

Mission Statement

The Society for the Exploration of Psychotherapy Integration (SEPI) is an international, interdisciplinary organization whose aim is to promote the exploration and development of approaches to psychotherapy that integrate across theoretical orientations, clinical practices, and diverse methods of inquiry.



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THE *Integrative Therapist*

ARTICLES • INTERVIEWS • COMMENTARIES

Training Issue

A Word From the Editor

Jeffery Smith

Dear Readers,

This is my final and farewell issue as editor of *The Integrative Therapist*. I am deeply grateful to the leadership of SEPI for having given me the opportunity over the past three years to reinvent and reshape the organization's informal publication. When first confronted with a blank slate for what the publication should look like, I sought inspiration from the original newsletter produced by the founders over 30 years ago. I hope I have done justice to their early example in leaving aside the constraints of formal academic publication to make accessible the best from both leaders in the field and from individual members through our survey series.



This bountiful issue is dedicated to the question of introducing integrative concepts at the outset of training. At the end of no less than 14 contributions by pioneers, experts and innovators, you will find an extraordinary, penetrating synthesis by Jack Anchin, our guest editor. In addition, Alexandre Vaz, who will be taking over as editor with the next issue, has pulled together thoughts about the 74 responses to what has turned out to be our most popular survey ever. All together, we hope you will agree that we have assembled a remarkable collection of the best thinking on the subject of integrative training in psychotherapy.

For this final editorial, in the spirit of thinking about early integrative training and about its place in launching a psychotherapist's developmental journey, I have decided to share my own path to practicing integrative therapy and to teaching it at the outset to psychiatric residents.

Perhaps it was an early interest in theory that made me take notice. In a 1974 residency course on sex therapy, I was introduced to Helen Singer Kaplan's technique of giving a behavioral prescription, then, when the couple didn't follow it, using psychodynamic principles to interpret their resistance. That was my first exposure to integrative therapy.

In those days, psychodynamic residency training did not cover trauma. That was for military psychiatrists. Soon after graduation, working with a patient who had suffered horrific childhood abuse and lacking previous exposure, I turned to what was on my shelf, the early papers of Freud on trauma therapy. After several years of working through anger and building a holding environment, my patient's dissociated experiences of terrible abuse emerged as if they had just taken place. Her pain and grief were all that a human could bear. But once those feelings had been felt and shared, what astonished me was to see how affects that had been so energetically avoided were healed, within hours, to a dull ache. It was catharsis, just as Freud had described it in 1893.

Soon after, we began the process of dealing with chronic low self-esteem and inappropriate shame and guilt. Those had not melted away, and now presented an even greater challenge. Helping my patient to share those feelings did not resolve them. Catharsis did not apply. Her acute pain did not return, but those symptoms persisted and would re-awaken with any setback in life. One day, it occurred to me that resolution of these symptoms had to be a distinct healing process. It was then that I decided to make the study of change processes the focus of my career.

A new job at New York Medical College included teaching psychotherapy technique to each class of second-year residents. I showed the residents how to encourage free association, identify resistance, and, with exposure of

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"It was then that I decided to make the study of change processes the focus of my career."



"Early life trauma led to internalization of the negative attitudes of the perpetrator."

successive layers of avoided affect, create an environment for healing. However, my growing confidence was soon shaken when I took the job of directing the hospital's alcoholism service. Exploration of free associations was of little use in helping alcoholics get sober. Behavior change had to come first. The sex therapy model came back into view.

What was driving this behavior and what change processes were involved in recovery? Members of AA clearly knew a lot more about alcoholism than did psychiatry, so I watched. Seeing alcoholics who truly did not want to drink, but couldn't stop, I began to think of free will and motivation as brain functions that could be compromised. What AA provided was powerful support for a convalescing free will. That's what I wrote in a 1988 paper. But what process was that? How could free will undergo change?

Over the next ten years, following developments in the science of motivation, it became clear that the alcoholic brain had been hijacked into "thinking" that drinking was synonymous with survival of the species. All the mind's faculties for ensuring survival of the species were now directed at supporting the drinking behavior. Among these, the most intriguing were the spontaneous thoughts of people in early recovery. In AA, they called it "the disease talking." Suddenly an idea would pop into the mind of the recovering person that "I'm not really an alcoholic," or "my willpower is really strong now." Soon after, they would relapse. It seemed no different from the thoughts of a person admonished not to eat or drink before surgery. Here were observable manifestations of the mind's purposeful but unconscious efforts to serve evolution.

What it took to bring about change brought me full circle. In rehab, alcoholics were isolated from familiar people and places. Under the stress of abstinence, they were exposed to an entirely new way of looking at life. They were simultaneously bonding with peers and internalizing a new set of values. In a book entitled Snapping, Conway and Siegelman describe the conditions necessary for sudden change in values and how faulty ones can be "deprogrammed." The conditions of stress and aloneness that lead to new and lasting internalizations are the same as those implicated in the Stockholm syndrome, and, surprisingly, in the way early life trauma led to internalization of the negative attitudes of the perpetrator. At last I had some understanding of the source of my patients' shame and low self-esteem.

Around that time, my training director, Rob Feinstein asked me if I would be interested in teaching a course for senior residents on how to combine cognitive-behavioral and psychodynamic techniques. I was intrigued and soon found SEPI. I joined and attended my first conference. In teaching, I focused on the two processes I now understood clinically: one in which painful emotions were brought to consciousness and processed to the point where they no longer generated efforts at avoidance, and another in which human bonds, attitudes, values, ideals and prohibitions were first internalized and could be replaced therapeutically with healthier ones.

For my students, I wrote a handout, which evolved each year with further understanding of the acquisition and maintenance of pathology and the two processes of therapeutic change. In 2004, the year when, unbeknownst to me, reconsolidation was first described, I published a paper giving a clinical description of the two change processes I had observed. Now it is clear that the one by which painful emotions could heal permanently matched precisely the clinical characteristics of reconsolidation. I was no longer practicing as I had been taught, applying a method and waiting for results. Now, in practice, and increasingly in teaching, I was focusing on how to foster processes of healing threatening emotions and changing internalized unhealthy values. Activation of emotions was part of both processes and could be brought about through relationship, changes in cognition, and, as in the case of alcoholism, changes in behavior.

For much of my career, I had the idea in mind of one day pulling all I had learned into a synthesis that would cover the wide range of pathologies encountered in 40 years of clinical practice. In the course of writing a book for lay people and a textbook (2017), describing one form of integrative therapy, two things came clear. The first was that psychotherapy was aimed primarily at the contents of the mind and patterns of reaction that were retained in memory. For pathologies of mainly biological origin, therapy could help with maladaptive coping, but was not mainly directed toward altering the biological source of trouble. That simplified the synthesis, which was now focused on changing mental contents. The second realization was that in pathologies ranging from attachment disorders, originating in early life, to addiction, manifested in the teens, the common factor was avoidance of negative affects. But there was a complication. Sometimes negative affects were inferred, rather than conscious and sometimes they appeared to be anticipated, rather than actually experienced.

Since then, a dive further into neurophysiology helped with loose ends. Core emotions, such as fear and anger are not always manifested consciously, but still have the ability to trigger coping, including those spontaneous thoughts that CBT aims at changing. Starting with Richard Lazarus and going into computational neurobiology,

"Now, in practice, and increasingly in teaching, I was focusing on how to foster processes of healing threatening emotions and changing internalized unhealthy values."



it is clear that the non-conscious coping mind expends a great deal of energy anticipating future threats, gauging the adequacy of resources, and designing coping strategies to match. The final piece in the puzzle is that shame, the emotion mediated by judgment and values, is not one of the core, limbic emotions. It is generated in the cortex. That begins to explain why the low self-esteem and shame associated with trauma follow a different pathway to recovery than the raw, unprocessed emotions directly associated with traumatic experience. The past three years of editorship of *The Integrative Therapist* have brought many new influences and new challenges. How do the puzzle pieces fit together today? A draft paper written with Ben Johnson and visible on ResearchGate (under my full name) tells the story.

Jeffery Steven Smith

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The Integrative Therapist: Call for Content

The Integrative Therapist wants you to be an author. We are seeking brief, informal, interesting and actionable articles with a personal touch. Think of the way you would talk to a colleague over lunch. Please limit references to those that are absolutely essential. Our bias is towards articles relevant to SEPI's three missions: integration between researchers and clinicians, integration across cultures, and further development of psychotherapy integration.

Contributors are invited to send articles, interviews, commentaries and letters to the Newsletter's future Editor, Alexandre Vaz.

Submission Deadlines and Publication Dates

December 1 deadline for **January 15 Issue**

March 1 deadline for **May 15 Issue**

June 20 deadline for **July 15 Issue**

September 15 deadline for **October 15 Issue**

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Specifications

- The preferred length of submissions is 1,250 words or less
- Block style, single spaced with an extra space between paragraphs
- No paragraph indentations, page numbering, headers or footers
- Use subheadings and bullet points freely
- Bare Minimum references should be single spaced, in approved APA-style format
- Please include a photo of the author or authors, minimum 50K file size each.
- Photos should be submitted as separate JPEG, TIFF, GIF, or BITMAP files.

All submissions should be sent in the body of an email to alexmavaz@gmail.com with the subject line "Contribution to Integrative Therapist."



"With maladaptive pattern being a unifying construct that seemingly has salience across all theoretical perspectives, an economical way of accentuating a critical cross-cutting variable, what is not to like?"



"Discovery, serendipity, risk enacted over time are all involved in therapist becoming, developing an identity as a psychological healer."

Structured Interviews on Psychotherapy Training

The Integrative Therapist is proud to present a series of structured interviews on the topic of psychotherapy Training. We asked a group of leaders in psychotherapy theory, practice and research to respond to three questions designed to bring out opinions, scholarly reflections and questions at the cutting edge of this exciting topic.

Fourteen distinguished members of SEPI and beyond have kindly offered the contributions that follow. Enjoy!

C. Edward Watkins, Jr
University of North Texas, Denton



1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

I see much benefit to doing this. It gives students something empirically sound to have and to hold. Furthermore, with *maladaptive pattern* being a unifying construct that seemingly has salience across all theoretical perspectives, an economical way of accentuating a critical cross-cutting variable, what is not to like? What we have is a robust, meaning-making organizer that has theory-wide applicability. Let us use it to maximize student/supervisee learning.

But in my mind, this would be but one alternative to use in the teaching and learning of psychotherapy, a trans-theoretical vision, an additive perspective, not necessarily a replacement for anything. I believe that students, supervisees, benefit most from having the full panoply of theoretical possibilities on display and from which they can choose and experiment and build their own sense of therapist identity. Beginning supervisees often feel oh so strongly, "Don't just sit there, do something!" and in turn can most definitely act that out; part of their learning process involves finding those very "somethings" with which they can then actually "do something" in treatment, and maladaptive patterns/triggers would be one such invaluable "something" to use in their process of therapist self-creation navigation. Discovery, serendipity, risk enacted over time are all involved in therapist becoming, developing an identity as a psychological *healer* (Ford, 1963; Friedman & Kaslow, 1986), experiencing deep conviction to that effect (Chessick, 1971), and becoming able to say and feel loudly and proudly that "I am a Healer" (Watkins, Davis, & Callahan, 2018). May we as supervisors be *reflective instigators* and *mentalization maximizers* for our supervisees and open up the theoretical playbook for supervisee study, review, discussion, and practice inspiration (Watkins, 2018). And as supervisees learn and grow, may their trajectory of therapist becoming ideally evolve into a "Don't just do something, sit there" mentality (where supervisees learn the importance of listening to, learning from, and understanding their clients so as to best inform therapeutic action).

That monumental shift in supervisee perspective, however, is best aided and abetted in my view by having a host of meta-models and theory-specific models that (a) stretch and challenge thinking, (b) provide divergent, even conflicting, perspectives for consideration, (c) offer a rich array of interventions from which to choose and experiment, and (d) show the theoretical sameness in the difference and the theoretical difference in the sameness (e.g., maladaptive pattern may have trans-theoretical resonance, but its conceptualization and treatment can still show definite theory-specific particularities that matter). Becoming a therapist involves the successful merger of the personal with the professional, a process largely defined by the very person and personhood of the engaged learners (their uniqueness, individual variations, personality, and personal plurality; Bennett-Levy & Finlay-Jones, 2018; Klein, Bernard, & Schermer, 2011; Ronnestad & Skovholt, 2013); it is not a monolithic experiential unfolding best addressed by an educational monoculture. And if the future of psychotherapy itself is indeed about plurality and *not* a "one size fits all" monoculture (Leichsenring, Abbass, Hilsenroth, Luyten, Munder, Rabung, & Steinert, 2018), then let it be so that our future psychotherapy training and supervision efforts are also defined by that very plurality, where we as trainers/supervisors: (a) readily recognize that "One size does not fit all" students/supervisees in their experience of therapist becoming; (b) forever strive to accommodate to that educational reality and customize our teaching/supervisory efforts accordingly; and (c) eminently embrace our role as being *developmental facilitators*, with a superseding mission of helping supervisees to find their best personal theoretical/therapeutic fit in their ever-evolving journey to define a Practice Self (Watkins, 2012, 2017; Watkins & Scaturro, 2013).



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"Let us have both: A menu of interventions for responding to an identified maladaptive pattern or triggering situation and discrete bodies of intervention techniques associated with specific schools of treatment."

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?

The spirit of my answer here would be no different from what I said in response to the preceding question. In teaching, training, and supervising, let us have both: A menu of interventions for responding to an identified maladaptive pattern or triggering situation *and* discrete bodies of intervention techniques associated with specific schools of treatment (e.g., psychodynamic, cognitive-behavioral, humanistic). Adding such a menu of interventions (again, what is not to like about that?) to those discrete bodies of intervention techniques is a great way to expand the menu of theoretical/therapeutic possibilities. And as we work to foster supervisee development, menu expansion as opposed to menu restriction seems best to me. Becoming a therapist is a very personal and personalized process that results in the student/supervisee becoming able to say "This is who I am (as a therapist) (Klein et al., 2011; Skovholt, 2012). Having a menu of interventions may well be highly additive to the process of therapist self-definition. Again, however, that menu in and of itself is not a replacement for anything (or at least should not be in my view).

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

Having such a theoretical framework, I contend, is preeminently important for supervisee development. Let all frameworks count, let all have the possibility of being given voice, let all enter and be considered in the supervisory space. Throw the door wide for supervisees to theoretically explore, discover, and begin charting the uncharted. Therapist identity or Practice Self development often begins by taking the "outside in" and gradually moves to bringing the "inside out" (Rihacek & Roubal, 2017). Some form of conceptualization, though it may shape shift over time, can be crucial in and of itself to the therapist's evolving developmental journey into a Practice Self (cf. Rihacek, Danelova, & Cermak, 2012; Ronnestad & Skovholt, 2013; Watkins et al., 2018).

So whatever emerges as my supervisee's working conceptualization about maladaptive pattern (e.g., Acceptance and Commitment Therapy, psychodynamic), I go with it as a starting point, my primary objective being to help them find their theoretical best fit. And in the process, I collaboratively hope to also help them (a) explore why that conceptualization works for them now, (b) discover its ins and outs, (c) consider its strengths with and any potential limitations for the particular clients receiving treatment, and (d) examine how the chosen conceptualization compares and contrasts with other equally viable theoretical explanations. Thus, I encourage and validate my supervisees "trying out" and "trying on" different perspectives and interventions; I want them to see what feels "like me" and what feels "not like me". Such actions ideally (a) deepen supervisees' thinking about what they are doing and why and (b) help me to understand that "what" and "why" as well. Such deepening can accordingly deepen supervisees' conviction that they are on the right path or, conversely, it can lead to a *loosening and letting go* of the theory in question and desire to further explore other options. I view all this as developmentally normative, a pivotal part of being and becoming a psychotherapist. I want to do all that I can to actuate and actualize my supervisees' freedom to learn, to embrace, empower, and emancipate their therapeutic potential.

Although I welcome supervisees being theory specific, I also introduce them to Wampold's (2015, 2017; Wampold & Imel, 2015) contextual model of psychotherapy (CMP), an empirically-informed, trans-theoretical explanation about why psychotherapy works. Whatever might be a maladaptive pattern's origin story, the CMP is universally narrative accommodating. My hope is that, through providing perspective about *both* the theory specific *and* the trans-theoretical, supervisees' own evolving theoretical perspectives will be broadened and strengthened and challenged as a result. 🐾

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Stanley B. Messer
Rutgers University

1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

In general terms, I am in favor of identifying specific maladaptive patterns and their triggers. It is central to the therapy I do and, hence, to the supervision I conduct. This is usually conceptualized in integrated interpersonal and psychodynamic terms in a way that helps the student build a framework for thinking about the varied and sometimes confusing information that they hear from their clients. As such, it provides them with a way of listening to what the

"It provides them with a way of listening to what the client is saying along certain lines to help make sense of what the nature of their problem might be."



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client is saying along certain lines to help make sense of what the nature of their problem might be. Intervening in accordance with such a focus has been shown to correlate with outcome.

An important way of doing this, drawing on the literature of psychodynamic therapy, is known as the "triangle of person." This refers to parallels in the way the maladaptive, interpersonal pattern expresses itself in the client's current life and for which they are often seeking help; in their past, usually with parental figures, siblings, etc.; and in their experience of the therapist, namely the transference. Linking two or even three corners of this triangle helps the supervisee and client to see how pervasive this pattern has been in their life and points to its origins.

A potential limitation of this approach is that it neglects intrapsychic factors, which can also have important bearing on the maladaptive pattern—such as drive/defense constellations, specific fears, guilt, etc.

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?


A menu of interventions for responding to an identified intervention or triggering situation can be of some benefit to supervisees but can only take them so far. The benefits are that the supervisee has something to go on, to refer to in formulating the case, and to consider employing in connection with the identified trigger and maladaptive pattern. It also allows for the use of integrated kinds of interventions, which will be of benefit to some clients. Using discrete bodies of interventions deriving from specific schools of therapy can also be of use, even if they are not necessarily, at least at first, of an integrated kind.

The reason I say that the menu of interventions can only take you so far is that if they are predesigned, they may not fit the client closely enough. There are a great variety of triggers and interventions possible—some might even say an infinite variety—and they cannot all be known in advance—nor can they all be empirically validated. There always has to be the possibility of fitting the interventions to the particular client so that they are most likely to be effective. This applies to both the preset menu of interventions and to those deriving from specific theories.

Discrete bodies of intervention stemming from specific schools of treatment can also be useful in doing and teaching therapy. There is something very positive about learning more than one therapeutic approach and assimilating techniques or perspectives from one into the other. In this way students can be grounded in an approach to which they particularly resonate and can incorporate useful interventions from other therapy models.

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

As the social psychologist, Kurt Lewin, once famously said, "There is nothing so practical as a good theory." A theory helps us to understand the nature of the client's problems and where they came from. Even when it is claimed that an approach is simply technical or empirical, one can always discern an unarticulated, underlying theory at play. It is simply part of human nature to strive to understand the nature of the phenomena that we witness or with which we are working—in this case, human personality or maladaptive patterns and the effort to change them. Learning a theory or theories helps the student to appreciate how human personality is structured and how it is fashioned (at least in part) by life experiences.

The student will see this manifested in the therapy in so far as the client expresses some aspects of their personality and maladaptive patterns in the therapy itself. The supervisor's role is to help them listen in such a way as to notice them. Similarly, a theory will help the student understand the nature of the psychopathology or dysfunctional behavior manifested by the client, which helps lead the therapist to intervene along specific lines and in specific ways. For example, if I know that depression can be caused by the trigger of loss; or by the trigger of failure to achieve a goal; or by the trigger of anger turned inward, as suggested by psychodynamic theory, I will inquire more specifically along these lines and devise interventions that will help alleviate the problem. Teaching such a theory to students or supervisees gives them tools with which to conduct a sound interview, formulate it and plan the therapy to follow. 



"Patterns and triggers are a better framework than 'disorders,' which often involve simply giving a name to a complaint in a pseudo-medical reification."



"Integrative training entails teaching principles that are not limited to those of a single school."

Structured Interviews on Training, continued



Paul Wachtel
The City College, New York

1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

Understanding the patterns people get caught in, and the ways those patterns interact with life circumstances (triggers?) is always a good thing. I'm not sure how readily we can distinguish those that have "empirically been shown to benefit from therapeutic intervention" and those that have not. Human behavior and its problems are not as binary as that. Patterns and triggers are a better framework than "disorders," which often involve simply giving a name to a complaint in a pseudo-medical reification. But even with a focus on patterns, I would not want us to substitute a mechanical "treatment X for pattern Y" recommendation for the problematic "treatment X for disorder Y" that has sometimes been confused with evidence-based treatment.

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?

Whether drawn from one school or many, I'm not very receptive to the menu metaphor. It's not a matter of taking a technique off the shelf. For me the emphasis should be on understanding principles of change, and integrative training entails teaching principles that are not limited to those of a single school. Some of those principles amount to common factors, some are more specific to one school of thought. What students need to learn is the wide range of processes and principles that can lead to change in behavior and experience (I don't think they're limited to the few that have been highlighted by common factors theorists, though the few they've identified are important and robust). Students also need to learn to identify how to apply those principles creatively and individually with different patients. Guidelines based on systematic research are useful here, as is the role of research in validating or raising questions about the basic principles and processes. But I view the best psychotherapy as both a science and an art, and do not see a way around that. Indeed, one more important dimension of integration entails integrating the science and the art. Here, concepts like Safran and Muran's rupture and repair model are very relevant. In crafting an individualized approach, we will inevitably be engaging in trial and error efforts to meet the patient in the way that fits his or her needs at the moment. And trial and error does include error, which means that successful therapy is not a matter of always being right but of knowing what to do when (inevitably and frequently) we are wrong. The rupture-repair model has been a particularly productive way to think about how to ensure our errors don't undo the therapy -- and, properly handled, can even enhance it.

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

My original psychoanalytic training was too concerned about the origins, almost to the point where it seemed to imply that if we understand fully the origins, the lifelong consequences will disappear. When I encountered both behavior therapy and family therapy, I was impressed by their attention to the role of what is maintaining the problem now. I think we need an understanding that looks at both the origins and the maintaining factors. For me, the most effective framework for integrating the two is one that looks at how, at each point in our development and throughout our lives, who we have become thus far contributes to what we become next. There is randomness and chance, of course -- no one can predict what we will encounter over the years. But much of what we encounter is not so random, but is a result of what we are set to encounter, how we interpret and make sense of what we encounter, what we evoke in others and whether what we evoke creates more of the same (making it likely we will then continue to evoke more of the same) or whether it points toward something new. The pattern organizes itself into a self-perpetuating circle or self-fulfilling prophecy, and it is our job as therapists to break the cycle and help the patient to

"Sound empirical evidence is not available for many of the specific maladaptive patterns with which psychotherapy clients present."



"I am also a firm believer that unifying metatheories are the conceptual frameworks that help us conceptualize our clients in the least biased manner possible."

try out new ways of relating and behaving and to reappropriate the parts of our original potential that were cast aside in the course of development. We all have such a legacy of potential ways of feeling and seeing the world being cast aside, because even the most benign and loving of attachment figures will prize and resonate more with some parts of us than others. This is the model of development -- of ongoing development -- that I think is most useful to teach and best lends itself to an integrative model that can seamlessly incorporate the best of what the different schools have to offer.

Andre Marquis
University of Rochester



1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

It seems axiomatic that students must learn to identify their clients' maladaptive patterns and their triggers; without that capacity, I don't see how they will be able to help their clients. However, to my knowledge, sound empirical evidence is not available for many of the specific maladaptive patterns with which psychotherapy clients present. Thus, I think that principles and processes of treatment—in contrast to specific rules or step-by-step interventions—should be taught to students, so they can ultimately use their clinical judgment to inform their interventions in those cases for which empirical evidence is lacking. I have been developing a metatheoretical approach to psychotherapy integration called Integral Psychotherapy (IPT) for nearly 20 years, which is informed by Ken Wilber's Integral Theory. Some of the principles that guide my work, and which I teach my students, include conceptualizing clients in terms of two fundamental and interrelated dimensions: *opening-closing* and *comforting-challenging* (*stabilizing-destabilizing*). As Michael Mahoney emphasized, we need to open ourselves to novelty in order to learn and grow, but we also need to be able to close ourselves to what is not good for us, as well as to close in order to metabolize and make sense of experience. Some clients need stabilization (comfort), while others need de-stabilization (challenge) in order to restructure themselves and/or the emotions, cognitions, behaviors, or ways of relating that are maintaining their dissatisfaction and distress. The relative amount of comfort and challenge must be matched to each client's developmental capacities and readiness — both in general (is the client at a borderline level of personality organization or is he much more stable and grounded in his sense of self?) and within a given session (the client's cycles of opening and closing). Because I value approaches that are affect-focused, I train my students in defense and resistance work; thus, I teach the principles of the triangle of conflict and the triangle of persons, as well as how to closely monitor the client's discharge pathways of anxiety.

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?

I co-authored the text *Theoretical Models of Counseling and Psychotherapy* in 2004 and have consistently taught Theory and Practice courses for the last 18 years. Although I certainly believe there are limits regarding how much philosophical and conceptual background information is needed to effectively teach specific techniques, it is my experience that showing students how the specific techniques that emerged from a specific school are related to that school's conceptualization of human nature, psychopathology, and its view of human health helps develop students' capacities to *conceptualize* their clients. I am a firm believer that what we do (what interventions we use with a given client) should be related to how we are conceptualizing "what is going on" with the person in front of us. I am reminded of something Paul Wachtel wrote: that "the ways in which sharpening and reexamining how we *think* about people, how we *conceptualize* and *formulate* our observations, can have very specific and powerful implications for how we actually practice." I am also a firm believer that unifying metatheories are the conceptual frameworks that help us conceptualize our clients in the least biased manner possible, precisely because they are not operating from the same "level" as the single schools. Because they operate from a higher level of abstraction (metatheories are theories about theories), they are capable of recognizing the important concepts and techniques that each paradigm has provided while also recognizing that each paradigm is blind to other important phenomena.



"I point out the value of using conceptualizations and interventions from numerous schools of therapy."



"The four quadrants allow one to situate diverse perspectives such that they augment and complement, rather than compete with and contradict, one another."

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

I think such frameworks are essential, and I believe that metatheoretical frameworks are capable of valuing and integrating all of the major paradigms – from behavioral and cognitive behavioral to psychodynamic, humanistic, diversity/social justice, and systems etc. Thus, I may point out to students the relative benefits of conceptualizing the origin of the maladaptive patterns of the specific client under consideration from, for example, a behavioral, attachment or diversity perspective. Often times—especially with clients with more complex, co-morbid conditions—I point out the value of using conceptualizations and interventions from numerous schools of therapy, and the quadratic model of integral psychotherapy provides a coherent justification for utilizing approaches that have historically been considered to be incompatible based upon their epistemological or axiological foundations. The four quadrants are a model formed by the intersection of two axes: interior-exterior and individual-collective (see Figure 1). The four quadrants allow one to situate diverse perspectives such that they augment and complement, rather than compete with and contradict, one another; this applies to: client variables and dynamics (assessment), the etiology and treatment of psychopathology, therapeutic interventions (treatment), and research (Integral Methodological Pluralism) – all of which are described in Marquis (2018). As one example of how the quadrants are relevant to conceptualizing and treating psychopathology, consider that different clients with the same DSM diagnosis often require different treatment approaches, in large part because of the over-determined, multidimensional nature of the etiology of most DSM disorders. Thus, it is important to have a comprehensive understanding of the many etiological risk factors pertinent to each client's problem (see Figure 2 as an example pertaining to anxiety).

With regard to psychotherapy research, Jack Anchin wrote that "methodology constrains both the kinds of questions that can be asked and the kinds of answers that can be provided." Integral metatheory provides a comprehensive framework within which diverse methodologies complement and enrich, rather than contradict, one another, and this promotes a deeper understanding of the subject at hand. The fundamental methodological differentiation is between the empiricist-quantitative paradigm and the hermeneutic-qualitative paradigm (the right and left quadrants respectively). Also significant is that between a focus on decontextualized individuals in contrast to those contextualized within systems (the upper and lower quadrants respectively). As shown in Figure 1, the quadrants reveal that each of the major epistemologies derive from examining phenomena from particular quadratic perspectives (i.e., phenomenology explores interior/subjective experience (upper-left quadrant) whereas empiricism explores exterior/objective behavior (upper-right quadrant). I argue that any approach that calls itself "empirically supported" or "evidence-based" and proceeds to systematically exclude any of the major methodological systems that appropriately elucidate pertinent dimensions of psychotherapy is dangerously narrow in scope. In fact, I suggest that this sort of hegemonic oversimplification is largely what is responsible for the perceived incommensurability between research and practice that so many clinicians lament..

Note: Figures presented on the next pages

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Figures from Andre Marquis:

Figure 1. Selected Aspects of the Four Quadrants Pertinent to Psychotherapy

<p>Upper-Left (UL): Interior-Individual 1st-person/Self/Consciousness/Subjectivity <i>Experience</i> – as felt “from the inside” Freud, Rogers, Existentialism Validity Claim: Truthfulness, sincerity General Epistemology: Phenomenology</p> <ul style="list-style-type: none"> Any noteworthy patterns in the patient’s self-experience Self-image, self-concept, self-efficacy Instability-stability Joy, zest, purpose, motivation Depression, sadness, emptiness Anxiety, “jitters”, feeling “revved up” Cognitions (e.g., thoughts, beliefs, attitudes) Imagery Political, religious and/or spiritual beliefs and/or experiences Consciousness as experienced as <i>mind</i> The <i>experience of</i>, for example, depression: sadness, loss of interest in pleasurable activities, fatigue, feelings of worthlessness, difficulty concentrating, frequent thoughts of death, suicidal ideation, etc. Also <i>how one interprets</i> events such as the death of a loved one, divorce, profound loss, or child birth 	<p>Upper-Right (UR): Exterior-Individual 3rd-person/Organism/ Brain/Objectivity <i>Behavior</i> – as seen “from the outside” Skinner, Biomedical approaches Validity Claim: Truth (by correspondence or proposition) General Epistemology: Empiricism</p> <ul style="list-style-type: none"> Any noteworthy patterns of behavior: what specific behaviors bring the patient to therapy and what specific behaviors will indicate successful outcome? Medical disorders Medication Diet Alcohol and/or drug use Aerobic and/or strength training Patterns of sleep and rest Consciousness as described by neurotransmission and the functioning of <i>brain</i> structures <i>Observable changes</i> in, for example, depression: appears tearful, no longer engages in pleasurable activities, significant weight loss or gain, psychomotor agitation or retardation, lower levels of available serotonin, social withdrawal
<p>Lower-Left (LL): Interior-Collective 2nd-person/Culture/Worldview/Intersubjectivity <i>Cultural Worldview</i> – the group’s experience “from the inside” Stolorow et al., Wachtel, Diversity and Feminist approaches Validity Claims: Justness, mutual understanding General Epistemology: Hermeneutics</p> <ul style="list-style-type: none"> Patient’s meaning-making system(s) Patient’s relationships with significant others, especially spouse, boss, friends, and family Patient’s experience of ethnicity Patient’s experience of family dynamics The medium of the therapeutic relationship and how both the patient and therapist experience their intersubjectivity <i>Cultural meanings</i> assigned to, for example, depression: sick, lazy, irresponsible, heartbroken, hexed, bewitched, etc. 	<p>Lower-Right (LR): Exterior-Collective 3rd-person/Social Systems/Environment/Interobjectivity <i>Social Systems</i> – the group’s behavior “from the outside” Family Systems, General Systems Theory, Social Justice approaches Validity Claim: Functional fit, systems theory web General Epistemology: Systemic/ecological analyses</p> <ul style="list-style-type: none"> Patient’s socioeconomic status Condition of one’s neighborhood Environmental stressors and/or comforts; layout of household Analyses of interpersonal dynamics, including family (both current and historical) Treatment contexts (setting - inpatient/outpatient and physical nature of therapy setting; frequency and length of sessions; modality - individual/group/family therapy) <i>Social systems</i> that contribute to, for example, depression: economic, educational, and medical systems: poverty, drug- and gang-ridden neighborhoods; poor/dangerous schools; minimal access to medical care (brief therapy or none at all); racism, sexism, classism, ageism, etc.

Figures from Andre Marquis:

Figure 2. A Sampling of Etiological Risk Factors and Treatment Approaches for Anxiety

<p>Upper-Left (UL): Interior-Individual Etiological Risk Factors</p> <p>High anxiety sensitivity Views self as vulnerable, weak, incompetent, unlovable, etc. Views world and others as excessively dangerous, threatening, untrustworthy Fear, apprehension and other distressing concerns regarding one's capacities to meet future demands</p> <p>Treatment Approaches</p> <p>Cognitive Psychodynamic Existential</p> <p>Insight into deeper symbolic meanings of the feared situations Modifying maladaptive cognitions and catastrophic imagery</p>	<p>Upper-Right (UR): Exterior-Individual Etiological Risk Factors</p> <p>Biological and genetic predispositions <i>Avoidance</i> of the feared situations Neurobiological processes of the Hypothalamic-Pituitary-Adrenal axis and corticotrophin releasing factor activity Loss of cortical control of the brain's fear system Direct and vicarious conditioning Physical tension and increased sympathetic nervous system activity</p> <p>Treatment Approaches</p> <p>Behavioral</p> <p>Exposure and response prevention Modeling, behavioral skills training, assertiveness training, etc.</p> <p>Pharmacological</p> <p>CNS depressants, SSRI antidepressants, benzodiazepines, and unique compounds such as buspirone</p>
<p>Lower-Left (LL): Interior-Collective Etiological Risk Factors</p> <p>Insecure attachment histories Internalized representations of others as unavailable, unreliable, and unattuned Lack of intimate relationships that function as secure bases to help one mitigate the inevitable anxieties in life Psychological solitude amplifies any anxiety that one may experience Maladaptive meaning-making systems (some forms of religious education or otherwise rigid, harsh, and intolerant codes of conduct at home or school etc.)</p> <p>Treatment Approaches</p> <p>Attachment, Intersubjective, and other Relational Psychodynamic approaches</p> <p>Attend to the specifics of the client's significant relationships as well as the (cultural) meaning-making systems they use to understand themselves and their lives.</p>	<p>Lower-Right (LR): Exterior-Collective Etiological Risk Factors</p> <p>Childhood abuse and other <i>trauma</i> Parenting styles that are: overly-controlling, overly-protective, intrusive, non-attuned, non-responsive, and non-contingent Vicarious learning from a relative with an anxiety disorder Lack of social interactions or role inversions during childhood Actual interpersonal interactions that confirm anxiogenic thoughts</p> <p>Treatment Approaches</p> <p>Family Systems approaches Social Justice approaches</p> <p>Working as an advocate for change of inequitable social systems Re-organizing daily patterns in order to experience fewer stressors (i.e., working fewer hours/day, fewer days/year, making time for relationships, hobbies, exercise, meditation, etc.)</p>



"A downside of using such menus is that the interventions may not be consistent across problems."



"Therapists and patients co-create a space in which the process unfolds in a unique manner for each particular dyad."

Structured Interviews on Training, continued



Asle Hoffart
University of Oslo, Norway

1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

Perception is basic in psychotherapy. According to perceptual control theory, we do not control behavior but rather the perceived consequences of behavior. I adhere to the network approach to psychotherapy, in which symptoms are viewed as problems of living that interact in causal networks. Identification and elicitation of a patient's specific network is therefore a crucial initial step in psychotherapy. This involves perceiving the pattern of causal relationships between problems ("maladaptive pattern") as well as their external and internal triggers. Particularly important is to reveal the central problems in the network, that is, the problems that influence many other problems. These problems should be the focus of treatment. Training in perceiving and eliciting these patterns as well as empirical knowledge of typical problem patterns are of help in this assessment.

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?

Knowledge of maintaining processes of central problems guides the decision of interventions to use. For instance, if sleep problems are found to be central, sleep hygiene, restricted sleeping and cognitive interventions on concerns about not sleeping may be indicated. A downside of using such menus is that the interventions may not be consistent across problems, thus learning effects may carry over to a lesser degree than when discrete bodies of intervention derived from specific models are used.

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

I think it is important to have a generic model of how mental problems are maintained, of how they are changed, and of why this happen. Such explanations may ease students. The learning of a generic model may help case conceptualization and improve therapy.

Beatriz Gómez
Aigle Foundation

1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

The fundamental benefit is that it helps to learn which are the treatment plans and the most effective interventions for each clinical condition. The main limitations arise when misused in training.

Notwithstanding, applying the best results of empirical research to benefit patients can very well blend with an approach in which therapists and patients co-create a space in which the process unfolds in a unique manner for each particular dyad. These two approaches are more and more drawing together, and this is likely to move the field of psychotherapy toward greater integration.





"Conceptualization is the starting point for decision making in the clinical domain."



"Markers that point to interventions are specific, and have both empirical evidence and clinical confirmation."

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?

The main benefit is that it provides a more comprehensive and diversified approach, tailored to each client. While each traditional theoretical model has emphasized some aspect of the complex clinical phenomena, discrete bodies of therapeutic approaches have aimed to promote change accentuating distinct levels of a reality that is

wide-ranging and multifaceted. Integrative approaches have sought precisely to provide psychological help that can operate on multiple levels, is adjusted to the specific nature of each concern, and allows for changes in treatment plan and intervention levels according to each individual and their interactional and broader cultural context.

An integrative approach relies on the use of multiple resources, suitable to the complexity of each clinical situation. These different perspectives are of prime importance in understanding the reasons and circumstances that have brought about suffering in a particular person and facilitate a flexible stance.

A limitation in training therapists is that it requires acquiring more knowledge of the different interventions and their articulation, and therefore requires more time in training.

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

Some form of conceptualization is the starting point for decision making in the clinical domain. It seeks to combine theory, principles and evidence on the one hand and thoughts, feelings and behaviors on the other to develop a guiding map of interventions.

The clinical adoption of theory implies the appropriate articulation of the conceptual structure of the model with the idiosyncratic characteristics of the client to make the best possible decisions, according to the origin as well as possible prospects of the maladaptive pattern.

Marvin Goldfried
Stony Brook University



1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

Benefits: The markers that point to interventions are specific, and have both empirical evidence and clinical confirmation.

Limitations: Does not provide larger empirical and contextual information regarding patterns and how it fits into case formulation.

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?

Same as above.

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

This is related to the limitations noted earlier. A bottom-up conceptualization of theory (not THEORY) at a principle level would be best and applicable to different orientations.



"My own experience of training was characterized by theoretical pluralism. I had extensive input from cognitive-behavioral, psychodynamic, and existential/humanistic instructors and supervisors."



"Some patients fight with and reject the descriptive labels they receive, others take them in too-readily as identity and a seeming explanation for their problems."

Structured Interviews on Training, continued



Kenneth L. Critchfield
James Madison University

My own experience of training was characterized by theoretical pluralism. I had extensive input from cognitive-behavioral, psychodynamic, and existential/humanistic instructors and supervisors. My early training was rooted in the evidence-base around common factors. Concepts from interpersonal, object-relations, and attachment theories were knit together to provide a rich understanding of how and why those common factors might be in place. It also facilitated a student-led approach to integration. I had colleagues who chose to emphasize one approach over another, usually based on their connection to specific advisors, but the training was not deeply school specific. I liked that approach to training very much.

I am now director of a doctoral program that holds integration as central to what we offer and try to teach: James Madison University's Combined-Integrated (C-I) Doctoral Program in Clinical and School Psychology (<http://www.psyc.jmu.edu/cipsyd/>). Our students come to us with Masters degrees in mental health service professions (clinical, counseling, school psychology and related fields) and have a fair amount of real world experience. These students have typically been exposed to standard approaches, seen both their strengths and weaknesses in practice settings, and are seeking to round out their training. As such they tend to be inclined toward integration – of science and practice, across specialty areas, across schools of psychotherapy, and with applications over the lifespan.

The training we offer under "the Madison Model" approaches integration from a number of angles within specific courses and across our curriculum. My own perspective thus tends to have integration as a kind of baseline assumption – it's "the thing we do."

1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

I see several major benefits to learning how to assess and diagnose commonly identified problems. These include being able to: (1) coordinate care across multiple professions that share the same language, conceptual spaces, and narratives about shared cultural history, (2) identify and name the diversity of recognizable affective, cognitive, behavioral, and relational problems that patients experience and are told they "have" – regardless of their ultimate validity status, definitional boundaries, or best taxonomic placement, (3) access a wide range of theory, evidence, and intervention literatures that pertain to the various problem states, (4) be able to understand and respond to patient language and experience when it has been shaped by the professional lexicon in some way. Some patients fight with and reject the descriptive labels they receive, others take them in too-readily as identity and a seeming explanation for their problems. Therapists need to understand the lexicon and its "rules" well enough to help patients navigate the meaning of labels attached to their problems, even if the therapist would ultimately rather focus on something else. My own specialty area of working with personality disorders gives a nice example of a labeling system with diverse uses in professional and public spheres, not all of them helpful.

A limitation to identifying specific maladaptive patterns, etc., can occur if diagnostic labels are made to be too important, constitute an end unto themselves, or preclude awareness of additional patterns and comorbidity. Ideally they are to be used as orienting heuristics, not as a way to foreclose on other relevant data. I think it is very helpful to know that someone is depressed or not, hears distressing voices or not, and so on. However, each of the categories those symptoms implies carries a great deal of clinically relevant heterogeneity. Ideally, change attempts are undertaken at the level of the individual patient, rather than their category. It is important to teach that a diagnostic label does not have the same degree of specificity or relevance to an individual's as does a case formulation. It nonetheless has a healthy place in our training lexicon if contextualized appropriately.



"Programs can help anxious trainees feel there is some certainty in a complex world by carefully scaffolding their initial experiences."



"Over time the focus should shift to invoke a principles-based, rather than solely technique-based, platform for clinical intervention."

I believe there is also a tension here that relates to pedagogy and training strategy. Programs can help anxious trainees feel there is some certainty in a complex world by carefully scaffolding their initial experiences. For example, programs can use a screening procedure to rule out severity and complexity and then employ a structured, evidence-based treatment manual, authoritatively endorsed by experts and validated as better than nothing via RCT study designs. Clinical experience can be expanded on from there, along a gradient of complexity.

There are, of course, other ways to help anxious therapists get accustomed to the complexity and risk involved with helping others. One alternative is to begin with foundational "Rogerian basics" of empathy, congruence, and listening supportively. As students get their feet wet and become more confident in this role, the idea is often that they can be increasingly exposed to "real world" patients who are more complex and tend not to respond as readily. Over time the focus should shift to invoke a principles-based, rather than solely technique-based, platform for clinical intervention. In advanced practice, techniques are often shaped and presented in ways that best fit patient needs, preferences. This tailoring is best done, I believe, based underlying principles of psychopathology and change. Principles of the type I have in mind are inherently integrative and cut across standard schools.

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?

As I noted above, when it comes to intervention strategies and "techniques," what I think is most important is to teach about underlying principles of change. Specific interventions are optimally framed as useful ways of activating those principles. I think that knowledge of both the theoretical and empirical evidence-bases supporting use of specific techniques is important. The same is true for treatment packages and collections of interventions associated with particular schools. Theory and data in our field, I believe, do not support a foreclosed view of interventions

If we want to run with the 'menu' image, I find that many of the folks I work with (personality disorder; complex trauma; dense comorbidity; non-response to prior treatment) require 'special diets' and tend to 'order off the menu' besides. With this clientele, I need to know principles of food preparation and what ingredients I have on hand in order to cook something up separately for each of them. The principles upon which existing interventions are based, replete with examples taken from across our field, viewed with multiple theoretical orientations in mind - this is what I would prefer to see us all teach.

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

I think there is always a need for a conceptualization that links whatever-it-is a therapist chooses to do and a patient's problem patterns. I do not think that conceptualization of an individual is quite the same thing as "having a theoretical framework." I can have a theoretical framework and not know how it relates to an individual (especially prior to some kind of conversation or other assessment process). However, conceptualization of an individual's needs implies the therapist has some kind of world view involving human nature and what is requisite for change. The training process should involve exposure to existing theoretical frameworks, as well as help with 'unmasking' implicit theoretical stances when working with individuals. Ultimately, trainees should be helped with understanding how various theoretical frameworks come together (or not). I keep saying this: I believe that theoreticians and clinical scientists among us should be trying to articulate and develop principles of human psychopathology and change that are empirically testable, that cut across current "name brand" approaches, and that reflect psychotherapy as practiced with diverse patient presentations in the real world.

Not all theories are equally aligned with reality, and so evidence needs to be brought to bear for each principle we might articulate. Some initial work along these lines is represented in Castonguay and Beutler's (2005) *Principles of Therapeutic Change That Work*. I elaborated some of these principles as they relate to personality disorder treatment in Critchfield (2012) and have developed an associated measure of their application in therapy sessions.

In some future version of training, we might orient everything we do around evidence-based principles. From that vantage point, we could illustrate how many of our existing practices strategically activate those principles towards the attainment of healthy adaptation. This isn't a new idea. Goldfried (1980) long ago emphasized the key role of principles to bridge across different schools - residing as they do at a level of specificity between that of specific techniques and school-based theories. We're working on how to approach training from this vantage point in our C-I program at JMU.

"What I think is most important is to teach about underlying principles of change."



"Students should be taught to identify maladaptive dysfunctional patterns."

And finally, along with my colleagues, I am currently engaged in attempts to validate change principles using Benjamin's (2006; 2018) Interpersonal Reconstructive Therapy (IRT). IRT represents an approach to psychotherapy integration termed "unified psychotherapy" (Magnavita & Anchin, 2014). This kind of approach orients itself to an understanding of human problems and change processes, rather than to the diversity of existing schools. Therapists then choose techniques broadly from across approaches so long as they fit the needs of particular individuals. These needs are framed relative to principles, and solutions are tailored. IRT in particular emphasizes patterns learned in an individual's developmental history with close attachments / loved ones, and brings together cognitive, affective, behavioral, dynamic, and humanistic approaches in the process. The method emphasizes individual tailoring based on putative principles and mechanisms of change – and does so in a way that is amenable to testing. Preliminary findings predicting outcome from therapist and patient optimal use of those principles are promising (Critchfield, Dobner-Pereira, Panizo, & Benjamin, 2018).

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Georgio Alberti *Milan, Italy*



First of all, I want to thank you for inviting me to participate to this training interview. In general the question of training and of the theoretical basis of integrative therapy is in my mind since quite many years, in preparing lessons or seminars for the school where I teach. Even my trainees have posed that question explicitly. This happened about one and a half years ago when I was illustrating to them the concept and practice of assimilative integration (Wachtel, Frank, Bresler, etc.) and was focusing on the concept of switch. In that very moment many of them lifted their hands saying: "But how can we do that? We are no psychoanalysts, we don't have a basic theory and practice into which we could incorporate different procedures! We need a general theory of integrative psychotherapy!"

This is why I began searching in the literature and found indeed a certain number of important contributions (Andrews, Erskine, Fraser, Harris, Teyber & McClure among others and then Jeffery Smith's book). I saw that many authors assume dysfunctional self-perpetuating processes as the cause of neuroses, dysthymic and personality disorders.

This confirmed my idea, illustrated in a book on integrative therapy I published in 2016, that similar dysfunctional mechanisms cause, as part of the actual pathogenic process, those pathologies, and that they can be cancelled when appropriate relational stances and diverse interventions generate corrective experiences.

Now to your questions.

"Traditional schools tend to highlight what I call the historical pathogenic process."



"The use of integrative therapy as a menu of recipes for eliminating maladaptive patterns is an impoverished version of it."

1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

I believe that students should be taught to identify maladaptive dysfunctional patterns, with their triggers. As to the limitations, I think they reside in two possible errors in the identification process: a) when the therapist is biased in his observation/search, e.g. omitting to look for some of the possible mechanisms, and b) when the diagnostic conclusion is based on too few data. Both skew the identification of patterns.

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?

At first sight the second option seems to be more global, complete, human, and has the advantage for therapists-to-be of entering a selected group with tradition, rules, and a supporting organization.

In general traditional schools tend to highlight what I call the historical pathogenic process, whereas the integrative model focuses more on the actual pathogenic process, encompassing those maladaptive patterns we spoke about. But also the integrative model based on maladaptive patterns has a longitudinal prospective. We can explain the origin of these maladaptive patterns as produced by the patient's earliest negative experiences which deviate the child's development from its natural healthy course, inducing him/her to adopt, for defensive reasons or simply as dysfunctional habits, counterproductive interpersonal or intrapersonal ways of functioning.

In contrast, the use of integrative therapy as a menu of recipes for eliminating maladaptive patterns is an impoverished version of it. In order not to let them be eternal outsiders, I think the main problem is that of creating a general theory, a practical procedural tradition, and organizations that might give to future therapists a solid background and a good training, from the beginning simultaneously teaching them the different techniques. I don't think they need to learn all techniques of every historical psychotherapy, but they should know how to implement some basic ones: e.g. how to interpret a defense or the patients transference attitudes, how to make a confrontation and a clarification, how to organize an exposure in vivo or a systematic desensitization, how to manage a role induction by the patient and recognize one's own countertransference, how to promote an emotional experiencing, how to organize a two-chair session or a Gestalt dialogue between two parts of the patient's personality. Of course, these are my preferences.

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

My conception of integrative therapy is that the procedural methods, deriving from the diverse traditional psychotherapies and utilized by the integrative therapist, do not have an etiological scope, i.e. they do not bring about a definite result, as it is assumed in all traditional psychotherapeutic theories, be they cognitive, behavioral, dynamic, experiential or systemic. For an integrative therapist this means that, having corrected his patient's dysfunctional cognitions is not the end of his job, nor is it the successful promotion of the experiencing of a certain feeling which was inhibited, or the correction of a counterproductive relational disposition represented in the patient's schema or internalized object relations.

His job comes to an end when the complex dysfunctional actual pathogenic process has been changed, and when consequently all the visible dysfunctional patterns have been eliminated. An example helps illustrating my idea of the actual pathogenic process founded on maladaptive mechanisms. Imagine a patient who

- 1) has internalized object relations, or a schema, because of which, in particular situations,
- 2) dysfunctional thoughts are activated, that on their part evoke
- 3) emotional experiences which
- 4) generate an anxious reaction that inhibits them
- 5) because of anxiety socially inappropriate defensive behaviors arise
- 6) that impact negatively on other people
- 7) whose reactions give the patient a feed-back
- 8) which confirms his schematic representation of others



"An integrative therapist could begin from the at the moment most evident maladaptive pattern."



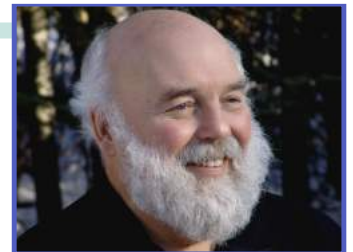
"This is not a mechanical method but a responsive one using a helpful intervention at a helpful time."

In front of such a sequence of events an integrative therapist could begin from the at the moment most evident maladaptive pattern, be it the dysfunctional thoughts, the inhibited emotions, the faulty relational dispositions, the defenses etc.. But then, other aspects of the pathogenic process generally emerge and new technical procedures are needed.

We make all the time the experience that e.g. after having promoted emotional experiencing memories and other cognitions come up, or when we explore automatic thoughts hidden emotions come to the foreground, or when we explore the patient's relational attitudes towards some significant other ideas and feelings pop up. And in these new therapeutic situations the therapist is called to implement other kinds of intervention, appropriate for the new maladaptive mechanism facing up on the scene. Thus, every heterogeneous intervention is a just way to access the dysfunctional sequence of the actual pathogenic process.

As to the origins of the maladaptive patterns, I think it could be sufficiently explained by ideas coming from the pathogenic assumptions of humanistic therapies and relational psychoanalytical therapies, which assume that negative events distort and deviate the child's natural healthy course of development. Similar pathogenic conceptions have been expressed by Dollard & Miller already in 1950. And what's important is that they are well compatible with a general theory of integrative therapy.

Leslie Greenberg
York University



1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

I think this is the way to go but I would say we need process markers which are specific in-session patterns that are opportunities for particular types of interventions that have been shown to benefit from particular types of intervention for this problem at this moment. So this is not a mechanical method but a responsive one using a helpful intervention at a helpful time. Timing of interventions is crucial as they need to gain access to implicit processes which are not easily accessible by deliberate application of methods which ignore the current in-session state of the client.

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for an identified responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?

This moves therapy from religious adherence to a school to a scientifically based set of procedures based on principles and processes that have been studied and shown to be therapeutic. It stops therapy from being a pseudo-scientific power based system as it now is.

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

It is not that students may need it rather it is an essential part of having a scientifically based discipline. Theory of functioning and theory of dysfunction are essential aspects of scientific explanation. If we don't know what the mechanisms of disorder are that the method of intervention is treating and how the intervention works to correct the disorder, we are operating in the dark.

Society for the Exploration
SEPI
of Psychotherapy Integration

Structured Interviews on Training, continued



Diana Fosha
AEDP Institute, New York

"Patterns help us organize our clinical thinking. the more systems of pattern making one has, the better."



"It is a mind-blowing experience to learn to interpret the world in one way, which one may think is "the" way, only to then discover another whole coherent paradigm."

1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

The benefits are enormous. Pattern recognition, even when one chooses to do something different with it than what is considered -- to date -- standard practice, is very important to the practice of therapy. Patterns help us organize our clinical thinking. the more systems of pattern making one has, the better. Much comes with experience, but learning the basics is great. Even greater is having experience, and going to the basics and getting something that re-organizes one's thinking.

Now, AEDP does NOT focus on psychopathology. However, that doesn't mean that it doesn't exist. Knowing about it is very important, even when one opts to not focus on it.

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?

What I actually think is that it is better to teach a discrete body of intervention techniques associated with a school of treatment. Which I do. Much better. Almost -- and I emphasize "almost" -- any coherent mode will do. Much like my answer to question #1, I think the most important thing one can do as a teacher of psychotherapy is to teach a student how to think clinically. Once one learns how to think in one model, then it is important to learn to think in another model. It is a mind-blowing experience to learn to interpret the world in one way, which one may think is "the" way, only to then discover another whole coherent paradigm. It is like reading Justine, volume 1 of Lawrence Durrell's Alexandria quartet, only to read the opening pages of Balthazar, volume 2. The world as one came to believe in, and love, is blown to smithereens, when one realizes it is only one person's perspective. Only after learning a few powerful and coherent explanatory paradigms, is it important to then teach a menu of interventions. And then, the more the better, for no matter how coherent and convincing a systematic paradigm is, nothing created thus far applies to everybody or helps everybody, for that matter. Thus, menus and toolkits as latter developments in one's educational trajectory are very helpful. With beginners, I would not start there.

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

It is hugely important. See my answer to question #1. Thus AEDP. And, by the way, not only students. And at the same time, à la Thomas Kuhn's The Structure of Scientific Revolutions, it is highly useful to see what a model cannot gracefully explain. That is the mother of invention. It is precisely how AEDP was born. I am deeply grateful for the coherence of Davanloo's ISTDP (intensive short-term dynamic psychotherapy) as a ridiculously (I say this as praise) coherent -- AND thus limited -- model. It is only because it was so coherent that I learned it, saw its limitations, all of which contributed to the development of AEDP. It is another hopefully coherent model, but also inherently flexible because of its dynamic systems theory thinking. Nevertheless, I look forward to those exceptions that it cannot explain.

"The limitations are that students will become dependent on the interventions and miss crucial 'moments of meeting.'"



"If there is a good rationale and evidence for their use, I am happy to map specific interventions with specific kinds of problems."

Structured Interviews on Training, continued



*Kristin Osborn
Harvard Medical School*

1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

Hugely beneficial to identify specific maladaptive patterns/and or trigger as helps students conceptualize how their patient may be experiencing different stimuli.

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?

The benefits are that students can practice different skills so that they are available to them on an 'as needed' basis. The limitations are that students will become dependent on the interventions and miss crucial 'moments of meeting' due to not being fully engaged with the patient's process.

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

I think it is very important to have a starting place, a container to begin treatment. More often than not, new material will be revealed through the process of psychotherapy that will alter the original hypothesis and so what is important is to be flexible.

*Gregg Henriques
James Madison University*



I appreciate the need for reflections on these issues. My entire career as a clinician, from graduate school onward to being a professor and (now former) director of an APA Accredited training program in Combined-Integrated Health Service Psychology has centered on how to conceptualize psychology and psychotherapy from a more effectively integrative view. I am happy to say that I believe that the "Madison Model" of training integrative "psychological doctors" represents a successful enactment of this vision, across the multiple domains of being a health service psychologist (assessment, intervention, consultation, professional competencies and identity).

1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

When it comes to interventions, I generally operate as a technical eclectic in practice. By that, I mean I see interventions as specific techniques to foster change in particular domains. If there is a good rationale and evidence for their use, I am happy to map specific interventions with specific kinds of problems. However, in order to effectively do this, in my opinion, one must be grounded in a clear, broad, deep and coherent rationale that is readily formulated by the clinician and shared with the client.

"It is central to guide therapy that both clinician and client have a deep, shared narrative that sheds light on what is happening and what one can do about it."



"You need models to simplify the complexity that exists already, and a research program that continuously simplifies and consolidates."

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?

The major limitation to thinking of psychology as a menu of interventions is that it lacks any kind of conceptual coherence. A clinician needs to know, why this intervention, why now, and why are you attempting to effect the changes you are. A menu of interventions does not do this. A coherent, integrative conceptual scheme is required to bring order to the menu. Without it, there is much danger in applying techniques "willy nilly," which almost certainly will have ineffectual results.

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

Such students are wise to raise these kinds of issues. As noted in my reply to question #2, I think one's conceptual or theoretical framework is crucial. That is not just because I like coherence. Rather, it is central to guide therapy that both clinician and client have a deep, shared narrative that sheds light on what is happening and what one can do about it. I believe we desperately need such a system, and that is why I have devoted my career toward developing a system that allows for (a) a workable language/conceptual system for human psychology; (b) the capacity to coherently integrate the key insights from the major approaches in psychotherapy; (c) develop a general conceptualization of neurotic functioning, which centers on a (i) comprehensive assessment that generates a (ii) case conceptualization (who the person is, given past and current situation) and (iii) problem formulation; and then leads to a (iii) principle based psychological mindfulness approach to negative affect and conflict, as well as other personal growth modes that foster adaptive living.

That principle-based approach is captured in the acronym, CALM MO. The 'MO' stands for Metacognitive Observer that adopts a reflective responsive stance to what is happening. The CALM stands for the attitudes of the MO, in particular, curious, accepting, loving/compassionate and motivated toward adaptive or valued states of being.

Steven C. Hayes
University of Nevada



1. What are the benefits and limitations of teaching students to identify specific maladaptive patterns and/or their triggers that have been empirically shown to benefit from therapeutic intervention?

The benefits could be considerable. This is the core conception behind "process-based therapy" which Stefan Hofmann and I have been writing about. With the collapse of the hegemony of "protocols for syndromes," it is time to apply what we have learned about therapeutic change processes to those we serve. Evidence-based processes of change can be linked to evidence-based intervention kernels in a new form of functional analysis. We already know that treatment kernels increase outcomes over treatment packages; and we know that tailoring interventions on the basis of change processes does better than non-tailored interventions. The limitations are that we need more specific evidence, and a lot of it. Loose collections of so-called transdiagnostic processes (a concept with one foot firmly in the past) are too numerous to be a guide.

Some traditions such as the "contextual behavioral science" group behind Acceptance and Commitment Therapy (ACT) has been doing a lot of component and process research over the decades, but other traditions have not. You need models to simplify the complexity that exists already, and a research program that continuously simplifies and consolidates. That is not very easy to assemble.

"Science is not a free for all, and some processes are more important than others in a given moment in a given case."



"Theories with precision are easy to build; theories with scope but no precision are likewise; getting both precision and scope is hard."

2. What are the benefits and limitations of teaching psychotherapy as a menu of interventions for responding to an identified maladaptive pattern or triggering situation, rather than as discrete bodies of intervention techniques associated with specific schools of treatment?

I think we are seeing a reduction in the importance of schools if you mean approaches defined by a set of methods created by founders. Really that was an era that was not mature scientifically and practically. The benefits as we move in a process direction are that we can more readily use methods from a variety of approaches that are fitted to the needs of the client. But you cannot do that responsibly and effectively as a form of vapid eclecticism. It needs to be systematic, tested, and coherent. There are inconsistencies in our therapy literature, and clients will detect inconsistencies. Clinicians have strength and weaknesses in specific areas, and intervention needs to be fitted to them.

I think we need comprehensive process-oriented models that reach across "method and tradition" divides in a systematic way, and those models need to be compared in new and pragmatically useful ways. Science is not a free for all, and some processes are more important than others in a given moment in a given case. We need to learn how best to do a new form of functional analysis at the level of the clients we serve.

Ironically in my view you need good philosophy of science training to be more open to the ideas of others in ways that can be progressive. Metaphorically, if you are not balanced over your feet (if you know not know and own your own assumptions) you will just be knocked into a heap by entertaining a much wider range of ideas. I've done a lot of work in pragmatic and contextualistic philosophy of science (my work on functional contextualism) because you can't apply pragmatic meta-cognitive thinking even to yourself as a scientist and therapist and still maintain your balance if you haven't thought hard about your assumptions.

And you need data. Lots of it. Psychological intervention is not an Alice in Wonderland world in which all must have prizes. Let's let the data decide, but in a new kind of research program that is more idiographic, fitted to the needs of people, and more focused on key processes of change. That is an old idea in some ways, but the world has turned and we now have enough data on processes of change and new methods of statistical analysis that will allow it to be more successful this time around.

3. Students may feel the need for some form of conceptualization to explain the origin of the identified maladaptive pattern or triggering situation and why the chosen intervention will be of benefit. What are your views about the importance of having such a theoretical framework?

It is critical in my view. That is one reason I reject the idea that mere eclecticism is progressive. You cannot give a good example of empty integration turning out well in the history of science: real integration refines and tests our ideas. Intervention is not chicken gumbo. Yes, we need to develop models that are more catholic but theory is essential in any science. Ironically you need really good theory to responsibly expand the range of possibilities. Theories with precision are easy to build; theories with scope but no precision are likewise; getting both precision and scope is hard, and then testing theories across the depth of different dimensions and levels of analysis in science more generally is harder still.

The Acceptance and Commitment Therapy wing has been at that effort for a long time. ACT is based on Relational Frame Theory, behavioral principles, and evolution science. All of those ideas are so basic they stand on their own. A given applied theorist may not want to appeal to the principle of reinforcement, say, but that principle is too useful in its domain to ignore. It stands. I think RFT will be looked at that way not too many years from now – the data are just getting to be too voluminous not to.

ACT is also based on the Psychological Flexibility Model as an applied theory. It can be stated so broadly that it fits fairly easily with many core ideas in humanistic, analytic, and cognitive approaches, not just behavioral ones. Empirically speaking there are a growing number of studies showing that psychological flexibility processes are involved in a very wide variety of psychotherapeutic approaches. There are successful meditational studies of such things as experiential acceptance and lack of emotional attachment, cognitive defusion and decentering, attentional flexibility and present moment focus, chosen values, and so on in a list of methods and protocols.

Now, is something like the Psychological Flexibility Model adequate to integrate the great majority of the data we have on processes of change and kernels of intervention? It is a great start but it may not be enough. I suspect it needs to be supplemented by nesting with principles at the social/cultural level and at the biological/physiological level, for example.

But a multi-dimensional, multi-level approach to evolution science might be able to provide that guidance for that nesting. The Psychological Flexibility Model is an applied evolutionary theory and seeing that makes it easy to do things like nest flexibility process in with Elinor Ostrom's Nobel Prize winning Core Design Principles for successful groups.

"Empirically speaking there are a growing number of studies showing that psychological flexibility processes are involved in a very wide variety of psychotherapeutic approaches."



"Maladaptive patterns can be seen to be a transtheoretical unifying construct".

David Sloan Wilson, Paul Atkins, and I have done that with our "Prosocial" project for enhancing prosociality in group (see www.prosocial.world). That's not ACT, but the Psychological Flexibility Model is key to the Prosocial approach.

The bottom line: we need process-based models and they need to be tested.

Stefan Hofmann and I have argued that evolution science provides a useful "model of models" for process-based therapy approaches and we should consciously try to develop that linkage and use it to test the adequacy of our ideas. That is attractive in part because all responsible life scientists (including psychotherapists) recognize evolution science as the best established theory we have about life, bar none. Because of that most people are willing to let their own efforts be viewed from that advantage point and evolution science itself has advanced enough you can now do it. David Sloan Wilson and I just published a book on evolution and contextual behavioral science that argues that case in its broadest form, and Stefan and I have articles and chapters coming that argue it as it applies to process-based therapy.



From our Guest Editor

"Themes of Early Training in Psychotherapy Integration"



Jack C. Anchin

Medaille College and University at Buffalo, SUNY

At the outset of this analysis and synthesis of responses to the structured interview on early integrative training, I would like to express my deep appreciation to our contributors; the opportunity to sit with and reflect on the thinking of such an incredibly esteemed group of scholar-practitioners has been a privilege—thank you all.

Here I have sought to extract a number of major themes from the wealth of ideas, perspectives, and recommendations presented above. These are among my major takeaways, and there is no doubt that in the course of poring through the rich material above readers have been struck by alternative or additional themes; herewith I articulate four that I have found to be especially salient.

1.) Teaching and learning knowledge and skills that foster trainees' ability to recognize and identify maladaptive patterns is a viable focus of early integrative training.

Scholar-practitioners contributing to this issue unanimously resonate to the value of teaching trainees to identify specific maladaptive patterns at an early point in their integrative training. In one respect, this unanimity is not totally surprising: the premise that maladaptive patterns—however theorized—are integral to a client's problems in living and distress is a shared proposition across systems of psychotherapy. However, in another respect, the explicitness of this consensus gives pause for thought; implications are embedded.

Watkins points the way in his keen insight that "*maladaptive pattern*" can be seen to be a transtheoretical "unifying construct...a robust, meaning-making organizer that has theory-wide applicability." Meaning in the complex realm of human affairs is not infrequently multidimensional (Anchin, 2006)—begging the question: What may in fact be some of the key dimensions of clinical meaning effectively organized by this meta-level construct? Extrapolating from contributors' varying perspectives, some of these significant attributes, visually depicted in Figure 1, include the maladaptive pattern's:

"The ineluctable role of theory in identifying, understanding, and treating a patient's maladaptive patterns is unmistakable."



"Theory overarchingly defines the very content of how a patient's maladaptive patterns are construed and understood."

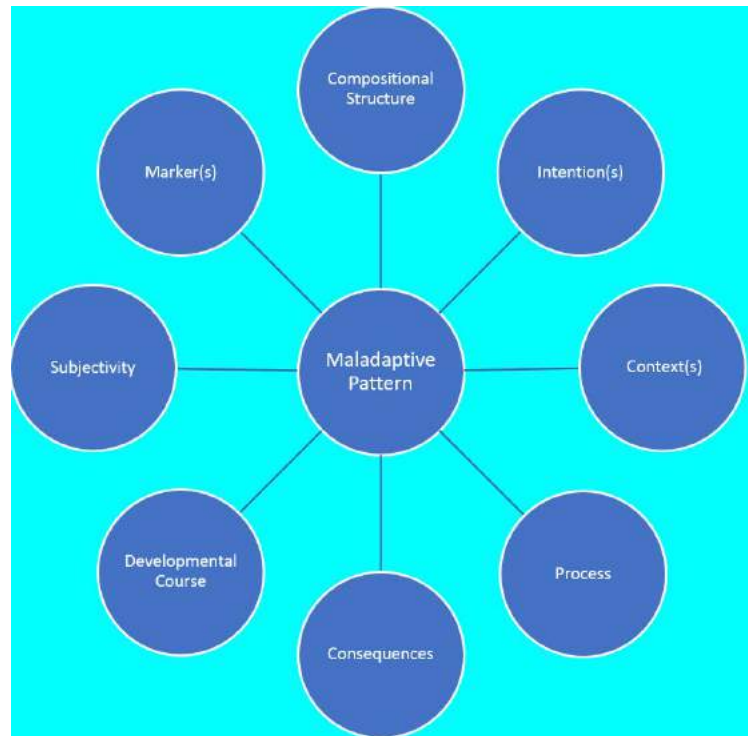


Figure 1. Multiple dimensions of a maladaptive pattern (area in turquoise represents the contents of a given dimension)

- a.) compositional structure: a pattern's architecture; specific, identifiable biological, psychological, and sociocultural structures which, in their recurrent organized configuration, comprise the pattern (Critchfield; Alberti; Hayes)
- b.) intention(s): aims, goals/valued-outcome, or preferred states that the pattern is designed to achieve; purposes or functions this pattern is designed to serve; motivations fueling the pattern (Alberti; Henriques)
- c.) context(s): a pattern's situationality, broadly conceived, elements of which may contain (socio)environmental triggers and/or may activate internal biological and/or psychological triggers (Marquis; Gomez; Goldfried)
- d.) process: the pattern in action; the real-time concurrent and sequential flow—that is, spin out—of linear and nonlinear interrelationships between and among the pattern's compositional elements (Alberti; Hayes)
- e.) consequences: immediate, proximal, and distal results of enacting the pattern; the pattern's functional effects (Wachtel; Hoffart; Hayes)
- f.) developmental course: the pattern's longitudinality, beginning with its originating historical context(s), and its evolving structure, intentions, contexts, processes, and consequences over time, on up through the present (Wachtel; Critchfield; Alberti)
- g.) subjectivity: the subjectively-felt experience accompanying enactment of the pattern; the pattern's subjective phenomenology (Marquis; Critchfield)
- h.) marker(s): one or more observable and/or experiential indicators that a maladaptive pattern is in the process of being enacted during a given segment of time (Goldfried; Greenberg)

And it goes without saying, for dimensions of a maladaptive pattern to be captured and depicted, they need to be denoted in the terms of some particular content (e.g., one client engages others in dominating patterns, motivated by the reflexive need to experience power, whereas another enacts avoidant patterns, motivated by the need to experience safety, and so forth).

Stepping back, the maladaptive pattern construct, in serving a unifying function, may thus provide a multilevel, multidimensional scaffold for capturing, organizing, and interrelating multiple domains of phenomena at play in distressogenic functioning. In these respects, it is a metaconstruct that may have crossover utility for integrative practice, training, and research.

"Not only is it desirable that therapists have a rationale for the nature and directions of their treatment work, in point of fact it is imperative."



"Teaching techniques solely as a menu of interventions is inherently problematic."

2.) Theory is instrumental to identifying, understanding, and treating maladaptive patterns and thus endures as a vital focus of integrative training.

Over a half-century ago, Shoben (1962) argued the case for the indispensability of theory for sorting through, organizing, and bringing meaning to the welter of client data, and present contributors' responses speak to the enduring veracity of this claim. Indeed, though compelling arguments have been advanced for moving beyond traditional theoretical orientations as explanatory systems (see, e.g., Melchert, 2013), the ineluctable role of theory in identifying, understanding, and treating a patient's maladaptive patterns is unmistakable across contributors' discussions—as is firm endorsement of the time-honored integrative axiom that a therapist's effectiveness is potentiated by progressively acquiring knowledge of and capacities to apply a plurality of theoretical approaches to psychotherapy (cf. https://www.sepiweb.org/page/teach_train).

Key to understanding the enduring essentiality of theory is the fact that, instrumentally, it provides a tool serving multiple functions for psychotherapists at any level of experience (Anchin & Singer, 2016). Among its functions, theory overarchingly defines the very content of how a patient's maladaptive patterns are construed and understood. Whether a therapist recognizes and understands dysfunctional patterns in, for example, principally interpersonal, (second- or third-wave) cognitive-behavioral, psychodynamic, or experiential terms, or some combination thereof (see, e.g., Messer; Wachtel; Marquis; Critchfield; Alberti; Fosha; Henriques; Hayes), is intimately tied to the conceptual filters she or he uses to sort through, select, and give meaning to the continuous flow of client data. And in the clinical realm, these conceptual filters are nothing more or less than applied expressions of theoretical systems.

Skill in understanding a patient's dysfunctionality through the lens of one or more theoretical systems is an integral component of clinical expertise [American Psychological Association (APA), 2006]. So, too, is the ability to take this a vital next step: based on this theoretically-tied understanding, formulating "a cogent rationale" (APA, 2006, p. 277) for one's intervention strategies and techniques. Indeed, responses to the third question of this structured interview leave no doubt that not only is it desirable that therapists have a rationale for the nature and directions of their treatment work, in point of fact it is imperative. Greenberg crisply draws the connection between theoretical understanding and having a rationale for how one clinically proceeds: "Theory of functioning and theory of dysfunction are essential aspects of scientific explanation. If we don't know what the mechanisms of disorder are that the method of intervention is treating and how the intervention works to correct the disorder, we are operating in the dark." Henriques articulates a highly complementary perspective and—relative to this structured interview's second question—illuminates in the process a key reason why teaching techniques solely as a menu of interventions is inherently problematic:

A clinician needs to know, why this intervention, why now, and why are you attempting to effect the changes you are. A menu of interventions does not do this. A coherent, integrative conceptual scheme is required to bring order to the menu. Without it, there is much danger in applying techniques "willy nilly," which almost certainly will have ineffectual results.

Intervention decisions and actions need to be founded on a sound rationale, and theory contributes robustly to this justificational grounding. However, in and of itself, theory does not completely proscribe teaching psychotherapy as a menu of interventions; Watkins, Messer, Gomez, Goldfried, Critchfield, Greenberg, Fosha, and Osborn each cite one or more ways in which the menu perspective can be beneficial. By the same token, these benefits hold only up to a point. Resoundingly, the far more favored approach to teaching interventions and techniques entails, alongside fostering development of the procedural skills requisite to their effective implementation, helping students learn and understand their theoretical provenance and infrastructure—that is, the school of treatment from which they originated, the way of understanding personality, psychopathology, and psychological health they embody, structures and processes they therefore especially target, and their intended outcomes.

Theory serves still additional key functions. Watkins illuminates the critical role that encouraging students to actively experiment with and experience—and indeed, wrestle with—multiple theoretical perspectives, conceptualizations, and intervention options plays in fostering development of a trainee's profoundly meaningful "personalized...[t]herapist identity or Practice Self..." And in ways that can complement this decisive identity function, theory provides a student entrée into "a selected group with tradition, rules, and a supporting organization" (Alberti)—professional soul brothers and sisters who provide a secure base for one's emerging development and ensuing evolution as a psychotherapist.

"The synchronicity of incorporating principles and processes of change into integrative training is very much tied to their transtheoretical character."



"A challenge for integrative practitioners, trainers, and students lies in developing conceptual and applied skill in integrating principles of change associated with different theoretical orientations."

When we consider these various purposes served by theory in psychotherapy, it becomes abundantly clear why building trainee's theoretical knowledge, understanding, and clinical abilities in applying diverse therapeutic approaches continues to be an absolute sine qua non of integrative training. The present contributors do differ in their perspectives on how different theoretical systems of psychotherapy should be taught, for example whether trainees should be exposed to multiple schools of thought from the very outset of training (Watkins; Alberti; Critchfield) or whether they should first learn one particular theoretical approach and then sequentially add on others (Fosha; Messer). Each such approach carries advantages and disadvantages, a rich pedagogical topic warranting continued discussion by integrative trainers and trainees. Still and all, there is clear concurrence that whether the domain of interest centers on identifying and understanding a client's current maladaptive patterns, bringing to light those patterns' origination sources, or choosing from the wealth of available therapeutic interventions, mapping the way with the tested and testable concepts and propositions that comprise scientific theories of psychotherapy is integral to effectively navigating any of these tasks.

3.) Training in psychotherapy integration will benefit by expanding in the direction of educating students about principles and processes of change.

Another key training focus that emphatically emerges from these contributions centers on teaching and learning principles and processes of change (Wachtel; Marquis; Goldfried; Greenberg; Critchfield; Hayes). Change principles and change processes are highly interrelated, but differentiating between them is important.

Drawing directly on the concepts and language of Beutler and Castonguay (2006) and Levitt, Neimeyer, and Williams (2005), principles of change are broad, abstract statements intended to guide a therapist's judgment, decision-making, and actions in directions that are likely to facilitate therapeutic change; they do so either (a) by providing general prescriptions (as opposed to rules) for how the therapist should proceed in relation to identifiable factors (e.g., participant, relationship, and technique factors) operating in the therapeutic situation, or (b) by articulating circumscribed elements of knowledge pertaining to any such factor. An example of the former, applicable across the treatment of dysphoric, anxiety, personality, and substance use disorders, would be "Therapy is likely to be beneficial if a therapist facilitates change in clients' cognitions" (Castonguay & Beutler, 2006, p. 363), while an example of the latter, pertaining specifically to treating substance disorders, would be "In general, psychiatric co-morbidity predicts worse substance abuse treatment outcome, and the more severe the associated psychiatric symptoms, the worse the outcomes" (Haaga, Hall, & Haas, 2006, p. 286). Note that both of these principles can inform a therapist's treatment decisions regardless of her or his preferred theoretical approach(es), a point to which I will return shortly.

Whereas a principle of change is in certain respects therapist-focused by virtue of its primary purpose of providing a therapist with guidance and direction, a change process is in some respects more patient-focused. It explains how a given therapeutic outcome at a given point in treatment comes about by describing—in response to therapist intervention—the internal and overt behavioral processes on the part of the patient whose sequential transpiring produces meaningful change. Greenberg and colleagues' (Elliott, 2010; Elliott, Greenberg, & Lietaer, 2004; Greenberg, 1986, 2010; Greenberg & Paivio, 1997) seminal conceptual, clinical, and empirical work on change processes in psychotherapy offers convincing evidence that, with fore knowledge of change processes that produce particular therapeutic outcomes, the therapist can strategically intervene in ways designed to activate those processes.

The synchronicity of incorporating principles and processes of change into integrative training is very much tied to their transtheoretical character. Critchfield provides a representative statement of this feature in discussing the value of teaching change principles: "Principles of the type I have in mind are inherently integrative and cut across standard schools." Integral to this transtheoreticism, change principles and processes carry no a priori specification of specific interventions to be used when drawing on them as treatment unfolds. Rather, informed by sensitivity to here-and-now contextual and client factors, the therapist can implement a particular change principle or activate a given change process by drawing on interventions associated with her or his preferred treatment approach and/or assimilating techniques from other schools of thought (Messer). This way of working concords with the flexibility and pluralism inherent to psychotherapy integration (see Anchin, Fernandez-Alvarez, Botella, & Iwakabe, 20016).

By the same token, while integrative therapists understandably favor transtheoretical change principles, it is important to keep in mind that there are also theory-specific principles of change, a point well captured by Hayes: "A given applied theorist may not want to appeal to the principle of reinforcement...but that principle is too useful in its domain to ignore. It stands." In incorporating transtheoretical principles of change into training, it is important that we not throw out the baby with the bath. Paralleling the manner in which psychotherapy integrationists have vigorously and

"The study of principle-based intervention kernels may offer another fruitful direction of investigation."



"The longitudinality of maladaptive patterns points to the expansion of understanding to be had by building a bridge to the rich field of developmental psychopathology."

productively worked on integrating concepts and interventions from different schools of thought, a challenge for integrative practitioners, trainers, and students lies in developing conceptual and applied skill in integrating principles of change associated with different theoretical orientations. For example, how might a change principle clearly associated with cognitive-behavioral treatment (e.g., "Actively test the validity of erroneous and maladaptive ideas through behavioral experiments"; Woody & Ollendick, 2006, p. 173) be integrated with a principle of change grounded in systemic theory (e.g., "A therapist may be more effective if he/she does not restrict him/herself to individual procedures: Being with others during treatment can be beneficial for some clients."; Castonguay & Beutler, 2006, p. 362)?

One additional point about principles and processes of change bears mention. Hayes makes clear that building the evidence-base for specific principles and processes of change is a work in progress (cf. Wachtel; Critchfield), elaborating along the way intriguing research directions grounded in his and Stefan Hofman's process-based therapy. Among these is the continued study of intervention kernels (Embry & Biglan, 2008), and this respect, the intricate link between principles of change and processes of change suggests that the study of *principle-based* intervention kernels may offer another fruitful direction of investigation.

4.) An ongoing challenge in integrative training is teaching students how to integrate the nomothetic and the idiographic in fostering therapeutic change.

Contributors' perspectives on early integrative training reflect the enduring pertinence of the nomothetic-idiographic dialectic, a classic duality in the discipline of psychology generally and in the field of psychotherapy more specifically (Anchin, 2008b; Anchin & Singer, 2016). Evidence-based practice, in establishing "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006, p. 273) as the guiding framework for clinical practice, teaching, and training, may well stand as the most salient contemporary manifestation of this dialectic in action—and its crucial role in training integrative therapists echoes through contributors' discussions.

Nomothetic knowledge assumes a number of different forms; in the psychotherapeutic realm, theory, principles and processes of change, and empirical evidence pertaining to these and numerous other facets of the therapeutic enterprise are chief among these. Contributors' discussions reflect the centrality of nomotheticism in their approaches to treatment and views on integrative training, but they also highlight the inseparable importance of idiography—that is, sensitivity and attunement to the unique individual before them. Consequently, whether their clinical judgments, decision-making, and interventions are informed by theory, change principles, change processes, and/or empirical findings, they consistently tailor this knowledge to a given client's unique characteristics and qualities (see, e.g., Messer; Wachtel; Hoffart; Gomez; Critchfield; Greenberg; Osborn; and Hayes). As incisively crystallized by Wachtel, this is the art and science of psychotherapy; fostering integrative trainees' ability to therapeutically negotiate this dialectic is the privilege and challenge of psychotherapy educators and trainers alike.

Concluding Comments

Limitations of time and space preclude elaborating on other important directions and implications contained within contributors' responses. For example, the need for students to learn philosophy of science (Hayes) resonates strongly with me (e.g., Anchin, 2008a), as does the potency of teaching metatheory (Magnavita & Anchin, 2014) as a framework to facilitate the integration of concepts and therapeutic methods from diverse schools of thought (Marquis; Henriques). The longitudinality of maladaptive patterns points to the expansion of understanding to be had by building a bridge to the rich field of developmental psychopathology (Cicchetti, 2006; Cicchetti & Toth, 2009), and the therapeutic value of balancing a focus on maladaptive patterns with the insights and methods of strength-based and solution focused approaches (e.g., de Shazer, 1985; Lutz, 2010) merits greater attention by integrative therapists than it has yet to receive. However, these are all questions for another day—and perhaps another structured interview.

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SEPI Survey on Psychotherapy Training

Alexandre Vaz



Dear friends, no Newsletter issue is finished without a survey from our integrative community. This time around we asked you on integrative training, its promises and possible limitations. This particular survey marked a new record, with 74 respondents leaving their opinion and comments. Let's hope this sparks even more dialogue in the future!

You can now browse through all the survey answers in our archive. [\[Survey Link\]](#)

Here are some take-home messages from the answer we got:

Integrationists (still) dislike either/or questions.

For example, when asked if specific client markers were more important the diagnostic criteria, our respondents upheld a proud "both/and". And when asked if learning multiple options for intervention in a specific situation is better than learning thoroughly the techniques of one school of therapy, again a mixed pattern emerged. Respondents commented on this point that one cannot learn everything at once, that this would depend largely upon the level of training, and that learning multiple skills must be balanced carefully with a grounding in solid conceptualization. It seems that just as integrationists value responsiveness in therapy, they also do so in integrative teaching. And maybe most of these questions could be answered with what eclectic virtuoso Arnold Lazarus used to say: "it depends!".

Learning universal skills and common factors is a, if not *the*, integrative teaching priority.

An overwhelming 74% "totally agreed" that universal principles should come at the start of training. Our respondents generally feel that "this is essential in order for the learner to develop a solid foundation in what is most important".

A "simple, non-aligned, explanation of mechanisms of change and psychopathology, applicable to all orientations", sounds too good to be true -- but still largely worth investigating.

I was particularly happy to see our SEPIan community not being too keen on the idea of a "simple" explanatory system. Not that it would be great to have one, but it (still) seems too idealistic on many fronts, with respondents stating that "there's nothing simple about it.", "good luck finding it or getting agreement", etc. Having said that, many believed in its possible utility, which may be linked to a final take-home message we got:

Integrationists greatly value meta-theories and attempts to formally organize our broad therapeutic field.

Be it through the recent unified theories spoused by some prominent integrationists contributing to this issue, or simply a love for common principles and change strategies, our respondents seem more interested in viable, coherent, and scientifically-oriented ways to organize our knowledge than to create yet another "all-knowing" new theory. But also regarding these "umbrella theories", respondents warn that they "should be treated as conceptual tools", which seems to imply that we must be cautious to not create a new "brand war", this time between opposing meta-theories.

A final **thank you** to all those who answered the Survey! See you soon for our Newsletter's January Issue.



"An overwhelming 74% "totally agreed" that universal principles should come at the start of training."

