

The Integrative Psychotherapy Scale for Assessment of Therapist's Activity

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Abstract:

The article describes a new assessment instrument for measuring the activities of an integrative psychotherapist. The first part of the instrument is concerned with establishing and maintaining a therapeutic alliance, and includes the competencies of forming an effective empathic bond, contracting and dealing with ruptures in the alliance. The second part focuses on the methods of integrative psychotherapy, and includes competencies of effective Inquiry, Attunement, Involvement and the use of therapeutic interventions. The scale also includes scales which inform about the philosophy of the therapist and his dealing with transference / countertransference. The scale is currently in the preliminary phase of development and further research is needed to examine the usefulness, validity and reliability of the scale.

While training future integrative psychotherapists at our Institute for Integrative Psychotherapy and Counselling in Ljubljana, we have become increasingly interested in how to assess the practical work of our trainees. Although there exist different scales for measuring the work of a psychotherapist, as of yet we have no assessment tool within the integrative relational approach developed by Erskine, Moursund and Trautmann (1999). Therefore, the Integrative Psychotherapy Scale for Assessment of Therapist's Activity (IPSATA) was developed in order to assess a psychotherapist according to the methodological frame of Integrative Psychotherapy. Such a scale shows the potential of being used for different purposes:

- 1) Assessment of the trainee
- 2) Supervision of the psychotherapist's work
- 3) Self-supervision
- 4) Research purposes.

The scale consists of four main parts:

- 1) Establishing and maintaining the therapeutic alliance
- 2) Methods of integrative psychotherapy
- 3) Additional scales for understanding the therapist's work
- 4) Overall rating.

Establishing and Maintaining the Therapeutic Alliance

This part of the scale assesses the therapist's capacity to establish and maintain a therapeutic alliance, which is a very important factor in psychotherapy. Many researchers have explored the effectiveness of different kinds of therapies, yet over the years, they have come to similar conclusions. Firstly, no particular treatment is more effective than any other and secondly, the therapeutic alliance is an essential integrative variable (Evans & Gilbert, 2005). Bordin (1979) suggested that a good alliance is a prerequisite for change in all forms of psychotherapy. Furthermore, the alliance consists of three interdependent components:

- client and therapist agreement on Goals of treatment
- client and therapist agreement on how to achieve the goals (agreement on Tasks)
- the bond between the therapist and the client (Bordin, 1979).

The strength of the alliance depends on the degree of agreement between the client and the therapist regarding the tasks and the goals of therapy, as well as on the quality of the relational bond between them. Additionally, Safran and Muran (2000, 2003) emphasize the importance of mutual agreement on treatment tasks and goals, and highlight the critical role of ongoing negotiation and mutual accommodation. Establishing and maintaining a therapeutic alliance is a common factor in all psychotherapy approaches.

The Integrative Psychotherapy Scale for Assessment of Therapist's Activity includes three significant competencies which are important for the therapeutic alliance:

- 1) The Empathic Bond – Assess the therapist's capacity for empathic responding which is crucial for developing contact between the client and the therapist. Such therapist is able to show the capacity for decentering from his own experience in order to understand the client's phenomenological world.
- 2) Contracting – In Integrative Psychotherapy, the agreement between the client and the therapist regarding the tasks and the goals of therapy is conceptualized as contracting. For an Integrative Psychotherapist, process contracts, which negotiate the direction of the treatment and

determine which interventions are used on an ongoing basis, are of particular importance. Consequently, contracting is an ongoing process rather than a singular act in the initial stages of therapy.

- 3) Dealing with ruptures in the alliance – This competency includes the awareness of a rupture in the therapeutic alliance and an effective way of disembedding from the enactment that is taking place. The therapist can effectively deal with the rupture either implicitly (by changing the style of interaction) or explicitly (by acknowledging his part in the interaction and metacommunicating about the interaction which is taking place).

Methods of Integrative Psychotherapy

Erskine and Trautmann (1996) describe three main methods of relational integrative psychotherapy: Inquiry, Attunement and Involvement. With the help of Inquiry, Attunement and Involvement, the therapist provides a relationship that allows and invites the client to become increasingly contactful (internally and externally), to dissolve the defences and to recover the parts of self that have been lost from awareness.

The IPSATA assesses the following competencies:

- 1) Inquiry - Involves respectful exploration of the client's phenomenological experience. The therapist asks the client to reveal to him his subjective perspective; in doing so, the client becomes increasingly aware of his relational needs, feelings, behaviour and thoughts (Erskine et al., 1999). The therapist invites the client to search for answers, to think in new ways and to explore new avenues of awareness. For an effective inquiry, there is no expectation that the client will come to some predetermined goal or insight (Erskine et al., 1999). Inquiry promotes awareness and increases internal and external contact. The IPSATA differentiates inquiry from other forms of questioning processes which focus more on data and wherein a therapist has a predetermined goal and directs the client in a certain direction.
- 2) Attunement - Erskine and Trautmann (1993/1997) describe attunement as a two-part process: 'the sense of being fully aware of the other person's sensations, needs, or feelings and the communication of that awareness to the other person.' (p. 90). Attunement goes beyond empathy – it provides a reciprocal affect and/or resonating response. Effective attunement also requires that the therapist simultaneously remains aware of the boundary between client and therapist. With the help of attunement, the therapist gently moves through the client's defences and makes contact with the client's long-forgotten split off parts of the self. The

therapist can be attuned to a wide variety of client behaviours and experiences, but especially to his rhythm, nature of affect, cognition, developmental level of psychological functioning and relational needs. Effective attunement is not just concerned with the immediate experience of the client. What is even more important is that the therapist is attuned to the unaware and denied aspects of the client. With effective attunement, the split off parts of the client are accessed and brought into awareness and experience.

- 3) Involvement - Involvement means that the therapist is willing to be affected by what happens in the relationship with the client (Erskine et al., 1999). Therapeutic involvement includes *acknowledgment*, *validation*, *normalization*, and *presence*. With *acknowledgment*, the therapist demonstrates that he is aware of what the client is feeling and experiencing. *Validation* is the acknowledgment of the significance of the client's experience. It communicates to the client that his affects are related to something significant in his experience. *Normalization* depathologises the clients' definition of their internal experiences or their coping mechanisms. In this manner, the therapist communicates to the client that his experience is a normal, and not pathological or defensive reaction. *Presence* means that the therapist 'is there' for and with the client, i.e. the therapist is committed to the client's welfare. The goal of Involvement is to dissolve the defences which interfere with the satisfaction of current needs and which prevent full contact with self and others in the here and now. Involvement promotes new relational experiences which invite the client out of his old repetitive patterns.
- 4) Therapeutic Interventions - An integrative psychotherapist uses a variety of interventions which promote integration of affect, cognition, behavior, physiology and spiritual dimensions of the client (Erskine, & Trautmann, 1993/1997). Interventions are used within the frame of the main methods of Inquiry, Attunement and Involvement. The therapist checks the impact of interventions on the client on an ongoing basis.

Relational Epistemological Stance and the Use of Transference / Countertransference

The IPSATA includes additional scales which are not intended to assess the therapist's work. Their role is to facilitate further understanding of the therapist's work, his work philosophy and the use of transference and countertransference. As it is difficult to assess these issues based on an individual therapy transcript, they are used more in terms of providing additional information and clarification. These three scales are rather general and may be refined in the future for more clarity and differentiation.

- 1) Relational epistemological stance
Integrative psychotherapy is based on the relational paradigm of psychotherapy which states that the client and the therapist form a system of mutual influence (Žvelc & Žvelc, 2003).
An integrative psychotherapist is aware of the mutuality in a therapeutic relationship, and of his/her own contribution to this relationship. He/she acknowledges that the client and the therapist present a system of reciprocal influence and that neither of them possesses the 'objective' truth.
- 2) Working with/within transference/countertransference
An integrative psychotherapist works with or within the transference /countertransference matrix. Effective work with/within transference may promote insight and/or new relational experiences which invite the client out of his script. In Integrative Psychotherapy, the therapist may use his countertransference experience during a therapy session, either directly or indirectly, and through careful self-disclosure.

Conclusion

The Integrative Psychotherapy Scale for Assessment of Therapist's Activity was developed in order to assess the work of an integrative psychotherapist. It includes the fundamental competencies of the Integrative Psychotherapist. The scale is currently in the preliminary phase of development. The use of the Scale by different trainers, supervisors and psychotherapists will demonstrate its potential applicability and, hopefully, provide changes and refinements. Research is needed to examine the validity and reliability of the Scale.

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References

- Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice*, 16, 152-260.
- Erskine, R., & Trautmann, R.L. (1993/1997). The Process of Integrative Psychotherapy. In R. Erskine (Ed.), *Theories and Methods of an Integrative Transactional Analysis*. (pp. 79-95). San Francisco: TA Press
- Erskine, R. G., & Trautmann, R. L. (1996). Methods of an Integrative Transactional Analysis. *Transactional Analysis Journal*, 26, 316-328.
- Erskine, R. G., Moursund, J. P. & Trautmann, R. L. (1999). *Beyond empathy. A therapy of contact-in-relationship*. Philadelphia: Brunner/Mazel.
- Erskine, R. & Moursund, J.P. (2004). *Integrative psychotherapy. The Art and Science of Relationship*. Pacific Grove: Thomson. Brooks/Cole.
- Evans, K. R. & Gilbert, M. C. (2005). *An Introduction to Integrative Psychotherapy*. London: Palgrave Macmillan.
- Safran, J. D. & Muran, J. K. (2000). *Negotiating the Therapeutic Alliance*. New York: The Guilford Press.
- Safran, J. D. (2003). The Relational Turn, the Therapeutic Alliance and Psychotherapy Research. Strange Bedfellows or Postmodern Marriage? *Contemporary Psychoanalysis*, 39, 449-474.
- Žvelc, G., & Žvelc, M. (in press). Integrativna psihoterapija. [Integrative psychotherapy] In M. Žvelc, M. Možina, & J. Bohak (Eds.), *Psihoterapija. [Psychotherapy]*. Ljubljana: Institute IPISA.

APPENDIX

THE INTEGRATIVE PSYCHOTHERAPY SCALE FOR ASSESSMENT OF THERAPIST'S ACTIVITY (Žvelc, 2010)

Date: _____

Initials of the psychotherapist: _____

Initials of the assessor: _____

Assessment is based on:

- a) tape of a therapy session
- b) transcript of a therapy
- c) observation of a live therapy during psychotherapeutic training.

Instructions for the assessor: the IPSATA includes the list of competencies of an integrative psychotherapist. Based on your observation, please mark the number in front of the description of a certain competency:

- 1 – Poor or no sign of competency
- 2 – some signs of competency
- 3 – satisfactory (good) competency
- 4 – excellent competency.

PART 1: ESTABLISHING AND MAINTAINING THE THERAPEUTIC ALLIANCE

A. THE EMPATHIC BOND

- 1 – Little or no empathic connection. The therapist did not understand the client on explicit and implicit (non-verbal) levels.
- 2 – The therapist was able to reflect back on what was explicitly said, but failed to resonate with the client on affective level.
- 3 – Empathic connection was evident. The therapist was able to understand the client's internal reality on both verbal and non-verbal levels. The therapist demonstrated a good capacity for listening and empathy.
- 4 – Excellent empathic skills. The therapist was able to effectively communicate to the client what he had empathically grasped, both on verbal and non-verbal level (e.g. tone of voice, gesticulation). He was able to decenter from his own experience so as to understand the client's phenomenological world.

B. CONTRACTING

- 1 – There was an obvious disagreement between the client and the therapist in terms of goals and treatment direction. The therapist failed to address this and did not make an appropriate contract.
- 2 – There was no explicit sign of disagreement between the client and the therapist in terms of goals, treatment direction and the methods used. However, the therapist was too directive and 'pushy', leading the client towards his own (i.e. the therapist's) agenda.
- 3 – There was a clear agreement between the client and the therapist regarding the goals of the session, treatment direction and the interventions used. The therapist used process contracts to negotiate the treatment direction and the interventions used on an ongoing basis.
- 4 – The therapist expertly used process contracts. He neither led, nor followed the client. There was a marked balance between leading and following the client, combined with an ongoing process of negotiation between the client and the therapist on both implicit and explicit levels.

C. DEALING WITH RUPTURES IN THE ALLIANCE

- 1 – The therapist showed no awareness of a rupture in the therapeutic alliance. Enactment took place and the therapist did not reflect upon it.
- 2 – The therapist was aware of a rupture in the alliance, but his attempts to disembed were not effective (for example: he did not take responsibility for his part, did not change his style of interaction).
- 3 – The therapist was aware of a rupture and effectively initiated disembedding (either implicitly by changing his style of interaction or explicitly).
- 4 – The therapist demonstrated an excellent capacity to deal with ruptures. The process of dealing with the ruptures promoted insight and provided new relational experiences. Examples of behavior: the therapist acknowledged his part in the interaction, he apologised, metacommunicated about interaction that was taking place, etc. This code is used also if no rupture occurred.

PART 2: METHODS OF INTEGRATIVE PSYCHOTHERAPY

A. INQUIRY

- 1 – The therapist did not use inquiry. He was more focused on facts and gathering data than on the client's process of getting to answer. The therapist had a predetermined goal and directed the client in this direction (closed questions, investigatory style).
- 2 – The therapist used inquiry and was focused on the client's process. However, inquiry was evident only on one level (e.g. cognitive) and did not promote awareness or contact with self and others.
- 3 – The therapist effectively used inquiry on both non-verbal and verbal levels. He showed no expectation that the client ought to come to some predetermined goal or insight. Inquiry was connected to effective attunement and involvement. However, the client did not seem to discover anything new about himself.
- 4 - Contactful quality of inquiry. Inquiry promoted awareness and internal and external contact. During the session, the client discovered something new about himself.

B. ATTUNEMENT

- 1 – No sign of attunement between client and therapist. The therapist did not resonate with the client on cognitive, affective, developmental, rhythmical or relational level.
- 2 – There were few moments of effective attunement between the client and the therapist. The therapist was able to resonate with the client on one level (e.g. cognitive), but not on other levels. The other possibility is that the therapist had difficulties in differentiating between himself and others (i.e. he colluded with the client).
- 3 – The therapist and the client were attuned for the most part of the session. The therapist demonstrated a good capacity to resonate with the client on all levels. However, attunement of the therapist was more connected with the conscious materials than with the unaware split off parts of the client.
- 4 – Excellent attunement. The therapist demonstrated a capacity to attune at cognitive, affective and rhythmical levels, as well as in terms of relational needs. With attunement, the split off parts of the client were accessed and brought into awareness and experience.

C. INVOLVEMENT

- 1 – No sign (or few signs) of involvement from the therapist. The therapist was not emotionally present and not available for contact.
- 2 – The therapist was involved through the session and used acknowledgment, validation and normalisation. However, the involvement was not congruent with the client (involvement was not connected with attunement). Limited capacity for presence.
- 3 – The therapist showed good capacity for involvement and used acknowledgment, validation and normalisation of the client's experience. Involvement promoted new relational experiences which invited the client out of his old repetitive patterns (script).
- 4 – The therapist showed an excellent capacity for involvement. He effectively acknowledged, validated and normalised the client's experience. He was fully present and invited the client to a state of presence. During the session, it was observed that the client deepened the contact with himself and the therapist. The client made steps out of the script.

D. THERAPEUTIC INTERVENTIONS

- 1 – Therapeutic interventions were ineffective or even reinforced the client's repetitive patterns of behaviour, feelings and cognition (script). Interventions were not attuned to the client.
- 2 – The therapist used interventions, but it could not be observed during the session whether the intervention had a positive impact on the client. The therapist did not monitor the impact of the intervention on the client.
- 3 – Therapeutic interventions promoted movement out of script and were based on contact with the client. During the session, the therapist used few different interventions.
- 4 – The therapist skillfully used interventions, which promoted integration of affect, cognition, behavior and physiology. The therapist used a variety of interventions, focusing on different levels of experience (cognitive, affective, behavioral, physiological). The therapist checked the impact of interventions on the client on an ongoing basis.

PART 3: ADDITIONAL SCALES FOR UNDERSTANDING THE THERAPIST'S WORK

(These scales are not to be used for assessment purposes. They are aimed at understanding of the therapist's work from a relational perspective)

RELATIONAL EPISTEMOLOGICAL STANCE (PHILOSOPHY)

- A – The therapist worked primarily from a one-person psychology stance. He did not acknowledge his impact on the client's behavior and experience. The therapist was uninvolved and behaved as if he'd possess the truth.
- B – The therapists showed awareness of the process of co-creation between the client and the therapist. However, this was at the background during the sessions. The therapist was primarily concerned with the client's experience.
- C – The therapist was aware of the mutuality in the relationship and of his contribution to the relationship. He acknowledged that the client and the therapist form a system of reciprocal influence and that neither possesses the 'objective' truth. The therapist used his countertransference experience either directly or indirectly and through careful self-disclosure.

UNDERSTANDING AND THE USE OF TRANSFERENCE

- A – The therapists was not aware of transference.
- B - The therapist directly worked with or within transference. From the session, it was not clear whether this had a positive impact on the client.
- C – The therapist expertly worked with or within transference. New insight(s) or new relational experience was evident through this process.

UNDERSTANDING AND THE USE OF COUNTERTRANSFERENCE

- A – The therapist was not aware of his countertransference experience. He acted it upon the client without reflection.
- B – The therapist showed some awareness of his countertransference response. However, he did not use it to understand the client or the dynamics between them.
- C – The therapist made effective use of his countertransferential response (i.e. in order to understand the client, self-disclosure)

PART 4: OVERALL RATING

- A. How would you rate the psychotherapist overall in this session, as an integrative psychotherapist?
 - 1 – Poor or no sign of competency
 - 2 – some signs of competency
 - 3 – satisfactory (good) competency
 - 4 – excellent competency.

- B. FINAL SCORE (sum of all the numbers / 8): _____ / 8 = _____