

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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"IN THE TRENCHES"

A Word From the Editor

Jeffery Smith

*Dear SEPI members
and friends,*

We should all read this issue on the theme of integrative therapy "in the trenches." Taken together, the stories told represent, in a very real form, the state of integrative psychotherapy in North America and Europe.. Not only do they give poignant witness to the arduous process of becoming a thoughtful healer, they show how much room there is for those of us who have logged miles on the journey to help those who are starting out.



New York Botanical Garden Holiday Train Show

Note that in this issue, SEPI's Regional Networks are represented by no less than three articles. Richard Hanus shares the excitement at SEPI's Regional Network in Prague. Maximilien Bachelart, founder of the Paris Regional Network, tells of his own pathway as well as the state of psychotherapy integration in France. Jan Rubal and Jana Kostínková proudly represent a second regional network from the Czech Republic.

Moving Towards Convergence

At the time of SEPI's recent reorganization, we decided to retain the word "exploration" at the center of our name and identity. I am impatient. It is time to turn exploration into action. Giancarlo Dimaggio, speaking for the Practice Advo-

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President's Column

Nuno Miguel Silva Conceicao



Dear colleagues around the world!

Well, it's time for me to say hello to my function as the chair of this loved organization!

Happy New Year to all of you. Thank you to all for being a member of SEPI, learning and spreading the knowledge about psychotherapy integration.

What a pleasure to participate in this issue of The Integrative Therapist. The pleasure is naturally enhanced because I write to you on the first day of my winter break just before entering the SPA in a beautiful Pousada in Portugal. After finishing this, I have a sequence of days and nights off radar to recalibrate my clinical and academic sensors and instruments and to assimilate this new function at SEPI. In this time of the year I also wish that most, if not all, of you have had some time to relax, too.

In my statement I had expressed SEPI could benefit from addressing the needs of younger and senior members in a dialectical way and this issue of the newsletter provides us with a few glimpses of younger people "in the trenches" talking about their real life experiences as integrative therapists. I was definitely younger when, in 1999, I started prac-

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Integrative Psychotherapy: The Synergy Between Structure and Freedom

Richard Hanus

Student of Skál v Institut, Czech Republic

An essay inspired by the presentations of John C. Norcross, PhD in Prague in October 2016

Integration combines different, probably contradictory, perspectives in ways that are not always clearly understood. The first time I came across this notion concerned integrating people with disabilities into the educational system and, by extension, into everyday life. Here, two opposing parties of the 'welcomers' and 'rebufferers' fought, with a surprising emotional force; one side claiming 'this' is right and good because it is human, and the other side stating 'this' is bad as it is not favored by the majority, uneconomical, and unrealistic.



Similar division of opinions characterize the burning question of how to respond to the mass migration of refugees from the East and South to Europe. The immigrants are here and need to be integrated, because they bring economic and cultural potential and because we are obliged to take care of them, our fellow humans. Alternatively, we have to ban them, not even consider integration as 'nobody knows what could happen' and how they could threaten our values.

I believe that such intense emotions towards integration come from the lack of understanding of what the process means and includes. Most students of psychotherapy do not comprehend the unique complexity of the process, its entanglement, uncertain results, and long-term requirements for 'integrative' competence. How exactly should we integrate to avoid chaos, confusion, and threats?

Integration is such a complicated process and the risks are so high that it actually triggers ambivalence itself. In a way, integration is such a great thing, such an experiment, that it may lead to unmanageable outcomes.

Integration is probably not going to be much fun: it does not mean to accept everything that comes around and naively hope that an invisible hand will step in to arrange a favorable result. Nor does it simply mean peaceful coexistence in which we place diverse entities next to each other with borders in between. That would allow the whole aim of such an exercise to slip away.

Integration can be imagined as a virtual laboratory, in which we grow cooperation and connection of knowledge, experience, skills, and strengths. We believe the integrated blend will succeed and we will endlessly evaluate the overall effectiveness. The integrative process will creatively and responsibly use multiple tools together with accurate intuition, balanced by evidence-based guidelines.

No wonder so many people opt for a simple 'welcoming all' or 'refusing all' approach. Admittedly, effective integration is an immense task, and no simpler in the field of psychotherapy.

Psychotherapy is rarely perceived as scientific as it focuses on the treatment of the human soul and suffering. Thus, until recently, it was believed that it was easier and safer to hide behind the walls of dogmas, schools forming their own theories and techniques, often fundamentally different and even contradictory.

Integrative psychotherapy is taking on the difficult task of connecting diverse epistemologies and methodologies to enhance effectiveness. And that is not all. There is still the potential of synergy: through integrating and evaluating, the aim is to create a fusion of superior matter better than a simple sum of individual components.

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The integrative process confronts on one side a 'scarecrow of chaos' supported by a 'witch of fear,' intimidating us by the possible split of the key elements from the overall context. On the other side, integration faces moving sands and an 'evil fairy' made of uncertainty, unfamiliarity, and rigid practices.

I confess that when I entered my first integrative psychotherapy training, I was wondering what kind of a mishmash I would confront. I was concerned about accusations that integration 'is a great place to hide one's own amateurism and inability to understand a problem issue in depth' or even thinking 'finally my own intuition and creativity will make me competent enough.'

Training obviously helped me to master those naive expectations and gradually led me to believe I had chosen the right direction. Yet, I had failed to find something to help me to internalize these integrative principles and log them into my mental pictures. I had accepted being lost and decided to keep on soaking knowledge until the moment when I finally understand what to integrate with what, and where.

I encountered my first breakthrough when seemingly trivial information got stuck with me: 'if a patient has difficulty with emotions, use an approach focusing on emotions. If they have difficulties manifesting in the realm of cognitive ideas, use an approach focusing on cognitions....'. Perhaps it is the client's most pressing concerns that produce problems in their contact with themselves and the world. And so it becomes even more important to track their unique needs.

There is no therapeutic school that will prove most effective for all parts of this spectrum. The integrative approach, however, enhances our chances for the optimal match.



It is a lovely idea, but my doubts grow. I ask: 'is integration even within human power?', or more specifically, 'is it within my power? Is integrative psychotherapy a mere VIP space opened only for those with a high level of charisma, insight, and experience, allowed through the door that most of us cannot even reach? If only there was a simple, understandable, and transparent system.

And here comes my encounter with Dr. John Norcross. The moment of his presence, learning about his experience, research, and viewpoint.

At the outset, I had to grapple with my expectations and adjust them. I have been looking forward to meeting a genius, a mysterious superhuman, whose every sentence would communicate enormous discoveries. Instead, he presents as 'a normal American' waiting in front of the lecture hall, a guy that fits into our Central European preconceptions about this 'species' whom we would (if we had the power) just pronounce the next president of the United States of America. He is a friendly and professional looking guy with American confidence and the right sense of humor.

Norcross starts talking, and I fear disappointment. Is it possible that he is another rigid, evidence-based scholar, of whom we have so many in Czech academia, presenting material that an average student has no chance to grasp a clear message from through the mist of research findings? My initial fear fades away, and I start listening, not waiting long for a nice surprise.

Norcross is uncompromising. Any claim he voices is supported by both clinical experience and research-based data. He reveals the ways in which to integrate psychotherapeutic approaches towards the needs of the client. Even if that is just a fragment of what he teaches in his four-hour presentation, still it is enough. There is no need to fully understand the comprehensive system of integration; it is enough to realize that this system exists and is being developed even further.

I will always remember his figure showing the use of psychotherapy systems from the perspective of the stages of change. The well-known stages of change, which were beaten into my head during a motivational interviewing course, are now taking on a new dimension. Each stage is linked to powerful, evidence-based therapeutic approaches from behavior therapy to psychoanalysis. Hence, if we learn how to effectively assess the client's stage of change, we will have a tool allowing us to 'speed it up' to the next stage. It tells us what approach to use to achieve the client's ideal outcome. Even if we do not know the application of all of the therapy methods, we already can understand much better what is likely to work for the client.

A simple and relatively short assessment of the client's treatment preferences (and particularly the therapeutic relationship) allows us to easily learn what our client wants during sessions. It is likely that during the course of therapy we

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discover a difference between what the client wants and what he/she needs. Not always are these two dimensions head to head. We do not need to be researchers to find the client’s preferences and check them out from time to time. We can draw them out, we can find discrepancies, we can assess what the therapeutic process has been like for the client, and use all of this to support further work. Even if we only achieve one of these aims, it already has an impact on strengthening the therapeutic relationship.

The presentation by Dr. Norcross demonstrated that a confident and elaborate system of integration exists. One simple slide presented effective methods of adapting psychotherapy to the individual client by creating a unique, tailored approach based on the client’s resistance level. When we assess the client’s resistance/reactance level it can help us pinpoint what treatment strategies are more likely to succeed. Same with the client’s stage of change, coping style, cultural background, and spirituality.

One idea was even more interesting than the last. It is enough to just take a breath and start studying diligently.

Suddenly, it does not matter how much theoretical information and clinical knowledge still lies ahead of me. I now am starting to look forward to discovering new material. The huge mass of entangled data has actually changed its appearance; a system is becoming visible in the shapeless cloud of overwhelming theories and truths. Norcross’s integrative approach sorts out all the information, giving it more meaning.

Getting back to research evidence: in my growing need to understand how to integrate, research findings no longer seem intrusive. On the contrary, they give me reassurance and reinforce a sense of purpose. They show that well-developed integrative psychotherapy works.

When we know how to integrate the strategies of individual schools to meet clients’ needs, adapt our therapeutic approach to them, create a unique path for each client—it logically must work better. And we have the confident proof, solid research evidence, the emotional security of know-how. If we still, however, miss a link somewhere in the system, we will look for it, examine it, and test it until we find it.

The American gave my faith in integrative psychotherapy the most-needed proof. Norcross offered a guiding rope, which I can always reach, when the complexity of the human soul overwhelms me, and when I feel helpless looking for an effective way to help an individual. At those times, there will be something for me to catch and to regain security.

With an integrative, research-backed structure, I can at any time find my ground in the given safety net without hurt, but with another new experience, allowing me to go back out there. Freedom, when protected by structure, keeps flourishing.

Integrative psychotherapy has begun to seem like the perfect direction for me. Its systemic approach is neither restraining nor dogmatic, not a path leading towards the loss of authenticity. Its structure provides safety, its research demonstrates effectiveness, and it creates a frame within which we can work with our clients and paint a unique and original scene.

Best of all, as a student therapist, I now have the two values—freedom and structure—linked together. And that connection is synergistic for me and my clients. Integrative psychotherapy safely and creatively combines these values and creates new entities. I am glad that I witnessed it. 🐦



Training the Flexible Mind: Science-Practice Integration Through the Eyes of a Young Therapist

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In seeing my first client for psychotherapy just over one year ago, I realized I was coming into the room with a host of preconceptions. These were not the preconceptions that I had often been warned of, biases against a client's race or a challenging countertransference; instead, I noticed that I had entered the room with scientific preconceptions. In spending the previous four years devoted to clinical research, I was now approaching therapy through the lens of a scientist, not a budding clinician. Diagnostic criteria had been reified in my mind, and I was seeing my clients from the perspective of the DSM. I was hyperaware of my clients' every word, not as it pertained to their distressed state yearning for solace, but as it highlighted specific symptoms I could check off on my mental list of disorder criteria.

In speaking with my supervisor a few weeks later, I brought to him my concerns. I explained to him that I felt I understood how to effectively capture the diagnostic picture in front of me; my years of conducting structured interviews with research participants had prepared me well for this. However, I expressed to my supervisor, "I can make a diagnosis easily enough, but how do I become a therapist?" I was being trained in motivational interviewing (MI; Miller & Rollnick, 1991) and felt I had begun to master the various techniques I was learning, such as amplified reflections. But something was missing: I was simply going through the motions. Seeing my clients in terms of their research diagnoses meant little when it came to applying MI principles to the nuance of their concerns. I felt I had reached an impasse in which I could not translate my knowledge of diagnoses and study protocols into effective therapeutic work.

I reflected on my experiences in therapy and compared them to what I had seen in tapes of expert clinicians. Carl Rogers with Gloria, Aaron Beck with Richard, Otto Kernberg with Kurt, each scientists in their own right, and yet each somehow able to fluidly transform their scientific understanding of human struggle into therapeutic interaction. It was as if they had pulled skin over the bones of their theories and created a living, breathing therapy in the room with their clients. But how?

In struggling to answer this question, I stumbled across my notes from the 2015 SEPI convention in Baltimore. I recalled a keynote by Nancy McWilliams who spoke about the two types of minds of therapists and researchers. In drawing on William James's 1907 Pragmatism, McWilliams described therapists as "soft-minded," expressing optimism, open-mindedness, and creativity, and researchers as "hard-minded," focused on empirical evidence and critical thinking. I began to realize I had come into my therapy training with a hard mind—analytical, diagnostic. The mind I needed to develop was a soft mind, able to look past diagnostic criteria and appreciate my client's humanity, their distress, their struggle for awareness and self-actualization hidden under a convoluted cloud of psychological symptoms.

But how was I to integrate these antipodal ways of thinking? Did an integration of science and practice mandate that I be able to simultaneously hold both of these minds in mind? Or to switch between the two depending on the task at hand? Or instead, to develop a new, integrative mind of the two, a flexible mind, durable enough to maintain the rigors and critical viewpoint of empiricism while also able to bend to the needs of each client?

The integration of science and practice, for me, has become not alternating between disparate forms of thought but developing this flexible mind. I am not Scientist-me in the lab and Therapist-me in the room. Instead, as I sit to write a "risks" section of a proposal to the IRB, I think of my recent client who was worried about her confidentiality being broken by the use of video recordings. And as I become agitated as my newest client expresses concern about the chances

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of success in her therapy with me, a student, I am emboldened by Eubanks, Muran, and Safran's (2010) empirical work on the importance of alliance ruptures and repairs to the therapy process. Integration of science and practice may often occur on an interpersonal basis—where researchers and clinicians join forces to advance both science and the well-being of individual clients. However, I believe that an integration of research and practice in the mind of each member of the field, researcher or clinician, may provide new insight and push the boundaries of successful psychotherapy.

Although developing a flexible, integrative mind was uncomfortable at first—not unlike stretching cold and unused muscles before a much-needed jog—I have finally begun to embrace this way of thinking. I have now seen many examples where my growing ability to think flexibly in a moment has facilitated positive outcomes for my clients. For instance, I have recently been working from a manual for GAD with a client I'll call “Kathy.” Several sessions ago, I commented on a particularly worry-ridden day on Kathy's thought log that was missing any noted precipitant. Kathy, who is already quite inhibited in her presentation, grew visibly more distressed and reclusive and I eventually determined that something upsetting that she did not want to share with me had occurred. In this moment, I chose to diverge from my agenda, putting on hold the material I wished to cover from the manual, and explore Kathy's emotional experience. I sat with Kathy in silence, at times gently pushing her to describe her emotions and eventually relate to me what had happened—which she did. I was transparent with her about my departure from our session plan and contextualized for her my silence and emotional exploration as fostering her exposure to negative feelings, vulnerability, and the potential disapproval of others, falling within the overarching CBT model we were working under. Although I arrived to supervision later that week apprehensive, my in-session decision was validated not only by my supervisor, but more importantly by Kathy at our next session: She described to me the benefit of my allowing her to explore her experience and face her fears and was more open with me in this session than she had been in the eight sessions I had seen her up to that point.

One might note that none of this piece discussed the type of psychotherapy integration that is probably more often the focus of *The Integrative Therapist* and SEPI broadly: theoretical integration. This is not at all because I am not in favor of such integration; in fact, having been trained in both psychodynamic and cognitive-behavioral approaches to therapy (with a splash of interpersonal and humanistic theory), and valuing the contributions and viewpoints of each, I consider myself a theoretically integrative therapist and work with the majority of my clients from this framework. Rather, despite the importance of theoretical integration, I consider the integration of science and practice to be a necessary foundation for any integration of theory. A basic prerequisite of theoretical integration, in my estimation, is understanding what works when and for whom and this knowledge can only be achieved when therapists are able to translate empirical principles into effective practice and to refine these principles based on clinical experience. Thus, I exhort my fellow members of SEPI, especially those that are students, to think flexibly about both their research and clinical work and to always be open to the insights to be had on the other side of the bridge.

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Society for the Exploration

 of Psychotherapy Integration

Piecing Together the Things That Work: My Attempts at Psychotherapy Integration

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Here is what I have come to observe about differing approaches of psychotherapy: everything works sometimes, but nothing works all the time. This is the dilemma we face as clinicians.

I'm a perfectionist. And psychotherapy is decidedly imperfect. This leaves me always on the hunt. If a client is not improving the way they'd like to, or the way I'd like them to be able to, I typically assume the problem lies with what I am doing. A favorite thought of mine is that Whatever I'm doing, I'm not doing it well enough. Another, more hopeful and less self-blaming reaction is the thought that Maybe this is not the right approach for this patient at this moment. The common assumption between the two reactions is the idea that out there, somewhere, is a perfect intervention which would magically accelerate the patient's progress, an incantation, if you will, which would finally put the client's perturbed soul at ease.

This of course is somewhat unrealistic. I say "somewhat" because, as my long-time mentor Baruch Fishman once said to me, in his famously emphatic Israeli accent, "If your question is whether you could have delivered an intervention better, the answer is always, 'Yes!'"

It's true: therapy is no different than any other human interaction in that way. The choicest words too often come to us only after the fact. And while I must accept this reality to carry on as a therapist, I also refuse to stop striving to do better and to do more. My clients' suffering is real, and the pain arising in me upon seeing it disallows complacency.

Thus, I am a seeker. To this day, I still seek to learn about the wide variety of approaches out there, in hopes that I may still find the one, ultimate approach, a particular form of cognitive behavioral therapy or a particular model of psychodynamics that will clearly outpace all the therapies I have learned thus far. One additional problem: I am also a skeptic.

One part of me is drawn to the purity of the theories each approach espouses and the notion that the intricacies of the mind can be understood through a single, unifying lens that allows diverse symptoms to coalesce neatly around a few organizing crystals. On the other hand, another part of me is dubious that the elegant simplicity of such theories can adequately guide a messy interaction between two real, complicated people such that one person, the client, comes out fully transformed and self-actualized. (And the other person, myself, would come out feeling self-satisfied and triumphant.)

With such internal forces, pulling me toward new ideas and pushing me to reject enveloping ideologies, and pecked all the while by my incessant tendency to question myself and my actions, I have found that I need to choose a secure base from which to work, a foundation which I do not question, a method from which I can leap away and on which I can always safely land. For me, this secure base has been cognitive behavioral therapy (CBT). Thus, I practice a form of what has been called "assimilative integration" (Castonguay, Newman, Borkovec, Holtforth, & Maramba, 2005; Messer, 1992). In order not to create a morass of mish-mashed interventions, I have found it is important to proceed into integration with caution and deliberation. This way, at worst, I am doing that thing called CBT, which seems to have some evidence behind it. At best, I am further optimizing the CBT by deepening my conceptualization of my client and infusing the work with enhanced techniques.

Why CBT? Admittedly, some of this choice has been influenced simply by early training experiences: I happened to train more in CBT than other approaches early on in graduate school. Additionally, I am drawn to a central organizing treatment principle of CBT—that of exposure therapy. By helping the client tolerate feared experiences, we can free them of their anxiety, sense of overwhelm, and concomitant, avoidant coping strategies. There is one thing I especially like about exposure therapy: you can often see it working right before your eyes. The effects can be dramatic. Watching a client tolerate an exposure and then being with the client in their ensuing moments of pride and self-efficacy can be

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“Whenever I see positive change happen before me, it is like seeing cherries align in a slot machine and hearing coins begin to pour out.”



“McCullough (2003) proposed that psychotherapy is the resolution of “affect phobias” and that shame is an inhibitory emotion aimed at preventing feared, adaptive emotion such as assertive anger and self-affirming pride.”

immensely gratifying. Working with a client as they take back their life by giving up immensely disruptive avoidant behaviors can feel like helping to set a trapped animal free of its cage.

I trust evidence. But inevitably, what I trust even more is what I see with my own eyes. Whenever I see positive change happen before me, it is like seeing cherries align in a slot machine and hearing coins begin to pour out. My whole organism wants to recall and build upon whatever I did just before that moment in order to make it happen again. Seeing the therapeutic power of exposure within sessions has made me thirsty for additional ways to make change happen within the therapy hour.

The more clients I have seen, the more I have come to broaden the scope of feared experiences worthy of some kind of therapeutic exposure. It is my observation that people appear to fear emotions themselves more than any external circumstance, as negative emotion is literally painful. If clients fear a future situation, it is because they believe that if the situation comes to be then they will feel something painful. Shame, the emotion that accompanies the belief that one is fundamentally unacceptable to others, comes up as one of the most frequent and pervasive sources of pain. Anxiety is often fear that one will feel bad about oneself (shame) over not doing something well enough or not making the right decision. Depression can be seen as an overarching syndrome of defeat in reaction to repeated evocations of shame. In this case, shame is like the painful electric shock administered at random that produced depression-like symptoms in Martin Seligman's canines and which lead to his learned helplessness model of depression (1972). The excessive scrupulosity frequently seen in OCD is rooted in excessive responsibility to others and fear of the inevitable shame and guilt that accompanies failure to fully uphold this responsibility. Substance abuse is a way to avoid feelings of shame, and eating disorder symptoms are an attempt to control one's body image in order to prevent shameful self-evaluations.

If clients have a fear of shame, then what do we want to expose them to? More shame? Clearly not. As humans, we cannot habituate to feeling that are fundamentally unacceptable. It goes against the grain of our being. The needed exposure is to the feeling of being fundamentally acceptable and worthy of unconditional love.

As early as 1977, Wachtel proposed that psychodynamic therapy could be seen as a form of systematic desensitization to important, warded off aspects of the self (Wachtel, 1977). Later, McCullough (2003) proposed that psychotherapy is the resolution of “affect phobias” and that shame is an inhibitory emotion aimed at preventing feared, adaptive emotion such as assertive anger and self-affirming pride. These insightful theorists have helped me see the importance of bypassing or undoing shame in order to help clients experience positive feelings toward themselves and to solidify a more positive self-concept.

In that I am known in my community as a CBT therapist, some referrals are sent to me that lend themselves to more “traditional” forms of exposure therapy—particularly panic disorder and OCD. The rest of my clients present with the all-too-common mix of anxiety and depressive symptoms, ranging from mild to severe, acute to chronic. For these clients (and often for the panic and OCD clients after progress is made on the panic and OCD symptoms) the brunt of therapy becomes the project of zeroing in on the core, shameful sense of self and working toward exposing the client to an acceptable, lovable, empowered sense of self. This ends up being the tricky problem that has sent me searching in all manner of directions. As every therapist has likely observed, simply telling the client that they are not so bad doesn't seem to do the job. The client needs to deeply feel this alternative, healthy sense of self in order for it to become their sense of self.

Let me attempt to articulate my approach, and how I stitch together the frameworks and techniques of a variety of therapies.

I like to begin with Socratic questioning and cognitive restructuring centering on specific, difficult moments from the client's recent memory. This brings focus to the therapy and helps the clients identify the recurrent themes and the core beliefs about themselves that give rise to their depression and anxiety. Through this process, we also begin to work together to make the client's shameful view of themselves more ego-dystonic. From here I segue into more experiential work, calling upon techniques from Leslie Greenberg's emotion-focused therapy (EFT; Greenberg, 2002), such as Gendlin-style focusing and Gestalt-style chair work. The chair work often begins with standing up to an internal critic. It can move toward chair work for “unfinished business” with parental figures who helped give rise to the internal critic. If successful, this can lead to outpourings of pent up anger toward caregivers for their roles in contributing to feelings of shame and the release of sadness over the love that was missed. This can be seen as exposure to adaptive affect as well. Assertive anger facilitates needed boundary drawing and separation from a negative, internalized parent. The sadness of grief over an important loss helps the client reach acceptance of the loss and reintegrated wholeness afterward.

For clients who are confronting more entrenched and long-standing emotional difficulties, I introduce the concept of early maladaptive schemas, drawn from Jeffrey Young's schema therapy (Young, Klosko, & Weishaar, 2003). I help the

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“I could call this extended conceptual framework and suite of techniques cognitively-guided-emotionally-focused-schema-centered-experiential-dynamic-exposure psychotherapy (CGEFSCDEP).”

client notice and differentiate the main ego-states used in the “mode model” of schema therapy, such as the vulnerable child, the internalized punitive parent, the angry child, the avoidant protector, and the healthy adult. This method allows for further experiential work linking currently experienced emotional difficulties to childhood experiences. In terms of exposure, it allows for exposing the client’s inner, vulnerable child self to protection, acceptance, and compassion. I would like to add that I owe an increasing debt to Diana Fosha’s accelerated experiential dynamic psychotherapy (AEDP; Fosha, 2000), in which I have recently begun training, and in which I plan to continue training. The AEDP approach has helped to train me to recognize moment-to-moment opportunities to help the client move away from defensive/avoidant states to more open, adaptive, healing emotional states. Schema therapy remains the larger framework guiding the therapy and techniques while the AEDP perspective helps me fill in all the little blanks, bringing close monitoring to the effect on the client of each thing that I say, helping me constantly gauge whether we are moving toward therapeutic exposure or away from it. When my interactions with the client feel messy and I feel lost or stuck, I retreat from more active interventions to Rogerian empathic responding, exploratory questions, and Socratic questioning of blatantly distorted statements.

That is the nutshell version of what I do, which either makes it sound more coherent or more messy than it really is (I’m not sure which). I could call this extended conceptual framework and suite of techniques cognitively-guided-emotionally-focused-schema-centered-experiential-dynamic-exposure psychotherapy (CGEFSCDEP). But I usually just call it “CBT.”

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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.

Each issue has a theme. The April 15 issue will focus on “Theoretical Convergence,” the issue of movement away from distinct, competing schools and towards a unified way of looking at our subject.

Contributors are invited to send articles, interviews, commentaries, letters to the editor, photos, and announcements to Jeffery Smith, MD, Editor, The Integrative Therapist.

Submission Deadlines and Publication Dates

December 1 deadline for **January 15 Issue**

March 1 deadline for **April 15 Issue**

June 20 deadline for **July 15 Issue**

September 15 deadline for **October 15 Issue**

Society for the Exploration

SEPI

of Psychotherapy Integration

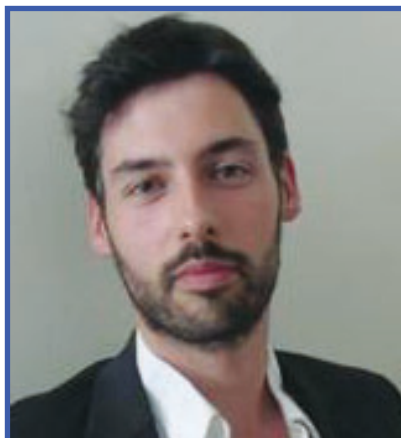
Specifications

- 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 jsmd@howtherapyworks.com with the subject line “Contribution to Integrative Therapist.”

My Country, My Way

*Maximilien Bachelart
Private Practice, Paris, France
Founder of SEPI Regional Network, Paris*



My Country

I'm 30, a PhD clinical psychologist and psychotherapist. I have an institutional and private practice and sometimes lecture in universities. In my country, France, for various reasons, the question of integration is not raised. I explore this in my first book, which I am currently writing on the subject "The integrative approach in psychotherapy : an anti-manual manual for therapists." French psychotherapists are integrative in practice, even if they are not familiar with the term or the concept. Integrative practice grows out of a rich and influential involvement in psychiatry. France is responsible for the release of the insane (Pinel & Pussin), the concept of hysteria (Charcot), trauma and dissociation (Janet), hypnosis (Liebault & Bernheim, Puysegur), suggestion (Coue), and antipsychotics (Delay & Deniker). In more recent times, France

has embraced psychotropic drugs along with two other important currents: an enthusiastic recognition of psychoanalysis and an equally enthusiastic but opposed adoption of cognitive behavioral therapy.

Psychoanalysis entered in our society in the 60's in response to two deep French characteristics: the love of theories and need for individuality. French thinking is historically individual and psychoanalysis found here its perfect ground. Then CBT, and its offshoots (MBSR, MBCT, ACT, EMDR) gained inroads in the past ten years. I think that the energy with which CBT was embraced came in reaction to an excessive grip of psychoanalysis and too many derivative phenomena in the hands of a few powerful men. Psychoanalysis and its sacred texts had become a perfect justification for outlandish and inappropriate conduct. CBT brought a dose of reality and pragmatism that French people fear but desire at the same time.

In my country, the introduction of new theories and the almost religious elevation of people associated with them have historically taken on more importance than the theories themselves. Soon the forces pro and con become diametrically polarized. We are forced to choose one side and oppose the other. We have to be radically for or against psychoanalysis or CBT with or without having an adequate knowledge of either. In the media, great and well known professors from one side caricature the practice of the other side to discredit it.

The problem is that within the university where we teach psychiatrists and psychologists, teachers and researchers are often "radicalized" to one or other position and have a little knowledge of opposing theories and practices. I think the consequence of this is suppression of diversity and the lack of development of humanistic, systems oriented and broad minded approaches.

Public universities teach psychology but are not involved in training for psychotherapy practice. A PhD is not required to practice psychotherapy and training for this is relegated to private institutions. Only recently was the practice of psychotherapy regulated at all. Psychologists could pronounce themselves "psychotherapists" without any training or oversight. A recent law, has established legal status and the title of psychotherapist, but fails to distinguish between psychologists, psychiatrists and anyone else who meets requirements. Those who voted for the law had no understanding of the domains of psychologists and psychiatrists or of training in psychotherapy!

In France we do not speak about psychotherapy integration because we haven't thought of theory and practice as related. There was a passion for psychoanalysis and then a place for CBT. Dogmatism was more important than pragmatism. A few institutions have begun to teach what they call "integrative psychotherapy," but actually they separate psychoanalytic, cognitive behavioral and systemic therapy approaches, without integrating them or joining theory with practice. But it is still an improvement. Six years ago when I was student, the major teaching was almost exclusively

Continued on page 11

"French psychotherapists are integrative in practice, even if they are not familiar with the term or the concept."



"I think that the energy with which CBT was embraced came in reaction to an excessive grip of psychoanalysis and too many derivative phenomena in the hands of a few powerful men."

“Public universities teach psychology but are not involved in training for psychotherapy practice.”



“Though I may be idealistic, I want to see our discussion trace the path from initial intuition to concept to theory and back to the embodiment of ideas in practice.”



“Fortunately I had the presence of mind to talk about this instead of rushing through the steps of various textbooks that I had on hand.”

psychoanalytic although few courses were about brief therapies.

I have established a new French SEPI Regional Network composed of only four members. Three articles exist on the subject including two I wrote, soon three in February. I'm trying to trace a path that doesn't exist in France, I'm writing about a nonexistent social phenomenon. But I'm hopeful.

My Way

During my own studies I had the impression that each course was a new manifesto praising the merits of an idea or technology and I had the feeling none was concerned with clinical aspects. My professors looked solely through their more or less convoluted theoretical prisms. It is extremely rare to meet a teacher who speaks more than one language (language of drive, of learning, of communication, and systems theory...).

Though I may be idealistic, I want to see our discussion trace the path from initial intuition to concept to theory and back to the embodiment of ideas in practice. In doing so, it becomes natural to integrate theories into a more cohesive fabric, of use in helping people in distress. I think that therapists do not choose their “tools” by chance. A friend of mine, Dr Jean Bruxelles (intensive care anesthetist and specialist on chronic pain), suggested an analogy between the therapist and *homo faber*, a man capable of making his own tools. This philosophical concept has been used to explain what distinguishes *homo sapiens* from the rest of the animal kingdom: it is not only biological but also intellectual. As Benjamin Franklin said, “Man is a tool-making animal”. In contrast to other mammals, *homo faber* uses different tools to do different tasks. We need to recognize the difference between the tool, itself, and its use. When we apply a tool to a task, we should do so out of knowledge and experience with its use. Some professionals are more interested in being right and demonstrating the importance of their sacred books and theories than to be close to humans. They remain devoted to the tools they see as their own precious creations, and resist change because, to do so, would pose a heavy risk to their pride.


During my training, I went through different explanatory systems, understood some of their subtleties, their justifications, their peculiarities, their specifics, and similarities. Four universities have shaped my training, including a Canadian one. In this way I have crisscrossed the world of cognitive behavioral therapy, hypnosis and a passage through psychoanalysis. My latest explorations are in the fields of phenomenology, existentialism and systems theory. For twelve years I have not been able to choose, not by indecision, immaturity or a wish to annihilate the differences. I reject the kind of dogmatism that labels and forces everything to fit a theory that then shapes and restricts observation. I still recall an internship experience in Montreal where I was reluctant to follow a manual of CBT in working with a patient. I was 21, and she had already met too many psychologists. Fortunately I had the presence of mind to talk about this instead of rushing through the steps of various textbooks that I had on hand. Even if I was willing, what protocol should I follow? Each one addressed a specific disorder and this patient had four or five of them from a DSM point of view. The need to step back rather than yield to the pull of urgent symptomatology seemed clear to me in this encounter. I tried later to generalize this approach even with the “simplest case” (apparently!). Then I read and wrote about the therapeutic alliance, I work with it with in all my therapies and I think it forms a focal point for integration.

I quickly realized I was not practicing in an orthodox way. Soon I understood that therapists around me did not either, nor did those I was watching or reading about. I tried to move towards practices that I did not know and did not hesitate to open the books that were never borrowed in university libraries. Without that, I had little chance of finding enough subversive counter-examples to make me think about what I was doing. To avoid hopeless confusion, I had to move in the direction of both clinical and theoretical integration. I wondered by what right I could move from one theory to another, from one strategy or posture to another. I questioned my own motives. Was I driven by personal discomfort or lack of effectiveness? Or was it eagerness to experiment? As my conceptual world shifted so did the reality I co-constructed with my patients, and the resulting uncertainty created a constructivist pit of anguish with which I had somehow to cope.

No final consensus in terms of integration has been found, and I think that's a good thing. I also think that integration raises the issue of the phenomenology of the encounter. Theory is a way to protect oneself from the uncertainty of a true human interaction. It organizes the apparently illogical nature of all phenomena reported by patients. To integrate is to ask how to meet the world of the other with more honest internal models. We need models to train our intuition and observation, but then we must deconstruct what we have laboriously built to finally understand human beings.

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Creating My Identity as a Therapist: Integration Through Diversity and By Daring to Be Real

Laurent Berthoud

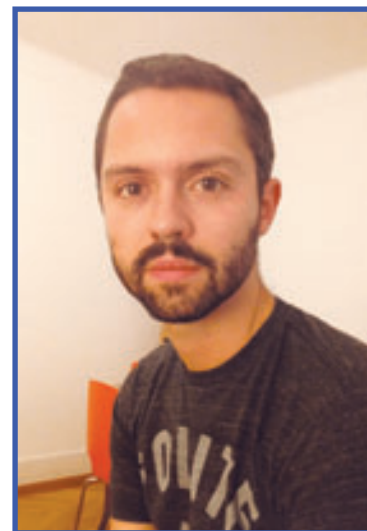
*Institut Universitaire de Psychothérapie - CHUV
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When I read the Call for Papers asking about people's experiences as integrative therapists, I realized that I was not only eager to share the changes I have been through in my still early career, but also to seize the opportunity to put them into words. It is important for me to state that my opinion solely reflects my current beliefs and will (hopefully!) continue to change as I live new experiences.

A few years back I would not have defined myself as an "integrative" therapist, as that term was too obscure and I needed clear guidelines to feel secure enough to "help" people. I still identify myself today as a person-centered therapist because of my training, my values and my beliefs, but also because of the psychotherapy landscape in the French-speaking part of Switzerland where person-centered therapy is not mainstream, making person-centered therapists a tight knit community often eager to clearly mark their affiliation and existence. In retrospect, the person-centred approach has been truly helpful to me as it has honed my sensitivity to clients' individual needs, to the importance of the therapeutic relationship, and to trusting the client and myself. I believe Carl Rogers was particularly open to alternative ideas of actualizing person-centered principles and that he understood the need to adapt to new knowledge coming from research. I have come to think that one can practice person-centered therapy in an integrative way by meeting the client at relational depth and focusing on emotions and experiencing.

Nevertheless, throughout my training and my practice, I have often been frustrated when facing reductive stances asking "am I doing this right, according to my approach?" and "which school is the best?". Too often I was—and still am sometimes—afraid to voice my concerns because of the danger of either not being taken seriously as others are not able to "label" me, or of simply being excluded or rejected. I was for some time disappointed as I felt that "being" with the client was occasionally not enough or—come to think of it—that I couldn't find a way to "be" with the client, for instance with Axis-II disorders and especially clients presenting with Borderline Personality Disorder. I felt torn between a loyalty to what I thought my approach was and seeking new developments and what I needed as a therapist. Fortunately, I had the chance of attending the SEPI conference that took place in Barcelona in June 2013. Looking back, this event was a turning point for me as several contributions helped me to realize how I could blend process research and clinical practice, understand clients beyond diagnosis and school specific concepts, and grasp the importance of moment-by-moment informed clinical decisions in assimilation and transformation processes.

This helped me to make the decision to focus my PhD training on different yet complementary approaches (with very sympathetic supervisors of course!). Klaus Grawe's consistency model—a detailed and comprehensive framework of mental functioning developed beyond the boundaries of psychotherapy schools—helped me give meaning to some of my clients' behaviours that I could not figure out. This model and its ensuing "psychological therapy" helped me further understand how behaviours aim to satisfy and protect basic needs through motivational schemas shaped by life experiences in a way that is consistent with the individual's perception of the world and his or her internal model of the world and of him- or herself. Practically, Franz Caspar's Plan analysis, a case formulation method based on an instrumental perspective partially resulting from Grawe's work, and the ensuing motive-oriented therapeutic relationship facilitated specific understanding of what was potentially at play in therapy and gave me alternatives of how to respond complementarily. This was of particular help to me as during my training some colleagues voiced their concern that



"It is important for me to state that my opinion solely reflects my current beliefs and will (hopefully!) continue to change as I live new experiences."



"Too often I was—and still am sometime—afraid to voice my concerns because of the danger of either not being taken seriously as others are not able to "label" me, or of simply being excluded or rejected."



"...behaviours aim to satisfy and protect basic needs through motivational schemas shaped by life experience."

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“As a practitioner, I feel very lucky to have pursued research in psychotherapy and to have worked on the understanding of in-session emotional processing as a key changing variable...”



“...I feel as though I can better meet clients at a personal depth by being real.”

using case conceptualization methods might put the therapist in an unhealthy role of expert, thus creating an imbalance of power with the client. I realized that even though I do share this concern, I also hold the view that developing a focus in therapy enhances the healing process. A formulation that I also found very helpful and that fitted perfectly with my own values was Leslie Greenberg's Emotion-Focused Therapy. Indeed, not only is it a humanistic and experiential approach where the focus is co-constructed by the client and the therapist, but the formulation is on the client's moment-by-moment process, focusing on his or her current level of functioning and experience.

As a practitioner, I feel very lucky to have pursued research in psychotherapy and to have worked on the understanding of in-session emotional processing as a key changing variable in individualized treatments based on the motive-oriented therapeutic relationship for borderline personality disorder. Research allowed me to also better integrate different methodologies such as qualitative video-analyses, theory-building case studies, quantitative between-group comparisons and predictor models. This work yielded an interesting pattern of results, notably that leaving global distress behind very early in the therapy process plays a productive role for symptom change (Berthoud et al., 2017), which influences the focus of my practice today.

My short journey in psychotherapy has so far helped me grow both as a person and as a professional, the latter role evolving from a naïve perspective where I would have sufficient “tools” to “treat” people to my current stance where I am now able to sense when I lack know-how and what training to seek to gain and develop ideas to better adapt to the situation and thus facilitate change in the client. This has allowed me to increasingly enjoy my work as I feel as though I can better meet clients at a personal depth by being real. This has also helped me genuinely realize that being a therapist is a privilege for me because I am trusted as a witness to the lives and amazing changes that my clients experience.

In sum, writing about my experience, my thoughts, my joys, my frustrations, and my hopes has led me to realize that for me, being an “integrative” therapist means putting an emphasis on the use of one's self, i.e. assimilating what works, trusting what feels right to the client and myself, and daring to be real and spontaneous with the client. As a passionate martial practitioner, Bruce Lee's quotation springs to mind: “Absorb what is useful, discard what is not, add what is uniquely your own.”

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SEPI Announces: UPDATED LISTING OF INTEGRATIVE TRAINING PROGRAMS WORLDWIDE

The SEPI leadership has completed a survey to identify integrative training programs and gather pertinent data about each. The list, now covering over 60 programs is available on the SEPI website at the following address: www.sepiweb.org

Society for the Exploration
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“One key difference between my individual therapy and couples work quickly became evident: With couples, I would have to be far more active in structuring the process.”



“...abnormal behavior was often an emergent property of groups, including the two-person group of the couple.”

From Couple Therapy 1.0 to an Integrated Model: My Personal Journey

Arthur Nielsen

The Family Institute at Northwestern University



I began doing couple therapy as a psychiatric resident at Yale in 1975. Of course, I didn't know what I was doing, but I was excited to be given the chance to try. As a child, I had been the confidante of both of my parents, who complained to me about problems with each other (problems similar to the ones I also had with each of them), but I had no license, let alone training, to be of much help. Those experiences, however, powered some of the journey that followed.

What made sense to me from the beginning was the idea of helping couples to talk directly to each other (unlike my parents who were conflict avoiders par excellence) while I observed them and tried to help them do better. This here-and-now model of diagnosis and treatment fit with experiences I had had with piano and tennis lessons, where it wasn't enough to tell the teacher what was going on, you had to show him or her, after which he or she would suggest that I try something new. This model of therapy also fit with the psychoanalytic model I was learning

that placed attention on transference-countertransference interactions and posited that for change to occur, patients would need to have new and “corrective” emotional experiences in the consulting room.

One key difference between my individual therapy and couples work quickly became evident: With couples, I would have to be far more active in structuring the process. As all beginning couple therapists discover, if they are to remain sane and prove helpful, I learned how to decrease the emotional room temperature (mostly by stepping between the partners and having them talk to me instead of each other, or by listening while I spoke empathically to them). I also learned how to increase the emotional room temperature, often by literally telling couples to make eye contact and address each other directly.

This “talk to each other model”—which I now call Couple Therapy 1.0—became and has continued to be the foundation for my work with couples. While useful as a foundation, for most couples it proved insufficient. To obtain better results, I would need additional interventions, what I now call “upgrades” to the basic model.

The first important set of upgrades drew on depth psychology and psychoanalysis. During my residency and later in my formal psychoanalytic training at The Chicago Institute, it became clear that many couples could be helped to talk more safely and intimately if we could uncover their deeper, hidden concerns and fears. We could then recast their defensiveness as self-protective and their troubles with assertiveness or responsiveness as based in negative transference expectations about their partners. Uncovering the historical origins of “transference allergies” and “core negative images” became central to my work. It was now possible to explain recurring fights over seemingly trivial matters as stemming from past sensitivities and unmet current needs. This was a huge advance over simply monitoring or refereeing a couple encounter.

During my residency and later after I moved to Chicago, I participated in many Tavistock Group Relations Conferences. These experiential events were essentially psychoanalytic explorations of group behavior. Above all, the conferences taught me the value of a systemic understanding of what might otherwise have been labeled individual psychopathology. Under the stress of these intense group events, highly intelligent, well-meaning professionals and students routinely “went crazy,” becoming extremely defensive and even paranoid and losing the capacity for rational thought and collaboration. The conferences, originated by Kleinian psychoanalysts, also taught me the conceptual value of projective identification as a bridge between individual psychology and group dynamics. Additional training at The Philadelphia Child Guidance Clinic with Salvador Minuchin and later work at The Family Institute at Northwestern reinforced my conviction that abnormal behavior was often an emergent property of groups, including the two-person group of the couple. This turned out to be of equal importance with my psychoanalytic upgrades. As I started describing to cou-

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ples how they got caught in negative cycles (“The more you do this, the more she does that, the more you do this, etc.”) and making this process our shared enemy, I saw that couples settled down and became a collaborative “work group” more capable of problem solving practical disagreements over sex, money, and kids.

The final mother lode of upgrades came from the opportunity to develop and teach Marriage 101: Building Loving and Lasting Relationships, a for-credit course for Northwestern undergraduates. The idea was to provide both academic and experiential learning to students well before they fell into the characteristic patterns seen in clinical couples. While Bill Pinsof (a Family Institute colleague) and I were developing the course, I was introduced to the extensive work of behavioral couple therapists (including the PREP group in Denver) and to John Gottman’s research on marital process. I began trying out new educational interventions with my clients (and at home!) and found that they had much to offer. Later, I also studied the work of The Harvard Negotiation Project (well-known from Fisher, Ury, and Patton’s book, Getting to Yes). Over time, I refined my own synthesis for teaching speaking and listening rules, problem-solving strategies, and emotion regulation.

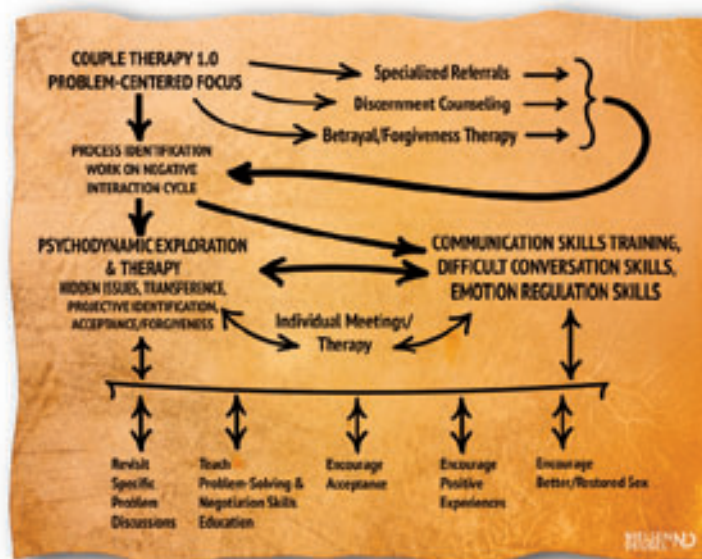
As someone who had grown up with conflict avoiders and learned the benefits of talk as a therapist, I was slow to appreciate the value of time-outs, something I now teach without delay to highly volatile couples. I also discovered that there was more to couple therapy than helping couples to fight fair: Additional upgrades derived from the behavioral literature included helping clients to accept unchangeable aspects of their relationships and to engage in positive activities that they had let slip due to marital conflict and extra-marital stresses.

After learning these new tools, I still wasn’t sure about how best to make them work together and in what order. The sequencing map I eventually came up with is shown in the accompanying figure. I elaborate on this integrative roadmap, together with the various component interventions and upgrades, in my recent book, A Roadmap for Couple Therapy: Integrating Systemic, Psychodynamic, and Behavioral Interventions.

How does it feel “in the trenches,” doing this sort of integrative couple therapy?

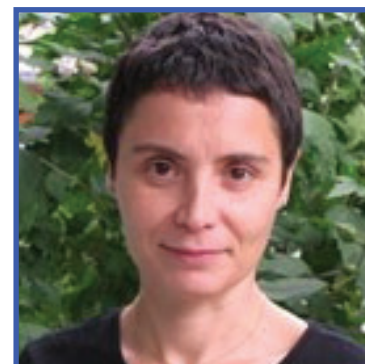
- It feels better now than it did when I had fewer tools in my toolbox. Having more options gives me more things to try when one approach fails.
- Having a map—an internal decision tree—feels essential; otherwise having more tools can lead either to brain freeze or to a retreat to unwarranted simplification.
- Despite the additional tools and a map for sequencing them, balancing educational and exploratory modes of working remains a challenge. When I am in teaching mode, I am trying to be systematic and convincing. When I am allowing space for depth psychological exploration and healing experiences, I experience more of the free-floating curiosity and openness that are the hallmarks of the listening psychoanalyst. Both are useful, but they are somewhat antithetical states of mind.
- Finally, as I enter my fifth decade of this work, couple therapy remains energizing, demanding, and rewarding. When things go well, marriages can be saved, relationships can be strengthened, and lives can be renewed and revitalized, so that it continues to be a privilege to be part of that process.

“The sequencing map I eventually came up with is shown in the accompanying figure.”



What Does it Mean to Be an Integrative Psychotherapist?

Gili W. Adler Nevo
Assistant Professor of Psychiatry
University of Toronto



I was nineteen the first time I realized that people in leadership positions don't advocate for what they objectively believe is best for all, but rather for a more modest goal, the one that would promote the current role they are occupying, the current "flag" under which they are acting. I was a young officer in the Israeli air force and participated in a meeting with "top brass;" all excited and wide-eyed, I observed admiringly people who were way out of my league. One of the colonels was advocating for a certain point, which seemed convincing and crucially important, when another reminded him that he was advocating for the exact opposite just the year before. "Well..." said the first, "I was wearing a different hat last year..." Luckily, I don't remember much from that meeting, no top secret information to disclose, but I do remember the shock of realization—"he can't do what's best for all of us, he just has to show success in his very specific role, and even if I'm in the same army, I have to fight him for my own department's resources."

I was a resident in psychiatry, studying psychodynamic psychotherapy, wanting to take it all in, elated by the writings of Freud, Jung and Adler. Their writings seemed to complement each other, but why were the actual men in disagreement? In a similar vein, I was saddened by the controversy between Anna Freud and Melanie Klein and couldn't help but see how Aaron Beck's CBT was wonderfully complementary to psychoanalysis. Could we have had a more comprehensive, rich and united theory and practice of psychotherapy had it not been for our human weakness of having to advocate for the one position we're occupying instead of what we believe is universally true?

I was a young researcher (yes, still young), eager at the prospect of quenching my curiosity and answering questions I was grappling with through research. I was interested in common factors, but my mentor, a successful, intelligent and kind man, recommended "carrying a flag." "You won't have a decent effect size by comparing similar therapies and you have to differentiate your work from others," he said. I didn't see the need for another "flag." Don't we have enough flags already?

Enter SEPI. Because no one theory has all the answers, because some theories have different nomenclature for similar constructs while others are tailored for a specific patient population, because we need a culture of therapy to raise us professionally and teach us how to BE therapists, I feel most at home under SEPI's integration "flag." But integration is one of those things that are "easier said than done." Theory is one thing, and practice so much harder. No wonder most of us choose a flag to follow rather than work at the seams.

I found constructs and definitions affiliated with integration therapy helpful in accomplishing the task; I educated myself regarding common and specific factors and different methods of integration such as assimilative integration, theoretical integration and technical eclecticism; I found publications and research by Paul Wachtel, Robert Norcross, Louis Castonguay and others helpful, validating, and invaluable in forging my own path towards integration. I would say my own integration scheme could be defined as theoretical integration. I believe the process of therapy is crucial; knowing how to provide a stable therapeutic structure, how to be warm, empathetic and authentic, yet provide minimal self-disclosure, and knowing how to move on the supportive-expressive continuum following intuitive understanding of patient needs are, in my opinion, the bases for all psychotherapies. On the other hand, the specific patient population I work with consists primarily of anxiety disordered children and teens, for which I do believe Cognitive Behavioral Therapy (CBT) is the treatment of choice. My "smushing" of theories, therefore, consists of a "psychodynamic" process and CBT content. Although time-limited, we don't limit ourselves to 10, 12 or 16 sessions in advance, but rather decide collaboratively on the length of therapy after a few sessions of working together. Yes, we use thought records, but as a tool when our open conversation reaches an "expressive" point that we'd like to understand in further depth. I view elucidating basic assumptions and core beliefs as interpretations and understand how difficult it may be

Continued on page 17

"...I do remember the shock of realization—he can't do what's best for all of us, he just has to show success in his very specific role..."



"I was interested in common factors, but my mentor, a successful, intelligent and kind man, recommended 'carrying a flag.'"



"My 'smushing' of theories, therefore, consists of a 'psychodynamic' process and CBT content."

for my patient to acknowledge them and have insight into them and so pay attention to the supportive-expressive continuum in the process. Exposures are crucial for overcoming anxiety and are integrated seamlessly into therapy after the patient and I have a good understanding of the basic assumptions and core beliefs, how they may generate anxiety and how exposures could be beneficial in alleviating that anxiety. The result is a powerful process, which does not feel technical and still promotes behavioral change as quickly as it can occur in each individual patient.

So, here I am (not quite so young), and trying my best to carry a flag, the integration flag, which I believe is the closest I can get to the utopic notion of not carrying a flag at all and best serves my patients. I'd like to thank SEPI for the opportunity to share my thoughts and experience vis-à-vis integration and am eager to read about other paths of integration and receive feedback regarding my own. 🐦

“Taken together, the stories told represent, in a very real form, the state of integrative psychotherapy in North America and Europe.”



“We have taken note of common factors that work for everyone, but still lack an agreed-upon framework to organize our knowledge.”



“It is time to line up with the rest of biology and view the mind-brain as an organ of behavior control evolved for survival under the influence of natural selection.”

A Word from the Editor, *continued from page 1*

cacy Committee outlines one of the goals as influencing the development of official treatment guidelines. That is exactly what we, as an organization, should be doing, but we will have to be more focused and work harder to make SEPI's voice loud enough and clear enough to be heard.

The prevailing system today has not changed from Greece and the Middle Ages. In those pre-paradigmatic times when there was no scientifically supported consensus about how the world worked, great innovators established their schools and gathered disciples to do battle against rivals, much like the city-states of past millennia. We have come a little way. SEPI has championed the idea that it is not really disloyal for a soldier to consort with rival camps and even adopt some of their ideas in what we call assimilative integration. On the other hand, the accounts in this issue tell of anxiety and confusion as each of us has had to chart a personal path through a minefield of cognitive dissonance, largely without guidance. We have taken note of common factors that work for everyone, but still lack an agreed-upon framework to organize our knowledge. Many of our authors tell valiantly, and with some nostalgia, about the formative effects of making such a brave journey, but does it have to be that hard? Are we really so far from the rest of biological science, which has converged on a common understanding of life as the result of natural selection?

In the September, 2016 issue of our own journal, Vieira and Vandenberghe report their finding that the obstacles to integration in Brazil are more economic and political than intellectual. I suspect this is true everywhere. The fear of change is keeping us tied to endless exploration and afraid of losing our individuality. Gili Adler Nevo, in this issue, tells of an influential mentor who argued against integration, saying that she should “carry a flag.” Let's not be afraid of losing our identities or flags. Unless we exit from the “comfort zone” of our schools and flags, unless we pool our collective wisdom, we will be eclipsed by others, more ready to take such a leap.

It is time to line up with the rest of biology and view the mind-brain as an organ of behavior control evolved for survival under the influence of natural selection. Our psychological theories are too consciousness-centric because they developed at a time when conscious experience was all we had to work with. We now know that 90% of the information processing that leads to conscious experience takes place outside of consciousness. It is time to dare to take anew look into the machine and hypothesize how it works. We now know that pathology is held as information in neural networks. We know how synapses hold the key to changing maladaptive information. We understand how central emotion is to our motivation and how approach and avoidance are the organizing principles of behavior. We know that we are social beings and that modulation of emotion starts out with an empathically attuned adult giving perspective to an upset child. Isn't it time to allow those pieces to converge into a framework to guide our understanding, our teaching, our research, and our clinical decision making?

Call to Action:

In anticipation of our Denver conference, let's move from common factors to common understanding. Let's ask why our mind-brain produces automatic thoughts and what really shapes them. Let's ask why PTSD patients avoid re-experiencing the emotions of their trauma. Let's ask how conflict between superego and id generate defensive behaviors. Let's ask what it is about the therapeutic relationship that changes emotions and information. Let's ask why self-judgment is so hard to change. Let's ask why mindfulness is calming. As we ask these questions, it is time to turn towards new knowledge of our social biology for answers that were not apparent before. The answers are not that far away. It is my belief that we are at a tipping point for building, adopting and then disseminating a new, convergent basis for clinical decision making in 2017.

Happy New Year! And please enjoy this rich collection of personal accounts.

Jeffery Smith 🐦

The Actions of the Practice Advocacy Committee: Making it Pragmatic!

Giancarlo Dimaggio

Centro di Terapia Metacognitiva Interpersonale, Rome, Italy



A committee named “Practice Advocacy” needs to be pragmatic. In an historical moment when the dominant spirit is orientation vs. orientation, when efficacy is almost only analyzed by pitting therapies against each other in randomized clinical trials, and competition for market share is the major driving force, the mission of SEPI becomes more and more important.

Therapists need to learn about generic principles of change, to consider aspects of the therapy process that are not included in the manual they have been trained in. The hope is to see CBT therapists able to address problematic patterns of relationship when they are dealing with a client with severe Generalized Anxiety Disorder and, in parallel, to see psychodynamic therapist asking their clients with the same disorder to deal with avoidance at a behavioral level and not just addressing interpersonal patterns. The hope is to see clinicians from different orientations adopt aspects of the technique coming from a long-standing humanistic tradition such as two-chair work, role-play or guided imagery.

So the main goal of the committee is making the actions of the integrative therapists visible and spreading a culture portraying clinicians informed by knowledge on general principles of change. I imagine a therapist that is willing to use techniques for reducing symptoms, minding the therapeutic relationship and addressing longstanding relational patterns, and not leaning to narrowing his or her scope on just one among these targets.

The actions of the committee in these first few months are moving along the line of making this line of reflection and practice visible. Currently the members of the committee and myself are following three main avenues in order to accomplish this.

The first leads to SEPI conferences. In cooperation with expert and open-minded clinicians, such as Rhonda Goldman and Marvin Goldfried, I created a space during the last conference in Dublin, in the form of “Practice Consultations”. The three of us performed live psychotherapy sessions with volunteers attending the conference. Conference participants first observed the session and then offered feedback about the therapy process depicted in it. Different orientations were represented and the discussions happened in a very cooperative spirit. Volunteers were satisfied, which likely means that the clinicians’ actions were informed by effective principles, and were not affected by the abundance of beers that Dublin offered. I do not see a better way to promote a practice than by making it observable—it is about moving back to the artisan’s workshop. The apprentices learn to create by observing the expert molding an object, and then using their own hands to replicate it, in their own ways. Integrative therapists are usually persons with longstanding clinical practice and multiple trainings in their history. Observing their actions live during a conference is a unique way to learn, to offer one’s own reactions, and to understand how a comprehensive therapeutic style can be enacted.

Actually, the participants’ feedback seemed very positive and people wanted for more. The idea is to make this format more present in future conferences, making it a part of the conference program. This means that some of the conference slots usually devoted to symposia might be covered by 45-minute sessions with the clinician organizing the event, and a volunteer, followed by a 45-minute discussion, where the participants comment on the session, each from their own unique perspective. This way, the therapy debate would not happen at the level of theory only, but in the context of discussing the therapy process in real time.

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“...when efficacy is almost only analyzed by pitting therapies against each other in randomized clinical trials, and competition for market share is the major driving force, the mission of SEPI becomes more and more important.”



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“I do not see a better way to promote a practice than by making it observable—it is about moving back to the artisan’s workshop.”



“The third action is speaking for integrative therapy where official guidelines or training protocols are recommended.”



“...in 1999 I started practicing psychotherapy from an integrative perspective from the very get-go, with no mother affiliation”

The second action initiated by the Practice Advocacy Committee is creating a web-forum, a Questions & Answers room where SEPI participants can submit a) questions about theory/practice e.g., is therapy alliance relevant in the treatment of Obsessive-Compulsive Disorder?; 2) requests for suggestions: e.g., I have a client with BPD. What kind of therapy should I deliver?; 3) requests for consultation: e.g., I have some difficulties with this client suffering from generalized anxiety disorder and paranoid personality disorder who is not trusting me and therefore is not willing to do homework for reducing anxiety. How could I address this problem?

This project is under construction and it will likely begin early in 2017, hosted by the SEPI Facebook page.

The third action is speaking for integrative therapy where official guidelines or training protocols are recommended. One example is the recent announcement of guidelines for treatment for adults with PTSD from the American Psychiatric Association. In the last draft posted on the APA website, these guidelines strongly recommended offering cognitive behavioral therapy (CBT), cognitive processing therapy (CPT), cognitive therapy (CT), and exposure therapy (EXP). The guidelines then suggested that brief eclectic psychotherapy (BEP), eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy (NET) could be offered, though the latter are not recommended as strongly as the formerly described protocols. These recommendations appeared biased, almost neglecting approaches that we know deliver effective interventions, such as interpersonal therapy, psychodynamic therapy, or mindfulness. Also, guidelines only recommended treatments including exposure as an ingredient. This does not take into account that, while on the one hand, exposure accelerates outcomes and often is the main road to overcoming post-traumatic symptoms, on the other hand it can be very distressful to many clients and cause drop-out. Moreover, it has been recently questioned whether exposure without rescripting really is a tolerable intervention for many with PTSD and this caveat was not carefully considered in the guidelines. Another observation we are raising is that interventions where exposure is not a mandatory ingredient should be considered as well as treatments working more at the level of underlying interpersonal patterns and taking into account ruptures and repair in the therapy alliance. Finally, what the guidelines did not underscore is that a significant proportion of clients enrolled in the trials for PTSD concluded treatment in a significant state of suffering and many did not respond to treatment at all. My idea is that this is because adherence to any specific protocol did not give the clinician the chance to tailor the treatment to the unique needs of the client, thus precluding the opportunity for many non-responders to overcome their specific problems.

Eventually, I will deal with this problem in the position of guest-editor of a special issue of the Journal of Psychotherapy Integration about treatments for PTSD. There many experts from different orientations will describe their principles of change so the reader can have a bird’s-eye view on how a clinician can approach these symptoms from different angles and, at the end of the day, deliver a tailored treatment approach for the suffering individual.

All these projects will see the light in early 2017 and 2018 (the special issue on PTSD). We are eager to see if they will be successfully implemented, in particular the Facebook Q&A page and the “Practice Consultations” with live sessions in the next conference, and the actual impact they will have. Our hope is the further dissemination of integrative practice. 🐦

President’s Column, *continued from page 1*

ticing psychotherapy from an integrative perspective from the very get-go, with no mother affiliation. At the time, most would say one had better have a school or an approach to first attach to, and only then to start integrating in an assimilative way, but I took a different route—an inspiring Portuguese painter, Amadeo de Souza Cardoso, who died quite young, once said “I do not follow any school. Schools are dead. Am I a cubist, a modernist, an abstractionist? A bit of everything.”

Later I became a professor of Clinical Psychology and Psychotherapy at Faculty of Psychology at University of Lisbon, and now have the responsibility and the fun of trying to teach, supervise and research on whatever is relevant to psychotherapy integration from the get-go, an activity not without risks. Recently, at faculty, in an event about a clinical case discussed from the four clinical perspectives taught there—psychodynamic clinical psychology, systemic clinical psychology, health and illness clinical psychology, and cognitive-behavioral and integrative psychotherapy—a colleague of mine was somewhat shocked when I naturally expressed that to our students we were not teaching them a specific model or approach. But most of the fun in supervision sessions is jumping from one inspiration to another according to different markers.

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Forming an Integrative Training Program

*Jan Roubal, Assistant Professor
Masaryk University, Brno, Czech Republic*

*Jana Kostínková, Assistant Professor
Masaryk University, Brno, Czech Republic*

“This text presents a short summary of a study focused on the process of developing a design of the Training in Psychotherapy Integration in the Czech Republic...”



“All the trainers have been trained in several single oriented approaches and arrived at an integrative approach through their professional development.”

Psychotherapy training is an inherently complex process, even in uni-modal form, and once psychotherapy integration is factored in, specific questions arise regarding the content of the training and the method of integration instruction. This text presents a short summary of a study focused on the process of developing a design of the Training in Psychotherapy Integration in the Czech Republic (TPI) and describes the specifics of the process. Findings could be understood as moments deserving attention during the formation of integrative training in general, as they play an important part in the process and can even facilitate it .

A Case Study of Training in Psychotherapy Integration

The team's members all have backgrounds in various therapeutic approaches and each trainer has received education in more than one. As a whole, the team's educational background covers the following approaches: psychoanalysis and psychoanalytic psychotherapy, psychodynamic psychotherapy, Gestalt therapy, Pessó-Boyden system psychomotor therapy, person-centered approach, systemic/family therapy, logotherapy and existential analysis, sati therapy (a mindfulness-based integrative psychotherapy), art therapy, and trans-personal therapy. The trainers have been providing therapy for 10 to 20 years and have worked as clinical psychologists, psychiatrists, and social pedagogues. A research question was stated in the process of the case study's creation: "How was the concept of this integrative training formed?". This question focuses on the process of training formation, which has been captured in the data from the 3 years spent developing the training concept of the TPI. The study was carried out using the action research method, where the research participants are considered partners in the development of the research, contrary to the idea of research being done on them. The data used in this case study come from several sources (e-mails, team meetings and focus groups, official materials).

Trainers individual path to integration

Even before the work on conceptualizing a training program, we can identify a factor that essentially foreshadows the dynamics of the whole process: the individual path to integration of each trainer before the process has started. All the trainers have been trained in several single oriented approaches and arrived at an integrative approach through their professional development. Their personal professional development was influenced by their belief that it is possible to bolster and speed up their journey toward integration by partaking in integration training from the beginning of their development. As the work on the training concept progressed, changes in each trainer's individual approach to integration began to occur. A continuous deep reflection of one's own therapeutic work, and the view of the original approach in which the trainer was trained both contributed to a precise identification of the essence of each trainer's therapeutic work. Understanding this essence is crucial, as it allows trainers to also identify approaches they would like to pass on to their trainees. For some trainers working on creating the training presented the possibility of stepping beyond the narrow field of the original approach. They understood the work on the training concept as a validation of their own approach to clinical work that was beyond the borders of their original approach.



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“It seems that this dialogical approach in the search for common bases fosters an increased trust among colleagues and strengthens the overall idea of integrative training.”



“These doubts prompted trainers to question the plausibility of a common concept of integration.”



“Theoretically, the training is grounded in the common factors approach to psychotherapy integration, with an emphasis on the principles of therapeutic change and the crucial role of the therapeutic relationship.”

Looking for a common ground

Trainers prefer to work with colleagues who were trained in a different approach, but are open to searching for a common language in the context of the training concept. It can enrich one's own practice, although it can also bring a certain amount of anxiety by upsetting routine therapeutic methods. The debates on theoretical psychotherapeutic principles and integration provide trainers with intellectual excitement, which strengthens their commitment to the project. To work on the concept of integrative training means to confront one's own professional identity, the bulk of one's knowledge (both theoretical and practical), and one's own attitude to therapy in general. The teamwork on the project also brought about some interpersonal dynamics among the trainers and a new degree of integrative maturity came to light. This is visible especially in the fact that some trainers are “ahead” in thinking about integration, while others' views are still settling. This seems like an advantageous moment for the training concept formation, as it requires explaining on one side and understanding on the other, and therefore calls for a high degree of openness among the trainers.

When working on the common concept of training it is important for trainers to map common therapeutic bases. The mapping involved the following areas: the aim of the therapy, the attitude toward psychotherapy and psychopathology, the understanding of the therapeutic relationship, and general clinical procedures. Finding a common, ideally atheoretical, psychotherapeutic language seems pragmatic to trainers' communication both among themselves and with future trainees. To arrive at such a language, each trainer introduced one of their case samples using their own theoretical conceptualization, giving the others a chance to have a dialogue with him/her. Then together they examined what they had in common and where their approaches departed from each other, both linguistically and fundamentally. It seems that this dialogical approach in the search for common bases fosters an increased trust among colleagues and strengthens the overall idea of integrative training.

What follows after mapping common bases is identifying a common approach to integration. Once such an approach is determined, the philosophy of training, its content, and the method of teaching integration can all be derived from it. A shared approach to integration is the basis of the training concept and at the same time functions as a stabilizer of the whole process; it is an idea to which one can return should the team get lost or stuck in the preparation of the concept. Identifying the umbrella idea of the training concept is related to the identity of the integrative training. The trainers defined their standpoint by formulating the basis of their integrative approach to the psychotherapeutic training, which teaches the trainees to consciously create their own integrative perspective.

Challenges on the way

While developing the concept for TPI, several factors were observed that either stabilized and facilitated the process or slowed it down. These could be, for example, anxiety, doubts about integrative training, or a question on the therapeutic identity of trainees. This was related, for instance, to their own knowledge and grasp of theory or to the difficulty of determining the integrative approach in psychotherapy that, had no handbook on instructional procedures. These doubts prompted trainers to question the plausibility of a common concept of integration. They described their path to integration as a journey guided by natural development owing to their experience with clients and as such started to question whether it was at all possible to skip or even merely speed up a trainee's natural development in order to reach this position.

To counteract doubts and anxiety, various stabilizing elements were employed, such as working with metaphors, the accreditation process, placing emphasis on dialogue, humility and openness, bracketing, or defining graduates' competency profiles. Metaphors can be a useful tool if the process begins to somehow falter – generally at moments when trainers are not able to find a common language or the concept does not hold together. One trainer used one such metaphor to help clarify the concept of integration: “They'll learn to walk, but it is up to them where they go. We'll teach them the basic skills of walking, but we don't want to give them the direction: you have to go there, this is the right way.”

How does the training finally look

Within our training psychotherapy integration is conceived as a process of long-life practice based learning, which uses resources and creativity of each individual psychotherapist. This shall lead to a therapy that is tailored to a particular therapeutic situation. Theoretically, the training is grounded in the common factors approach to psychotherapy integration, with an emphasis on the principles of therapeutic change and the crucial role of the therapeutic relationship. On an elementary level, trainees learn basic helping skills and, on an advanced level, they develop case formulation skills.

The training is provided by a private training institute, it takes five years and concludes with a final exam based on a case presentation. The training structure consists of 4 components: (1) personal therapy (300 hours of group experi-

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“...it might be the time for psychotherapy integration to take the simple unit of a decision as the focus of our judicious attention and integrating efforts...”



“Sound decision making implies an inner ... dialogue of automatic, effortless, quick, impulsive, and intuitive processes together with effortful, deliberative, orderly, rule-following...”

ence and 50 hours of individual experience), (2) theoretical lectures and skills training (500 hours), (3) supervision (150 hours) and (4) supervised practice (400 hours). TPI was accredited for the healthcare service professions in the Czech Republic and also by the European Association for Integrative Psychotherapy. The training was established in 2010 and a third group of 26 trainees has started in 2015.

TPI is a training focused on the development of trainees' individual integrative perspectives in psychotherapy and their own therapeutic approach. Trainees' professional development is viewed as the development of a personalized way of conducting psychotherapy which includes conceptual, technical, and relational aspects, as well as therapists' values and self-relatedness. In the interaction of psychotherapeutic theories and their own worldview and experiences, trainees develop their own personal understanding of the therapeutic process. They are encouraged to acknowledge their strengths and reflect their limitations and they are supported to practice their own, personalized way of practicing psychotherapy, which is congruent with their personal beliefs, skills, and preferences. 🐦



President's Column, *continued from page 19*

Despite the beautiful age of our organization, what is Psychotherapy Integration after all? It might not be a question that needs to cease to exist, yet answers must go on appearing. And decision making as a transtheoretical construct might be a nice meeting point for us from different approaches or models. We all want clinicians who have the knowledge, skills, and attitudes that enable them to make and carry out good clinical decisions. But despite the centrality of this concept, we are generally less likely to deliberately frame our work and teach our craft in terms of clinical decision making. In the last 30 years, our knowledge of decision making has advanced considerably and it might be the time for psychotherapy integration to take the simple unit of a decision as the focus of our judicious attention and integrating efforts - as simple as it can get.

So let me take the opportunity to invite you to our next conference that is now being prepared. The SEPI XXXIII ANNUAL MEETING will be held in Denver, Colorado, USA, on May 18-21, 2017 and we hope it to be a landmark event for psychotherapy integration. The topic of this meeting is: Clinical Decisions at Work: Navigating the Psychotherapy Integration Maze. By the time I write this, submissions are still being accepted, but by the time you read this, the program will be in its cooking phase. Forgive those of us for whom Denver is too far away to make it possible to attend. Yet, surrounded by lots of green and mountains—you can always consider making a bundle packet of SEPI+Holidays—we will try to design this meeting as a memorable moment and place to cheerfully enhance our decision-making skills and knowledge, advance the practice of integration, and allow us to adapt and thrive in the contemporary world.

Sound decision making implies an inner (and an outer two-chair) dialogue of automatic, effortless, quick, impulsive, and intuitive processes together with effortful, deliberative, orderly, rule-following, and slow processes, to maximize outcome. And by outcome I am not exclusively focusing on the client, as we can have as a slice of outcome a feeling of joy, vitality, enthusiasm or even love for the decisions or the work we do with our patients.

Thank you for deciding to read me, and I hope you will decide to come to Denver. Meanwhile, in your practice, notice if you are deciding to monitor your inferences, using counter-biasing tools, acknowledging your limits, guarding against overconfidence, obtaining feedback and processing it, not making yourself too comfortable in exercising your clinical judgment, not ignoring alternative hypotheses, searching for high quality information, searching for high quality empirical evidence, adopting a disconfirming, scientific approach to your practice. Just notice!

See you next issue! 🐦



“...one of SEPI’s most esteemed members, Héctor Fernández-Álvarez, has received the Award for Distinguished Contributions to the International Advancement of Psychology.”



“The field of psychotherapy is characterized by many challenges which integration may change into meaningful opportunities..”

Award Announcement: Hector Fernandez-Alvarez

By Marvin Goldfried

We are very proud to announce that the current issue of the American Psychologist has announced that one of SEPI’s most esteemed members, Héctor Fernández-Álvarez, has received the Award for Distinguished Contributions to the International Advancement of Psychology. In this same issue, Hector has co-authored an article on psychotherapy integration together with two other long-term SEPI members: Andrés J. Consoli and Beatriz Gómez (Betty is also SEPI’s current President). Here is some information on Héctor’s award and the article:



American Psychologist © 2016 American Psychological Association 2016, Vol. 71, No. 8, 816 – 819

2016 Award for Distinguished Contributions to the International Advancement of Psychology: Héctor Fernández-Álvarez
The Award for Distinguished Contributions to the International Advancement of Psychology is given to individuals who have made sustained and enduring contributions to international cooperation and the advancement of knowledge in psychology. The 2016 award winner is Héctor Fernández-Álvarez, who “has woven a sophisticated network of international cooperation in psychotherapy research, training, and service provision throughout Latin America, Europe, and the United States.” He was selected for his outstanding, innovative contributions to psychotherapy integration, clinical supervision, and the personal style of the therapist. Dr. Fernández-Álvarez’s award citation, biography, and a selected bibliography are presented in the article cited above.

The following is the Abstract of the article appearing in the American psychologist on psychotherapy integration that is based on Héctor’s invited presentation at the 124th Annual Convention of the American Psychological Association, held August 4–7, 2016, in Denver, Colorado. Correspondence concerning this article should be addressed to Héctor Fernández-Álvarez, Fundación Aiglé, Virrey Olaguer y Feliú 2679, C1426EBE, Buenos Aires, Argentina. E-mail: hfa@aigle.org.ar

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Integration in Psychotherapy: Reasons and Challenges

Héctor Fernández-Álvarez Fundación Aiglé, Buenos Aires, Argentina

Andrés J. Consoli University of California, Santa Barbara &

Beatriz Gómez Fundación Aiglé, Buenos Aires, Argentina

Abstract

Although integration has been formally influencing the field of psychotherapy since the 1930s, its impact gained significant momentum during the 1980s. Practical, theoretical, and scientific reasons help to explain the growing influence of integration in psychotherapy. The field of psychotherapy is characterized by many challenges which integration may change into meaningful opportunities. Nonetheless, many obstacles remain when seeking to advance integration. To appreciate the strength of integration in psychotherapy we describe an integrative, comprehensive approach to service delivery, research, and training. We then discuss the role of integration in the future of psychotherapy 🌿



Society for the Exploration
SEPI
of Psychotherapy Integration

SEPI XXXIII ANNUAL MEETING

Denver, Colorado, USA • May 19 - 21, 2017

Clinical Decisions at Work

Navigating the Psychotherapy Integration Maze

with pre-conference workshops on Thursday, May 18th



The Society for the Exploration of Psychotherapy Integration (SEPI) invites you to attend the 33rd Annual Conference to be held in Denver, Colorado USA May 19-21, 2017 (with preconference workshops on May 18th). The conference site will be the Sheraton Denver Downtown. Please view the Sheraton's website at: <https://www.starwoodmeeting.com/Book/sepi2017> for more information about the hotel, downtown Denver, or to make room reservations.

SEPI is an international, interdisciplinary organization of practitioners and scholars exploring the limitations of a single-school perspective and promoting alternative ways of meeting the needs of our clients. SEPI also advances the integration of practice and research.

CONFERENCE REGISTRATION FEES ARE:

Registration Fee (by April 1, 2017)

- SEPI Members - \$275**
- Non-Members - \$335**
- Student Member - \$80**
- Student non-Member - \$120**

Registration Fee (after April 1, 2017)

- SEPI Members - \$315**
- Non-Members - \$375**
- Student Member - \$120**
- Student non-Member - \$160**

Conference registration will be open soon! Please visit our website to register for the conference: <http://www.sepiweb.org/>

Sincerely,



Nuno Conceicao
Program Chair



Lavita Nadkarni
Local Organizing
Committee Co-Chair



Lynett Henderson Metzger
Local Organizing
Committee Co-Chair

