nontherapeutic manner	Some harmful responses are present. Therapeutic dialogue does not deepen as a result of harmful responses, and they do present some threat to therapeutic alliance if not checked. For example, there may be frequent: - jumping ahead without match - neutrality breaks (blatant and/or subtle)	Few harmful responses are present. They do not jeopardize the therapeutic alliance but may somewhat prevent the therapeutic dialogue from deepening. For example: - student may jump ahead without match, but he/she recovers (backs up) when client appears lost. - there may be occasional subtle neutrality breaks (i.e., evaluative minimal encourages like "okay," "yes," "right," "but").	Very few harmful responses are present. They are minor in nature, and student usually notices them in-session and quickly self-corrects. They do not jeopardize the therapeutic alliance nor prevent the therapeutic dialogue from deepening.
	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**
Self-critique	Grasp of therapy dialogue not demonstrated:	Uneven grasp of therapy dialogue demonstrated:	Grasp of therapy dialogue adequately	Grasp of therapy dialogue clearly demonstrated:

	- Client disclosures not labeled or largely inaccurately labeled - Therapist interventions not labeled or largely inaccurately labeled. - Rubric with self-assessment missing Awareness of self in therapy dialogue: - Little or no reflection on personal strengths/weaknesses (including counter-transference) observed in therapy encounter. Efforts to improve skills: - very few or no attempts at generating alternate interventions	- Some client disclosures not labeled or inaccurately labeled - Some therapist interventions not labeled or inaccurately labeled. - Rubric incomplete (no references to where skills are demonstrated; no scoring) Awareness of self in therapy dialogue: - Some brief reflection given on personal strengths/weaknesses (including counter-transference) observed in the therapy encounter, but with very little elaboration Efforts to improve skills: - A few attempts at generating alternate interventions, but these lack elaboration or remain off target	demonstrated: - Client disclosures usually labeled accurately. - Therapist interventions usually labeled accurately. Awareness of self in therapy dialogue: - Several reflections given which show growing awareness of personal strengths/weaknesses (including counter-transference) observed in the therapy encounter. Efforts to improve skills: - Several good attempts at generating alternate interventions, and these are on target	- Client disclosures labeled throughout and with consistent accuracy. - Therapist interventions labeled throughout and with consistent accuracy. Awareness of self in therapy dialogue: - Several reflections given which show deep awareness of personal strengths/weaknesses (including counter-transference) observed in the therapy encounter. Efforts to improve skills: - Many alternate interventions generated, and these are on target

Appendix C: Grading Rubric Session #5

Session #5 Tape/Transcript (5 pages): Previous tape skills; Self-syntonic Interpretation; Identifying and Empathizing with Defenses; labeling/self-critique

PREVIOUS TAPE SKILLS:

	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**
Alliance Building Skills	**Student has difficulty building the therapeutic alliance and eliciting client disclosure due to:** - inadequate attending skills (e.g., use of silence or breaking in) - poor execution of probes (e.g., over- or under-use of open opening, minimal encouragers, questions) - tone/pacing mismatch	Student has built an initial alliance, but has some difficulty eliciting client disclosure due to: - inadequate attending skills (e.g., use of silence or breaking in) - poor execution of probes (e.g., over- or under use of open opening, minimal encouragers, questions) - inconsistent tone/pacing match with client	Student maintains the therapeutic well and satisfactorily elicits client disclosure: - usually shows good attending skills and execution of probes). - good tone/pacing match with client	Student maintains a strong therapeutic alliance and effectively elicits disclosure: - shows consistently effective attending skills and execution of probes). - excellent tone/pacing match with client
	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**

Tracking/ Reflecting with Empathy Skills	Student shows poor apprehension of client communications —reflections may: - miss major elements of the client's disclosure - distort the meanings of the client's disclosures (e.g., misunderstands cultural, spiritual or other nuances of the situations client describes, misinterpret one feeling for another, misperceive client's automatic thoughts and/or mislabel client's behaviors) - does not attend to client's reaction to reflections.	Student shows rough apprehension of client communications —reflections may: - miss some elements of the client's disclosure (situations, cognitions, affect, behavior) - be off in capturing meaning. - shows some awareness of client's reactions to reflections, but shows difficulty backing up when match is not given.	Student shows clear apprehension of client communications —reflections are usually complete with occasional misses elements (situations, cognitions, affect, behavior) - usually accurate in capturing meaning - usually attends to client's reaction to reflections and backs up when match not given.	Student shows clear apprehension of client communications —reflections are usually complete (i.e., tracks the "bases") and accurate with keen grasp of cultural and spiritual nuances. - attends well to client's reaction to reflections. Easily revises when match not given.

	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**
Syntonic Pattern Analysis	Student does not adequately link client stories: - makes no attempts at summarizing pattern - has difficulty identifying psychologically relevant themes for pattern analysis - is off target in summary - gives little or no evidence of pattern - does not attend to client's reaction to pattern analysis	Student beginning to link client stories: - attempts to identify psychologically relevant themes for pattern analysis - at times is off target in summary - gives some evidence of pattern - shows some awareness of client's reactions to pattern analysis, but shows difficulty backing up when match is not given.	Student adequately links client stories: - identifies psychologically relevant themes for pattern analysis - summary is accurate - usually gives adequate evidence of pattern - usually attends to client's reaction to pattern analysis and backs up when match not given	Student effectively links client stories: - easily identifies psychologically relevant themes for pattern analysis - summary is accurate - gives clear evidence of pattern - attends well to client's reaction to pattern analysis. Easily revises when match not given.

INTERVENTION SKILLS GRADING RUBRIC (Practicum, Session #5 Tape, p. 2)

NEW SKILLS:

	(0 – 82)	**(83 – 89)**	**(90 – 97)**	**(98 – 100)**
Self-syntonic Interpret-ation	__Student shows poor apprehension of client wishes (VOS/VOO). Interpretations may be: __ not attempted __ clearly off target with client character issues __ poorly timed __ delivered with insufficient humility or empathy __ given at inappropriate character level (e.g., self-dystonic given instead of self-syntonic) __Student rarely obtains "match" for interpretations and has great difficulty responding when match not given.	__Student shows rough apprehension of client wishes (VOS/VOO). Interpretations may be: __ somewhat off target with client character issues __ inadequate delivery that detracts from client's preparation for insight (e.g., inappropriate timing/tone). __Match is not usually obtained. Student struggles to respond when match not given for interpretations.	__Student shows clear apprehension of client wishes (VOS/VOO) with usually accurate interpretations that are appropriately timed and delivered, and that adequately prepare client for insight. __Client often appears to consider the interpretations seriously as indicated by frequency of match. However, when match is not obtained, student has difficulty following client's lead.	__Student shows clear apprehension of client wishes (VOS/ VOO) with accurate interpretations that are deftly timed and delivered, and smoothly prepare client for insight. __Client often appears to consider the interpretations seriously as indicated by frequency of match. Student easily responds to client's lead when match is not given.
	(0 – 82)	**(83 – 89)**	**(90 – 97)**	**(98 – 100)**

Dystonic Pattern Analysis **(Identifying & Empathizing with Defenses)**	Student shows poor apprehension of client defenses: __No attempts or inaccurate identifying of repetitive affective states, assumptions or behavior (which serve to prevent dystonic fears). __When attempts are made to identify defenses, student lacks sufficient empathy (i.e., fails to connect defenses to self-object longings, perceptions or expectations). __Client may evidence feeling exposed, attacked or shamed. __Match is not obtained.	Student shows rough apprehension of client defenses: __Occasional and usually accurate attempts at identifying repetitive affective states, assumptions, or behavior. __Student lacks sufficient empathy when presenting defenses to client (i.e., fails to connect defenses to self-object longings, perceptions or expectations). __Client may evidence feeling exposed, attacked or shamed. __If match is obtained, it is occasional/partial.	Student shows good apprehension of client defenses: __Consistent and usually accurate identification of repetitive affective states, assumptions and behavior. __Student shows sufficient empathy when presenting defenses to client (i.e., usually connects defenses to self-object longings, perceptions or expectations). __Client usually appears to consider these seriously as indicated by frequency of match. __When match is not obtained, student has difficulty following client's lead.	Student shows exceptionally clear apprehension of client defenses __ Very consistent and accurate identification of repetitive affective states, assumptions and behavior. __Student shows clear empathy when presenting defenses to client (i.e., consistently connects defenses to self-object longings, perceptions or expectations). __Client often appears to consider these seriously as indicated by frequency of match. __Student easily responds when match is not given

INTERVENTION SKILLS GRADING RUBRIC (Practicum, Session #5 Tape, p. 3)

	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**
Harmful Responses to avoid	Numerous harmful responses are present. Therapeutic alliance is in jeopardy due to: - unchecked counter-transference - jumping ahead without match - blatant neutrality breaks (i.e., advice-giving, evaluative remarks, minimization, hostility) - subtle neutrality breaks (i.e., evaluative minimal encouragers like "okay," "yes," "right," "but" or omission of neutral phrases like "in your view," "as you see it")). - inappropriate personal disclosures - handling Christian issues in a nontherapeutic manner	Some harmful responses are present. Therapeutic dialogue does not deepen as a result of harmful responses, and they do present some threat to therapeutic alliance if not checked. For example, there may be frequent: - jumping ahead without match - neutrality breaks (blatant and/or subtle)	Few harmful responses are present. They do not jeopardize the therapeutic alliance but may somewhat prevent the therapeutic dialogue from deepening. For example: - student may jump ahead without match, but he/she recovers (backs up) when client appears lost. - there may be occasional subtle neutrality breaks (i.e., evaluative minimal encourages like "okay," "yes," "right," "but").	Very few harmful responses are present. They are minor in nature, and student usually notices them in-session and quickly self-corrects. They do not jeopardize the therapeutic alliance nor prevent the therapeutic dialogue from deepening.
	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**
Self-critique	Grasp of therapy dialogue not demonstrated: - Client disclosures not labeled or largely	Uneven grasp of therapy dialogue demonstrated: - Some client disclosures not labeled or	Grasp of therapy dialogue adequately demonstrated: - Client disclosures usually labeled accurately.	Grasp of therapy dialogue clearly demonstrated: - Client disclosures

	inaccurately labeled - Therapist interventions not labeled or largely inaccurately labeled. - Rubric with self-assessment missing Awareness of self in therapy dialogue: - Little or no reflection on personal strengths/weaknesses (including counter-transference) observed in therapy encounter. Efforts to improve skills: - very few or no attempts at generating alternate interventions	inaccurately labeled - Some therapist interventions not labeled or inaccurately labeled. - Rubric incomplete (no references to where skills are demonstrated; no scoring) Awareness of self in therapy dialogue: - Some brief reflection given on personal strengths/weaknesses (including counter-transference) observed in the therapy encounter, but with very little elaboration Efforts to improve skills: - A few attempts at generating alternate interventions, but these lack elaboration or remain off target	- Therapist interventions usually labeled accurately. Awareness of self in therapy dialogue: - Several reflections given which show growing awareness of personal strengths/weaknesses (including counter-transference) observed in the therapy encounter. Efforts to improve skills: - Several good attempts at generating alternate interventions, and these are on target	labeled throughout and with consistent accuracy. - Therapist interventions labeled throughout and with consistent accuracy. Awareness of self in therapy dialogue: - Several reflections given which show deep awareness of personal strengths/weaknesses (including counter-transference) observed in the therapy encounter. Efforts to improve skills: - Many alternate interventions generated, and these are on target

Appendix D: Grading Rubric Session #8

Session #8 Tape/Transcript (7 pages): Previous tape skills; Self-Dystonic Interpretation; Alliance Deepening Skills; labeling/self-critique skills.

PREVIOUS TAPE SKILLS:

	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**
Alliance Building Skills	Student has difficulty building the therapeutic alliance and eliciting client disclosure due to: - inadequate attending skills (e.g., use of silence or breaking in) - poor execution of probes (e.g., over- or under-use of open opening, minimal encouragers, questions) - tone/pacing mismatch	Student has built an initial alliance, but has some difficulty eliciting client disclosure due to: - inadequate attending skills (e.g., use of silence or breaking in) - poor execution of probes (e.g., over- or under use of open opening, minimal encouragers, questions) - inconsistent tone/pacing match with client	Student maintains the therapeutic well and satisfactorily elicits client disclosure: - usually shows good attending skills and execution of probes). - good tone/pacing match with client	Student maintains a strong therapeutic alliance and effectively elicits disclosure: - shows consistently effective attending skills and execution of probes). - excellent tone/pacing match with client
	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**

Tracking/ **Reflecting with Empathy Skills**	Student shows poor apprehension of client communications—reflections may: - miss major elements of the client's disclosure - distort the meanings of the client's disclosures (e.g., misunderstands cultural, spiritual or other nuances of the situations client describes, misinterpret one feeling for another, misperceive client's automatic thoughts and/or mislabel client's behaviors) - does not attend to client's reaction to reflections.	Student shows rough apprehension of client communications—reflections may: - miss some elements of the client's disclosure (situations, cognitions, affect, behavior) - be off in capturing meaning. - shows some awareness of client's reactions to reflections, but shows difficulty backing up when match is not given.	Student shows clear apprehension of client communications—reflections are usually complete with occasional misses elements (situations, cognitions, affect, behavior) - usually accurate in capturing meaning - usually attends to client's reaction to reflections and backs up when match not given.	Student shows clear apprehension of client communications—reflections are usually complete (i.e., tracks the "bases") and accurate with keen grasp of cultural and spiritual nuances. - attends well to client's reaction to reflections. Easily revises when match not given.
	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**
Syntonic Pattern Analysis	Student does not adequately link client stories: - makes no attempts at summarizing pattern - has difficulty identifying psychologically relevant themes for pattern analysis - is off target in summary - gives little or no evidence of	Student beginning to link client stories: - attempts to identify psychologically relevant themes for pattern analysis - at times is off target in summary - gives some evidence of pattern - shows some awareness of client's reactions to pattern analysis, but shows difficulty backing up when match is not given.	Student adequately links client stories: - identifies psychologically relevant themes for pattern analysis - summary is accurate - usually gives adequate evidence of pattern - usually attends to client's reaction to pattern analysis and backs up when match not given	Student effectively links client stories: - easily identifies psychologically relevant themes for pattern analysis - summary is accurate - gives clear evidence of pattern - attends well to client's reaction to pattern analysis. Easily revises when match not given.

	pattern - does not attend to client's reaction to pattern analysis			

INTERVENTION SKILLS GRADING RUBRIC (Practicum, Session #8 Tape, p. 2)

	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**
Self-syntonic Interpret-ation	__Student shows poor apprehension of client wishes (VOS/VOO). Interpretations may be: __ not attempted __ clearly off target with client character issues __ poorly timed __ delivered with insufficient humility or empathy __ given at inappropriate character level (e.g., self-dystonic given instead of self-syntonic) __Student rarely obtains "match" for interpretations and has great difficulty responding when match not given.	__Student shows rough apprehension of client wishes (VOS/VOO). Interpretations may be: __ somewhat off target with client character issues __ inadequate delivery that detracts from client's preparation for insight (e.g., inappropriate timing/tone). __Match is not usually obtained. Student struggles to respond when match not given for interpretations.	__Student shows clear apprehension of client wishes (VOS/VOO) with usually accurate interpretations that are appropriately timed and delivered, and that adequately prepare client for insight. __Client often appears to consider the interpretations seriously as indicated by frequency of match. However, when match is not obtained, student has difficulty following client's lead.	__Student shows clear apprehension of client wishes (VOS/ VOO) with accurate interpretations that are deftly timed and delivered, and smoothly prepare client for insight. __Client often appears to consider the interpretations seriously as indicated by frequency of match. Student easily responds to client's lead when match is not given.
	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**
Dystonic Pattern Analysis	Student shows poor apprehension of	Student shows rough apprehension of	Student shows good apprehension of client defenses:	Student shows exceptionally clear apprehension of

(Identifying & Empathizing with defenses)	client defenses: __No attempts or inaccurate identifying of repetitive affective states, assumptions or behavior (which serve to prevent dystonic fears). __When attempts are made to identify defenses, student lacks sufficient empathy (i.e., fails to connect defenses to self-object longings, perceptions or expectations). __Client may evidence feeling exposed, attacked or shamed. __Match is not obtained.	client defenses: __Occasional and usually accurate attempts at identifying repetitive affective states, assumptions, or behavior. __Student lacks sufficient empathy when presenting defenses to client (i.e., fails to connect defenses to self-object longings, perceptions or expectations). __Client may evidence feeling exposed, attacked or shamed. __If match is obtained, it is occasional/partial.	__Consistent and usually accurate identification of repetitive affective states, assumptions and behavior. __Student shows sufficient empathy when presenting defenses to client (i.e., usually connects defenses to self-object longings, perceptions or expectations). __Client usually appears to consider these seriously as indicated by frequency of match. __When match is not obtained, student has difficulty following client's lead.	client defenses __ Very consistent and accurate identification of repetitive affective states, assumptions and behavior. __Student shows clear empathy when presenting defenses to client (i.e., consistently connects defenses to self-object longings, perceptions or expectations). __Client often appears to consider these seriously as indicated by frequency of match. __Student easily responds when match is not given

PREVIOUS TAPE SKILLS:
NEW SKILLS:

	(0 – 82)	**(83 – 89)**	**(90 – 97)**	**(98 – 100)**
Alliance Deepening Skills/ Advanced Defensive Work (Immediacy & Process Comments)	__Student shows poor apprehension of in-the-moment relational dynamics (immediacy work). For example, student: __misses relational crises/opportunities (such as negative transference reactions from client, therapist errors and/or nonverbal clues). __ fails to make appropriate process comments which would allow the alliance to deepen.	__Student shows weakness in apprehension of in-the-moment relational dynamics (immediacy work): __ occasional attempts at process comments in response to relational crises/opportunities and/or nonverbal clues __student lacks sufficient empathy when presenting relational issues client (i.e., fails to connect negative transference to client's overall relational pattern or fails to take responsibility for own therapy errors). __ Client may evidence feeling exposed, attacked or shamed. If match is obtained, it is occasional and partial.	__Student shows clear apprehension of in-the-moment relational dynamics (immediacy work) by: __ usually responding to relational crises/ opportunities and/or nonverbal clues with process comments. __Student can improve in showing sufficient empathy when presenting relational issues to client (i.e. connecting negative transference to client's overall relational pattern more clearly; taking responsibility for therapy errors). __Client appears to consider these process comments seriously as indicated by frequency of match. However, when match is not obtained, student has difficulty following client's lead.	__Student shows clear apprehension of in-the-moment relational dynamics (immediacy work) by: __ responding to relational crises/ opportunities and/or nonverbal clues with process comments. __Student shows sufficient empathy when presenting relational issues to client (i.e., consistently connects negative transference to client's overall relational pattern; takes full responsibility for own therapy errors and skillfully assesses their impact on client). __Client often appears to consider these process comments seriously as indicated by frequency of match. __Student easily responds to client's lead when match is not given
	(0 – 82)	**(83 – 89)**	**(90 – 97)**	**(98 – 100)**

Self-Dystonic Interpret-ation	__Student shows poor apprehension of client fears (VOS/VOO). Interpretations are not on-target with client character issues. __Student does not adequately prepare client for interpretations (i.e., fails to adequately summarize defensive patterns and their impact/consequences) Interpretations may be: __ poorly timed __delivered with insufficient humility or empathy __Student rarely obtains "match" for interpretations and has great difficulty responding when match not given.	__Student shows rough apprehension of client fears (VOS/VOO). Interpretations may be accurate, but client is not sufficiently prepared for interpretations due to: __ inadequate summary of defensive patterns and their impact/consequences __ poor delivery of interpretations (e.g., poorly timed or delivered with insufficient humility or empathy). __Match is not usually obtained. Student struggles to respond when match not given for interpretations.	__Student shows clear apprehension of client fears (VOS/VOO) with usually accurate interpretations that are appropriately timed and delivered with sufficient humility and empathy. __Student usually prepares client sufficiently for interpretations by adequately summarizing defensive patterns and their impact/consequences. __Client usually appears to consider the interpretations seriously as indicated by frequency of match. However, when match for dystonic VOS is not obtained, student has difficulty responding with alternative intervention (i.e., following client's lead).	__Student shows clear apprehension of client fears (VOS/VOO) with accurate interpretations that are appropriately timed and delivered with sufficient humility and empathy. __Student prepares client sufficiently for interpretations by effectively summarizing defensive patterns and their impact/ consequences __Client often appears to consider the interpretations seriously as indicated by frequency of match. __Student easily responds to client's lead when match is not given for dystonic VOS.

INTERVENTION SKILLS GRADING RUBRIC (Practicum, Session #8 Tape, p. 4)

	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**
Harmful Responses to avoid	Numerous harmful responses are present. Therapeutic alliance is in jeopardy due to: - unchecked counter-transference - jumping ahead without match - blatant neutrality breaks (i.e., advice-giving, evaluative remarks, minimization, hostility) - subtle neutrality breaks (i.e., evaluative minimal encouragers like "okay," "yes," "right," "but" or omission of neutral phrases like "in your view," "as you see it")). - inappropriate personal disclosures - handling Christian issues in a nontherapeutic manner	Some harmful responses are present. Therapeutic dialogue does not deepen as a result of harmful responses, and they do present some threat to therapeutic alliance if not checked. For example, there may be frequent: - jumping ahead without match - neutrality breaks (blatant and/or subtle)	Few harmful responses are present. They do not jeopardize the therapeutic alliance but may somewhat prevent the therapeutic dialogue from deepening. For example: - student may jump ahead without match, but he/she recovers (backs up) when client appears lost. - there may be occasional subtle neutrality breaks (i.e., evaluative minimal encourages like "okay," "yes," "right," "but").	Very few harmful responses are present. They are minor in nature, and student usually notices them in-session and quickly self-corrects. They do not jeopardize the therapeutic alliance nor prevent the therapeutic dialogue from deepening.
	(0 – 72)	**(73 – 82)**	**(83 – 92)**	**(93 – 100)**
Self-critique	Grasp of therapy dialogue not demonstrated:	Uneven grasp of therapy dialogue demonstrated:	Grasp of therapy dialogue adequately demonstrated:	Grasp of therapy dialogue clearly demonstrated:

	- Client disclosures not labeled or largely inaccurately labeled - Therapist interventions not labeled or largely inaccurately labeled. - Rubric with self-assessment missing Awareness of self in therapy dialogue: - Little or no reflection on personal strengths/weaknesses (including counter-transference) observed in therapy encounter. Efforts to improve skills: - very few or no attempts at generating alternate interventions	- Some client disclosures not labeled or inaccurately labeled - Some therapist interventions not labeled or inaccurately labeled. - Rubric incomplete (no references to where skills are demonstrated; no scoring) Awareness of self in therapy dialogue: - Some brief reflection given on personal strengths/weaknesses (including counter-transference) observed in the therapy encounter, but with very little elaboration Efforts to improve skills: - A few attempts at generating alternate interventions, but these lack elaboration or remain off target	- Client disclosures usually labeled accurately. - Therapist interventions usually labeled accurately. Awareness of self in therapy dialogue: - Several reflections given which show growing awareness of personal strengths/weaknesses (including counter-transference) observed in the therapy encounter. Efforts to improve skills: - Several good attempts at generating alternate interventions, and these are on target	- Client disclosures labeled throughout and with consistent accuracy. - Therapist interventions labeled throughout and with consistent accuracy. Awareness of self in therapy dialogue: - Several reflections given which show deep awareness of personal strengths/weaknesses (including counter-transference) observed in the therapy encounter. Efforts to improve skills: - Many alternate interventions generated, and these are on target

Appendix E: Termination Tape Grading Rubric

Points Earned	**Skill/Points possible**
	Raises termination in opening, and raises it again at mid-session if client does not address ending (10 points)
	Invites client directly to discuss therapy course, tracks and reflects client's disclosures (20 points)
	Summarizes issues covered in therapy course, pauses appropriately to invite client response (20 points)
	Invites client directly to discussion feelings about ending. Uses immediacy appropriately to process feelings in the moment (20 points)
	Probes whether client needs a referral to continue counseling; discusses referral options (20 points)
	Uses appropriate self-disclosure to express thanks to client and terminate counseling relationship (10 points)

Appendix F: Survey of Demographics

Please fill out the survey to the best of your ability. Either circle the appropriate response or fill in the blank with the appropriate response.

1. Circle your age in years:
18-20 21-30 31-40 41-50 51-60 61-70 71-80 80+

2. Fill in your age: _____

3. Mark your gender: male ____ female ____

4. Check your ethnicity: African American__ Asian__ Caucasian__ Hispanic__ Other:_____

5. Circle your highest level of education:

8th grade High school Associates degree College Degree Other:_____

6. Circle your family income range:

$0-10,000 $10,001-20,000 $20,001-30,000 $30,001-40,000 $40,001-50,000 $50,001-60,000 $60,001-70,000 $70,001-80,000 $80,0001+

7. Have you ever been diagnosed with a mental illness?: Yes__ No__

8. If yes, please check which one(s):

Anxiety disorder__ Attention deficit disorder__ Bipolar disorder__ Depressive disorder__ Eating disorder__ Obsessive compulsive disorder__ Posttraumatic stress disorder__ Schizophrenia__ Schizoaffective disorder__ Substance abuse/dependence__ Personality disorder__

9. If you have been diagnosed with a personality disorder, which one?:

Antisocial__ Avoidant__ Borderline__ Dependent__ Histrionic__ Narcissistic__ Obsessive-compulsive__ Paranoid__ Schizoid__ Schizotypal__ Other:_____

10. Are you currently taking medication for mental health reasons?: Yes__ No ___

11. If you are taking psychiatric medications which ones:

_____

_____

12. Are you currently undergoing any other forms of therapy?: Yes ____ No ____
(for example, couples therapy, family therapy, group therapy)

13. Do you expect that therapy will be helpful for you?: Yes ____ No ____

Thank you for taking the time to participate. I appreciate your honesty and time.

Curriculum Vitae

Lindsay A. Sterious, MA, LPC, NCP

Academic Experience:

12/04 – Present	Candidate for Doctor of Philosophy – Clinical Psychology, Walden University, Minneapolis, Minnesota
12/98-05/01	Master of Arts – Community & Clinical Counseling, Eastern University, Pennsylvania
06/95-12/98	Bachelor of Arts – Psychology, minor in Coaching, Millersville University, Pennsylvania

Relevant Professional Experience:

08/01 – 05/10	Served as an adjunct instructor in the practicum and techniques courses, taught therapists-in-training to conduct integrative psychotherapy.
08/06 – 11/11	Served as an individual, group, and family therapist at Life Counseling Services. Worked with adolescents in the Light Program, an intensive outpatient program working to stabilize acute distress. Served as supervisor to the adolescent Light Program therapists.
10/07 – 7/08	Served as a graduate assistant in the testing sequence at Walden University. Assisted instructors at the face-to-face components of the personality and cognitive assessment courses. Helped to train students in standardized test administration, scoring, interpretation, and report writing.
04/08 – 04/11	Served as Director of Testing and Assessment at Life Counseling Services. Trained and supervised doctoral level students in cognitive and personality testing and assessment.
11/11 – Present	Serves as an individual, couples, and family therapist at Dayspring Counseling Services. Works with adolescents and adults who are working to manage everyday stressors as well as various mental health diagnoses.

Community Service and Consulting Experience:

08/00-05/01	Created and developed youth program for 6th through 12th grade Sunday school students at a new church plant.

Licenses and Certifications:

Certified	Nationally Certified Psychologist
License	Licensed Professional Counselor

Honors and Rewards:

1998	Awarded a lifetime member of Psi Chi. An honorable recognition at Millersville University for students who are committed to the advancement of psychology.

References: Upon request