THE Integrative Therapist

ARTICLES • INTERVIEWS • COMMENTARIES

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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.

Jeffery Smith
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In This Issue

A Word From the Editor

Jeffery Smith

Dear SEPI members and friends,

As **Antonio Pascual-Leone** says in our interview in this issue, "Change is hard." Resistance, the theme of this issue, is perhaps a fitting topic for our winter issue, but it is also an important and under-recognized common factor in therapy that cuts across all theories and traditions. It is the source of every clinician's most difficult cases and, as **Henny Westra** shows in her contribution, a rich area for researchers. No less important, **Beatriz Gomez** indicates how it is an issue for training and supervision.

There are three sources of potential confusion regarding resistance. First, its connotation. **Rhonda Goldman** shows how to avoid the negative and give it a humanistic touch This is why we almost never use the word with patients. Rather, we mean it as a technical term for the phenomenon of resistance to positive psychological change.

The second is that resistance implies a single force, but as **Leahy, Pascual-Leone** and others point out, there are many kinds of resistance. This is true, but what gives some legitimacy to the use of a unitary concept is that the emotional brain is organized in binary fashion to move us towards or away from potential experiences. The dysfunctional patterns that we seek to change in psychotherapy are held in place by emotional forces evolved to avoid all manner of anticipated negative emotions associated with change.

President's Column

John C. Norcross

Inevitable but Ignored Integration: Towards Advocacy

Dear SEPI colleagues:

Not a week flies by when my email fails to report on the "startling" results of a research study demonstrating the limitations of unitheoretical monotherapies. Some patients prosper more by learning to calmly accept their troubles instead of relentlessly trying to control or change them. Severely mentally ill patients benefit more from lower doses of psychoactive medications plus community programs compared to higher doses of medications alone. Clients receiving therapies congruent with their treatment preferences experience superior outcomes and lower dropout rates than those clients getting a single monotherapy.

A Swedish National Audit Office report recently concluded, "Steering towards specific treatment methods has been ineffective in achieving the objective" (of improved mental health). When all you have is a single theory or treatment, patients suffer.

Of course, none of this is surprising to psychotherapy integrationists or, for that matter, to seasoned practitioners. Integration of some fashion is clinically and empirically inevitable. Developmental theories of both individual clinicians and psychotherapy systems postulate a higher form of synthesis: differentiated parts are organized and integrated into the whole, in which the unity *and* complexity of psychotherapy are appreciated.

Antonio Pascual-Leone, PhD is director of the Psychological Services and Research Centre at the University of Windsor, Ontario, Canada, where he directs the Emotion Change Lab.

"...resistances are actually assets, ways of managing anxiety, occurring automatically and not necessarily a problem."

Featured Interview

Antonio Pascual-Leone On Resistance

Pascual-Leone's Background and interests:
Smith: What is the core of your interest and where you see yourself headed?

Pascual-Leone: Before Psychology, I began by studying theater and acting, where I was bewildered by how actors generated their internal emotional experience. My father was also a doctoral student of Piaget, so that probably influenced my switch to study psychology. I did a Masters in France in developmental psychology but then focused in on clinical work. During my PhD, with Les Greenberg, I studied emotion focused therapy. So, since the beginning, I have kept a curiosity about emotion and how people generate emotion to create change.

In therapy, people can have emotional experiences that are unproductive and leave them with nothing to show for it. On other occasions they get angry and sad and come out of it with a new perspective, or new insight, or a clearer sense of what the real issue is, and what to do about it. I'm interested in the specific criteria that show the difference between these two scenarios and how to make more of the productive kind happen in therapy.

Use and misuse of the term, Resistance
Smith: Resistance is especially relevant to clinicians and cuts across therapeutic modalities and cultures. How do you feel about the term resistance as technical term defined as the patient's tendency to avoid positive change?

Pascual-Leone: Change is difficult. Anything hard involves resistance–that's what makes it hard. Freud and Davanloo use the term resistance in a slightly adversarial context, "breaking down resistance," and pit the therapist against the client's resistance. Too often, the client is simply frustrating the therapist's intended intervention–either what the therapist thinks *should* happen, or what the therapist is trying to *make* happen. So then, saying, "the client is resistant," seems to me a common way of essentially blaming someone for the problem they initially presented with.

This is in contrast to Fritz Perls, who talked about "resistances as assistances" and "defenses as protectors." That view captures a more humanistic perspective on resistance. In this sense, resistances are actually assets, ways of managing anxiety, occurring automatically and not necessarily a problem. Clients need alternatives. They need a reason not to be resistant! Sometimes it can be as simple as offering a safe, but playful—if slightly irreverent—relationship style. Encourage the client to take a risk in some new way of engaging.

Is Affect the Key to Understanding Resistance?
Smith: Is affect a broad way to understand the difficulty of change?

Pascual-Leone: I'm going to say as a first stab that affect is the primary thing. Resistance is often used to label what is actually "fearfulness about change." I have mixed feelings about that. If a horse was reluctant to cross a bridge on fire, you wouldn't see that as resistant. On the other hand, change is hard. This is a universal phenomenon. It is risky and requires invention, which involves effort. Some people use the term resistance in very broad brush strokes, but that is not so helpful. Let's break it down into some different varieties.

One example is when clients are overwhelmed, and affect is too intense. They can't proceed, they lock up, freeze up, can't make sense. As a first step, emotional processing, and emotional regulation are just reducing intensity, not resolving the experience. But I feel odd calling that "resistance." It isn't willful or intentionally obstinate. They are resisting in a sense, holding back, but not in the usual way one understands the term.

Later, once regulated and able to process experience, the client might not have meaning to attach to the experience, and that could also look like "resistance." So in a case like that the client just can't formulate an experience: "I'm not

"Many in emotion research now understand negative emotions as being about unmet needs."

"Based on our research, therapists can anticipate the next change process within reach for clients..."

going there." But they don't know what is "there." They sense it is uncomfortable and so don't actually formulate it, they haven't gone there and have queasy feeling about it nonetheless. This isn't repression because it's prior to repression, it's unformulated a priori: sometimes clients really don't know yet! The trouble is, they don't know how to get unstuck from this.

A third scenario is when clients know what is stopping them, say, their negative self-evaluation, but here they don't know what to do about it. A CBT approach might be to help them find new ways to think about it. Still they might *know* it's not true, but it just *feels* true. Then what? As a therapist you are in a pickle. What are you going to do now? EFT would say it doesn't matter if it's true, and then take this as a chance to work with the affect directly. Sometimes client or therapist or both don't know what to pursue. So the client could appear resistant but essentially not know what they need. Many in emotion research now understand negative emotions as being about unmet needs. What kind of needs? Well, existential therapy talks about existential needs such as mastery, communion, survival, and agency. The challenge is that we have to help clients figure out what they need. Fortunately, any number of interventions could help do this.

Of course, yes, there is "real" resistance. With anger problems, for example, anger itself can be seen as an addiction to the power of being resistant. "If I beat up the cab driver then…"—The client *knows* it isn't the cab driver's fault, yet wants to vent or act angrily, and there is a choice point there, one which can be brought to the client's attention. Sometimes they choose otherwise, but other times this is where people literally choose the dark side, "—I'm going to do it anyway because I can or just because I want to." For me, that is true resistance to treatment: It's not stagnation, or ambivalence, it's when people knowingly do something that will make them worse.

A Developmental Model of Emotional Change
Smith: From the point of view of readers, you are circling around a unifying view of therapy. Do you see a way of pulling things together across theories?

Pascual-Leone: The quick answer is yes. I don't want to plug my research but I do want to give some highlights. My research approach is a developmental one. I see overcoming psychological problems as growth or change that simply has not happened along the normal lines, or has been interfered with, say, by trauma. The client has gotten stuck and is trying to get over it. Developmental research is not a "content area," but rather a "method." It assumes change processes in normal healthy people are similar to the changes that undo pathology.

This is different from the usual development in, say, children, which has to do with physically gaining more mental capacity. Many developmental changes for children simply come with time. When we get to "adult emotional development," it isn't usually an issue of organic development but rather of a kind of emotional-social maturity. In psychotherapy, whether we are talking about psychodynamic personality change or cognitive flexibility or new emotional experiences, they can all be thought of as adult social-emotional change—that is— "Growing people up."

More recently I have developed a model of emotional change. The idea is not an illness-recovery model, but a developmental one. Most psychotherapists interested in profound change would endorse the idea that when one is no longer depressed or anxious then one becomes a different kind of person, with changes in one's "infrastructure." If you think that way, then it tends be understood as a universal change process—the issue of maturity and emotional wisdom. Emotional change could in some sense be an axis of interpretation or formulation of what the problem is with respect to any case. Case formulation based on emotion can be applied across theories, and is a complement to traditional formulation.

Change occurs in a specific sequence. Based on our research, therapists can anticipate the next change process within reach for clients, and what is likely to come up next. You can build a clinical process map of your client that way. By following the map you can then use the process model as an empirically supported guide to what to do next.

Categorically New Experience
Smith: One last question: Lane et. al. in Behavioral and Brain Sciences (Vol 38, Jan. 2015) propose a unifying universal theory of change. Do you feel that is a significant article and, if so, could you briefly give your summary of what they have to say and how you would amplify or modify it.

Pascual-Leone: It is an excellent piece of work and an important contribution. The main gist is perhaps that you can explain psychotherapy change using two ideas: First, the idea of memory trace reconsolidation, the notion that

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> *"Physicists define work as moving an object from point a to point b against a resistance. This is a good metaphor for psychotherapy as well."*

memories are actually updated and not static recollections. Every time you remember, memory must be reconsolidated and can change if one remembers within a new experiential context. Second, emotional arousal can be used to boost certain experiences so they can be updated more easily.

This is excellent, but it still misses something that I think is key. What is missing, in my opinion, is the fact that often in therapy there are truly novel changes, not just progressive updates, but rather something that lays down a new, let's say, "innovative" experience. Often clients come up with categorically new experiences such as an insight that is categorically new, not reducible to either addition or modification of existing experiential components. We are talking about changes to one's operating system here, not just changes to one's memories.

An example is observed changes in alexithymia over a relatively short period. A few studies show that people in therapy can start out with that trait and at the end of therapy are surprisingly no longer alexithymic. Another example from experimental research is where people are asked to imagine a trauma that is not their own, but one they have only read about. Yet, they still recover as well as if it were discussing their own content. A final example is the client who always feels afraid or ashamed and in one session says, "….you now, it wasn't really about me. It was about the other guy, and I missed out on being treated with care and respect." The invention of a novel solution in terms of having more emotional awareness, or the emergence of a categorically new experience, requires a different model of change. But what?

The largest puzzle in psychotherapy research (and in cognitive science) is to explain how truly "novel" things happen. The ABC model of behavior therapy, or explaining the role of arousal in terms of memory consolidation, are valuable and important contributions that are useful and profound, respectively speaking. Yet, neither of them help us understand where the categorically new insight, new behavior, or these first-time new experiences actually come from. That's where the magic happens! So, how is the experience spontaneously generated? And under what conditions? A neo-Piagetian model of development argues that dialectical syntheses can produce higher orders of meaning. This requires holding seemingly contradictory experiences in tandem. So, the piece that's missing from "memory reconsolidation and arousal" as an explanation for change, is the extraordinary amount of creativity required on the part of the client. The client develops into a person with new "infrastructure" for solving complex emotional-social difficulties. Newfound ability and wisdom isn't explained by theories of memory change. ❧

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

The third conundrum is more subtle. Physicists define work as moving an object from point a to point b against a resistance. This is a good metaphor for psychotherapy as well. Our job is to help patients move from A to B against a greater or lesser natural resistance. The elements we seek to change include irrational emotions, thoughts, values, attitudes and behavior patterns. Resistance to change is also embodied in many forms, including emotions, thoughts, values, attitudes and behaviors. Does this mean that what we want to change and what makes change hard are the same? In physics resistance and the object to be moved are clearly distinct. In psychology they seem not to be.

The answer, to me, is that the dysfunctional patterns of psychopathology and the layers of resistance that guard against change are indeed made of the same stuff. They are both manifestations of our instinctive avoidance of negative affect. They are created by the same mind (though not always at the same point in development) and driven by the same dread of anticipated painful, overwhelming or uncomfortable emotions associated with particular experiences, perceived or real. Thus, paradoxically, the pathology we want to change consists of avoidance mechanisms similar to those that stand in the way of the changes we seek.

Jennifer and I sincerely hope you enjoy this issue. We welcome your feedback, and want to urge you to take up the pen. It's fun and creative. Just a hint: The theme of our next issue is going to be "Training New Therapists Around the World."

And let me not forget to point you to yet more features of this edition: **John Norcross's** call for advocacy, his and **Beatriz's** invitation to Dublin, a new article on Trinity College by **Pierce, Finnerty** and **Kearns**, **Tom Holman's** practical guide to running a Regional Network, a heartfelt piece on integration by **Mark Sisti**, and our traditional recaps of conference presentations you might have missed.

Jeffery Smith, MD ❧

Dr. Leahy is the director of the American Institute of Cognitive Therapy in New York City. He has received the Aaron T. Beck award for outstanding contributions in cognitive therapy and is the author and editor of 23 books, including *Overcoming Resistance in Cognitive Therapy* (2011).

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Featured Interview

Robert Leahy on Resistance in Cognitive Therapy

Davidtz: You talk about different models of resistance in your book, but in a nutshell, what does "resistance" mean to you as a master cognitive therapist?

Leahy: I think from the point of view of cognitive behavior therapy, we have certain assumptions about what we want the patient to do and, as in many things in life, people don't always do what you want them to do. In cognitive behavior therapy, the expectation is that we're going to stay in the present moment. We're going to focus on self-help. We're going to have homework assignments. We're going to be responsive to what's going on in the session. I would look at resistance as any behavior, or thoughts, or feelings, or whatever, that get in the way of accomplishing the goals of therapy.

One of the models I have in my book is the model of risk aversion, that people who are depressed or anxious are quite risk averse. There are lots of reasons why that might be the case, but, if they're going to be hesitant to try new behavior, they're going to "resist" new behavior. Some people don't like the word "resistance" because they think it blames the patient, but I don't think there's anything pejorative in viewing it as resistance. My view of it is to try to understand how non-compliance, or therapy-interfering behaviors, or resistance, or whatever, makes sense to the patient. Just simply saying the patient's not motivated, or the patient's not ready, or not using the techniques, is not going to be that helpful. It's important to understand how resisting change makes sense and is actually a way to protect oneself. I don't believe that patients want to feel bad. I think most resistance is because they already feel bad and they don't want to feel worse. Much of resistance is really a self-protective thing.

Davidtz: Can you elaborate on the therapeutic value of examining resistance in cognitive therapy?

Leahy: The reality of it is that the average patient in therapy only goes for a few sessions, so you have a great variation in the amount of time or effort or commitment that a patient is going to put into therapy. I've been training therapists for many years and I've been doing therapy for many years. What I observe is that there are some therapists who have really high dropout rates and some who don't. If you don't look at why patients aren't using the CBT techniques, you're not going to be effective, and there are a lot of people you're not going to be able to help.

For example, one of the things I describe in my book is validation resistance…I think validation is an extremely important thing and sometimes it's undervalued in CBT. So I began realizing that there are some people who believe that if you don't validate their emotions, validate how hard it is, they're never going to do anything you want them to do. And I think this is true in everyday life. It's a perfectly human desire, the need for validation. Having said that, there're some people who have extremely demanding ideas about validation, like, "You have to understand everything I say. You have to agree with everything I believe. You have to have the same feelings that I have. You have to tolerate everything I do." I think that sort of perfectionistic demand for validation can get in the way of therapy, but you can look at the resistance as opening up a line of inquiry. It may be that this person was never really fully validated when they were a child. They were ridiculed, humiliated, and they have a schema, "People will humiliate me and make me feel like I'm worthless when I share my emotions." If you think about resistance as opening up new avenues of deeper inquiry and helping people on a deeper level, it becomes really exciting. It becomes a really challenging type of thing and it makes CBT, I think, a more meaningful kind of therapy.

Davidtz: How do you address resistance in cognitive therapy?

Leahy: You can use cognitive therapy techniques to identify *and* address the resistance. You don't just have to wait for the patient to work it through. You don't just have to label it or relate it to early childhood experiences.

"Using cognitive therapy techniques to look at the underlying assumptions about inertia, avoidance of regret, risk aversion, or validation resistance, you get the resistance out in the open and you can deal with it with right in the here and now."

People do it in different ways and Marsha Linehan in DBT will look at chain analysis, go back and analyze the sequence of events, thoughts, feelings, and situations that led up to the therapy interfering behavior and that's a very effective way of dealing with resistance. Using cognitive therapy techniques to look at the underlying assumptions about inertia, avoidance of regret, risk aversion, or validation resistance, you get the resistance out in the open and you can deal with it with right in the here and now.

One of the things that I always think about is when you give a patient a homework assignment, if they don't do the homework assignment – and many times they won't – is to look at all the reasons not to do the homework assignment. Let's say, for example, a patient worries a lot and the homework assignment is try to set aside the worries for worry time at 4:00pm, and the patient doesn't do it. You can then go back and look at all the reasons not to set aside the worries. "I'll forget them, so I have to keep reminding myself of the worry," or "I have no choice. If I have a worry, I have to deal with it." There are many reasons not to do the worry time. Unless you address them, some patients are not going to comply with the worry time.

I think a lot of times therapists will say, "I've used these three or four techniques and therefore I've done my job." My view is, "I've used these three or four techniques and I want to know now why three out of those four techniques were not working. What happened? How did the patient experience that?" It's really developing a curiosity to see how it makes sense to the patient not to do the behavioral assignments. What may be underlying it? What would it be like to be experiencing the world like this person experiences it?

I think the other part is to use your own feelings. This is the countertransference part. If you really don't like a patient, or you're angry at a patient, or you're bored with a patient, or you feel like you're somehow being pulled in and charmed by the patient, ask yourself, "How does this reflect the world that this person's living in? Is this what they do?" If they discount everything you say, are they doing that with their friends? If they are complaining and ruminating a lot, are they doing that with other people? Understand the context.

I think there may be a tendency sometimes for us to jump ahead and try to get the person to feel something differently. "I don't want the person to feel unhappy. I want them to feel good," but it may be useful for the therapist to be able to be with that emotion, at least for awhile, so the patient can understand, "This person is able to tolerate the way I feel and they care enough about me to let me be who I am."

I think with cognitive therapy, not only can we identify the points of resistance via our countertransference and the patient's non-compliance; we can actually do something pretty straightforward to address them.

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Resistance: Let s look at the therapist

Beatriz Gómez, Ph.D.
Aigle Foundation

Resistance is an expected response in therapy as a force against change. Much has been studied about the patient's part in responding with resistance to the therapist's actions, but there has been less focus on the professional attitudes that stimulate or exacerbate resistance. In the past years, there has been a growing emphasis on looking at the role and characteristics of the therapist in every constituent of the therapy process (Beutler, Machado, Allstetter Neufeldt, 2009). The variables of the therapist have earned an increasingly important place so we will turn our gaze towards that participant when looking at resistance within the therapy space.

"...the therapist's reactions to the patient's resistance can have the effect of exacerbating it."

Resistance is conceptualized as an interpersonal phenomenon that reflects either the patient's ambivalence or internal conflict regarding change and the way the therapist responds to this ambivalence (Moyers & Rollnick, 1999). According to reactance theory, resistance is a normal process that is designed to protect a sense of personal freedom (Beutler, Moleiro & Talebi, 2002). A proportion of this phenomenon may be attributed to mismatches with the patient stemming from the therapists personal characteristics or in their interventions. Guilfoyle (2002) points out that resistance indicates a refusal of therapeutic knowledge in certain areas of a person's experience, and correspondingly, a refusal of the therapeutic power supported by that knowledge. Therapeutic actions can at times be seen as somewhat disrespectful, even though the therapist may view these actions as acceptable, appropriate, and perhaps necessary for the process. Therapists are entitled to explore, to extend, and to apply therapeutic knowledge to a wide variety of a patient's experiences, but are at risk of going beyond the discursive boundaries proposed by the other. Under the threat of being subjected to the therapist, the patient becomes actively defensive to strengthen preexisting attitudes, beliefs, or opinions. Also, the therapist's reactions to the patient's resistance can have the effect of exacerbating it.

"Misestimated cultural differences are likely to generate resistance as well."

What are some of these typical misattunements on the part of the therapist that may activate resistance? They include: errors in selecting or implementing techniques, timing mistakes, out-of-step interventions performed when the patient is still not in a condition to incorporate them, misled interpretations of what is taking place in the therapy space. According to Wachtel (1999), what one might label as "surplus" resistance is often the product of the therapist s rigid or mechanical application of a set of rules learned from a particular therapeutic orientation. Relationship difficulties may also appear in understanding the patient and in sustaining empathy. Early psychoanalysts pointed out that what could be seen as resistance might be a byproduct of the analyst's countertransference to the treatment (Winnicott, 1955). Furthermore, Claiborn & Goodyear (2005) point out that resistance can be prompted by an inadequate balance of positive feedback (communication that praises, supports, and encourages the patient) and negative feedback (communication which describes the patient behaviors as ineffective relative to a criterion or as hindering change). Misestimated cultural differences are likely to generate resistance as well. Therapists are increasingly aware of cultural differences (gender, race, ethnic, nationality, religion, etc.) but can be less attentive to deeply rooted family traditions, customs, and values manifested in subtle and hardly visible ways of behaving, language use, intonation, or glance.

The personal style of the therapist and its impact on the patient needs to be taken into account as another important factor (García & Fernández-Alvarez, 2007), especially when they are not sufficiently aware of it. It may not be easy for the therapist to detect how their own responses contribute to increasing their patient's resistance response. For example, patients with low resistance-like traits tend to benefit from directive interventions, while high resistant-like traits seem to make patients vulnerable to authoritative styles (Beutler, Moleiro, & Talebi, 2002). Therapists can have difficulties in adjusting their personal style to the needs of the patients according to their level of resistance.

> "*The magic ingredient for promoting awareness, flexibility, novelty, and self-care is the interaction with colleagues, both junior and senior therapists.*"

Potential antidotes to resistance exacerbation by therapists

- Identify resistance on the part of the patient, e.g., "You are annoyed".
- Evaluate the level of resistance with the aid of instruments.
- Be respectful and responsive to resistance.
- Acknowledge interaction difficulties and discuss them, e.g., "What could be helpful for me to do?"
- Tolerate a certain level of uncertainty and accept "we don't always know what is best".
- Leave room for doubt.
- Understand and work with own ambivalence.
- Prevent resistance with negative feedback, presenting it along with positive feedback.
- Consider how one s own cultural values, aims, attitudes, beliefs, and social context influence therapeutic actions.
- Accept responsibility for mistakes and take a step back with a genuine attitude whenever necessary, for example in the face of strains or ruptures of the therapeutic alliance.
- Facilitate autonomy by the patient.
- Provide information about therapeutic actions.
- Use cautious self-disclosure.
- Provide support.
- Cultivate patience.

How can therapists acquire these antidotes?

The *via regia* to incorporating ways to deal with resistance is continuous education, training, and supervision. Especially useful is training directed to developing metacompetencies, which are supported by metacognitive processes, that assume comprehension of the mental states of self and others and the ability to assess what one knows and what one doesn't know (Fernández-Alvarez, Castañeiras & Wyss, 2015). Self-reflection fosters a self-critical attitude, which is necessary for the therapists to become aware of both their strengths and those personal aspects where they need more work in order to not hinder good psychotherapy practice. Learning to look through the eye of the beholder requires training and work on personal characteristics and, whenever necessary, personal therapy.

Self-reflection makes it easier for professionals to identify their own personal style as a therapist (PTS), which is defined as the set of characteristics that each therapist applies in every psychotherapeutic situation, shaping the basic attributes of psychotherapy (García & Fernández-Alvarez, 2007). Exploring the evolution of the personal style of the therapist along his/her formative years gives trainees another tool to develop self-awareness.

Training is also very helpful to approach patients rigid mental patterns leading to repetitive responses, by expanding the therapists technical resources such as the use of rhetoric interventions, imagery, meditation, expressive writing, role-playing or information and communication technology.

Supervision, on the other hand, is a key element, since it is oriented to experiential learning and evaluation is one of its most widely accepted and recognized components. Supervision provides a remedy to what could develop into a misalliance or therapeutic rupture by drawing attention to what is not known, by initiating self-assessment and observation, and by providing ongoing feedback. Attention is directed not only to the patient but also to the awareness of cultural influences affecting the interactions between patient and therapist (Falender & Shafranske, 2014). Supervision facilitates the therapist acquiring a good balance between a critical own view and self-acceptance.

Last but not least, teamwork is critical for the development and acquisition of the antidotes to resistance, and has nowadays been made easier by technology when living in distant areas (e.g., rural areas, small towns, isolated regions). The magic ingredient for promoting awareness, flexibility, novelty, and self-care is the interaction with colleagues, both junior and senior therapists. It is a powerful containment barrier against a sense of omnipotence and at the same time an optimal way to protect the therapist's self-esteem in order to help him/her be prepared to foster a climate of free choice towards change.

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> *"...the integration movement, and sepi in particular, have not been sufficiently proactive in advocacy."*

President's Column, *continued from page 1*

What IS surprising and depressing is how the results of these hundreds of research studies are not widely recognized and immediately identified as integration. And that is *integration* in both SEPI senses: synthesis of diverse psychotherapy approaches, and synthesis of practice and research.

The causes of this disconcerting pattern are multiple and complex, no doubt. But the integration movement, and SEPI in particular, have not been sufficiently proactive in advocacy.

Thus, we delight to announce the establishment of the SEPI Practice Advocacy Committee. Formally, their responsibilities are to: promote and enhance the practice of integrative psychotherapy throughout the world, including the integration of different orientations and of research and practice; administer the Practice Consultation Program in consultation with the conference Program Committee; and, at the direction of the Executive Committee, prepare and disseminate advocacy materials.

Informally, think of them as our action team—advocates for thoughtful integration around the globe. Look for periodic updates from the Practice Advocacy action team on our website and on these pages. The Committee features Giancarlo Dimaggio (Italy, chair), Heidi Levitt (US), Paul Lysaker (US), James McElvaney (Ireland, early career member), Zofia Wrzosinska (Poland), and Barry E. Wolfe (US).

Three Cheers
Elsewhere in this issue of *The Integrative Therapist* is a compilation of those who have generously served on SEPI Committees during 2015. The Executive Committee and I gratefully acknowledge their contributions and service. Thank you, one and all.

SEPI on the Move
SEPI's leadership team continues to add value-added benefits for members. Among the prominent examples are publication of this newsletter (*The Integrative Therapist*), formation of SEPI Archives on the website, expansion of committees, increased opportunities for participation, creation of a Fellow category of membership, enriched video and audio content on the website, and expanded awards for graduate students and early career professionals. Two of those awards are now permanently named in honor of SEPI's co-founders, Paul Wachtel and Marv Goldfried.

Ave Atque Vale
"Hail and Farewell" is a traditional expression to celebrate coming to and departing from an organization. It is my time both to depart and to welcome those joining; it embraces continuity through change.

As 2015 slides into 2016, I bid adios as SEPI president and warmly welcome our incoming president, Betty Gomez. She represents the first non-North American to be elected president of SEPI. Hail and Farewell!

Resistant to 'Resistance'

By Rhonda Goldman, PhD

"I do not want to interpret, 'break it down,' or even 'play to it.' I instead, I choose to understand and validate it."

"…what always lies underneath the harsh critic is protective fear."

"In gestalt groups, we were continuously encouraged to ask ourselves, 'what are you avoiding in this moment?'"

Steeped as I am in the Humanistic-Experiential Tradition, I find myself resistant to the concept or term, 'resistance.' In fact, I tend to bristle (inside) when, in supervision, my students use such terminology to describe clients. In such instances, I immediately move to reframe their understanding, working to help them see how the client might be trying to protect him or herself. My underlying driving fear is that by viewing the client as "resistant," there is the potential to rupture the delicately created therapeutic alliance, by creating a distance and viewing the client as 'other.' Suddenly the therapist and client are working against each other, in a sort of 'tug of war.'

The concept of resistance implies that clients are both asking for help and working against the change they are trying to attain. While dichotomies such as this are perhaps tempting to endorse, they do not actually fit my conceptual understanding of clients or with my view of human functioning and dysfunction. I think there is an issue of intention. I do not believe that clients are negatively motivated, have inherent destructive tendencies, or unconsciously or secretly do not want to be helped. I do believe that clients are trying their best to survive in what is often a very difficult world to navigate.

Some might say that these are simply different terms that we use to describe the same phenomena; however, I am of the belief that how we think about and conceptualize our clients, even to ourselves, influences how we interact with them. Seeing them as 'resistant' implies a negative motive or self-destructive tendencies and, for me, this is problematic and has the potential to alter my therapeutic relationship, one that is typically marked by unconditional positive regard, empathy, and genuineness.

From a Humanistic perspective, resistance is seen as self-protection. Protection is generally seen as related to survival in the sense that clients are seen as attempting to protect tender parts of themselves that have been hurt or damaged. Such protectiveness is a learned response and I do not want to interpret, "break it down," or even "play to it." Instead, I choose to understand and validate it. In my experience, reframing clients as vulnerable or fragile rather than resistant helps the therapist to develop compassion and greater intimacy with their clients.

As an EFT therapist I often work with the two-chair dialogue for self-criticism or negative self-evaluation. When facilitating clients working through this process, I am continuously struck that what always lies underneath the harsh critic is protective fear. In the early stages, when the 'critic' is actively 'criticizing' and harsh it is difficult to see how this aspect of the self might have any merit or function in the personality or be promoting healthy processing. And yet, when the process is followed through, and after shameful vulnerability and assertive anger is expressed, the 'critic' will soften and invariably, underneath in its soft underbelly, is fear and a quest to protect the self. This is the wisdom of the self. This expression and understanding leads to a rebalancing of the self. In facilitating this process, the therapist never takes an adversarial position with respect to clients, neither confronting nor working with "resistance" but rather facilitating the various aspects of self-expression, allowing people to re-organize themselves.

There are different words that are sometimes used to describe 'resistant' behavior and one of them is 'reluctance' which is sometimes seen as a milder form of resistance. Some clients may in fact be reluctant and this may be sensible until they understand how the therapeutic process works and how it may be of help to them.

Another term that is often used is 'avoidance.' Perhaps because of my Gestalt background and training, this is a term that I am somewhat more comfortable with. In gestalt groups, we were continuously encouraged to ask ourselves, "what are you avoiding in this moment?" I found this to be an interesting question that could yield useful insight or paths to change. However, to view clients as simply 'avoidant' is to perhaps miss the ways in which they are sensibly self-protecting or just trying to get by in what is or has been a harsh, unfriendly, or unsupportive environment. While sitting face to face with my clients, I much prefer to ask the question (sometimes to myself) "what is the painful experience that you have had that leads you to want or feel you must protect or take care of yourself in this moment?

Tom Holman, PhD, is the coordinator for SEPI's Washington, DC-area Regional Network and in private practice in Maryland where he sees mostly children and adolescents.

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"...I knew many people who were interested in psychotherapy integration, but relatively few who were SEPI members."

"The first, and most important, question in running a SEPI regional network is what will happen in the meetings."

SEPI Washington Area Regional Network

Tom Holman, Ph.D.

Our current Washington, DC-area Regional Network in the U.S. began with complaining. I was an enthusiastic SEPI member, and complained about not having a group of like-minded people to meet with. I had much experience as a sort of misfit among people who promoted their own approach and denigrated other approaches, and very much wanted to find integrative discussions. Fortunately, I was complaining to some local people who have vast experience with SEPI, including Carol Glass, Diane Arnkoff, and Barry Wolfe. We first met for a planning meeting on March 10, 2013. They well remembered previous local groups, and invited me to set one up. They also gave me a lot of support, and provided several of the initial presentations at the meetings.

As I thought about how to set up a local group, I realized I knew many people who were interested in psychotherapy integration, but relatively few who were SEPI members. I felt it was important to open up a SEPI Regional Network to everyone in the area. This open approach was an important reason for the success of the group, so that a good number of people would attend the meetings. I hoped that word would spread that interesting things were happening. Three years into the group, I continue to see that many people are interested in integration, but a frustration is that only 4 or 5 have joined SEPI as a result. I encourage people to join and have a table of books, journals, information on the upcoming conference, and the membership flyer at each meeting. Given how little SEPI membership costs, and how interesting the journal is, I don't really understand this. Thus, as a tool of recruiting actual members, our network is unsuccessful so far. It has, however, promoted a greater awareness of SEPI in the community.

The first, and most important, question in running a SEPI regional network is what will happen in the meetings. My original idea included open-ended discussions, case presentations, and bringing in articles of interest, as well as structured presentations about a research topic or psychotherapy approach. In fact, people have been much more interested in the structured presentations than the open-ended discussions. When a hot topic is presented by an expert on that topic, then, of course, the meeting has been more successful. In the Washington, DC area, we have been very lucky to have such people who are willing to give a presentation on a Sunday afternoon without any honorarium. These tend to be loyal SEPI members. To date, we have met 12 times. We have enjoyed (and will enjoy) the following presentations:

4/21/2013	Children Who Need More than One Approach	Tom Holman, Ph.D.
5/5/2013	Integrative Treatment of Anxiety Disorders	Barry Wolfe, Ph.D.
11/17/2013	Integrating Mindfulness into Different Approaches to Psychotherapy	Carol Glass, Ph.D and Diane Arnkoff, Ph.D.
1/26/2014	Accelerated Experiential Dynamic Psychotherapy	Barbara Suter, Ph.D.
3/9/2014	Therapeutic Imagery	Tom Holman, Ph.D.
11/2/2014	Teaching Psychotherapy Integration	Linda Smoling Moore, Ph.D.
10/11/2015	Interpersonal Reconstructive Therapy	Kenneth Critchfield, Ph.D.
1/31/2016	Practicing Empirically Supported Cognitive Behavioral Therapy within a Psychoanalytically Informed Model	Stephen Holland, Ph.D. with Roger Segalla, Ph.D., discussant
3/13/2016	Research on Meaning in Life	Clara Hill, Ph.D.

We have also had planning meetings and a couple of meetings devoted to discussing articles or books.

"...I have almost learned how to disconnect my self-esteem from the attendance figure."

"A good tolerance of uncertainty helps in starting and maintaining this kind of network."

Second, I haven't yet been able to get attendance at our meetings to count for continuing education (CE) credits that people need to renew their licenses. This involves issues of cost, paperwork, and partnership with an organization that can grant the credits. We have met on Sunday afternoons, and it requires some dedication and strong interest to attend at that time with no CE credits. As the organizer of the meetings, I have almost learned how to disconnect my self-esteem from the attendance figure. Attendance is not very predictable; I ask for a commitment so that I can plan for the space and the refreshments. The only fee I ask from people is $2 towards the refreshments.

Third, the location of the meetings has depended on the generosity of our members to offer their homes. This year (we use the academic year because few meetings are held in the summer) our first meeting had a large turnout; we were lucky that one of our members offered her large group practice waiting room. We are also lucky to have our January 2016 meeting hosted by another large group practice, and this meeting even has a waiting list (!). We have investigated a more regular location, such as a meeting room in a public library, but these have involved fees that we did not want to incur.

I have used a small amount of technology to plan and keep track of the meetings and members. Using my contact manager software, I can group all interested people and link them to emails and scheduled meetings. I have an email list (that has grown pretty large) of people interested in the meetings. Some of these are SEPI members. The SEPI membership director sent me names and emails of SEPI members in the area, and those who attended the Washington, DC national conference in 2011, which I added to my list. The non-SEPI people are those whom I invited and others who emailed me and asked to be included. I send an email to the whole list to announce each meeting. This announcement email includes a link to the web-based scheduling app, Doodle. On Doodle I set up a "poll" that presents a choice of dates and times that have been cleared with the presenter(s), and a convenient way for people to indicate when they are available. This allows me to select the date and time that works for the greatest number of people. In order to use Doodle, I first had to set up a free account. Sometimes, a speaker can only come on one date, and then the voting is unnecessary. After it's clear when most people can come, I send a follow-up email. Shortly before the meeting, I send a reminder by email.

Planning a series of meetings for the year involves a good deal of networking. It is essential to have colleagues who can give suggestions and feedback. I am also learning that it's better to plan a few really good meetings, rather than try to have many meetings. This year we have three very solid programs, with a fourth possible. A good tolerance of uncertainty helps in starting and maintaining this kind of network.

To date there has not been much coordination between SEPI and the Regional Network, and SEPI doesn't have official divisions or chapters. More coordination would probably help the regional efforts. One could imagine a speakers' network, or SEPI providing some funds to Regional Networks to support organization and programs. However, more superstructure might require an increase in SEPI dues, and could require the regional groups to be more official and less freewheeling and "ad hoc." These issues would definitely be worth discussing at an Executive Committee meeting or annual conference.

Organizing this group has been a great opportunity for me; I've gotten to know many new people and learned a lot from everyone. I would welcome hearing from other SEPI members! Please contact me if you have any questions or would like more detailed information on my experiences with the Washington, DC-area group (tom@tomholman.com).

Jennifer Callahan: SEPI Journal Editor

"Woven throughout my research and clinical work is a longstanding dedication to advance beyond single-theory or single-school approaches to psychotherapy or behavior change."

Dear SEPI Community,

I am very excited to be the incoming editor for the *Journal of Psychotherapy Integration* (2017-2021) and look forward to our working together to advance psychotherapy across domains: research, theory, practice, and training. Before introducing myself to you and opening the door for our on-going dialogue and collaboration, I would like to thank Bruce Liese, chair, as well as the members of the search committee (Veronica Bagladi, Jacques Barber, Michael Lambert, Alberta Pos, Bernhard Strauss, and Kate Esterline) for their time and effort throughout the search. I also want to thank John Norcross and Golan Shahar for their ongoing support during the transition process that will be unfolding throughout 2016.

Since its inception in 1991, JPI has been a valued resource for psychotherapy communities both nationally and internationally. For me personally, the journal has mirrored my professional identity and shaped its development from the time I was a doctoral student. In fact, my very first publication in psychotherapy (Callahan, 2003) was an illustrative case study highlighting the essential role of an integrative approach for complex comorbid presentations of longstanding distress and interpersonal problems. Since then, my research and publications include several case studies, meta-analyses of existing literature, and new research (including both single clinic and multi-site investigations) into expectancies, preferences, transtheoretical processes and models, and training. I am committed to my broader professional identity and 2016 marks the 10th anniversary of my attaining board certification (ABPP: Clinical). Woven throughout my research and clinical work is a longstanding dedication to advance beyond single-theory or single-school approaches to psychotherapy or behavior change.

Working together with you, my hope is that we will invigorate the journal's readership and comprehensively influence the emerging trajectory of the psychotherapy integration field. Our success will require high quality submissions that yield immediate impact on practitioners, as well as long-term reach in stimulating needed research and serving as key citations that shape the field. I am looking forward to hearing your ideas for the journal, including special issues or topics, and discussing possible manuscripts with you while in Dublin for SEPI 2016.

Blain úr faoi shéan is faoi mhaise duit! [Happy New Year to you!]

Jennifer

INVITATION TO CONTRIBUTE TO SEPI'S OFFICIAL NEWSLETTER

—Come Write for *The Integrative Therapist!*—

The theme for our next issue will be "Training New Therapists Around the World." Deadline for submissions: March 1, 2016.

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

Contributors are invited to send articles, interviews, commentaries, letters to the editor, and announcements to Jeffery Smith, MD, Editor, The Integrative Therapist. The preferred length of submissions is 1,250 words or less, following APA style. All submissions should be sent in the body of an email to jsmd@howtherapyworks.com with the subject line "Contribution to Integrative Therapist"

SEPI — Society for the Exploration of Psychotherapy Integration

FORMATTING

- Block style with one space between paragraphs, no paragraph indentations
- Yes, use subheadings and bullet points freely!
- Single spaced
- No page numbering
- No headers or footers
- References should be in approved APA-style format
- Photos should be submitted as separate JPEG, TIFF, GIFF, or BITMAP files, not imbedded in other documents.

INQUIRIES ABOUT SEPI OR MEMBERSHIP SHOULD BE DIRECTED TO:

Tracey Martin
Administrative Officer
e: sepimembership@gmail.com

Invitation to Attend SEPI's
2016 Dublin Conference

Dear Colleagues:

It s a pleasure and honor to invite you to attend SEPI's 32nd Annual Conference, June 16–18, 2016 in Dublin, Ireland. SEPI`s international conference will focus on The *Therapist in Integrative Therapy: Implications for Practice, Research, and Training.*

As is our tradition, we will build bridges between practitioners and researchers, and serve as a forum for different theoretical perspectives.

The conference provides an opportunity for attendees to share their own clinical work, research findings, and educational practices. We welcome the participation of all intrigued by psychotherapy integration.

The presentations will foster a collaborative environment and will cross nationalities, professions, theories, and work settings. It will afford opportunities for both social and professional networking.

We look forward to seeing you in Dublin in 2016!

Beatriz Gómez, Ph.D.   *John Norcross, Ph.D.*
Program Chair   President

While You Are In Dublin for SEPI 2016

Laura Pierce (IICP)
Triona Kearns (IICP)
Marcella Finnerty (IICP)

TRINITY COLLEGE DUBLIN

Photo: Philip Milne/Flickr– Creative Commons

Trinity College was established in 1592, in part, to consolidate the rule of the Tudor monarchy in Ireland, and it was seen as the University of the Protestant Ascendancy for much of its history. Catholics were permitted to attend the college under certain restrictions from 1793, though, up to as recently as 1970, the Catholic Church in Ireland forbade its devotees from attending the college without permission from their bishop.

The University houses the spectacular Trinity Library. It is a legal deposit library, meaning the college is entitled to one

> *"Trinity takes its place alongside Oxford and Cambridge as one of the seven ancient universities."*

> *"Some of those who have attended include Al Pacino, Nancy Pelosi, Terry Pratchett, Naomi Campbell, Courtney Love, Bono, Germaine Greer, Jimmy Wales, Stephen Fry, David Trimble – and going further back, the likes of WB Yeats and Winston Churchill."*

Photo: Bjaglin/Flickr– Creative Commons BY 2.0

copy of every book that is published in the UK and in Ireland. The Library now contains around 5 million books (including the Book of Kells), but doesn't store this on college grounds. Most of the library stores are in Santry, in a place fondly known to students as "stacks." If you request a book in the morning, you'll have it by lunchtime.

Trinity takes its place alongside oxford and cambridge as one of the seven ancient universities. As a student you can walk in the footsteps of famous graduates who have helped shape the history of Ireland and the wider world, including Ireland's greatest Poets and Novelists—Jonathan Swift, Oscar Wilde, Samuel Beckett and surprisingly Abraham "Bram" Stoker, best known today for his 1897 Gothic novel, Dracula.

Trinity College also has a sporting tradition and the college has 50 sports clubs affiliated to the Dublin University Central Athletic Club. The newest club in the University is the American football team, who were accepted into the Irish American Football League (IAFL) in 2008. Initially known as the Trinity Thunderbolts, the club now competes under the name "Trinity College".

TCD also gives its students the opportunity to hear top academics and world celebrities speak through societies like the Hist (Historical society) and the Phil (Philosophical Society). Well-known names like *American Pie's* Stifler have been lured by the promise of an honorary patronage of the society. Some of those who have attended include Al Pacino, Nancy Pelosi, Terry Pratchett, Naomi Campbell, Courtney Love, Bono, Germaine Greer, Jimmy Wales, Stephen Fry, David Trimble—and going further back, the likes of WB Yeats and Winston Churchill.

The college occupies 47 acres and is divided into three faculties comprising 25 schools, offering degree and diploma courses at both undergraduate and postgraduate levels. The university has a community of 17,000 students who represent 122 nationalities. The campus's state-of-the-art facilities include a modern Sports Centre; the Science Gallery, the first of its kind in the world; and Trinity College Library, the largest research library in Ireland. ◞

Rapprochement: "This is Not Your Father's CBT, Nor Your Mother's Psychoanalysis"

Mark Sisti

Mark Sisti, PhD is the director of Suffolk Cognitive-Behavioral, a group treatment & training center committed to "third generation" treatments.

> *"...therapy all too often still seemed to depend on an underlying onto-logical philosophy of determining the absolute truth about the content of one's cognitions."*

> *"This FAP & ACT conceptualization complements very nicely, what Paul Wachtel calls 'elic-iting accomplices' in his cyclical psychodynamics."*

Let me share the deep satisfaction of seeing the full arc of a long-term journey, which at least for now, peaked during a daylong NYC workshop I gave this November. The workshop, "This is Not Your Father's CBT, Nor Your Mother's Psychoanalysis," brought together an audience made of communities from both sides of the therapeutic isle. The collaborative workshop, given by myself (Mark Sisti), an Acceptance & Commitment Therapist (ACT), and Paul Wachtel, a relational psychoanalyst/integrationist, was for me in many ways the culmination of three decades of professional and personal development.

My professional journey started as a traditional cognitive behavioral therapist (CBT), then over the past decade I have committed myself to understanding and applying its third generation CBT incarnations, particularly Acceptance and Commitment Therapy (ACT). My slow evolution into being an ACT therapist was largely due to my growing dissatisfaction with the overly verbal and intellectualized struggle that all types of therapists can find themselves in with their patients. As a traditional CBT therapist, these over-intellectualized impasses particularly occurred during some types of evidence based "cognitive restructuring," To the credit of Aaron Beck, the best of this cognitive restructuring is supposed to be done through so called "behavioral experiments," However, to my experience, the general context for therapy all too often still seemed to depend on an underlying ontological philosophy of determining the absolute truth about the content of one's cognitions. Whereas, ACT and other mindful/acceptance based therapies approached "truth" from a more contextualist or constructionist viewpoint. It is our relationship with our thoughts that is emphasized, not the content, and that is best explored experientially. For example, cognitive flexibility and interpersonal resilience are explored more as an ability to accept or assimilate the simultaneous truth of two seemingly opposite ideas, rather than on deciding which was "true," Also, the more emotionally evocative elements of ACT emphasized that often emotional vulnerability, rather than needing to be "symptom reduced," could alternately lead us to needs, values, and to courageous psychological growth. Paradoxically, rigidly controlling or experientially avoiding emotion could often get us more deeply stuck in iatrogenic vicious cycles.

In addition ACT's interpersonally enhanced branches, i.e., Functional Analytic Psychotherapy (FAP) and Compassion Focused Therapy (CFT), emphasized the socially co-constructed nature of our selves. FAP and ACT therapies are ongoing real-time reminders to practice living in the here and now. While an oversimplification, one way to see ACT and FAP working side by side, is to say that ACT can emphasize intra-personal processes, while FAP tends to emphasize inter-personal processes. I was also drawn to FAP and ACT due to the experientially expansive way that ACT and FAP dealt with self-concept or "core-beliefs," They pointed the way to getting less caught up in "content" struggles and impasses with "self-worth" or "self-esteem," They encourage contacting and experiencing a sense of self, which is expansive and transpersonal, a reflective experience in which the thought is not identical to the thinker, nor the thinker's narrative (self-as-content). When over-identifying with our narrative selves, we often find ourselves reinforced in the short term for maintaining consistent self-narratives, and eliciting the complimentary roles required of others to fulfill them. This FAP & ACT conceptualization complements very nicely, what Paul Wachtel calls "eliciting accomplices" in his cyclical psychodynamics.

Eventually FAP led me to wanting the cumulative insights gained from nearly a century of psychoanalytic focus on inter-personal dynamics. I therefore decided to study Relational Psychoanalysis via the Mitchell Center. I found that critical therapeutic processes could be targeted through many "radical" psychoanalytic concepts like altering context through altering cyclical co-construction of self-other repertoires, the use of countertransference for insight into values and avoidances, and strategic self-disclosure for modeling vulnerability, intimacy and courage. I also hoped to broaden my use of reflective functions like mindfulness through conceptualizing these processes via interpersonal connection, secure attachment patterns, inter-subjectivity and mentalization.

Mitchell's relational psychoanalysis attempted to integrate the inter-personal and intra-personal, while maintaining precision and parsimony. I committed to a year at the Mitchell center hoping I would find a community able to see the potential for emerging common ground among third generation CBT's (ACT, FAP, CFT, DBT, etc.) and contemporary psychoanalysis. Furthermore, I explicitly went there, hoping to find colleagues willing to collaborate, to create rapprochement and dialogue between two typically divided communities. This rapprochement required that we stop objectifying "the other," deprecating the other and holding our straw men narratives about "the other" more mindfully. Such mindful and compassionate rapprochement needs fewer xenophobic accusations about what type of therapy is superior, and instead attention devoted to locating effective processes and the means to influence them. I had already found such open minded and welcoming professionals within my own third generation CBT organization (Association for Contextual Behavioral Science ACBS) and now I am glad to say, I have also found another such community within the Mitchell Center, as well as of course SEPI.

> *"These are trans-diagnostic, trans-theoretical times."*

Over the past few years, I have had the pleasure of meeting, and in some instances collaborating with, ACBS, SEPI and Mitchell, colleagues who have had rapprochement as a mission for many decades, e.g., Paul Wachtel, Marvin Goldfried, Jeremy Safran, Chris Muran, Jill Bresler, Karen Starr and Lisa Lyons, to name but a few. These are the beginnings of a new generation of open-minded therapists, professionally inter-subjective, if not necessarily integrative. Whatever our home community may be (and for now we may all need a "home theory," not to mention a "home community" or tribe). Today I believe we all find ourselves in a more welcoming theoretical public space, with language and concepts that are not so dissimilar. I believe that acceptance-based CBT's have worked within separate but parallel contextual (aka constructionist) philosophies, which also underlie relational psychoanalysis.

The underlying contextual philosophies common to both the relational and acceptance oriented therapies have brought us quite far from the "absolute truth," "one-person," drive reduction models of traditional psychoanalysis and just as far from the experientially avoidant, symptom-reduction models of our CBT fathers and mothers. Through recognizing our mutual constructionist commonalities, our mutual emphasis on emotional and experiential evocation, we can speak, hear and dialogue more than ever before; we can begin to truly see ourselves in each other.

> *"...I invite you to commit to reading several pieces of writing from the 'other' side."*

These are trans-diagnostic, trans-theoretical times. Discussions of ACT as a unified protocol, along with other unified protocols (e.g., Fonagy & Bateman's Mentalization Based Therapy, David Barlow's trans-diagnostic unified protocol) are on the increase among third generation CBTs. This is a hopeful trend of therapy based on identifying empirically mutative processes, not protocol-driven horse races between therapies. Contemporary clinicians who are ignoring developments on both sides of the isle are neglecting to apply their own prescriptive wisdom and are instead locked in old preconceptions. Such out of date preconceptions are now likely lead to increased isolation, from not only a larger therapeutic community, but also from disowned aspects of their own potentially expanded identities. There is a new generation of open-minded and flexible clinicians afoot in both of these communities. For those who have been reading or attending conferences and workshops with the "others," it has been great traveling with you. For those who might not have done much of that lately, I invite you to commit to reading several pieces of writing from the "other" side. For the more experientially courageous among you, follow such reading up with a workshop or two. This is not about switching allegiances, you don't need to leave your local tribe permanently, just visit the community next door and get to know them from the inside out and yourself from the outside in.

Society for the Exploration
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Rolling with Resistance

Henny Westra, Ph.D., York University

Dr. Westra is Associate Professor of Psychology at York University in London, Ontario. She is a prolific researcher and author of Motivational Interviewing in the Treatment of Anxiety, Guilford (2012).

"Although clients come to treatment because they desire change, they also simultaneously fear and oppose it."

"...it turns out that therapists have a high degree of control over the level of resistance."

Change can be a turbulent process that is fraught with competing and opposing feelings. Although clients come to treatment because they desire change, they also simultaneously fear and oppose it. And helping clients understand and work with these competing forces (i.e., ambivalence) is a critical therapeutic task. When a therapist takes a more directive approach aimed at accomplishing change with a client who is ambivalent about change, a predictable response occurs, resistance. And what begins to happen is that the client and therapist 'act out the ambivalence,' with the therapist typically arguing for change (taking all the good lines), while the client is forced into a position of defending the status quo and arguing against change. For example, the therapist may indicate a healthier way of viewing a stressful situation and the client disagrees (e.g., "I wish I could see it that way but I don't") or the therapist suggests a homework assignment and the client objects (e.g., "That sounds too hard"). The presence of such interpersonal resistance essentially reflects a lack of collaboration and represents strains or ruptures in the therapeutic alliance. This phenomenon of resistance has become the focus of our research efforts in the last number of years and this article briefly summarizes what we have learned about resistance in the context of our research.

We have developed a system for identifying resistance which quantifies the level of client opposition to the direction of the therapist in a given therapy session (Westra et al., 2009). Resistance is most typically indicated not by verbal content but by nonverbal cues (tone, pacing, interrupting, ignoring, etc.). And we have examined the impact of observed resistance in the context of cognitive behavioral therapy (CBT). This is an ideal context to study this phenomenon given that resistance is more likely to arise in the context of a more directive treatment that is more 'action-oriented.'

Given its consistent toxic relationship to outcomes, resistance should be considered a 'key' process marker. Resistance is actually relatively rare in the context of an entire session since clients and therapists usually spend most of the time cooperating. And we find that only around 10-20% of the time on average, are there signs of resistance using our coding system. This makes resistance more intriguing, however, since even within this limited range, higher doses of resistance are very powerfully predictive of outcomes. In other words, you don't have to be arguing all the time in order for this tension to have a negative impact on outcomes. And others have also observed that a little bit of negative process can go a long way (e.g., Binder & Strupp, 1997). But this also means that resistance is a 'key event' that therapists should learn to 'pick out' in a session.

Moreover, it turns out that therapists have a high degree of control over the level of resistance. In Motivational Interviewing (MI: Miller & Rollnick, 2002), sustained resistance is actually considered a clinician skill error. That is, resistance is thought to be the by-product of the client's level of ambivalence about change and the way the therapist manages that ambivalence (directive rather than supportive). And one of the major contributions of MI is that it gives therapists a way of thinking about and working effectively with resistance. This specific focus in MI on a key phenomenon is critical since it turns out that resistance can be difficult for therapists to identify and harder still to navigate. This is because there is a natural 'pull' when a client resists change, for therapists to 'take control' and convince and persuade (called the 'righting reflex' in MI language).

In fact, learning how to 'roll with resistance' might be the major benefit of learning MI and integrating it into one's practice. Two recent studies we conducted (that are currently being reviewed for publication) have supported this conclusion. We recently finished an allegiance controlled clinical trial (Westra, Constantino, & Antony, 2015) in which clients with severe generalized anxiety disorder (GAD) were randomly assigned to receive either 15 sessions of CBT alone or 4 sessions of MI followed by 11 sessions of MI integrated with CBT. In the integrated MI-CBT treatment, therapists could shift back into MI during CBT in the presence of resistance and ambivalence markers, and the entire treatment was foundationally informed by MI 'spirit' (empathic, supportive of autonomy, evocative). Importantly,

"...resistance is a key moment/time and what you do then may be particularly important."

therapists were nested in treatment group, such that therapists delivered only one of the treatments (either CBT alone or MI-CBT), self-selected the treatment they wished to deliver, and were supervised by expert(s) in the respective treatment. This ensured that the control group (CBT alone in this case) was high quality CBT and the best possible CBT. Overall, the results showed that those in the CBT alone group maintained their gains or showed some evidence of relapse at follow-up up to one-year post-treatment, while the MI-CBT group actually continued to improve after the treatment was completed. Thus, individuals in the integrated MI-CBT group were over 5 times more likely to no longer have the diagnosis of GAD at one-year post-treatment, compared to those receiving CBT alone. There were also half as many dropouts in the integrated treatment.

The findings of this study are particularly interesting with respect to resistance. That is, the level of observed resistance at mid-treatment was found to strongly account for the differences in outcomes between the groups (Constantino et al., 2015). That is, the CBT alone group had substantially higher levels of resistance than the MI-CBT group, which in turn was responsible for why the integrated MI-CBT group did better long-term. In other words, having the skills to prevent and diminish resistance (to avoid argument) seems powerful in improving client outcomes.

But another interesting aspect of this study is that when we looked *just* at the CBT alone group, we found exactly the same thing; that rolling with resistance seems to matter a lot. Aviram et al., (2015) identified and pulled out the specific moments of disagreement *within the CBT alone group* in the larger Westra et al. (2015) trial because we wanted to ask the following question ,"Even if they are not trained in MI, do those CBT therapists who are naturally more empathic and supportive (more MI-like) during disagreement have better outcomes?" The answer was a resounding "Yes, absolutely". In fact, Aviram found that even a modest increase in being more MI-like in the context of disagreement yielded large dividends in improving worry outcomes for GAD clients who received CBT alone. And the good news is that you may not have to be as skilled as Carl Rogers at empathy in order to improve your outcomes, but trying to be more like him at the right time could be very helpful indeed.

Moreover, Aviram went on to find that being more MI-like in the context of disagreement was 10 times more powerful than being more MI-like at randomly selected times in therapy. In other words, doing the right thing (empathy, support) at the right time (during resistance/disagreement) seems to be vastly more potent than doing that same thing at any time. That is, timing matters and context is critical. And in general, this supports the conclusion that resistance is a key moment/time and what you do then may be particularly important. So if you are a CBT therapist looking to learn a skill that could pay huge dividends in improving outcomes, learn how to identify and then roll with resistance. By the way, Adi Aviram will proudly be receiving the SEPI Dissertation Award for this work at the 2016 conference in Dublin.

In closing, studying resistance has been and continues to be vastly rewarding. The phenomena itself is incredibly intriguing and much more powerful than we suspected. Although it is far from simple, the exciting news is that therapists can develop tools (like those in MI), for responding to resistance in order to maintain collaboration and improve outcomes.

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Take-Home Points from some SEPI 2015 Presentations You Wished You Could Attend

Stress Levels, Coping and Psychosocial Issues of the Family Members of HIV/AIDS Patients: Nguyen- Intervention Program

Nguyen Thi Loan

This paper described an intervention program that was developed to help family members of HIV/AIDS patients in dealing with the stressors of their lives. A group of family members of HIV patients (parents, partners, siblings) participated in a program that initially identified their stress level and coping and psychosocial issues. Several socio-demographic variables (age, gender, religion and relationship with the patient) of said family members were found to have a highly significant relationship with their perceived stress level, coping and psychosocial issues. HIV patients' partners ranging in age from 30 to 39 and without religious affiliation were found to be most affected. Hence, a five-day intervention program was developed to help family members of HIV/AIDS patients in dealing with the stressors of living with and caring for a loved one with HIV/AIDS. The primary goal of the course was to improve the participants' general life skills, help them maximize their inner potential, and support them in finding meaning in their lives. Participants who completed the course showed an increased ability to reduce their stress levels, improved coping strategies, and reported feeling that they had changed positively as a result of the intervention.

Applying George Stricker's Tier Approach to Inform a Forensic Evaluation

Nancy Nichols-Goldstein

It was indeed an honor to present at the recent SEPI conference in Baltimore. I knew immediately that I was among open-minded clinicians who embrace therapeutic objectives. No one flinched or frowned when I suggested that even those paragons of "science," the astrophysicists, are questioning their approach and wondering if even in the study of physics there might be a "unified theory," a way of understanding that is not based exclusively on "empirical" methods. They seem to be searching for something we already have. Integrative concepts.

The realm of forensic evaluations is a land of potentially slippery, even slimy slopes. The pressure is on to use numbers to predict human behavior. I encourage students to consider instead the myriad of possible contributing factors that affect human actions, those highly variable individual elements that preclude empirical generalized predictions. Forensic examiners new to the field may inadvertently and unknowingly adopt the perspectives of the prosecutor or the defense and as a result lose some measure of objectivity.

My suggestion was to use Stricker's tier approach in order to find a more objective understanding that will also hopefully lead to more effective treatment recommendations. My example was a composite adolescent charged with robbery. Using a behavioral approach to highlight signals of impending problems as well as thinking about the reinforcement inherent in "getting away with" prior criminal activities, I then considered strengths evident in the young man's cognitions. For example, I noted his capacity for empathy. Finally, we addressed developmental psychodynamic perspectives including separation/individuation and attachment theory. Other clinicians could of course use any other combination of applicable perspectives individualized for their particular clients.

Integrative thinking is a way of combining recent empirical work with historical theoretical perspectives in order to better understand and help those who seek assistance.

Panel: The Art of Child Pschotherapy: Improvisation and Technique

Steven Spitz, Wade Anderson, Ken Barish

Introduction

We live in an age of technique. In our culture and in our family relationships, we now seek technical solutions to interpersonal problems. In the field of child psychotherapy, recent research has focused on the development of new techniques to help children resolve emotional and behavioral problems. In many respects, this is a salutary development. These therapeutic advances have been helpful to many children and families.

> *"...even in the study of physics there might be a "unified theory," a way of understanding that is not based exclusively on 'empirical' methods."*

But psychotherapy cannot be reduced to a set of techniques. Effective clinical work with children and adolescents requires a creative responsiveness to the individuality of each patient. From beginning to end, at every phase of the therapeutic process, child psychotherapy remains an empathic art. This symposium explored the art of child psychotherapy.

Orchestrating Relational Integrative Psychotherapy: Trusting The Empathic Arts of Internal Listening, Patience and Clinical Choice

Wade Anderson

In this paper, I juxtaposed two treatment cases—one failure and one success—in order to illuminate vital aspects of psychodynamic psychotherapy integration. I attempted to stick to the data of my experience in each of the cases; the aim was to highlight the real dilemmas of clinical choice and overall treatment orchestration.

I framed the subtle and not-subtle clinical decision-making process through the lens of daniel kahneman's *fast* and *slow* modes of thought. Psychologist Daniel Kahneman is an expert in decision-making and a Nobel laureate. According to Kahneman (2011), *fast thinking*:

> ...operates automatically and quickly, with little or no effort and no sense of voluntary control. The automatic operations of [fast-thinking] *generate surprisingly complex patterns of ideas*... [Fast thinking...] effortlessly originate[s] impressions and feelings that are the main sources of… explicit beliefs and deliberate *choices*. [Italics added]

All human beings use their visceral reactions or deliberations, or both, to inform all choices in everyday life. Clinicians worth their salt rely on these built-in human capacities in their work. My ability (or lack thereof) to be emotionally present *for* and *with* the persons showcased distinguished the respective case outcomes. My technical and methodological choices in the *failed* case were narrowed and then nonexistent as a function of countertransference, encapsulated in my immediate, *fast-thinking,* "**WATCH OUT!**" response when I heard the patient's initial phone message to me. In contrast, the broad, varied and truly integrative techniques I employed in the *generative* treatment were a direct outgrowth of my being more present—with equilibrium—and deeply relating and attuning to the family's emotional realities.

My juxtaposition of these cases underscores the fact that artful integrative treatment is about internal awareness and trust in our empathy. Successfully navigating integrated dynamic treatments demands that we listen and attend to our inevitable internal reactions in the service of our patients and without over-reliance on any one theoretical or methodological bias.

Creative Use of Self and the Therapeutic Relationship in Psychoanalytic Child Therapy

Steven Spitz

This paper explored the role of the creative process in psychoanalytic child psychotherapy by looking at my work with 9-year-old Dan. Spontaneous acts that seem to arise from unknown origins may exert a profound influence on the therapeutic relationship and the therapeutic process. Thoughts, feelings and behaviors often come to us as if unbidden. As the poet Hayden Carruth put it in an interview discussing his creative process, one might say that the pen writes the poem.

The creative process is quite comparable in the arts and psychotherapy. In thinking about the creative process, the topic of impediments to it invariably comes up. Conversations with musicians and artists are replete with the frustrating effects of creative blocks. This is in contrast to the excitement of improvisational music or the feeling one has in seeing a painting for the first time. Creativity usually involves linking the conscious with the unconscious.

Creative blocks are a useful vantage point from which to view both child development and stalemates in psychotherapy. Patients who show up in our offices can be thought of as having 'stuck' development. We are all familiar with feeling stuck in our work at different times. My work with Dan had been filled with deadness and stagnation; the same game was played over and over with the same rituals and outcomes. Conversation was avoided and there was a distinct lack of energy. I was at my wits' end and perhaps Dan was, too.

"I framed the subtle and not-subtle clinical decision-making process through the lens of daniel kahneman's fast and slow modes of thought."

"The creative process is quite comparable in the arts and psychotherapy."

Things changed quickly in an unanticipated moment between us that was spontaneous, funny and broke through our interactive block. Although space doesn't permit my going into it fully here, I borrowed a line from a movie we both knew. It fit the moment and released a great deal of unspoken tension between us. We both felt free to laugh and consider the powerful competition between us that had been not very far under the surface.

Many factors went into the creation of this moment, but it is important for the therapist to be open to the influence of his (and the patient's) unconscious—and sometimes to ride the wave of a spontaneous gesture which may open up a stagnant and closed process.

Get a Real Job!
Ken Barish

I began my work with Michael when he was an anxious, angry and hyperactive 6-year-old boy. At the time of the incidents I will recount, Michael was 24, working as a salesman in a retail store.

Over the years, Michael and I spent many hours discussing the psychological disturbance of his mother, a borderline psychotic woman whose unusual psychopathology we struggled to understand, as well as the (less severe) disturbance of his alternately withdrawn and explosive father, and many hours helping Michael understand and contain his own explosive anger.

In the course of our work, Michael often teased me. When I challenged him, he would reply, "Dr. B., get a real job!" Then, at the end of the session, he would warmly shake my hand. "Thanks, Dr. B, you know I tease you, but it helps me a lot to talk to you." And so it seemed.

Are there lessons about the art of psychotherapy and about therapeutic change that we can draw from these, admittedly atypical, therapeutic interactions? Certainly we are reminded of the importance of humor. When children tease us, it is almost always a sign of strong therapeutic relationship and often a prelude to moments of insight and change.

In response to his mother's bizarre behavior, Michael had developed contemptuous attitudes, which he took with him into the world and that he needed to change. At these times, I challenged him and corrected him.

More than anything else, however, I listened to Michael. Every psychotherapy has this common essence, what Sheldon Bach, in a deceptively simple formulation, called, "being heard."

We all know the experience of *not* being heard. We become angry. Our voices get louder. We become more insistent and demanding, more stubborn and self-righteous. Or, we may give up. We may become over-sensitive, as Michael did, to feeling criticized and misunderstood. Over time, these attitudes become part of our character; we may come to believe that our attitudes and demands are necessary and right, or that trust and understanding are not possible. Being heard arrests these pathological intrapsychic and interpersonal processes.

The art of child psychotherapy often lies in a moment of choice—at what point in a cyclical pattern of cause and effect we can most usefully intervene to arrest vicious cycles of anger and withdrawal; and then promote, in their place, positive cycles of understanding and appreciation, of accomplishment and pride.

"When children tease us, it is almost always a sign of strong therapeutic relationship and often a prelude to moments of insight and change."

Society for the Exploration

SEPI

of Psychotherapy Integration

SEPI XXXII ANNUAL MEETING
Dublin, Ireland, June 16-18, 2016

The *Therapist* in Integrative Therapy:
Implications for Practice, Research, and Training

**Thursday June 16 through Saturday June 18
with pre-conference workshops on June 16**

CALL FOR SUBMISSIONS

The Society for the Exploration of Psychotherapy Integration (SEPI) invites submissions for the 32nd Annual Conference to be held in Dublin, Ireland, June 16-18, 2016 (with preconference workshops on the morning of June 16). The conference site will be Trinity College, located in the heart of Dublin. Attendees will have the choice to stay at the College for a very reasonable fee or in one of the hotels around the College. When finalized, information about lodging choices will be available at the SEPI website: www.sepiweb.org

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.

DEADLINE FOR SUBMISSIONS

TThe submission deadline is December 18, 2015. Submit online through the SEPI Conference submission portal at http://www.mymeetingsavvy.com/sepi which will open October 15, 2015. Submission guidelines can also be found there. The program committee will send notices of acceptance by **January 30, 2016.** Simultaneous translation will not be available at this conference; the conference language is English.

CONFERENCE THEME

The *Therapist* in Integrative Therapy:
Implications for Practice, Research, and Training

Continuing with SEPI s goal to expand and enrich our mission of promoting innovative applications of integrative psychotherapy, the major theme for our 2016 meeting will address the topic of the **therapist**, with its numerous practice, theoretical, research, and training implications The therapist's contribution is of growing interest in treatment process and outcome studies. It has become increasingly important to identify therapist actions that are associated with effectiveness..

A number of questions emerge from this interesting intersection of therapist and integration:

Practice
- How do integrative models influence or modulate the therapist's practice?
- Is an integrative therapist better prepared to treat diverse clinical problems than a therapist who adheres to a single theoretical model?
- How does an integrative therapist adapt to cultural differences?
- How do therapists' factors operate with internet-delivered therapy?

Research
- What are the distinguishing characteristics of an integrative therapist? What is the impact of these characteristics on their work?
- What characteristics of the therapist contribute to relationship factors such as alliance or empathy?
- How do integrative psychotherapists adapt their relational style to patients' proclivities and personalities?
- Do certain therapists obtain better outcomes overall or do particular therapists have better outcomes with specific patient populations?

- What effects do the characteristics of the therapist have on continuance in psychotherapy? How do therapist variables interact with attrition?

Training
- How and when does a therapist choose to become integrative?
- When is the right moment to "become" an integrative psychotherapist?
- What is the optimal way to be trained as an integrative therapist? Do therapist singularities influence different ways to be trained?
- What are the skills and competences that characterize an integrative therapist, and how can they be acquired?
- What are the distinctive ways of supervising an integrative perspective?

While submissions are especially encouraged that speak to this theme, we welcome submissions that are not directly related to the conference theme but bear on the broader theme of psychotherapy integration.

PROGRAM FORMAT

We encourage the participation of practitioners and scholars from all psychotherapy traditions and disciplines to attend our 2016 conference. While some may not necessarily identify themselves as *integrative*, we welcome the participation of all intrigued by the opportunity to discuss psychotherapy integration, pro or con.

The program will consist of **pre-conference workshops, symposia/panels, discussion groups, mini-workshops, individual papers, and posters** that address themes related to psychotherapy integration. There will be two keynote speakers and three plenary panels featuring invited participants.

We wish to underscore that:
- SEPI is particularly devoted to facilitating dialogue among participants. As such, all presentations should allocate ample time for audience participation and discussion.
- We encourage the use of videotaped sessions, verbatim transcriptions, demonstrations, case presentations, or other methods that ground the dialogue, clarify practical considerations, and demonstrate clinical application. (Please be sure to secure client's informed consent for the ethical use of session material).

TYPES OF PRESENTATIONS

The following descriptions indicate the session formats that are possible for submissions.

POSTERS

Posters are graphic representations of the results of studies. Interested attendees have one-on-one discussions with the presenter whose work is displayed. Poster dimensions should approximate 91 x 122 cm (or 36 x 48 inches). Many attendees appreciate receiving a handout that summarizes a poster's findings.

INDIVIDUAL PAPERS (15-20 minutes)

Papers are formal presentations submitted by individuals. A paper may or may not be part of a panel. Papers that are not part of a panel will be assigned a specific slot by the organizing committee.

PANEL SESSIONS/SYMPOSIA (75 minutes)

A panel/symposium is a formal presentation that includes no more than three (3) papers and a discussant. Each panel must have a chairperson who will introduce the presenters and topics, monitor time allotments, and guide audience participation. A link in the submission portal provides an example and instructions on how to group papers together in a panel/symposium submission.

MINI-WORKSHOPS (75 minutes)

Mini-workshops are designed primarily for applied and practitioner audiences and focus on skill development or experiential involvement. A workshop "summary sheet" (overview of the topic) and handouts (if applicable) should be available to participants. Only a limited number of mini-workshops will be possible during the conference. Due to the short nature of these workshops, a pointed focus is desirable.

PRE-CONVENTION WORKSHOPS (3 hours; held on the morning of June 16))

We will consider up to four half-day (3 hour) workshops to allow participants to learn about and explore a particular approach in more depth. Workshop proposals must be approved by the SEPI program committee.

CONTINUING EDUCATION

There will be continuing education for psychologists offered at the Dublin meeting through the APA Society for the Advancement of Psychotherapy (Division 29 of the American Psychological Association). The Society for the Advancement of Psychotherapy is approved by the APA to offer continuing education for psychologists. The Society for the Advancement of Psychotherapy maintains responsibility for the program.

We require all formal sessions (not posters) to be CE approved. To make your session CE accredited, you will follow certain APA CE guidelines: provide complete CVs for all first authors and provide learning objectives (at least one per every submission, or at least one per hour if any single submission is longer than one hour). You will do this through the submission portal when you submit your conference proposal. For information about CE and writing acceptable learning objectives, please find more information here: http://www.sepiweb.org/?page=ConvCE

There will be a charge to obtain CE for anyone who is not a member of the Society for the Advancement of Psychotherapy.

CONFERENCE LANGUAGE

When making your conference submission, please note that presentations must be given in English. Please rest assured, however, that perfect grammatical English is NOT a requirement, but being understandable to English speakers is required for presentations. No translation services will be available.

SUBMISSION GUIDELINES

Follow the instructions at the SEPI website posted at http://www.sepiweb.org

STUDENT STIPENDS AND SEPI MEMBERSHIP

A limited number of stipends are available to defray costs for students presenting at the conference. To qualify for a stipend, students must be the first author and presenter of a paper/poster and must be SEPI members. If you or a member of your panel wishes to be considered for such a stipend, contact SEPI Treasurer Dr. Steve Sobelman at steve@cantoncove.com. For membership information, go online or contact Membership Committee Chair Dr. Marvin Goldfried, marvin.goldfried@stonybrook.edu

LIMITS ON FIRST AUTHORSHIPS

The program will include posters, individual papers, panels/symposia, discussion groups, mini-workshops, and preconference workshops (as detailed above). There is **a limit of two first-authorship presentations at the conference;** however, there is no limit on other forms of participation such as discussant, chair/moderator or second authorship. Presenters will be subject to the usual registration fee for the conference.

PROGRAM COMMITTEE

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