

Mission Statement

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



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A Word From the Editor

Jeffery Smith

*Dear SEPI members
and friends,*

We are pleased to present a trove of riches. In keeping with the Dublin conference on the theme of *The Therapist*, we wanted this issue to focus on how one *becomes* a therapist. This issue's theme, therefore, is *Training Around the World*. Don't miss the featured interview with Nancy McWilliams for an intimate glimpse into her experience with integration in a context of single orientation teaching. James

Boswell gives a counterpoint on introducing integration at the beginning of training and Jill Bresler and Ken Frank further deepen our insight into the assimilative model. Finally, Jennifer Davidtz interviews her graduate mentor, Richard Halgin, on his experiences and contributions to the teaching of integrative psychotherapy.

That is only the beginning. With a salute to the hard working SEPI committees of 2015, we turn to the world at large with a new piece from our Dublin local conference committee on the revolt of 1916. China is the next stop, where I interview Lana Fishkin on teaching psychoanalysis by Skype to new therapists in that country. Jack Anchin and members

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President's Column

Beatriz Gómez

A wonderful meeting in Dublin coming up soon!



Dear SEPI colleagues:

I am delighted and honored to take over this challenging role at SEPI with the precedent set by the magnificent work done by Rhonda Goldman and John Norcross, and with the sound foundations of previous SEPI leaders. I am also encouraged by the exciting prospect of the upcoming Conference in Dublin.

With remarkable hospitality and efficiency, Marcella Finnerty and the Local Organizing Committee are preparing what will undoubtedly be a memorable meeting at Trinity College.

We share an amazing time ahead with the spread of integration, which is continuously growing throughout the world. More and more surveys are informing us of this trend. My homeland, Argentina, constitutes a good example. Our profession has traditionally been psychoanalytically oriented. Its roots can be traced back to the late 1930s, and the blossoming of psychoanalysis in Argentina can be explained by the social and psychological climate of a country that was made up mainly of immigrants, especially from central Europe. At the beginning of the 21st century, Muller and Palavezzatti conducted a survey to provide information about the relationship between theoretical orientation and clinical practice in the hospitals of Buenos Aires, the city with the largest population of therapists per capita. In 2000, the psychoanalytic model emerged as the predominant model,

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Nancy McWilliams teaches at Rutgers University's Graduate School of Applied & Professional Psychology. She has a private practice in Flemington, NJ, and has authored several books on psychoanalytic therapy.

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“I’ve been as critical of psychoanalysts who idealize some form of psychoanalytic technique and try to fit the patient to that, as I am of anyone else.”

Featured Interview

Nancy McWilliams

Smith: Nancy, let me start with a bit of curiosity. Your name has come to be synonymous with the psychoanalytic point of view and, at the same time, you're a staunch member of SEPI. I wonder if you could help us understand your commitment in both areas.

McWilliams: I learned psychoanalytic theory before I learned other approaches and went through an analysis myself when I was quite young. I was radically helped by it. So, certainly, that's been my base. But, I've never seen the wisdom in viewing psychotherapy as a set of techniques. I much more believe it to be a relationship and a process, within which specific techniques may be valuable.

I've never defined my psychoanalytic orientation based on a particular way of working with people because my whole shtick has been—and I think this is consistent with psychoanalytic ideas about personality—that you start with the person. And you figure out as best you can, how to understand this person, this situation, this person's background, the person's contexts, the person's challenges, now.

Then you derive your interventions from that, rather than starting with a favorite intervention set and applying it no matter who the person or the problem is. So, I've been as critical of psychoanalysts who idealize some form of psychoanalytic technique and try to fit the patient to that, as I am of anyone else who tries to fit the patient to the technique, rather than the other way around.

Smith: Is there anything else that drew you, in particular, to SEPI?

McWilliams: I've always been integrative. Within psychoanalysis, I've never joined up with a particular sub-theory. I'm not a Kleinian, or a Freudian, or a Sullivanian, or any of the number of things you can call with an “-IAN.” I haven't been an intersubjective person, or a relational person, or an ego psychologist. I just find that different theorists and different writers are focused on different problems. And they have somewhat different angles of vision and are not necessarily in competition with each other. I've been temperamentally integrative from very early.

I learned a lot from humanistic people—from Rogers and that tradition, from the early behaviorists. Like Skinner, I did not see a major problem with integrating behavioral theory and psychoanalysis. So, it's partly temperamental, it's partly from the point of view of being a practicing therapist. I think most therapists are integrative. The vast majority of therapists of any orientation are happy to take any approach that's going to help their patient, if they see the evidence.

Smith: That's a good lead in to the topic of training. I wonder if you could talk about your philosophy with regard to teaching integrative psychotherapy.

McWilliams: Well, I've always been very happy to be at a program that represents a diversity of theoretical orientation. My friend Stan Messer is the dean at Rutgers and, as you know, he's the incoming president for SEPI. So, he's always been interested in integration and used to having public, very respectful conversations, such as with Arnold Lazarus, about different ways to work with people.

First of all, I've been in an environment that supports teaching students more than one way of thinking about things. So, I do feel very strongly that students should get exposure to the different theories and language systems of the main theoretical orientations. You should not just be illiterate in the language of your colleagues, even if they are of a different orientation than the one you're attracted to.

But, as a teacher myself, my main role at Rutgers has been to teach students what it's like to actually be a therapist. And I'm a full-time therapist and only a part-time academic. So, I can only represent what I know really well, which was

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“I might understand somebody psychodynamically and end up recommending to the student that they do exposure therapy.”

based in psychoanalytic ideas and gradually integrated others. I could never teach my students what it's like to have been a cognitive-behavioral therapist from the beginning. That just wasn't my path. So, I tend to represent the position that you should teach from one orientation and then gradually students can expand on it.

I think that was coming from my sense that when I'm trying to model what it's like to be an actual therapist, I can't take the position of, “Well, you just do whatever works.” I think you have to teach them a way of thinking about things from the perspective that makes the most sense to you, and then you can integrate other stuff when your own perspective has limitations.

Smith: *It seems like the standard approach in teaching psychotherapy is to survey six, or seven, or eight different orientations and then ask students to make a personal choice about what style of therapy they're going to adopt. That seems like it's asking a lot of young people with little experience. I wonder what you think about that.*

McWilliams: I think that's true. But, fortunately, I think all the orientations are greatly valuable and whatever direction they go, if they are really interested in being effective healers, they are going to, over a period of time, expand themselves. So, yes. Those decisions get made for very arbitrary reasons. What some professor told them, or what their own therapist identified with, or what teacher they happen to idealize. And later on, they branch out. But I think all the main approaches to psychotherapy have enough evidence behind them and enough of a tradition of helping people that it doesn't really matter so much where you start. It does matter if you get very ideological and closed-minded about having the only way to do this. That's really not helpful to anybody, especially your patients.

Smith: *So, you're recommending an experience somewhat similar to yours and I guess mine, as well, some sort of an initial bonding experience, a little like ducklings bonding with somebody or something that appears at the right time.*

McWilliams: *[Laughs]* Yeah. I think that's a good metaphor. Because I think it's very hard to learn psychotherapy and there's so much anxiety about it. Students get very difficult patients assigned to them. Sometimes they're suicidal or dangerous. And they need to believe that there's somebody who knows what they're doing. And that's where mentoring fills a very important need for the beginning person.

Smith: *Tell me a little more about your approach to teaching.*

McWilliams: I put most of my energy into trying to understand first. I might understand somebody psychodynamically and end up recommending to the student that they do exposure therapy. Because that's what this particular situation would respond to best. And again, I think that's what therapists do in the real world. I have colleagues who are cognitive behavioral who refer to me when they feel there is a personality problem that a psychoanalyst might have a better handle on. And I refer out to people who have specific problems that I know my CBT colleagues are better at than I am.

Smith: *Clara Hill has a textbook that presents a different approach to teaching, in terms of non-specific helping skills, rather than one orientation or another. It de-emphasizes the understanding and emphasizes the skills of being a listener and a healer. I wonder if you could comment on that approach to training.*

McWilliams: I admire her work very much. And there was a man in my department, now deceased, John Kalafat, who did that kind of training with students. I suppose I take it for granted because they would come to my courses having learned those basics in how to just sit, listen, educate the person about the process you were going to go through together, be clear about the contract, explore any concerns that the person had.

All of the things that tend to be under-emphasized in other textbooks which go right to what you should do if you already have a working alliance with them. So, I really like that approach. Obviously, we're all looking at the same suffering human beings and we're going to come up with different language for how to help them. But after more than 100 years of psychotherapy, there ought to be some basics that can be stated about how to just start a therapeutic relationship. And that I think is an excellent contribution on her part.

Smith: *I wonder if you have some follow-up about what happens to the students you see early in their careers. Where do they wind up in terms of the kind of pattern you described or starting with one orientation and then absorbing wisdom from other ones?*

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“We are looking forward to a more relaxed issue for the summer highlighting the Dublin conference. In September, the Newsletter theme will be Research.”

McWilliams: They are all over the map. I have not done a systematic study of any kind about what happens to my students. But I’ve done a lot of unsystematic observation, not only those that end up in the United States, but I have students who are all over the world now. And, mostly, they expand into some specific area and they end up being very expert in the literature relevant to that area. Whether it’s drug abuse, or college counseling, or trauma, or personality disorder. A few of them went on for psychoanalytic training and have really immersed themselves in that. But more often, they put together a kind of general practice somewhere or they get excited about some specific area.

I have a former student who, for example, is a leader in the movement to get prescription privileges, who has five different degrees—a couple of them are in neuroscience. And she’s, I think, very friendly with psychoanalysis, but would never call herself particularly psychodynamic therapist. And I would say that most of my students feel glad to have had that background, but they’ve taken it and gone to get the kind of learning that they needed to solve whatever clinical problems they ended up working with.

Smith: For the SEPI readership—people who may be less experienced than yourself as a teacher—do you have some take-home insights, tips, experiences that you might think that other teachers would find interesting?

McWilliams: You know what? Students say to me that what was helpful about my style of teaching is that I made them feel safe to say what they really did. One can’t really underestimate how much anxiety students have and how much they need some sense that you have trust in their basic capacity to care about people, and help people, and repair if they make a mistake.

In my diagnosis book, frequently, people will say they were helped by it. But if they add the sentence “there’s one story I just loved,” I always know which story it was. It was about a psychotic man that, in the grip of crazy rescue fantasy, I lent him my car and, of course, he drove it into a tree. People are so relieved when supervisors and experienced people cop to all of their mistakes. I think that’s critical.

And also embodying not knowing. Sometimes, people don’t tell you things for two years until they’re safe with you. So, the idea that you know what this patient needs when they may not have told you that they’re gay or they’re bulimic, or they have an addiction, even though you’ve asked. You just can’t go into this with the idea that you have the true way to educate the young person. They will only feel inferior if you pull it off and contemptuous if you don’t.

Smith: Are there any other things that you would like to add for readers around the issue of training?

McWilliams: I just want to say I’m so glad that SEPI is out there to try to represent and open this to more than one point of view. I feel as critical of the dogmatically psychodynamic programs—although there aren’t too many of those left—as I do of the dogmatically CBT programs or any other kind of dogmatism. And SEPI invites us to open a space to learn from other people instead of getting the cheaper consolation of feeling some kind of superiority based on the illusion that we know more than they do. 🐾

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

of the Education and Training Committee weigh in on teaching the value of difference. Representing our regional networks, Margarita Dubourdieu reports on the state of integrative psychotherapy in Uruguay. After that, the not-to-miss piece by Jerzy Dmuchowski on group therapy in Poland in the wild and crazy 70s and 80s followed by three brief pieces from the Baltimore conference on therapy and culture in Turkey.

Whew! We are looking forward to a more relaxed issue for the summer highlighting the Dublin conference. In September, the Newsletter theme will be Research, so authors, please begin thinking about your contributions, especially in light of political and funding issues currently in play.

Hoping to see you all in Dublin.

Jeffery Smith, MD 🐾

James Boswell is a teacher and researcher in psychology at SUNY Albany. His interests are psychotherapy process and outcome and integration of science and practice.



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A Perspective on Integrative Psychotherapy Training

James F. Boswell



I believe the integrative vs. single model training debate sets up a false dichotomy and simultaneously oversimplifies and restricts what it means to think and work integratively. Within an integrative model, there are multiple (non-mutually exclusive) pathways to psychotherapy integration (Boswell et al., 2010). My argument is that effective training in integrative therapy should meet two conditions. First, there needs to be in-depth learning of the substance of two or more theoretical traditions, and second, there must be an orienting framework for theoretical and/or technical assimilation and accommodation. In line with both requirements I believe in the adage that one cannot competently integrate what one does not know well. Furthermore, mere exposure to multiple models is not enough to promote competent integrative practice (Boswell, Nelson, Nordberg, McLeavey, & Castonguay, 2010). Below I will suggest one over-arching framework to guide therapeutic decision-making, including when working from the perspective of technical eclecticism.

How did I come to this view? Louis Castonguay’s work on psychotherapy integration was a major factor in my decision to apply to Penn State’s clinical psychology graduate program. My interest in this program intensified after learning more about its clinical training and science-practice integration philosophies. This was (and still is) a place where one could receive intensive training in cognitive-behavioral therapy (CBT), psychodynamic psychotherapy, and humanistic psychotherapy by experienced faculty who were not only expert clinicians, but also researchers who conducted research on these models. In addition, these faculty members were not on separate islands. They actually talked to one another, respected one another’s ideas and perspectives, and even published together! This was definitely the place for me. A program such as this is often counterposed with so-called “single model training.” Here I will argue that exposure to multiple theoretical orientations is not a proxy for psychotherapy integration, and that, although admittedly anecdotal, I think it is extremely rare for so-called single model training approaches to be devoid of integration (explicitly or implicitly). Finally, I briefly highlight a conceptual framework and a recent study that holds promise for finding common ground on these issues.

Integrative vs. Single Model Training

Competent integrative practice requires a coherent framework or over-arching structure for integration, as well as sufficient knowledge of the components to be integrated—whether these are theories, techniques, and/or interpersonal stances—to make it go. As such, I believe that trainees who are interested in learning how to work integratively should also be exposed to single models, and this exposure should not be cursory. The field has yet to identify the most effective training models for developing an overall framework for thinking integratively, and learning and applying principles and techniques commonly associated with specific theoretical orientations. A starting point to identifying effective models has been the discussion of whether training in psychotherapy integration should begin early or at the start of one’s training, or should be introduced toward the end or at a more advanced stage (e.g., internship, residency, post-doctoral training)? This issue was addressed in a very interesting series of articles published in the *Journal of Psychotherapy Integration* (see Castonguay, 2000a,b). In this series, Castonguay outlined a developmental training model that combines intensive exposure to specific theoretical orientations with a focus on common factors and principles of change as an orienting framework for integration. An underlying assumption is that a full appreciation of the benefits of psychotherapy integration comes with more exposure to clinical work.

While I believe that one cannot effectively integrate what one does not know well, I also believe an integrative approach can, and probably should, be introduced at the beginning of one’s training. Specifically, trainees can be instilled with an integrative “attitude” and begin to develop a structure for thinking and working integratively. For example, trainees can be exposed to writings on principles of change (Castonguay & Beutler, 2006; Goldfried, 1980), relationship factors (e.g., Norcross, 2011), and exemplar models of integration (Norcross & Goldfried, 2005). This is consistent with the training approach at Penn State University, and can create a meta-cognitive structure that can be applied while learning and applying specific models of behavior and therapeutic change (e.g., CBT, emotion-focused, psychodynamic). Within this structure, single model training is not antithetical to psychotherapy integration or the teaching of integrative psychotherapy.

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Is Integrative Training in the Eye of the Beholder?

I have, thus far, advocated for single model training in the context of valuing and promoting psychotherapy integration in training, rather than address the relative pros and cons of “integrative vs. single model” training. Conversely, I have found that even in training programs that identify strongly with a particular theoretical orientation, trainees are often exposed to exogenous theories and intervention strategies. For example, even when a director of clinical training checks a box that indicates that their program’s predominant orientation is CBT, it is likely that their students are also receiving training (both didactic and experiential) in working alliance development, meta-communication, reflection, mindfulness, and motivational interviewing. Although, in my view, this represents something that is qualitatively different from single model training, it also may fall short of the working requirements for integrative training listed above if (a) the exposure to exogenous strategies and principles is cursory, (b) there is a lack of recognition of the activity of practicing integratively, and/or (c) there is no provision of an explicit framework for understanding how seemingly divergent assumptions and techniques cohere or fail to cohere. Although I believe that such exposure is a step in the right direction, it may also be the case that the absence of an explicit integrative structure (or attitude) ultimately undermines the subsequent clinical responsiveness of the trainee. Such responsiveness is perhaps the most important “gift” one receives by being trained formally from an integrative perspective.

A Useful Framework and Research Example

Constantino and colleagues (e.g., Constantino, Boswell, Bernecker, & Castonguay, 2013) have offered a cross-cutting approach to psychotherapy integration labeled *context responsive psychotherapy integration*. In line with emotion-focused theory and research (Greenberg, 2010), this approach proposes an “if-then” structure for therapists to respond to patients’ personal characteristics and emerging clinical scenarios with context-relevant, evidence-based therapeutic strategies. Context-responsiveness draws on both theory-specific and common treatment factors in response to significant markers that require responsive intervention. One such marker discussed by Constantino et al. (2013) is change ambivalence.

Change ambivalence can reflect low motivation, uncertainty about change, the therapist, or treatment, or conflict between a desire to change and a desire to maintain familiar patterns. If present, therapists may consider intervening with motivational interviewing (MI) strategies. In order to do so effectively, one must (a) have a firm understanding of both the humanistic underpinnings of MI and the endogenous model, and (b) the markers of ambivalence that should trigger such context-responsiveness. Recently, Westra, Constantino, and Antony (in press) completed a randomized clinical trial (RCT) that examined the efficacy of MI plus CBT compared to CBT alone for severe generalized anxiety disorder (GAD). Trial therapists were trained to competence in both MI and CBT for GAD. Consistent with the context-responsive framework, the overall treatment approach was gold standard CBT, yet therapists were trained to identify within-session markers of change ambivalence and to shift to MI strategies when indicated. Based on ratings from independent observers, therapists demonstrated adequate adherence and competence in applying both MI and CBT. Drop-out rates were lower in the MI plus CBT condition and significant between-condition differences emerged at long-term follow-up, all of which favored the integrative condition.

The spirit of psychotherapy integration is the building of bridges. I believe that Constantino’s context-responsive integration framework has the potential to bridge the gap between integrative and single model training approaches, as well as models of integrative practice (assimilative, technical eclecticism, common factors). This approach allows one to work from a predominant theoretical framework, while offering a rationale and pathway (if-then) for rigorous exposure to alternative models. Consequently, this approach meets the main requirements for integrative training noted above. Furthermore, Westra et al. (in press) have demonstrated the *feasibility* of this approach for training and practice. I am hopeful that this exciting and clinically meaningful work will be extended. Thinking about this ideal example of integrative training, practice, and research, I can’t help but wonder what the weather is like in State College, PA right now. . .

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“Clinicians who have studied psychoanalysis, with its long history and its multiple evolutions and revolutions in thought and practice, are very adept at appreciating a history of co-existing and competing ideas.”

Training in [Assimilative] Psychotherapy Integration: Notes from the Field

Jill Bresler and Ken Frank

Over the years, we have seen growing interest in the psychoanalytic community in both an acknowledgement of the relevance of research and science to psychotherapy, and in attaining proficiency in alternate modalities. Like therapists of many other orientations, a growing majority of psychoanalysts now endorse the idea that one's home model may not be the most efficacious model for some patients, or for some problems that arise within an essentially psychodynamic treatment. This idea compels a desire to open oneself up to becoming an integrative therapist.

The Psychotherapy Integration Program (PIP), a certificate program in psychotherapy integration at the National Institute for the Psychotherapies (NIP) based in New York City, was launched in September 2015. NIP was founded in 1970, and chartered by the NY state Department of Education in 1972. Ken Frank, among the leading integrative psychotherapists in the psychoanalytic tradition, spearheaded the project. Jill Bresler, another leader in psychoanalytic integration was subsequently named co-director. Frank assembled and consulted with a distinguished group of advisors, among them SEPI founders Marv Goldfried, George Stricker, and Paul Wachtel, and an eager faculty, including Jill Bresler and Lisa Lyons. All instructors and supervisors work from a relational psychoanalytic baseline and share the program's theoretical orientation of assimilative integration.

The program is designed to teach psychotherapists with an analytic orientation both the theory and practice of assimilative integration, a method for importing techniques and concepts from other modalities into their "home" orientation in order to improve therapeutic efficacy. We focus initially on historical and theoretical aspects of integration so the clinician can feel conceptually grounded. After this, we teach both CBT and DBT as models and methods that can be effectively integrated into a psychodynamic approach. If we think of therapeutic change in terms of affective-cognitive-action-body schemas, CBT and DBT techniques such as exposure therapy and mindfulness training are used to work with the body to improve affect regulation. Once these therapeutic skills are taught we work intensively with students on implementing them in their clinical work.

PIP is unique. There is no other training program that is specifically aimed at teaching integration to experienced psychodynamic therapists. Frank, who was among the founders and architects of NIP's psychoanalytic curriculum in the 70's, observed that formulating effective training in psychotherapy integration is even more challenging than psychoanalytic training. There is no roadmap for this new terrain. Our students are learning from us, and we are learning from them, as we continually fine-tune a curriculum that addresses the needs of our group. Below, we will describe some of what we have learned.

Students often come to us without having had any exposure to the field of psychotherapy integration. Although they are opting to become integrative therapists, they don't have much grounding in the theory and science of integration. They must be taught that an integrative approach can be theoretically grounded and disciplined, rather than random and eclectic. Teaching about integration as a subject in its own right allows students a conceptual framework for what they are doing, and equally important, allows our students to begin to develop an identity as assimilative integrative therapists.

Our educational goal is threefold: First, we want our students to have an appreciation for basic models of both integration and of the specialty areas studied, including recent developments and current controversies; second, we want them to develop proficiency with skills; and third, we want them to begin to selectively incorporate specific CBT and DBT skills into their practices. One idea that has been challenging for students to master is that proficiency and uncertainty are not antithetical to one another, but dialectical. Every integrative therapist engages with the question, what method should I employ now? The answers to these clinical questions are not always clear, even to the senior integra-



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tive clinician who has mastered the principles on which to base such decisions. Grappling with such issues can lead to theoretical advances.

Our first objective is easily met. Clinicians who have studied psychoanalysis, with its long history and its multiple evolutions and revolutions in thought and practice, are very adept at appreciating a history of co-existing and competing ideas. They are interested in how some ideas are central to both psychoanalysis and other schools, as well as how the models diverge conceptually. Our conversations along these lines have been rich, thought provoking, and useful, since they further ground the class in what is meaningful and useful about various approaches. Throughout our studies, core concepts in integration, like the importance of common factors, emerge. For instance, students begin to appreciate the historical significance of exposure in treatment, understanding the through line from Freud to Wolpe and beyond.

Of course, practical skills training, and learning to implement skills, is the most valued part of the program by our students. We have learned a lot about how to make this aspect of the program strong. We find it crucial to engage our students in both seeing and experiencing the typical conversational patterns and techniques associated with each modality. We model techniques, use videos, provide written protocols of techniques, and most important, have our students practice themselves, either in class or with each other. For the most part these can be in-person experiences, but we have been studying how technology is making it more convenient for our students to learn with us, and with each other.

Not surprisingly, the most complex part of the training is skills implementation. We can and do provide guidance on the question of when to do what. It is easy to make clear that when your patient complains of panic attacks, it often is an ideal time to implement CBT skills for working with panic. It is perhaps more difficult to identify when not to switch and why; likewise, when it might be useful to switch from an exploratory to a more directive stance with a patient; or what kinds of homework might be most useful in a particular treatment. As psychotherapy researchers know, these kinds of fine-grained questions don't always have clear answers. Becoming adept at these kinds of shifts, and evaluating their effects clinically takes practice, and it is the shared experience of the class as they experiment together that is the most effective teaching tool in this regard. Ultimately, we teach our students, every patient and every therapeutic pair requires a uniquely developed therapy.

Another observation that has struck us as a faculty is the variability of willingness to try new things seen in a group of clinicians that are eager to become integrators. Although we initially found it disheartening that more often than not students are slow to adopt new techniques, we came to see this phenomenon as expectable. (Reckless application would of course be equally or even more problematic; however we have not seen much of this.) Following up on the theme from the last SEPI newsletter—resistance, we consider this clinician resistance to be normative and informative. Understandably, it is anxiety provoking to enter the unknown and to use new techniques that are not tried and true. When there is reluctance it's our job to help our students past it. It is rare for a student to shy away from experimenting within their own practice if their reluctance is understood and explored, and they are properly supported. While encouraging responsible clinical experimentation, we respect that each trainee's pace is individual.

Although our program was developed as a way to teach psychodynamic therapists additional models, we believe it is a model that could form the basis for an assimilative integrative program for any home orientation. We are intrigued by the possibilities, both for the development of more programs like ours, and for the opportunity to share what we are learning about teaching integration with others.

Please direct questions about our program to either of us. Ken Frank will be presenting at the SEPI meeting in Dublin. He would welcome meeting you and taking your questions at the conference. We are taking applications for a new class in September 2016.

Jill Bresler
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“In the hospitals of Buenos Aires... the integrative group has risen to 41.7%”



“The conference theme: The Therapist in Integrative Therapy: Implications for Practice, Research, and Training.”



“Please join us with others from around the world to engage in a meaningful scientific dialogue in the beautiful and historic city of Dublin.”



President's Column, *continued from page 1*

representing 74% of the sample. Integrative models were the second largest group with 26%. Five years later the landscape had become significantly different. In 2005, 54.5% represented the psychoanalytic orientation, and 40.3% based their work on some form of integration. The latest survey was conducted in 2015. Now, 52.9% represents the psychoanalytical orientation, and the integrative group has risen to 41.7%. This growth in integration points to the importance of expanding our knowledge to improve our practice.


SEPI Conferences are the perfect environment to foster this growth of integration and exchange of knowledge. Every annual meeting has, along with the aim of advancing knowledge and expertise in the practice and application of integrative approaches, open, friendly, and productive dialogues among therapists at different levels of experience and cultural diversity.

Our 2016 meeting promises to be both clinically enriching and scientifically stimulating. There was an excellent response to our call for submissions (over 300 proposals were submitted) with 27 countries represented from all over the world. On behalf of the members of the Program Committee, who helped to ensure a program that is diverse and widely representative of many points of view, let me thank all of you who have submitted such wonderful presentations. Many submissions address the conference theme: *The Therapist in Integrative Therapy: Implications for Practice, Research, and Training*. This year the therapist stands out as the central character. We chose this theme to foster engagement in the labor of self-reflection, to evaluate our work, to look at our difficulties, to highlight our strengths, and to share our experiences. This will allow learning from each other, as well as nurture creativity and innovation. This year, we have topics covering numerous areas, new visions of very well-studied topics such as client and therapist factors, therapeutic alliance and change processes, as well as new contributions in individual, couple, family, and group therapies, therapeutic approaches all across the lifespan and in different cultures. The topics of training and supervision will also be magnificently covered in this meeting. Seasoned and novice therapists will present their experiences in these areas to ensure a fruitful dialogue.


There is something for everyone in the program with two Pre-Conference Workshops, Structured Discussions, Mini-workshops, Symposia, Panels, Posters, an Opening Presidential Plenary, and a Closing Plenary. This year, in addition to our traditional research consultations, organized by the Research Committee, the Practice Advocacy Committee offers practice consultations aimed to be a wonderful learning experience for clinicians. We will also have the opportunity to have an open dialogue with the editors of the *Journal of Psychotherapy Integration* and the *SEPI Newsletter: The Integrative Therapist*.

The Dublin Conference promises to be a special experience for all participants bringing together clinicians and researchers. The Local Committee has ensured that we will also enjoy ample opportunities for meeting informally with colleagues and students. Meetings are meant to improve our work with our clients but to also make this profession a good abode in which to dwell and encourage young people to join.

The conference program will begin on Thursday June 16th. The Pre-Conference workshops are from 9:30 to 12:30, and we will gather at 2:00 for opening comments followed by the Presidential Opening Plenary and exciting conference sessions thereafter. We look forward to an intensive and enriching three days' work with traditional SEPI sessions together with innovative presentation formats.

In Dublin we'll try to find the hidden treasures at the end of the rainbow. Maybe it won't be necessary to ask the Leprechaun for the three wishes but to just expand the borders of our science. This is best done when we all work together. Please join us with others from around the world to engage in a meaningful scientific dialogue in the beautiful and historic city of Dublin. We look forward to seeing you all there! 

A Perspective, *continued from page 5*

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Teaching Psychotherapy Integration: A Conversation with Richard Halgin

Richard Halgin, Professor in the Department of Psychological and Brain Sciences at the University of Massachusetts Amherst, has published widely in psychology, especially on training and supervision, and maintains a part-time private practice.



Davidtz: *First of all, before I ask you about how you train students in integration, how did you become integrative yourself?*

Halgin: That's a great question. Most of my training, both at Fordham University and then three years at Cornell Medical Center, for my internship and two-year postdoc, was very psychodynamic. And at Cornell Medical Center, it was extremely psychodynamic, which was fine, but it was also very constricting. I found that I was inclined to incorporate techniques and styles with my clients that were antithetical to what my supervisors wanted me to do. But I did what we were expected to do. And then, when I finished up my three years of training there, I came to UMASS and, at UMASS, I said, okay, now I'm free to use what I've written about in my own writings, my own personal idiom. What is it that makes sense, in terms of my interaction with my clients, such that I can be therapeutic and effective and also be me? And so I started branching out and incorporating some more humanistic and some more interpersonal techniques and even some behavioral and cognitive techniques.

And around that time, I came across Paul Wachtel's book, *Psychoanalysis and Behavior Therapy*, and it was so liberating, and so exciting as I read that book and said, yes, this is who I am, this is what I want to do. I really want to bring different kinds of techniques together. And then I was fortunate enough to be invited to the first meeting of SEPI, which was held in Annapolis, Maryland, which was the most exciting professional meeting I had ever gone to. Marv Goldfried and Paul Wachtel were just launching this and we spent three or four days very, very excitedly talking about these new approaches they presented at that meeting. And, at the time, I was developing my own approach to it, which I called pragmatic blending, which is probably more commonly referred to by other people as technical eclecticism. Pragmatically bringing together techniques of therapeutic models into an approach that was responsive to each individual client.

That's the history. And then the more I got into it—I started publishing on it and was asked to write chapters and articles—it seemed just right for me and I still do it to this day. It's responsive to the needs of each client that walks into my office.

Davidtz: *Okay, so now I want to jump right into asking you how you teach integration. How do you teach your students, in the classroom, in supervision, to become integrative psychotherapists?*

Halgin: That's a thought-provoking question. I think it's probably more spontaneous and organic than planned. What I usually do is I try to start with where the trainee is. Rather than saying, okay, we're going to take this integrative approach, I usually will start with their comfort level. And, as you might guess, most incoming students these days are not aligned with the psychodynamic and exploratory approaches. Many want a cookbook, a technical manual, a script of what to say, so I'll work with them and do some gentle challenging, as they're coming in with more manualized treatment approaches. And, in time, they will learn that it's just not working or the client is not really responding the way the textbook would have led them to believe. Then we expand it a little bit... through the process of some challenging questions.

I can think of one client I'm treating right now. He's a 20-year-old sophomore at the University and he came to see me and said, 'I just can't make friends, people don't like me, they feel that I'm overbearing.' So, part of the work, at the outset, is going to be teaching him some social skills. With the trainee, I'd say, 'let's really appraise the way he's talking to other people, the way he interacts with them.' But in the back of my mind, I'm also thinking, 'There's a history to this. Let's try to do some kind of uncovering of the history.' So I'll say to the trainee, 'what do you know about his life, what do you know about his early childhood?' In the case of this individual, he tells me, 'Oh, I was born in Romania and I lived in an orphanage for a year and my parents came over and adopted me and brought me to the States.' Well, that's a big deal and, in my mind, that's related to some of the insecurities he has with current relationships. And again, to the trainee, I'll say, 'what relationship do you think that birth and early life event might have had on his social anxiety now?'

So doing some probing, some exploring, working with them, but I always want to be attuned and respectful of, what I said before, the personal idiom: 'Who are you? Are you a problem solver? Are you an explorer as a therapist? Okay,

Continued on page 10

“What is it that makes sense, in terms of my interaction with my clients, such that I can be therapeutic and effective and also be me?”



“Even when a clinician is starting with an approach that I feel is going to be too narrow, unless it’s obviously countertherapeutic, I feel okay to let them try it and see how it goes.”

“You sort of have to, as a supervisor, let people find themselves.”



let’s start there and try to expand that so that you’re going to be much more responsive to the issues and the needs of the client.’

Davidtz: *I want to go back to something you said about today’s students not being aligned as much with dynamic approaches and wanting a manualized approach. Why do you think that is? How do the training needs of today’s students differ from the training needs or the sensibilities of the students you were training forty years ago?*

Halgin: I think that a lot of it is that undergraduate education is very different now than it was forty years ago. When I was an undergraduate, we really did learn personality theory and we really did explore, mostly, the psychodynamic, behavioral, and humanistic theories. We had much more exposure to that. Most undergraduates these days are just being exposed to cognitive approaches. If you look at abnormal psychology textbooks, the preponderance of therapeutic techniques that are recommended as evidence-based is cognitive. So they’re coming in with that mindset and in textbooks, unfortunately, there’s a simplistic narrative that just about any problem, including schizophrenia, can be effectively treated with CBT techniques. So they come into a graduate training program, especially if they’re young, without a particular amount of experience, and with this naïve perspective, ‘Okay, I’m a good listener, once I apply these CBT techniques, I’m going to be able to cure everybody.’

And it doesn’t take very long for them to realize CBT is wonderful, and it’s great, but it’s not the cure-all. It’s not going to take care of every client and it’s not going to take care of every facet, even for the client that comes in with clinical issues that would be responsive to CBT. And I have found in so many of the students that come in with this expectation, once they come up against the wall and they get broadened, they say ‘wow, there is more to this’ and it’s much more gratifying.

Davidtz: As you’re talking about this, it sounds like you are less focused in your work as a supervisor and as a teacher on teaching particular ways of working, than you are on helping student therapists develop their identity as a therapist, whatever that identity is.

Halgin: That’s accurate. I think it’s really good for them to be exposed to different models...but I think it’s overwhelming to a student to say, ‘Okay, you’re going to be integrative.’ Rather, I say, ‘Where do you feel most comfortable?’ We all need a home base to start from, whether it’s a more exploratory psychodynamic home base or a cognitive behavioral home base...As I say, the overwhelming majority is coming in CBT-oriented, which is absolutely fine because that’s a great starting place. And then I say, okay, let’s start stretching him again: ‘What do you think the client might have meant when he said that’ or ‘Why did she forget the appointment,’ or ‘Let’s go deeper than that.’ Once they’ve started doing it with their clients, the payoff is there...and they can see that bringing in divergence, in terms of their approach, really is beneficial.

Davidtz: *Before we wrap up, what have I not asked you that you think is important for the SEPI community to know about teaching psychotherapy integration?*

Halgin: I think you’ve really hit on the most important part. I think that the challenge that you highlighted is really the greatest challenge. How do you teach this? How do you supervise somebody, especially a beginning clinician who’s coming to the work with such a high level of anxiety? That’s why I’ve always found that the most important thing to do is be supportive and reassuring. Even when a clinician is starting with an approach that I feel is going to be too narrow, unless it’s obviously countertherapeutic, I feel okay to let them try it and see how it goes. It’s challenging. You have to have sufficient confidence as a supervisor to do that and early in my career as a supervisor, I made some mistakes... When I’m training somebody, I have to tell them about the mistakes I’ve made and the anxieties I’ve experienced...the empathy I can feel. Yeah, I remember when I was there; I remember how terrifying it was. Believe me, even at this point, after forty years of experience, I turn to my colleague, David Scherer, for peer supervision. I don’t know it all. I’ve got to work through my own countertransference, my own knowledge limitations...

I remember my first year here on the faculty, I was supervising a student and was watching her do therapy from behind the mirror. I said to her, ‘Don’t worry, I’m not going to be critical of what you do.’ After the session, we sat down and we talked about it and she said, ‘Rich, you told me you weren’t going to be critical, but you really are being critical.’ She was right! I was being too heavy-handed. I wasn’t attuned to the vulnerability, especially in the beginning trainees, the anxiety and the apprehension. That’s what I’ve learned over the years, especially with the beginners. Particularly the young ones are really terrified and you have to work with them and build their confidence and trust them. Really trust them. Our students are so good, we’re not going to have anybody do anything that is outrageously countertherapeutic. You sort of have to, as a supervisor, let people find themselves. 🐦

Salute to the 2015 SEPI Committees

Three cheers for SEPI's Committees! The Executive Committee and John Norcross (2015 President) gratefully acknowledge their contributions and service. Thank you, one and all.



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Society for the Exploration
SEPI
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Invitation to Attend SEPI's 2016 Dublin Conference

Dear Colleagues:

It is 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.
Program Chair

John Norcross, Ph.D.
President

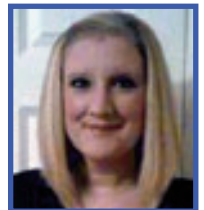


More About Dublin

Laura Pierce (IICP)

Triona Kearns (IICP)

Marcella Finnerty (IICP)



“But what was the 1916 Easter Rising in Ireland actually all about?”



2016 is a big year for Ireland and what a wonderful year for our capital city to host SEPI's 32nd Annual Conference. Ireland is a land steeped in history and, this year, we celebrate the fact that it is 100 years since the (in)famous 1916 Easter Rising. This short, 6-day, rebellion put into motion events that would ultimately change the course of Ireland's history, leading to the Republic's independence.

But what was the 1916 Easter Rising in Ireland actually all about? As the local organizing committee, let us offer you a brief overview:

The Rising was a major attempt by Irish republicans to end British rule in Ireland and establish an independent Irish Republic. While the United Kingdom was heavily engaged in World War I, the rebels sought to catch them off guard! Thomas Clarke, Sean McDermott,

Patrick Pearse, Eamonn Ceannt, Joseph Plunkett, James Connolly, and Thomas MacDonagh formed the Irish Republican Brotherhood's Military Council and it was they who planned the rising.

The Rising began when the rebels successfully took over preselected buildings such as the General Post Office (GPO),

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“By Friday, April 28, 1916 the number of British troops rose to about 19,000 while the Irish only amassed 1,600 fighters.”



“The leaders of the rebellion are forever a part of Ireland’s history, songs and cities.”

the Four Courts, St Stephens Green and the Royal College of Surgeons in Dublin with little resistance. The GPO, which stands to this day, became the main headquarters of the rebellion.

It was there, on the steps of the GPO, that the 1916 Proclamation, which outlined the establishment of this independent Irish Republic, was read out by Patrick Pearse to a small crowd on Easter Monday, April 24, 1916. The Proclamation outlined Ireland’s ambition and was signed by those responsible for igniting the rising. It has become a lasting symbol of Ireland’s fight for freedom. This proclamation, considered treason at the time, ensured certain death by firing squad for the leaders of the Irish Republic if independence was not obtained. There are only 30 original copies of the Proclamation of Easter 1916 and, some ninety years later, in 2006, one sold for \$1 million in New York.

The rising was not, in and of itself, a success. A large supply of arms, sent by Germany, was to be delivered on 21 April 1916 but was intercepted by Britain’s Royal Navy. Due to this incident, the Rising, which was originally planned for Easter Sunday, April 23, 1916, was postponed by a day. This confusion resulted in many volunteers missing the fighting on Monday. The Easter Rising lasted just 6 days, but the ripples of the rebellion endured until freedom was eventually obtained.

By Friday, April 28, 1916 the number of British troops rose to about 19,000 while the Irish only amassed 1,600 fighters. With defeat apparent and to prevent further loss of civilian life, Pearse surrendered unconditionally on 29 April to Brigadier-General Lowe, who led the British troops. The Irish rebels suffered 64 casualties, though the civilian death toll was said to be as high as 254 people, and over 2,000 civilians were injured. 132 British officers also perished, many of whom were actually Irish citizens. As is often the case, it really was a case of brothers fighting brothers.

Most of the leaders were executed following courts-martial; however, Éamon de Valera, the senior commandant of the Easter Rising was not shot because of his natural born American citizenship. He would spend much of the next fifty years as either Taoiseach (prime minister) or President of the Republic of Ireland. He died in 1973 at the age of 92, having watched Ireland develop into the country it is today.

Another leader Joseph Mary Plunkett was also executed but married his fiancée, Grace Gifford, at Kilmainham Gaol, eight hours before his execution in the Catholic chapel at Kilmainham. Grace wore her widow’s mourning clothes the rest of her life. Their story is immortalised in the song *Grace*, written by Sean and Frank O’Meara.

The Easter Rising ended April 29, 1916 and was considered a betrayal at first by many of the Irish citizenry. The loss of life, the carnage, and the bloodshed evoked anger in the populace and the 1916 leaders were spat at on their way to jail. It was only when the executions began that the national mood changed. In death, they were martyrs and their sacrifice evoked the patriotic spirit in those left behind.

After the Rising, republicans came together under the political party Sinn Féin. In the 1918 general election to the British Parliament, Sinn Féin won 73 of Ireland’s 105 seats. On 21 January 1919, they declared the independence of the Irish Republic. Later that day the Irish War of Independence began, which ultimately led to the creation of the Irish Free State.

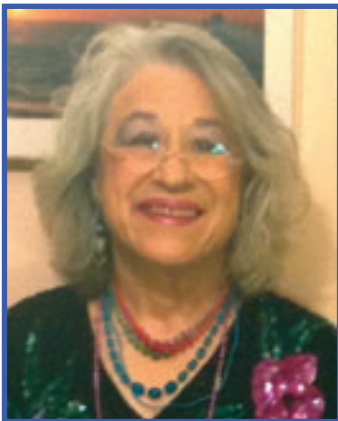
The leaders of the rebellion are forever a part of Ireland’s history, songs and cities. As you wander the streets of Dublin in June, you will no doubt encounter those names on the streets that you roam and some of the songs that were borne from the rebellion will be sung with gusto at our traditional Irish Gala dinner. Freedom was fought and won by a proud people and with that pride we welcome you to Dublin for the 32nd Annual SEPI Conference. 🐾

Society for the Exploration

 of Psychotherapy Integration

Training Around the World: The Chinese American Psychoanalytic Alliance

An Interview with Lana Fishkin



Smith: First I'd like you to explain a bit about CAPA, the Chinese American Psychoanalytic Alliance. From my own experience teaching and supervising Chinese students, I think our readers will be very interested.

Fishkin: CAPA was actually founded by Elise Snyder about eight years ago after she had visited China and realized that there were hardly any opportunities there for training in psychodynamic psychotherapy for mental health professionals.

What happened was that the Cultural Revolution killed, imprisoned, or sent out to be farmers, the professionals who would have been the mentors and teachers of the current generation of mental health professionals in China. So, there were few around who were available to train them.

Elise responded to that need by creating and expanding a program which started out modestly. With just a couple of sites, she began training over the internet via Skype. It's encrypted, which makes it secure and private so that we were able to use it for therapy, as well as for teaching and supervision purposes. The program has now expanded over the past eight years to include a number of different cities in China. Beyond the main big cities of Beijing, Shanghai, and Wuhan, it now includes some less well-known cities. The current protocol that we're using is called Zoom, which is amazingly clear and allows half a dozen individual windows connected to students all over China. And a class is formed with the teacher somewhere in the United States, or in Israel, France, England, or Germany. We also have Argentinians, Mexicans, and Canadians. We really have become an international group.

All the teaching, supervision, and therapy is done in English. For some teachers, English is their second language. But they're all fluent. Our students are screened for facility with English before they're accepted.

Smith: How many candidates are there now?

Fishkin: Well, each class has about 40 to 45 students. The training program, the basic program, is 2 years of weekly classes. They may be invited to go on for 2 more years in the advanced CAPA training program, and that's about half the number – about 20 or 25 in years 3 and 4. Those years are by invitation only.

In addition, there are opportunities for training in child treatment and child observation. Also, there are supervision training classes for CAPA students, because eventually they will take over the training and CAPA will sunset some years down the road.

So, basically, we're training a whole new generation of mental health professionals who would have been trained by mentors who were mostly wiped out by the Cultural Revolution.

Smith: How do you recruit students and faculty?

Fishkin: That's a good question. Well, mostly by word of mouth. The experience has been so positive for both teachers and students. We now have almost 400 members in CAPA around the world. Not all of them are teaching and supervising, but they're all supporting CAPA in other ways—paying very modest dues each year.

Basically, it's word of mouth because it's a very exciting and interesting experience to do this. The students also are by word of mouth. It's become a very prominent training program in China.

“... the Cultural Revolution killed, imprisoned, or sent out to be farmers, the professionals who would have been the mentors and teachers of the current generation of mental health professionals in China.”



“We now have almost 400 members in CAPA around the world. Not all of them are teaching and supervising, but they're all supporting CAPA.”

Continued on page 17



“He actually would lie down on his bed with his computer—his laptop—next to his bed so that we would open up the program face to face. ‘Hi, how are ya?’ And then he’d go lie down.”

“I think this is probably a general problem where the Chinese students have to learn how to speak up.”



Smith: *Could you say a little bit about training in China other than CAPA?*

Fishkin: Well, there are various sources of training – Usually, the model is that some therapists from the U.S. or Germany come to a city in China for a one to two week intensive module where they do a lot of case presentations and theoretical classes. But it doesn't provide for continuity. Then they leave. Ours is really the only training program that runs a full academic year with three months off in the summer.

Smith: *Before going further, I would like to ask you a little bit about your own history with CAPA and what your current role in the program is.*

Fishkin: Sure. Well, Elise Snyder is an extremely effective, seductive recruiter. *[Laughs]* About eight years ago, Elise invited us to a brunch at her home in New York. And once there, during the brunch, she put the make on me, basically. *[Laughs]* She told me about this fantastic PhD candidate who's trained as a psychiatrist, and he's got an anxiety disorder, and he really wants an analysis. So, it was kind of intriguing. I thought about it. I was kind of phobic about the computer, but I thought it was a good a time as any to conquer my anxiety about it. I said, "Okay, I'll give it a try."

We did a three-day-a-week analysis for about three years and he made enormous progress. He actually would lie down on his bed with his computer—his laptop—next to his bed so that we would open up the program face to face. "Hi, how are ya?" And then he'd go lie down. So, it would be just like a patient in my office lying down on the couch and having a session.

It was a very gratifying experience for me. And, after a while, Elise invited me to be on the Board of Directors of CAPA, which I accepted. Then she asked me if I would take charge of the treatment program, which I have done now for about six years.

The program has blossomed where I have recruited an increasing number of psychodynamic psychotherapists and psychoanalysts for treating Chinese patients who are students. They have to be full-time CAPA students. And then I assign them a treater.

Smith: *Are sessions at reduced fees?*

Fishkin: Oh, yes. Absolutely. What a Chinese mental health person can earn in China is nowhere near what they can do in the U.S. So, they agree—Well, we've learned a lot about the bargaining culture in China over the years. We have gradually increased the minimum fees for students there, so that they're paying anywhere from \$30.00 to \$75.00 a session, depending on the frequency.

Smith: *Can you talk a little bit about the particular challenges and solutions that you and the rest of CAPA members have found for teaching, therapy and supervision in such a different culture?*

Fishkin: Well, one problem has been the educational system in China where the teacher is a respected elder, regardless of his age, and there's a great deal of deference to the teacher. The teacher mostly lectures at the students, and they dutifully listen and take notes.

It's been a challenge for me, personally, to get my class to participate in a seminar, in a discussion, which is my preference for teaching. I think this is probably a general problem where the Chinese students have to learn how to speak up. That also would carry over to supervision. If they disagree with the supervisor's analysis, interpretation, they might say, "Well, I can't challenge this because he's my elder, my superior, and I have to just listen." So, to get them to loosen up the way an American student would interact, I think, is a challenge.

In therapy, I really haven't noticed any specific cultural effect. For me, and I'm now with my third CAPA patient, the transference develops as it would with a patient sitting in my office. I find myself developing countertransference reactions in much the same way. So, for the therapy, I think there's been a minimal impact of culture.

Smith: *I hadn't realized how much CAPA is unique and, actually, way out in front of many international teaching models. And the vision of Elise Snyder in making a self-terminating program is remarkable.*

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“She tells the students that we in CAPA—we westerners—are there to turn this program over to them in 10 or 15 years when they’ve got a cadre of well-trained people in psychodynamic psychotherapy to take over.”



“He was just horrified, and I didn’t realize why he was so upset at first. Then I realized that there was no equivalent expression in Mandarin and he was taking it literally.”

Fishkin: It really is. She tells the students that we in CAPA – we westerners – are there to turn this program over to them in 10 or 15 years when they’ve got a cadre of well-trained people in psychodynamic psychotherapy to take over, to take charge.

Smith: *What do you find in terms of students exposure to CBT and various other therapeutic modalities.*


Fishkin: Oh, they like to do all of those things. We have to be tolerant of that because they feel the more modalities that you learn about, the better therapist you are. There’s some truth to that. They have “sand therapy,” whatever that is. They have play therapy, they like CBT, they want to learn about family therapy. You know, they have exposure to all of those things.

Smith: *Psychodynamics for us is a cultural tradition, but for them, that doesn’t really exist. It’s simply is another interesting way of looking at people.*

Fishkin: Yes. Right.

Smith: *Are there other things that you haven’t touched on?*

Fishkin: Let me think. Yes. I’ll tell you a funny anecdote. It reminds you of some of the language or cultural differences to keep in mind. My first patient was talking about some problem he had encountered in his PhD program and he was kind of struggling with a way around the problem. And he came up with a creative way around it that he was feeling pretty good about. So, my comment after him telling me this whole story was, “Well, there’s more than one way to skin a cat.”

He was horrified. He took it literally. He had an image in his mind of flaying a cat and *[Laughs]* he was just horrified, and I didn’t realize why he was so upset at first. Then I realized that there was no equivalent expression in Mandarin and he was taking it literally. I explained to him that it was just metaphoric. . 

Society for the Exploration

 of Psychotherapy Integration

Training New Therapists Around the World: Making the Implicit Explicit

From The SEPI Education and Training Committee

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“The attitudes that we bring to our clinical work are intimately bound up with our values.”

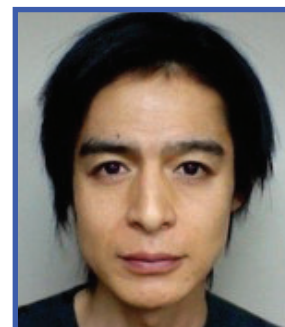
*Jack C. Anchin
Hector Fernández-Alvarez
Luis Botella
Shigeru Iwakabe*

Irrespective of one's theoretical orientation and professional discipline, there seems to be considerable consensus that conducting effective psychotherapy requires knowledge, skills, and attitudes—a triad of competencies—in a number of core task areas. These include:

- Forming and maintaining the therapeutic alliance
- Conducting a meaningful assessment
- Based on data so gathered, formulating a case conceptualization guided by one's preferred theoretical perspective(s)
- Developing an initial treatment plan that follows logically from one's case conceptualization
- Implementing therapeutic strategies and interventions in accord with one's treatment plan
- Monitoring treatment effectiveness
- Modifying facets of the treatment process as warranted by ongoing outcomes
- Instituting termination in a manner that optimizes the client's therapeutic experience
- Engaging the client in all such facets of the treatment process in an ethical manner

Fundamentally, the stimulating challenge for, and privilege of, those training new therapists is to both impart and educe knowledge, skills, and attitudes essential to carrying out these various therapeutic processes—and equally important, to do so in ways that take into account the particularities of given trainees. Plans for training therapists should also aim to provide a set of tools that enable the clinician to operate with findings from research in every field of clinical care. Like good psychotherapy, effective training bridges the nomothetic with the idiographic

This is a very general encapsulation of some, though by no means all, of the key tasks and responsibilities involved in the doing and training of effective psychotherapy. However, the theme of this issue of *The Integrative Therapist*—training new therapists around the world—necessitates that we take this conception a next step by virtue of reflections that it stimulates about both distinct features of psychotherapy integration and essential requirements of culturally competent training and practice throughout the globe. In particular, juxtaposing the realms of psychotherapy integration and cultural competence brings forth a number of implicit commonalities that may carry implications for facilitating new therapists' learning and that may therefore warrant being made explicit to students very early in the course of their training. Here we identify three such emergent commonalities and suggest these may provide elements of a globally-



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“...we recommend that from the very outset of training that trainers of new psychotherapists cultivate explicit appreciation of and respect for differences.”

“Encouraging a pluralistic approach to knowledge and understanding by no means precludes emphasizing a singular theoretical orientation early in trainees’ education...”



relevant metaframe that can meaningfully assist and enhance the education and the learning of knowledge, skills, and attitudes instrumental to effective psychotherapy. Our broad-stroke depiction of this still-evolving metaframe starts with attitudes, which we view as the linchpin of our perspective.

Attitudes: Cultivating the Valuing of Differences

The attitudes that we bring to our clinical work are intimately bound up with our values. Judgments and decisions that we make about ways of interacting with the client (e.g., self-disclosure; when to accept and when to challenge) in the service of building, maintaining, and strengthening the alliance, phenomena to target in the course of intervention (e.g., core beliefs; interpersonal style), and desirable outcomes of treatment (e.g., greater self-compassion; greater comfort with relational intimacy) are unavoidably influenced by our underlying attitudes towards and valuation of particular kinds of human experience and domains of functioning.

Examining the realm of values and attitudes towards psychotherapy through the dual lens of psychotherapy integration and cultural competence illuminates the valuing of differences as a shared core value. Indeed, with experience therapists develop increasing awareness of clinically-relevant differences (e.g., in numerous client variables; in the impact of different types of interventions) and discern important implications of these differences for tailoring ways of interacting and intervening that enhance therapeutic effectiveness. However, for therapists at the very beginning of their training—*anxious*, for example, about making the “right” content choices as a session unfolds or about whether they can truly foster meaningful change—*tuning into* or thinking about differences may be among the farthest things from mind. Nevertheless, we recommend that from the very outset of training that trainers of new psychotherapists cultivate explicit appreciation of and respect for differences, reinforced in part through discussing and demonstrating benefits that can be derived from bringing this awareness to bear on therapeutic judgments, decisions, and processes. Manualized forms of treatment provide trainers with a valuable illustrative context. Although highly structured and sequenced for uniformity of administration vis-à-vis a given diagnosis, a clear stance that—*despite carrying a particular diagnosis*—every client is also different and unique opens space for adapting and customizing a given manual to a client’s distinct needs, goals, values, and so on. The advisability of doing so is buttressed by empirical findings that sensitively tailoring, as opposed to rigidly administering, treatment manuals improves treatment outcomes (American Psychological Association, 2006).

The merit of valuing differences is also implicit in the title of SEPI’s 2003 Annual Conference, *A Dialogue on Difference*; the perspective underlying this theme is especially instructive: “By creating a forum for a frank discussion of differences, we hope to establish a richer, more nuanced understanding of the psychotherapy process while clarifying where apparent differences may obscure clinically important common ground” (Muran & Costello, 2003, n.p.). We venture to guess that, regardless of the global region in which they are being trained, novice therapists who approach clinically-relevant differences with this attitudinal perspective will experience enriched learning that in turn can foster enhanced development and application of therapeutic skills.

Knowledge: Cultivating Pluralistic Understanding

Those training new therapists around the world can draw on the implicit lessons of psychotherapy integration and culturally sensitive practice by not only cultivating an attitude of valuing differences but also—as an organic outflow from this attitude—presenting to trainees, from the very inception of training, the epistemic perspective that there can be multiple understandings of a given clinical phenomenon. Inseparably, helping new trainees to solidly grasp the powerful role played by their knowledge base in mediating understanding strengthens the very foundation for exposing new therapists to concepts, research findings, treatment strategies, and techniques from different theoretical orientations in the course of their training.

Encouraging a pluralistic approach to knowledge and understanding by no means precludes emphasizing a singular theoretical orientation early in trainees’ education; however, we caution that imparting this knowledge as orthodoxy is equivalent to putting blinders on someone who is learning to see. However strongly a given training program may emphasize a specific single-school approach, an overarching pluralistic perspective on knowledge creates a context that frames that particular approach’s declarative and procedural knowledge structures as *one* way to understand psychopathology and its treatment, respectively, but not the only way. Ironically, this same caveat applies to programs devoted to training new therapists in psychotherapy integration. That is, as students learn and practice psychotherapy and develop into free-standing professionals, there are those who find they are most comfortable and effective operating with a particular single-school approach, a discovery that may understandably be accompanied by progressive es-

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“If an attitude of valuing differences and the intimately related cultivation of pluralistic understanding are to have pragmatic meaning for trainees, they must translate into differences at the level of action.”

chewal of previously-learned integrative ways of working.

A parallel process warrants consideration here. As therapists we seek to promote growth partly through helping our clients see that they have options, assisting them in identifying those options, enjoining them to think through potential consequences, and emboldening them to be the ones who ultimately make and assume responsibility for choices made. Correspondingly, we believe trainers can advance new therapists' development by explicitly attuning them to the fact that there are variations in how phenomena can be understood, fostering acquisition of different knowledge structures that mediate these differential understandings, facilitating reflection on these alternative understandings and their implications, and conveying the professionalizing message that integral to their evolution as therapists is developing the ability to make and sharpen independent clinical judgments and decisions based on understandings rooted in both breadth and depth of knowledge.

Skills: Cultivating Flexibility in Action

If an attitude of valuing differences and the intimately related cultivation of pluralistic understanding are to have pragmatic meaning for trainees, they must translate into differences at the level of action. In psychotherapy, skills are the action-based expression of attitudes and knowledge—and they are where the rubber ultimately meets the road for new psychotherapists. When we look to integrative psychotherapy and culturally competent practice for commonalities containing assistive implications for training therapeutic skills, their shared prizing of flexibility is unmistakable. Vital to effectiveness, flexibility is the capacity to adapt and adjust one's actions in ways that are responsive to changing circumstances. And if psychotherapy is anything, it is—within and across clients—a dynamic and changing process by virtue of the highly context-dependent nature of the enterprise. Thus, while core task areas delineated earlier operate as constants, a therapist's effectiveness in any such task area is likely to depend in part on flexibility in making adjustments in implementing and enacting required skills as variations in circumstances warrant.

Fostering explicit appreciation of psychotherapy's dynamicism and cultivating the flexibility in action that it speaks to are certainly different didactic processes, but our hunch is that new therapists can benefit from both. The former provides a realistic picture of psychotherapy that trainees can mentally assimilate and accommodate as they gain knowledge and experience. The latter includes customary collaborative skill building on the part of a trainee and her/his clinical supervisors in the context of the trainee's cases—but crucially, skill building accompanied by explicit collaborative reflection on and attunement to properties that comprise flexibility in different skills, the trainee mindfully adjusting elements of a given therapeutic skill as warranted by clinical circumstances, and in supervision looping back to processing these adjustments' effects and meanings. In our view, flexibility is not a singular skill that can be taught. Rather, it encompasses both covert and overt processes that can be nurtured within the context of trainees' learning and development of specific skills as they engage in different core task areas of psychotherapy with their cases. Still another critical component of this learning process brings to mind the classic joke sometimes (wrongly) attributed to Jack Benny: *“How do you get to Carnegie Hall? Practice, practice, practice.”* Flexibility in psychotherapy, as in many other realms, takes practice. And not only practice but, here again, *supervised* practice, the kind that helps novices become experts and develop tacit processes of action that allow them to adapt based on anticipation of their client's processes.

Concluding Comments

This brief article has presented the sketches of a metaframe for training that centers on explicitly cultivating—from the inception of training onward—the valuing of differences, pluralistic understanding, and flexibility in therapeutic skills. We propose that this metaframe, culled from fertile common ground shared by integrative psychotherapy and culturally competent practice, may facilitate and enhance new therapists' acquisition of specific knowledge, skills, and attitudes instrumental to effective psychotherapy. We conclude by providing several clarifying comments—again, seeking to make explicit that which lies implicit.

First, adapting and customizing treatment on the basis of clients' differences need not result in the lack of a clear therapeutic structure or focus in general or within a specific therapy session in particular. Almost every therapeutic technique from almost every theoretical approach can be adapted to the differential needs, values, and preferences of our clients. In fact, most therapeutic techniques are devised towards triggering and fostering meaningful change processes, not necessarily specific contents. Accordingly, the challenge when training novice psychotherapists is how to help them see “beyond the obvious,” that is, to help them understand that techniques are not *things* that you *apply* to a passive client, but malleable resources that you invite the client to use and make sense of in her or his own unique and creative ways. Tapping into the wisdom of Zen, the challenge is how to help trainees to look not at the finger pointing

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“Almost every therapeutic technique from almost every theoretical approach can be adapted to the differential needs, values, and preferences of our clients.”

to the moon, but to the moon itself. Therapists' capacities to adapt their work to their clients' differences are facilitated when they are able to see therapeutic techniques as tools to be offered to the client (as opposed to unalterable procedures to be prescribed) and theoretical approaches as frames of intelligibility that give focus and structure to the therapy (as opposed to absolute truths about human psychological functioning).

Second, as trainers grapple with the question of how best to expose trainees to the specifics of different theoretical orientations in the service of cultivating pluralistic understanding, it is important they also keep in mind the pragmatic question of trainees' age and lived experience. Despite their previous training in psychology, most of them are in their 20s or early 30s; as such, they are still in the process of developing the emotional subtlety and personal construct system complexity—and have yet to experience additional distinctly challenging as well as positive life events—that help them advance towards, and eventually transcend, more contextualist and relativist epistemologies.

Third, amid increasing consensus that supervision is of central importance to all therapists, a significant development in supervision programs has included a rise in the training of specific competencies with an eye towards, among other goals, facilitating the identification of trainees with their role as therapists and promoting self-care. However, as educators and trainers we also need to remain mindful that in real time the person of the therapist cannot be separated from the competencies she or he possesses. The suitability of a therapist reveals itself as a combination of competencies. Some of them are natural (e.g., empathy, level of intellectual understanding, openness, warmth), while others arise as the result of systematic learning. Exploring, in supervision, the personal style of the therapist and its evolution during the formative years gives trainees a powerful tool to develop their competencies.

Last, but far from least, the potential contribution of SEPI in the training of psychotherapists at large is limitless. SEPI members traverse different cultures of psychotherapy while at the same time bridging different views of psychological health, development, and treatments. Although we come from different parts of the globe, we share a deep commitment to our mission. As we explore and develop the culture of SEPI, it is important that we also illuminate guiding principles underlying the training of future psychotherapists around the world. The present article is in an effort in this direction.

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SEPI Announces: UPDATED LISTING OF INTEGRATIVE TRAINING PROGRAMS WORLDWIDE



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

Uruguay SEPI Regional Network

Margarita Dubourdieu

Margarita Dubourdieu is a pioneer in integrative psychotherapy in Uruguay and author of Integrative Psychotherapy: Psychoneuroimmunoendocrinology, Integration of the body-mind-environment.

*Translated by Wendy P. Bamatter, M.A.
The Catholic University of America*



Background

Argentine and Uruguayan colleagues in the fields of Neurology, Psychiatry, and Psychology collaboratively formed the *Institute for Neuroscience* and a study center called the *Humane Center* in Argentina in 1991, and subsequently in Uruguay in 1995.

In this center the model of Integrative Psychotherapy was developed, which united psychotherapists from the American Federation of Psychoneuroimmunoendocrinology (FLAPNIE), a federation that connects physicians and other health professionals. Training and refresher courses in Psychotherapy and

Psychoneuroimmunoendocrinology (PNIE) were developed, also drawing from the fields of Neuroscience, Medicine, Quantum Physics, Sociology, Eastern Philosophy, and various theoretical frameworks in Psychology.

The beginnings of the **Integrative Psychotherapy Model PNIE (PI.PNIE)** were formed during an interactive process of clinical and theoretical debate. PNIE, which is scientifically based, draws from the Paradigm of Complexity, General Systems Theory, Stress Theory, and Chaos Theory. Additionally, PNIE is informed by the developments in Allostatic, Epigenetic, and PNIE Neuroplasticity processes.



SUPNIE (Sociedad Uruguaya de Psiconeuroinmunoendocrinología) & Humane Center office, Malvín neighborhood in Montevideo, Uruguay, 2000

Integrative Psychotherapy PNIE (PI.PNIE) thus emerged from this supra paradigm, which also includes contributions from different models of psychology including cognitive, interpersonal, systemic, existential, humanistic, neuroscience and others consistent with these epistemological frameworks.

PI.PNIE has a non-deterministic conceptualization regarding matters of biopsychic constitution and health/disease processes, thus remaining open to new research findings regarding plasticity and psychophysical responses. It proposes a therapeutic approach to promote overall well-being, integrating the PNIE network, multifactorial, multidimensional, and temporal (past-present-future) processes.

The treatment strategy entails three phases:

- Teaching in the form of bio/psychoeducation
- Diagnostic evaluation
- Treatment (according to the diagnosis)

The following dimensions are considered throughout all phases:

- Biological
- Cognitive

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“The treatment strategy employs cognitive, interpersonal, and systems techniques.”



“In 2013, we developed a 2-year training curriculum in the Humane Center that, just as in university programs, should be complemented by supervised practice.”

- Psychoemotional - relational
- Socioecological
- Spiritual

In the diagnostic evaluation, we create a multidimensional biopsychological biography derived from PI.PNIE. The evaluation includes an individual's personal timeline, a personality assessment, Jeffrey Young's Schema Inventory, and other measures as deemed appropriate (e.g., assessing beliefs, anxiety). The treatment strategy employs cognitive, interpersonal, and systems techniques as well as others stemming from PI.PNIE.

Integrative Psychotherapy (PI): Training in Universities, the Humane Center and Scientific Societies, and Certification of Integrative Psychotherapists

In 1995, we initiated university level and graduate courses. In 2003, we developed graduate specializations, as well as master's degrees. Additionally, we incorporated training in psychotherapy, PNIE, neuroscience, and tools such as relaxation, mindfulness, tai chi, etc., into university level training.

Psychology degree programs, at the graduate and master's level, were developed in several Latin American countries. Integrative Psychotherapy (PI) was also included in medical programs, thus contributing to an understanding of the importance of transdisciplinary work in medicine and psychotherapy.

Within PI.PNIE, we also developed PI programs in foreign universities as well as thesis tutorials for graduate, master's, and doctoral programs in the country and abroad.

In 2013, we developed a 2-year training curriculum in the Humane Center that, just as in university programs, should be complemented by supervised practice.

This theoretical and clinical training provides credits for National and Latin American Psychotherapy Certification to integrative psychotherapists and psychotherapists of various theoretical models.

We also participate as teachers in Integrative Psychotherapy master's-level online courses in both Venezuela and Spain. Furthermore, we offer online courses through the Humane Center, one on stress and disease processes and another on psycho-oncology from PI.PNIE.

Dr. Dubourdiou receiving the integrative psychotherapist certificate in recognition of pioneering psychotherapy models in Uruguay, at the Government Palace in Montevideo



Contributions to Medicine and Psychology, and Psychotherapy Meetings at Hospitals and Clinical Centers

We developed PNIE Integrative Psychotherapy (PI.PNIE) healthcare teaching units at:

- Clinical Hospital in the School of Medicine focused on oncology, psychiatry, gastroenterology, and mental health, with approaches at the individual, couple and group levels, as well as interdisciplinary centers.
- School of Psychology in a neighborhood general hospital offering services in individual, couples, and group psychotherapy with adolescents presenting with suicide attempts, addictions, and personality disorders.
- Clinical centers and supervised practica in psychotherapy with children, adolescents, adults, couples, and families at the Humane Center.

Workshops in Bio/psycho-education and Stress Management

- Developed for patients, relatives, and health, recreational, and occupational staff, among others.
- Weekly supervision and monthly clinical activities.
- We have five study and clinical supervision sessions weekly with 6-12 members. During those meetings, patient referrals are made with subsequent supervision.

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“We have prioritized training, clinical work, and the dissemination of Integrative Psychotherapy in our country and abroad.”

Supervision and team meetings

- Supervisions and weekly team meetings in psychiatry, gastroenterology, inflammatory diseases, oncology take place in the children’s hospital and hospital teaching units.
- Supervision is conducted face-to-face and/or online in other Latin American countries through the PNIE Federation (FLAPNIE).

Research

We have conducted some research through the Schools of Medicine and Psychology; however, this area has been the least developed. Instead, we have prioritized training, clinical work, and the dissemination of Integrative Psychotherapy in our country and abroad.

In 2014, we formed a research department to develop various projects in the Children’s Clinic on topics including Integrative Psychotherapy and Holistic Health.

Scientific Publications

In 2008 in Uruguay, I authored and published the 1st Edition of Integrative Psychotherapy: Psychoneuroimmunoen-docrinology, Integration of the body-mind-environment. [In Spanish, Psicoterapia Integrativa. Psiconeuroinmunoen-docrinología. Integración cuerpo-mente- entorno] I also co-authored “Motivation and health in older adults,” as well as other chapters and books on Integrative Psychotherapy in the Health Sciences in Uruguay and Argentina.

We are close to publishing a book on oncology in Medicine and Integrative Psychotherapy PNIE, which will be co-authored with a medical oncology specialist at Harvard University. We are also close to publishing another book with a pulmonologist from Argentina regarding the treatment of asthma.

We have also written numerous publications about PI.PNIE in scientific and academic journals, both nationally and abroad.

Additionally, we publish on Integrative Psychotherapy in magazines and newspapers in the mass media. Furthermore, we have participated in health programs on television and radio shows.

About Our SEPI Membership

The Humane Center Training Institute of the PNIE Uruguayan Society and American Federation PNIE in the area of Integrative Psychotherapy is a member of the American Association of Integrative Psychotherapy (ALAPSI). Internationally, I am a member of ISPNE (International Society of Psychoneuroendocrinology) and SEPI.



Signing of the ALAPSI Constitution in Quito 2006, with representatives from Argentina, Chile, Ecuador, and Uruguay



Colleagues from the SUPNIE Department of Integrative Psychotherapy in Uruguay and from the Latin American Federation (FLAPNIE), of which I am Honorary President, appreciate the existence of ISPNE and SEPI as well as the professional exchanges between colleagues from different countries and continents. For economic reasons, however, some colleagues have not wanted to take on new memberships in addition to those they already have.

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Honorary Members of ALAPSI: Dr. Opazo (Chile), Dr. Fernández-Álvarez (Argentina), Dr. Dubourdieu (Uruguay), and Dr. Balarezo (Ecuador) in the second ALAPSI Meeting and 1st FLAPNIE Congress in 2008, held in Montevideo, Uruguay, with more than 300 participants

But the main limitation has been that lacking a fluent command of English hinders one's ability to fully take advantage of all that both SEPI and ISPNE have to offer. For this reason, many colleagues from PI.PNIE in Uruguay and other Latin American countries do not participate in the SEPI conferences.

SUPNIE has approximately 180 members including doctors, psychologists, and nutritionists, of which 100 psychologists and a number of psychiatrists are a part of SUPNIE's Integrative Psychotherapy/Humane Center.

In the future, it would be ideal if efforts could be dedicated to integrating Latin American participation through translating publications and providing translation services during the conferences.

Personally, having been motivated by my dear colleagues and ALAPSI friends, Héctor Fernández-Álvarez and Beatriz Gómez, I participated in the SEPI Meeting in Florence and will participate in Dublin as well. It would be wonderful if other Latin American colleagues were also able to enjoy these valuable exchanges.

Links to our websites:

www.supnie.todouy.com

www.picoterapiaintegrativapnie.org

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Therapy in Poland in the 70s and 80s

Jerzy Dmuchowski

Jerzy Dmuchowski is a psychotherapy supervisor and group training supervisor. His practice integrates psychodynamic, existential and interpersonal approaches at the Laboratorium Psychoedukacji in Warsaw, a short walk from the Vistula River.



“Aren’t the participants disappointed that the therapist and the psycho-therapy do not shelter them from fear, loneliness, responsibility, pain, and impermanence? The therapist’s comment makes a strong impression.”



Some notes on how the experiences of therapy of the seventies and eighties in Poland inspire integrated group psychotherapy of today.*

In the previous session, the patient, a 35-year-old immigrant from Spain, who couldn’t make up her mind about whether to move in with her long-time partner and establish a family, had recounted with intense emotion that she had been informed of what may be a serious problem with her health. Her condition is such that she may never fully recover, always have to be careful, and permanently have to maintain a strict diet and medication regimen. She was shocked, scared, and angry. She did not expect to ever have problems with her health. She was weeping. Her weeping was moving others, who were trying to support and comfort her, sharing their experiences, giving advice, talking about the physicians’ mistakes. At today’s session the group members are talking about failure. That when they lose, fail, cannot achieve something, make mistakes, have problems, can’t cope, they think they are nothing, and they blame and torture themselves. They are talking about this as a sign of low self-esteem; they fear being rejected... They have talked about this many times. The therapist shares his impression that the emotional atmosphere in the group does not relate to the content of this conversation and to how the participants understand what they are talking about. Isn’t the condemnation of oneself for failure and the descent into hopelessness the way to avoid the experience of oneself as the one who fails, loses, is fragile, and weak? And isn’t the attempt to avoid this experience futile? That is, even if we succeed in avoiding it sometimes, we are still basically weak, helpless, living from one loss and failure to the next, and always ending up with failure. Isn’t this also about our group... That despite intensive work, we keep falling into the same holes? Aren’t the participants disappointed that the therapist and the psychotherapy do not shelter them from fear, loneliness, responsibility, pain, and impermanence? The therapist’s comment makes a strong impression on the group. Members cry. Someone expresses feeling deeply understood. Others share their feelings. It is becoming very intimate. At the end of the session, the participants gather by the clinic yard and seem to not want to say goodbye to each other.

This vignette is supposed to give the reader a sense of the group psychotherapy that we practice in Psychoeducation Laboratory of Warsaw, Poland. We define it as an integration of the interpersonal, psychodynamic and existential approaches, considering both the group as a whole, and the individual, within an interpersonal context.

Psychoeducation Laboratory was established as a psychotherapy center in 1978. It was a cooperative of friends. It was the first financially and organizationally independent center in Poland—independent not only from the state system of medical care, but also from the medical model of psychotherapy—the only one that then existed in Poland. This is why the term “psychoeducation” was used - to distinguish our ideas and practice from “psychotherapy,” a term which, at that time, meant basically counseling in the frame of a medical model of health care. And the word “laboratory” was used because everything we were doing was more or less an experiment. This was the mark of the time - Jerzy Grotowski’s famous theater was called the Laboratorium Theater.

The process of the emergence of integrated group psychotherapy was more historical than conceptual in nature. The different approaches, theories, methodologies and technologies were being integrated not always on the basis of considered choice but more or less accidentally. Someone, for example, went to London (it was hardly possible to get a passport) and in a flea market bought a book on bioenergetics and got interested in it. Or some Gestalt therapist from America got interested in his Polish roots, was motivated to come to Poland, and was willing to pay for his airfare and to work without a salary.

These were the seventies and eighties. Poland was still under the Communist regime. People were worn out by the system, often demoralized by it, with no hope that it could be changed. The individual with a few choices could have felt relatively safe, but he or she was not yet able to meaningfully shape the surrounding reality, and so was also not able to take responsibility for it. And the reality was gray, dull, twisted, and corrupted. Words didn’t mean what they

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“These were the seventies and eighties. Poland was still under the Communist regime. People were worn out by the system, often demoralized by it, with no hope that it could be changed.”

“Also, at that time, Carl Rogers visited Poland, and he led a workshop for an audience of about 80 people. Eric Marcuse, a Gestalt therapist from Los Angeles, started to come to Poland each year and gave workshops.”

mean—for example, our oppressor, the Soviet Union, was seriously called in the media our “big brother”, and the military invasion of Czechoslovakia in 1968 was called the “brotherhood help” (perhaps this kind of help does sometimes happen between brothers...). Nobody believed in what was publicly said, and nobody cared that nobody believed it.

As I have said, the Psychoeducation Laboratory was created by a group of friends. One of them had come back from America, where he was on a stipend from the Los Angeles Gestalt Institute. Also, at that time, Carl Rogers visited Poland, and he led a workshop for an audience of about 80 people. Eric Marcuse, a Gestalt therapist from Los Angeles, started to come to Poland each year and gave workshops. And soon after, body work therapists, like Michael Randolph, started to come to train and teach us.

At the beginning we offered mostly 6-day group workshops. The format—but also the culture, the role of the leader, and the style of leadership—were influenced strongly by the ideas and practices of the T-groups and encounter groups of the era. The theoretical base of our work was humanistic and existential—mostly Gestalt. The most influential author for us was Rollo May, particularly his *Psychology and the Human Dilemma*. As some of us had been introduced to Zen meditation, some of the Zen ideas were also present.

“Psychotherapy boom, boom, boom.” Today this is what the not-so-young-anymore American Gestalt therapists teasingly call the therapy they used to practice 40 years ago. One could have recognized the operation of group psychotherapy in this mode by the bunch of shoes left outside the room, the lack of the furniture inside, and the absence of equipment other than mattresses and cushions and plenty of tissues. This was what we were doing in the Laboratory. Our workshops still maintain some such scenery, though because of the sentiment for the past rather than any practical reason. Our general work style does not require such conditions any more.

This was a dramatic psychotherapy, based on cathartic experiences, very intense emotional expression, accommodation, and the overwhelming experience of intimate community. There was a lot of crying, hugging, howling, biting, and hitting the mattresses. When someone reported the feeling of wanting to throw up, he or she was encouraged to imitate the movements and sounds of vomiting and to do this stronger and stronger and louder and louder, until the person “got completely into the experience” and lost control. When someone was angry with his mother and said “Fuck her!” Then he or she could have been given a mattress and asked to choose another participant with whom to have intimate eye contact, and then the same procedure followed as with throwing up. The idea was to act rather than to talk; to experience rather than to think, speculate and discuss; to get fully into experience; to “lose one’s head.”

The group psychotherapy we were doing was therefore inspired by the ideas coming from the West, sometimes by shreds of ideas. These included the encounter and training groups movements, the Gestalt therapy of the West Coast, the Rogerian approach, and different body work therapies. And then, by our experience leading a lot of groups, our style of work evolved. We gradually limited and stopped using structural exercises (designed to lower the resistances), encounter, body work, Gestalt techniques and psychodrama. We now concentrate on interpersonal relationships, the group process, and group-as-a-whole phenomena, and we do much less individual work in a group. Our groups today are less dramatic. There are a lot of emotions involved, but they are not so intense and not so dramatically expressed. Much more rarely are the emotions expressed in action. Patients, for example, more often say they feel close to each other than they jump into hugging. There is much more space for reflection and understanding of one’s experiences in the group. And also for recognizing, examining and re-owning problematic patterns of thinking, experiencing, behaving, contacting, and relating; and the dynamics of these behavioral patterns and their consequences for a patient’s relationships with others, sense of identity, and well-being. A therapist helps to uncover the meaning of experience, to generalize and transfer it to life outside of therapy.

One can see that our group psychotherapy evolved into a model that is in accord with what Irvin Yalom elucidated in his *Group Psychotherapy*. We read this book much later, finding in it a confirmation of what we had come up with and an encouragement to develop our practice further in this direction.

Our approach has also been strongly enriched by Wilfred Bion’s concepts: the group as a whole theory, the basic assumption, and his introduction of the theory of projective identification into group psychotherapy. Some of the other authors that inspired us strongly were Moris Nitsun and his antigroup theory, and Yvone Agazarian.

Besides the evolution of our thinking and practice, one can still see the influences of our early years. This is the em-

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“This was a dramatic psychotherapy, based on cathartic experiences, very intense emotional expression, accommodation, and the overwhelming experience of intimate community.”



“And what happens often is that this extraordinary intimacy is accompanied by a floating, foggy veil of sadness and melancholy.”

phasis on the emotional experience in the group (often the corrective experience), body, breath, movement, emotional expression and contact-orientation. This is the concentration on the present, on the here and now. Our therapy still considers the past, but it also considers the future. This is also its democratic and dialogical stance. The distance between the psychotherapist and the group is not so big. And this is the special appreciation of a patient's responsibility, choice, and will.

Psychotherapists who had personal experience of the groups of the seventies and eighties seem to be more sensitive to the emotional temperature that may signal the patient's unknown or deep problems and pain. Perhaps they are better prepared to accompany the patients when they experience deep, intensive emotions and anguish. The groups led by the therapists with that experience more rarely take the shape of the talking heads encounter, wading through and getting lost in futile explanations and looking for causes. The question “why?” was discredited then on behalf of the “what?”, the “how?”, and the “what for?” One emphasized, and still does, the examination of process, its structure and function, rather than the discovering of roots in the past.

The creative inspiration of the seventies and eighties that persists in our group psychotherapy is also the sensitivity to the existential perspective—the vignette in the beginning of this text shows this. A very deep intimacy often develops in a therapy group. For many members, as Yalom wrote, this can be the only such experience in their life. And what happens often is that this extraordinary intimacy is accompanied by a floating, foggy veil of sadness and melancholy. It seems to proclaim that no matter how close we get to one another, we will remain basically lonely and alone.

I would conclude with the conviction that even though psychotherapy as a quite young discipline changes dynamically, it is important to respect the background and keep continuity.

**These notes are the excerpts from the unpublished article on integration of different approaches in group psychotherapy, described as a historical process. The author thanks Nancy McWilliams for help in editing the original article. 🐦*

Society for the Exploration

 of Psychotherapy Integration

Take Home Points from Last Year's Conference: Three Sessions from Turkish Presenters

Application of Emotion-Focused Therapy in Turkey & Evaluation of Cultural Differences

Betul Sezgin

EFT is a process-oriented experiential psychotherapy based on exploring, understanding and transforming how emotions are experienced in life as well as in the therapy room. Cultural characteristics shape the varying forms and degrees of how individuals can reveal their emotions in therapy.

In cultures where individualization is deemed important, individuals are accepted as the most important social unit. Individuals' uniqueness, separation and autonomy are highly valued. Emotional expression, self-assertion and speaking up are encouraged. In community-based societies, unity, togetherness and harmony are valued over individual needs. Emotions are considered to be clues to one's relationships with others rather than a form of self-expression. Emotions are controlled to ensure group cohesion in community-based societies. In community-based societies, individuals must please others to receive acceptance. They are expected to sympathize with others' feelings and thoughts, and to behave accordingly. Otherwise, they will face separation anxiety and fear, or feelings of shame.

In individualized societies, anger is deemed important for self-confidence, self-assertion and personal freedom. It is even encouraged for clarification of events. In community-based societies, anger is less accepted due to its threat against authority and social harmony.

Feelings of sadness and fear make one feel weak and want to withdraw. Because they do not threaten the group cohesion, these feelings are accepted more in community-based societies than in individualized ones.

In Turkish society, like in other community-based societies, it is not welcome to share personal feelings and family events with outsiders. It is accepted and encouraged for people to hide their sufferings resulting from their community and to protect the community at any cost. In failing to express their feelings and thoughts, people may give up on their needs.

EFT process values experience and expression of anger as a step towards protection of personal boundaries and gaining individual autonomy. However, clients with predominantly community-based characteristics find it more difficult, compared with those from individualized societies, to overcome traditional assumptions and express their anger at the point of speaking up and protecting their boundaries against violations by significant others. Expression of needs makes them feel selfish, and they fear others will see them as selfish. Intense feelings of guilt over a sense of selfishness and being unfair to others constitute challenges in therapy.

Religious beliefs and customs may also make them think of themselves as sinful, reinforcing the feelings of guilt. Emotional expression is avoided by leaving therapy or emotional numbness.

In conclusion, studies indicate that there are cultural and gender variation in emotional experience, but also that emotions are universal. Therefore, gender differences or cultural challenges do not constitute an obstacle to working with emotions. It would facilitate working with emotions to recognize cultural challenges, gender differences, and to know the cultural characteristics of the client. It is critical for individualization that one's cultural characteristics, religious beliefs and values of judgment are recognized and respected in the process of encouragement of deep feelings. Traditional sense of humor, folkloric elements and metaphors of a particular culture may be invited to facilitate therapeutic alliance.

Application of Masterson Approach in Turkey & Evaluation of Cultural Differences

Nimet Kirisci

J.F. Masterson places all disorders of self on a descriptive and integrative theoretical ground within the context of object relations, while at the same time defining an approach including intervention techniques used in psychotherapy practice.

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“In Turkish society, like in other community-based societies, it is not welcome to share personal feelings and family events with outsiders. It is accepted and encouraged for people to hide their sufferings resulting from their community and to protect the community at any cost.”



“Turkey’s social structure is changing from a community-based nature to a society-based one. While part of the society embraces individuation and separation more easily, the majority of the society is characterized by a community-based structure, opposing separation-individuation.”



The emphasis of Masterson’s approach is on the contrast between real self and false self. In the face of abandonment depression affects, the child gives up on building the real self to replace it with a false self, taking on the identity demanded by the caregiver. If the development of the real self is supported by caregivers in separation-individuation stages, whole object-whole self representations are internalized, and the person develops capacities to love and work.

Masterson approach is based on two fundamental hypotheses: 1. Infants need to separate from their mothers; 2. Separated infants need to gain autonomy. It is a fundamental goal to reach a potential to achieve object constancy. In Turkey’s culture, infants are encouraged to separate from their mothers and gain autonomy. However, they need not to lose respect for the elderly. Autonomy is socially accepted and appreciated only when respect is preserved.

In European and American societies, the separation-individuation process is appreciated and affirmed, while community-based structures dependent on family unable to achieve separation-individuation are less welcome. There is a community-based society in Turkey predominantly. People are supported to separate and gain autonomy only in the presence of certain conditions. Autonomy is only affirmed when it takes place within the standards of judgment of the family and the society. Otherwise, autonomy is challenged and interfered with.

Major therapy techniques of neutrality and frame-setting need to be flexible depending on culture-specific situations. Otherwise, it may not be possible to initiate and maintain a psychotherapy program. Confrontations and interpretations would be rendered stronger when conveyed through culture-specific metaphors and examples.

Turkey’s social structure is changing from a community-based nature to a society-based one. While part of the society embraces individuation and separation more easily, the majority of the society is characterized by a community-based structure, opposing separation-individuation. Therefore, it is crucial for the therapist to accurately evaluate the cultural background of the client including ethnicity, religious beliefs and cultural values of judgment in order to adopt specific flexibilities and apply therapeutic techniques at the proper times and places.

Culture-specific advanced studies should be conducted. A theory originating from a specific cultural atmosphere may not create the desired effect in different cultures. Theories should contain culture-specific flexibilities. The balance between standardization and flexibility should be established carefully.

Application of Transference-Focused Psychotherapy in Turkey & Cultural Differences

Tabir Ozakkas

Transference-focused psychotherapy is a psychodynamic psychotherapy developed for treatment of personality disorders by Otto Kernberg and his colleagues. It is practiced in the US, and is now being implemented in various centers across Europe and the rest of world. It is informed by contemporary object relations theory, developmental psychology, attachment theory, and neurobiological findings.

Three relevant characteristics of the US society are Liberal, Individualist and Competitive: (1) Liberal, because of an understanding of democracy based on secular values, human rights and fundamental freedoms, and elections; (2) Individualist, because of a legal system protecting the rights of individuals in front of the state and the society; and (3) Competitive, because of a capitalist economic view of the world adopting open market conditions.

The society of Turkey is moving along the path of liberal democracy towards the goal of meeting the criteria of the European and American understanding of liberal democracy. Therefore, there are cultural differences in terms of the functioning of democracy and freedoms. Community-based social structure is dominant. Family and society are prioritized over individualism. Sharing is valued over competitiveness. There is a closed way of living over freedom. Turkey is organized with the perspective of communitarianism rather than individualism. Although legal regulations are based on an individualistic system of law, social dynamics are heavily influenced by a community-based structure.

Two major cultural challenges to implementing TFP in Turkey are local cultural factors, and theory-specific differences of culture and epistemological factors.

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“There are cultural differences in terms of the functioning of democracy and freedoms. Community-based social structure is dominant. Family and society are prioritized over individualism. Sharing is valued over competitiveness.”

Major categories of local cultural differences challenging the application of TFP are gender, age, political preference, racial differences, taboo issues, therapist's sexual orientation, religious beliefs, way of dressing, and others. Turkey's culture-specific challenges apply not only for TFP, but for almost all kinds of psychotherapy. Therefore, therapy practice may be stretched to gain some flexibility without contradicting the core of the theory. The issues of gender, age, race, ethnicity, belief and orientation may be left to the client's choice, and the therapist may bring up these issues in therapy if needed. Other than these preferences, discussion of culture-specific tough topics may be postponed until a therapeutic alliance is formed.

TFP may be stretched in various situations for the essential aim of achieving the goals of therapy. In this regard, epistemological fundamental assumptions of the theory may need to be given careful consideration in the application of TFP in Turkey. Such assumptions include therapeutic neutrality, the therapist's all-knowing stance, the therapist's gentle imposition of his/her absolute truths on the client through certain tactics, acceptance of transference-countertransference as a deep-seated structural system, adherence to theory, method and methodology, and achievement of changes specified as therapy goals by means of other treatment options. Furthermore, while functionality is prioritized in theory, some cultures do not place the same importance on functionality and, while therapy goals are aimed at symptom reduction, there are certain culture-specific factors promoting symptom formation and sublimating symptoms such as a view of suffering as a path to maturity. Finally, the developmental line referred to as internalized object relations may be a Western-origin line of development, and Eastern or other cultures' cultural atmosphere may be formed on the basis of split object relations. As a result, there is need for recognition of the fact that behavioral adaptation to modern society, higher functioning, and whole internal representations may be assumptions that are accepted to be fundamental in the Western civilization where TFP is rooted. All these assumptions may be applied flexibly, rejected outright, or a reverse system (society vs. individual) may be anticipated in Eastern cultures.

There is need for serious study to investigate multi-cultural application and causality regarding the aforementioned issues. These studies should examine the application of a theory in different cultures and its results as well as questioning the presuppositions of the original cultural atmosphere of the theory. 🐦

INVITATION TO SUBMIT ARTICLES, ARTWORK, PHOTOS

The Integrative Therapist wants you to be a contributor. 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 are absolutely essential. Articles should be relevant to the issue's theme and to SEPI's three missions: integration between researchers and clinicians, integration across cultures, and further development of psychotherapy integration.

For the July Issue:

The theme will be **Dublin 2016**. We want articles, photos, and reminiscences of interest to our readership, especially ones focused on savoring the conference and sharing with those who couldn't attend.

For the September Issue:

The theme will be **Integrative Psychotherapy Research**, so articles, etc. should be relevant to that topic.

SEPI Society for the Exploration of Psychotherapy Integration

General Author Instructions

Contributors are invited to send articles, interviews, commentaries, letters to the editor, photos, art, and announcements to Jeffery Smith, MD, Editor, The Integrative Therapist. All submissions should be emailed to jsmd@howtherapyworks.com with the subject line "Contribution to Integrative Therapist"

ARTICLE SPECIFICATIONS

- The preferred length of submissions is 1,250 words or less
- Block style, single spaced with an extra space between paragraphs
- No paragraph indentations, page numbering, headers or footers
- Use subheadings and bullet points freely
- Minimal references should be single spaced, in approved APA-style format
- Photos should be submitted as separate JPEG, TIFF, GIF, or BITMAP files, in addition to any imbedded in documents.

Society for the Exploration
SEPI
 of Psychotherapy Integration

SEPI's 32nd Annual Conference

June 16-18, 2016 - Dublin, Ireland – Trinity College Dublin

Join SEPI in Dublin

Deadline fast approaching! Early bird conference registration ends May 1st.
Register on-line now for all events - <http://www.sepiweb.org/event/sepi2016>
with pre-conference workshops on June 16

SCHEDULE OF EVENTS

Thursday

Pre-conference workshops 9:30am-12:30pm
 Opening Remarks and Presidential Panel 2:00pm-3:30 pm
 Breakout sessions 3:30pm-6:30 pm
 Opening Cocktail Reception 7:00 pm

Friday

Breakout sessions 8:30am-6:30pm
 Awards Ceremony 6:30pm-7:00pm
 Poster Session 7:00pm with cocktail hour

Saturday

Breakout sessions 8:30am-3:30pm
 Closing Plenary - 5:00pm-6:00pm
 Saturday Gala - buses leave at 6:30pm

Pre-conference workshops June 16th – 9:30 am -12:30 pm

Workshop 1 - Master Supervisors and Their Supervisees Show/Discuss Their APA Supervision Videos

Presenters - Hanna Levenson, Ph.D. and Arpana G. Inman, Ph.D.

Workshop 2 - Metacognitive Interpersonal Therapy as an integrated treatment for personality disorders

Presenter - Dr. Giancarlo Dimaggio

Optional Saturday Night Gala at the Merry Ploughboy Irish Music Pub - \$75

An evening at the [Merry Ploughboy Irish Music Pub Dublin!](#) Playing Irish Music in Dublin together since 1989, the Merry Ploughboys have provided the best traditional Irish entertainment for visitors to Dublin and locals alike for over twenty five consecutive years. The band owns and manages this traditional Irish pub in Dublin called "the Merry Ploughboy Irish Music Pub Dublin." The evening will be filled with highly entertaining performances of live traditional Irish Music, Song and Irish Dancing. Your ticket will include a three course meal serving the very best of fresh Irish food and free round-trip shuttle transfer from Dublin City center to the venue.

Make your room reservation now!

This year, 2016, is momentous in the history of Ireland, since it is the 100th anniversary of the Easter Uprising. Hotels in Dublin will fill quickly, so please make your arrangements now—Don't Wait! We have liaised with some Dublin hotels to hold a limited number of rooms at discounted prices for the duration of the conference. To book or enquire about these rooms, please contact the hotels directly

Jurys Inn Christchurch

€160.00 Bed & Breakfast per room per night, based on single occupancy
 €170.00 Bed & Breakfast per room per night, based on twin/ dbl occupancy
 Visit their website: www.jurysinns.com/hotels/dublin/christchurch to learn more about this hotel and to make a booking please contact their central reservations office on email ireland@jurysinns.com or by phone +44 870 4100 800. They will also need to quote the block code SEPICO160616.

O'Callaghan 4 Davenport Hotel*

€199.00 Bed & Breakfast per room per night, based on single occupancy
 €209.00 Bed & Breakfast per room per night, based on twin/ dbl occupancy
 Visit their website <https://bookings.ihotelier.com/Davenport-Hotel/bookings.jsp?hotelID=77538&groupID=1562945> to learn more about this hotel

O'Callaghan 4 Alexander Hotel*

€199.00 Bed & Breakfast per room per night, based on single occupancy
 €209.00 Bed & Breakfast per room per night, based on twin/ dbl occupancy
 Visit their website <https://bookings.ihotelier.com/The-Alexander-Hotel/bookings.jsp?hotelID=77536&groupID=1562946> to learn more about this hotel

The contact name for the above 2 hotels is Tanja Paredes and her email is tanja.paredes@ocallaghanhotels.com and you will need to mention SEPI Conference when booking.

Clayton Hotel Cardiff Lane

€175BB Bed & Breakfast per room per night, based on single occupancy
 €185BB Bed & Breakfast per room per night, based on Double or Twin Occupancy
 Visit their website claytonhotelcardifflane.com to learn more about this hotel
 Delegates are asked to book accommodation directly with the Hotel, via weblink <http://www.claytonhotelcardifflane.com/promotional-offers> Password SEPI2016

