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.

A Word From the Editor

Jeffery Smith

Dear SEPI members and friends,

In this special double issue, in an attempt to seek theoretical convergence, we have brought together leaders in our field and asked them to respond to a “Structured Interview,” reproduced below. At the end, I have exercised my editorial prerogative with a summation of what I have learned and a new proposal. Going one step further, The Integrative Therapist is asking readers to give your reactions through an online questionnaire asking you (Yes, we really, really do want your feedback!) to give your reaction to each of the ten proposed principles. Please read the articles first, but if you must peek, here is the link: SurveyMonkey-theory-principles.

We look forward to continuing the discussion in Denver.

Jeffery Smith

President’s Column

Nuno Miguel Silva Conceicao

Dear SEPI members,

Behind me there is a common Roman bridge, about 2000 years old in perfect shape due to a particular specificity in its construction, making it flood-proof. I am enjoying to be your current president, as SEPI navigates through its 3rd decade of existence, building bridges in and for psychotherapy, and beyond. We are a young adult organization facing a number of challenges and opportunities, committed to promote dialogue in the field. I loved the giant acronym, CGEFSCEDEP (cognitively-guided-emotionally-focused-schema-centered-experiential-dynamic-exposure psychotherapy), mentioned by a student in our last issue, attempting to capture his current approach. I always had similar temptations.

As previously announced, the preliminary program of our coming conference—Clinical Decisions that Work: Navigating the Psychotherapy Integration Maze—was ready by March 1st. All of you are welcome to meet in Denver, Colorado, USA, on May 18-21, 2017 for our 33rd (nice number) annual meeting. Assuming its risk I took the liberty of adding “th” to the title to again stress the unit under scrutiny—concrete types of decisions or choices. How many acronyms or other frameworks or organizations are there represented? And countries? Check the maze online for the diversity and coherence of the program. We can say we managed to stay considerably on topic, even if at times more tentatively than voraciously. My wish is that this thematic conference will be a memorable event for all who decide to attend.

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Structured Interview for The Integrative Therapist

Will SEPI provide the leadership in moving the science of psychotherapy from competing schools to a single overall paradigm? The stakes are high. We need urgently to move from exploring differences to pooling our knowledge. Using the metaphor of the blind men examining an elephant, the critical issue is not which orientation will “win,” but when and how to agree on a single overall picture of the animal in question. Diagrammed below is a framework aimed at lowering barriers to adoption of a common view. Note that consensus does not require accepting all aspects of the model as important; only that they might be true.

Barlow et al (2011) describe the primary underlying principle of the Unified Protocol:

“The main premise of the treatment is that individuals with emotional disorders use maladaptive emotion regulation strategies—namely attempts to avoid or dampen the intensity of uncomfortable emotions—which ultimately backfire and contribute to the maintenance of their symptoms. Thus, the UP is an emotion-focused treatment approach; that is, the treatment is designed to help patients learn how to confront and experience uncomfortable emotions, and to respond to their emotions in more adaptive ways.”

Question 1: Regarding the possibility of a common view of emotional healing (“bottom up therapy”).

Daniel Stern (2004) describes how the nonverbal 12 month-old infant makes use of the healing properties of relationship.

“A common example is when an infant just learning to walk falls and is surprised but not really hurt. She will look to her mother’s face to “know” what to feel. If the mother expresses fear and concern, the infant will cry. If she smiles, the baby will probably laugh. In other words, in situations of uncertainty or ambivalence, the affect state shown in others is pertinent to how the baby will feel.”

This interaction brings together, in one, easy-to-grasp image, relationship, empathy, exchange of information, the child gaining a wider perspective, mindfulness(?), and emotional regulation.

Descriptions of the emotional healing in therapy tend to emphasize different components of the process. How would you feel about adopting this interaction as a unifying prototype for the emotional healing component of psychotherapy?

Question 2: Regarding work with conscious thoughts and behaviors, aimed at changing maladaptive appraisal and patterns of reaction (“top down therapy”).

The proposed model aims to be inclusive but simple. Towards this aim, it boils therapy down to just two modes of action. How do you feel about this? How comfortable are you with the notions that most therapies include some form of “top-down” work, and that this “thinking together,” along with emotion centered “bottom up” therapy, describe the two primary interactions of psychotherapy? If not, why?

Question 3: Regarding the universality of affect avoidance as a cause of pathology:

Smith and Lane (2016) summarize broad based evidence for the importance of nonconscious emotion. In the present model, emotions, both conscious and nonconscious, are the critical elements in a chain that places bottom up therapy and top-down therapy on the same map. Without this link, the two modes of therapy devolve into competing approaches rather than alternative points of intervention.

Barlow (2011) identifies affect avoidance as the mediating factor between appraisal and maladaptive reactions, but does so within a limited range of pathology. Hayes (1996) summarizes traditional thinking and more recent research suggesting that experiential avoidance covers an even wider swath of dysfunction.

How do you feel about a more universal view of those maladaptive patterns (of thought, feeling and behavior), that can be changed through psychotherapy, as fulfilling a basic instinct to avoid conscious and nonconscious (or anticipated) negative and overwhelming emotions? 😢
Response to the Structured Interview

Gregg Henriques
James Madison University

I am pleased to have the opportunity to offer some reflections in response to Dr. Jeffrey Smith's Structured Interview on exploring the possibility of a unified consensus regarding psychotherapy and emotional processing. I would like to offer a general comment of support regarding this kind of enterprise. The field of psychotherapy is a “jungle” of approaches, and much effort is needed in cutting through the diversity to identify unifying visions and perspectives. There are many different ways in which we might explore the possibility of “seeing the elephant,” and interviews such as this is one potentially valuable avenue.

Question 1: Emotional Healing and a “Unifying Prototype”

The effective processing of emotions is absolutely central in understanding psychopathology and well-being and in conducting psychotherapy; thus the idea of a unifying prototype is appealing. In seeing this question, I am reminded that one of the oldest ideas in integrative psychotherapy is that of a “corrective emotional experience.” First articulated by Alexander and French in 1946, they define it as the process of re-exposing “the patient, under more favorable circumstances, to emotional situations which he could not handle in the past. The patient, in order to be helped, must undergo a corrective emotional experience suitable to repair the traumatic influence of previous experiences” (p.66).

As noted in the preface of the question, the particular vignette does highlight a number of key elements related to healthy emotional processing. It includes the importance of the relational context and attachment, empathy and mirroring, early development, and provides some guidance on healthy emotional functioning. I agree that healthy emotional processing is crucial and vignettes such as this can be helpful in highlighting key elements.

I do have some questions about whether a single vignette can or should capture all the key elements of emotional processing. In this case, for example, I can’t help but note that the actual emotional experience was not particularly painful or traumatic, so that raises some questions. But I agree in principle that we need unifying conceptions of healthy emotional functioning. The way I have approached this issue is with the concept of “the emotional sweet spot.” The sweet spot is the dialectical tension between being aware of and attuned to one’s emotions on the one hand and adaptively regulating them in the context of one’s identity and long-term goals on the other.

Question 2: Two Modes of Action; “Bottom-up” and “Top-down”

I regularly utilize the language and frame of “bottom up” and “top-down” approaches. And, consistent with the premise of the question, I see bottom up approaches as attending to the feelings and opening one’s self to them and “top down” approaches as regulating potential maladaptive consequences. Notice, this frame parallels the dialectic of the sweet spot formulation (awareness and attunement versus adaptive regulation). In teaching my integrative psychotherapy class, after providing an overview of the history of single school approaches and the context of the integrative movement, I then proceed to teach cognitive behavior therapy (e.g., Beck, 2014), as emphasizing a “top down” regulation approach and emotion focused therapy (e.g., Greenberg, 2014) as offering a complementary, largely bottom up view point (although Greenberg clearly includes both). I completely agree with a central premise of Greenberg’s formulation, which is that there are two primary modes of mentation, one that is perceptual-affective, holistic and fast and a second that is semantic, reason-giving, reflective and slow.

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Although I like the top down and bottom up angles, there is not enough explication here for me to be able to state whether or not they are inclusive of the work I am doing in therapy. For example, when I am trying to help someone understand the impact that their mother's cold and withholding style had on their developing a counter-dependent relational stance, what is this from the vantage point of this model? In my model of psychotherapy, a primary task is to build awareness of the psychological dynamics. It is unclear if this would be bottom up or top down. And I am not clear as to why we would be restricting psychotherapy to these “two modes of action.”

**Question 3: Maladaptive patterns stemming from avoidance of negative affect: A Universal issue in psychotherapy?**

If I had to boil down problematic psychological patterns to one particular issue, the avoidance of negative affect may well be the single most important element that both plays a cause in many presentations of psychological disorder and is a focus of psychotherapy. I believe that most presentations of anxiety and depressive disorders have, as a central feature, affective avoidance. I also believe that the avoidance of negative affect plays a key role in many problematic relationship patterns and processes.

Although affect avoidance is clearly central, I don’t see why we would reduce all of psychopathology to the avoidance of negative affect. It is clearly crucial and a very important piece of the puzzle, especially for depression and anxiety. But there are many other elements and processes that contribute to maladaptive psychological functioning. Of course, there are severe disturbances, such as Bipolar I and schizophrenia, which are much more complicated than affective avoidance. In addition, there are maladaptive learning process, impulsive actions, hostilities, self-centeredness, miscommunication, and so on and so forth. I am unclear about the need or value in attempting to reduce all problems to this issue. That said, however, it is the case that negative affect avoidance is central and does cut across many problems and many approaches to therapy, and thus in that regard it is a good candidate for a central feature of a unifying movement.

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**President’s Column, continued from page 1**

to attend. I would also be glad if it calls for more research on psychotherapy integration, on clinically informed/informative decision science as well as on its interplay.

Consider the case of a student member who decides to register before April Fools’ Day to get the early bird rate. All extra events (two pre-conference workshops + gala dinner) and registration fee cost $305. All extra events cost $145 more than registration fee. How much does registration fee cost? I am sure not everybody answered 160$. Ahaha!

Research on judgment and thinking-and-reasoning has focused mainly on the quality of the reasoning processes, but for those who did answer that, incorrectly, it is not necessarily the case that you do not have the correct logical reasoning principles stored or that you fail to inhibit the intuitive answer. It might be just as important to consider whether cued intuitive answers conflict with other intuitions, such as those based on past knowledge. The same for the quality of the representations on which your reasoning processes were based. Plain attention and accurate comprehension of a problem is the foundation on which sound reasoning is built. In-session decisions are often far more complex, yet this same conflict between a response that immediately comes to mind, and a more thought-demanding deliberate response in decision-making can prove a fruitful arena for what has been a hallmark of SEPI, that of dialogue—I am curious how Denver’s meeting will set the stage for it. Are you not?

As I mentioned, even before intuition or deliberation can operate, attentional processes can determine the course of reasoning, and of integration as well. As SEPI draws its membership from a spectrum of therapeutic approaches, and many of our members have also part of their heart lent to other organizations, we will all keep working closely together in the coming years to keep cheerfully flourishing on the segments of theory, research, training and practice of integration in psychotherapy. The field of integration has relevance for organizational, societal, and cultural relationships, beyond those of our most cherished clinical setting. In general, communication from and within SEPI can certainly be improved. It is my impression that there must be enough tacit, unconscious or even dissociated psychotherapy integration going on in the world, whereby it is practiced or implied without being stated nor affirmed.

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Response to the Structured Interview

Paul Wachtel
New York University

Question 1: Regarding the possibility of a common view of emotional healing (“bottom up therapy”)

There is much in Stern’s description that seems to me useful as a guideline for our work. To begin with, in the process he is describing much of the “action” is nonverbal. The mother may also say things to the infant, but the communication primarily has its impact through bodily cues, tone of voice, the unspoken history between them, etc. I think in psychotherapy too, much of the “action” occurs on this nonverbal level and that we tend to overvalue words and “content” compared to the nonverbal and experiential. I did, of course, write a whole book about how to frame the words we say to the patient (Wachtel, 2011). In my defense (as it were) I would say that the book was especially concerned with the emotional tone conveyed by the therapist’s words, pointing out how the same “content” can have very different meanings depending on the emotional “metamessages” that are conveyed. In that sense, the book is about the same thing I am saying here. In like fashion, the example from Stern similarly suggests that often the words are more the container than the content. That is, we use words as our medium, but the message lies in a realm that is lived out together.

I want to be clear here that I don’t mean by this that all we need to do is be warm and fuzzy and loving. I agree with Barlow (and many others—see below) that much of what brings people to therapists derives from their retreat from feelings that have become uncomfortable (and from the consequences of that retreat). The perceptive identification of what the person is avoiding is critical to how we encourage and facilitate the person’s re-experiencing and reappropriating those cast off parts of the self (switching to my language from Barlow’s). This is by no means easy. Defenses are far more subtle, complex, and insidious than the initial lists of “defense mechanisms” by psychoanalysts would suggest (Wachtel, 2017). The skill of a good therapist consists in large degree in sensing what is being omitted, in helping coax it out, and in creating conditions in which it can be experienced as safe and reintegrated into the person’s emotional and behavioral repertoire.

As suggested by the Stern example, we also help the patient make sense of his experiences and frame them in ways that promote his growth. Foragy and colleagues’ concept of epistemic trust is a related useful guideline. But I fall short of thoroughly endorsing the paragraph from Stern as a model for psychotherapy because I think there are limits and drawbacks to thinking of the therapy relationship as like a mother-child relationship. Some aspects of the patient-relationship have parallels to that between a parent and child; but we are unlikely to be good “parents” with our adult patients if we think of them as just children with larger size clothes.

Question 2: Regarding work with conscious thoughts and behaviors, aimed at changing maladaptive appraisal and patterns of reaction (“top down therapy”)

First of all I would ask, what makes conscious thoughts and behavior “top” and emotional and automatic reactions “bottom”? I have suggested (Wachtel, 2017) that a more apt model would be the Mobius strip, where inside merges into outside and outside merges into inside in a continuous flow.
schemas in more automatic fashion. I have never been a fan of the efforts to talk people out of their “irrational” assumptions that sometimes characterizes cognitive therapy, and the way I read the literature, the evidence is scant that the “cognitive” interventions contribute a lot of the variance in the success of these therapies (though it seems to me very clear that they are indeed successful). Nor have I been a big fan of the versions of psychodynamic thought that, to my mind, overly emphasize insight and interpretation. Increasingly, I have seen the procedural and experiential elements of the work (“bottom up”) as doing most of the heavy lifting. But in order for the patient or client to participate in these processes in ways that will be curative, doing so must make sense to him or her. Human beings are creatures for whom language is at the heart of who we are, and as crucial as is the mobilization of emotion and the generation of experiences that promote exposure to incipient versions of warded off inclinations and affects, our relationships are also built on a foundation of language. Using language wisely and skillfully is essential for all of the elements to fit together and work to the patient’s benefit. If talking about combining “bottom up” and “top down” approaches helps the reader to avoid falling in love with only one facet of the complex therapeutic enterprise because it happens to fit the ideology of his theory, then I take my hat off to it and say, “bottoms up.”

Question 3: Regarding the universality of affect avoidance as a cause of pathology:

I do view the avoidance of feelings that have come to be experienced as threatening as central to what gets people in psychological difficulty. Barlow’s ideas in this regard largely converge with those Freud articulated in Inhibitions, Symptoms, and Anxiety, with Dollard & Miller’s reformulation of those ideas into learning theory terms, with Leigh McCullough’s work on affect phobia, and with a wide range of other formulations. Both Dollard & Miller and Sullivan discuss the importance of anxiety gradients, a concept which enables us to understand how thoughts, feelings, or behavioral inclinations can be the source of anxiety and conflict and yet be avoided so silently and invisibly. The urgency of avoiding the anxiety creates an avoidance response to the slightest inkling of the danger, so that the source of the avoidance (and, usually, the fact of the avoidance) is not noticed by the person manifesting it. In good part, the therapist’s skills lie in noticing what is not noticed, in being sensitive to absences, to changes of the subject, or to signs of discomfort that the individual himself does not notice.

One final comment about the map or diagram that begins the framing of this discussion. It portrays life circumstances as the starting point from which all the rest of the diagram flows. In my own view, there should be an arrow pointing back from the “Pathological Reaction” to the life circumstances, because although some circumstances do confront us out of the blue, the life circumstances most relevant to the dilemmas we try to help people move beyond are usually as much a product of our reactions (pathological and adaptive—not so easy to separate outside of forms filled out for insurance companies) as they are a cause. It is the self-perpetuating cycles that characterize people’s lives that, in my view, should be the central focus of our therapeutic efforts.

References
An Interview with Jeffery Smith

Marvin Goldfried
Stony Brook University

Question 1: Regarding the possibility of a common view of emotional healing (“bottom up therapy”).

Goldfried: Let me begin by saying something about language. I think one of the things that keep the therapies apart is that we don’t speak the same language, and I think that’s certainly one of the goals that you have in this project. For example, your question talks about “emotional healing” in therapy, which is a very phenomenological term. I know of no CBT therapist who has written about emotional healing.

Smith: [Laughs] Right.

Goldfried: But I think I know exactly what you mean; it involves some kind of an empathic understanding. And then there is a positivistic, more observable way of understanding. I don’t think one is right and the other is wrong. I think from the client’s point of view, obviously they talk from a phenomenological point of view, and the therapist has to relate to them and that point of view if they want to maintain a connection. However, I believe that the therapist also has to think in an objective way. We should think clinically in terms of principles and procedures, but interact with compassion.

So that was my first reaction to that, which is not really addressing the question, per se, but it’s addressing how I think we need to dialogue about the issue.

Smith: I was conscious of using that language and did it in the hope that everybody could relate to it and translate it into their own jargon, but I hear what you’re saying. I thought about “emotional processing,” for example, which I think behaviorists would be more comfortable with, but, to my mind, it doesn’t describe the phenomenon as well.

Goldfried: Well, we’re talking about how to change people and evaluating the problems and issues they came in for, or have agreed upon to be changed. And you know, sometimes a problem is emotional, cognitive, and/or behavioral.

I’ve written about this, using the acronym STAIRCASE: situation, thoughts, affect, intention, response, consequence, and self-evaluation. For example, the notion of mindfulness raises an issue. I have trouble with, even though it’s very popular in CBT circles. I’m not quite sure if mindfulness is a cognitive process. Is it an emotional process? Or are we dealing with acceptance? Are we dealing with calming one’s body and mind? Are we dealing with a person’s development of and more effective executive functioning and metacognition?

So I’d prefer to look at variables, mediators, moderators, processes—whatever you want to call them. And some of them involve changes in behavior. So I mean this gets to some of the other questions. It overlaps.

Smith: Well so maybe you could address the first question directly for a moment.

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“By bottom up therapy, I’m interpreting that as focusing on a person's experience—on a patient's experience—and providing them with new experiences that perhaps they haven't had...”

“So I’m thinking of the need to start by breaking the link between thought and emotion.”

“If there is not an intimate relationship—with very clear boundaries—you’re missing something.”

Goldfried: Okay. By bottom up therapy, I’m interpreting that as focusing on a person’s experience—and providing them with new experiences that perhaps they haven’t had, either because they’ve avoided it or they’ve never learned it.

So this is the way I teach CBT to graduate students—which sometimes goes beyond CBT. This is the way I supervise them. A client may be very, very upset about having a certain emotional experience. Let’s suppose they are socially anxious and they’re in a situation where they avoid and then they berate themselves for doing that. I want to break the cycle of situation, thought affect, response avoidance, and negative self-evaluation.

As a matter of fact, I’m seeing a 17-year-old later this week. I haven’t seen her yet, but she has been socially anxious all of her life and probably has a negative view of herself. So I’m thinking of the need to start by breaking the link between thought and emotion. You can break the link by various means. You could put the emotion in one chair and then a thought in the other chair and have the client dialogue with the two. That’s the distinction between the conception of what the problem is, what needs to be done clinically, and then the method of doing it.

Smith: Do you think that the fact of her coming and sitting in your office and experiencing the anxiety within the session has an effect in itself?

Goldfried: Oh, absolutely. And I urge my students, even though they’re learning CBT, to go beyond that and say the change sometimes occurs within the interaction. It doesn’t have to be homework between sessions.

Smith: Do you have thoughts about the mechanism of that change?

Goldfried: Oh absolutely, yes. It’s based on the corrective emotional experience that a person has in a situation. She has certain expectations that it’s dangerous for her to disclose things about herself, because people—including me—will think negatively of her. And then she holds back and is silent.

So I might even say what’s going on? Is it hard for you to be here? Tell me about that. What does it feel like? And what are the concerns you’re having? Am I going to think negatively of you? And then I could say well, you need to know that I really, really value what’s going on with you and I really want to hear that. And then she then tells me something about herself. I could then ask her, how do you feel about having said that?

Smith: What if they just are feeling bad? Just feeling sad about something? How do you see the mechanism for helping with that?

Goldfried: Yes, we validate private emotion. The person does not feel alone. I mean the nature of intimate relationships involves self-disclosure to the other person and there is acceptance. If there is not an intimate relationship—with very clear boundaries—you’re missing something.

So I’ll give you a vignette associated with supervising a third year graduate student who is working in our clinic. The patient is a socially anxious guy, the therapist has a notepad, and she is noting down everything he says. He is very, very hesitant in all of that. And I said, what are you doing? Are you taking dictation? Wording it exactly that way to let her know that I don’t think it’s a good idea. I said, you know, deal with this person. Interact with this person. Next time put away your notepad. And she did, and she said it was an amazing session.

Question 2: Regarding work with conscious thoughts and behaviors, aimed at changing maladaptive appraisal and patterns of reaction (“top down therapy”)

Goldfried: Let me tell you what I’m thinking of with top down. It involves what’s going on in the cerebral cortex, and it’s kind of becoming aware of things you were not aware of before. Some people call it executive functioning. Some people call it reflective functioning; metacognition; self-observation; mindfulness; de-centering. Is that pretty close?
“I’m going to help you learn how to cope better with different situations in your life. In essence to learn to be your own therapist...”

“It definitely needs to involve emotion. I mean very definitely.”

“Behavior therapy, particularly desensitization and exposure, involves getting the person to face up to and remain in situations that they had previously avoided...”

Smith: Yes. Yes.

Goldfried: So this goes back to something that Freud once spoke about, which I think is right on target. He spoke about the therapy alliance as an alliance between the mature ego functioning on the part of the patient and the therapist as they both examine the neurotic conflict.

I think that is a depiction that occurs in all forms of therapy. You can talk about it as involving a process of experience. You can talk about it as insight. You can talk about it in a number of different ways, and it also involves a distinction between emotional knowing and cognitive intellectual knowing.

And the way I present this or think about it with my patients is, I’m going to help you learn how to cope better with different situations in your life. In essence to learn to be your own therapist, and basically, you’ve got to do the work between sessions.

And it’s essentially taking risks and doing things you may not have done before and doing it because of your growing awareness, perhaps from our sessions, that these are antiquated ways of behaving. They may have been appropriate to your early life situation, and also be a function of your constitutional makeup, but they’re not working in your current life.

So you’ve got to learn to do things differently, understanding that what you’ve been doing that doesn’t work and knowing what would work, and then taking those steps. Then we can talk about it and process it and talk about how you were able to step back and be reflective and serve as your own therapist.

Smith: Do you see a distinction between the component of risk taking that your patient does, which I think is an emotional event versus the component of behavior change that comes with trying out a new strategy?

Goldfried: It definitely needs to involve emotion. I mean very definitely. If there is no emotion, it might be because emotion is dealt with by behavior—which we can call from a behavioral point of view, avoidance behavior. If the person is approaching something that they’ve been avoiding because it prevents them from feeling distress, then if they approach they’re going to be distressed.

Which is not too far from Freud’s notion of anxiety, except for that which is being avoided. The content of that varies at least from a drive point of view versus a relational point of view. But I do think that the avoidance paradigm is the foundation of behavior therapy.

Smith: That’s a good lead in to the third question.

Question 3: Regarding the universality of affect avoidance as a cause of pathology:

Goldfried: Yes. Behavior therapy, particularly desensitization and exposure, involves getting the person to face up to and remain in situations that they had previously avoided, so that they’re not experiencing negative consequences that they thought would happen. I mean basically that is a corrective emotional experience.

Smith: Right. The thrust of the third question is, is how would you feel about the idea that avoidance of uncomfortable emotions is the driver of all kinds of pathology, including the original formation of a maladaptive pattern learned in order to avoid some uncomfortable emotional experience?

Goldfried: I think there is certainly a lot of that. I don’t know that it is all of it. For a lot of the people we see clinically, yes. But there are narcissists that don’t come into therapy or somehow get forced into therapy that may not have that pattern necessarily.

Smith: Do you think that narcissistic pathology originally started out as a way to protect from painful emotions around self-esteem?

Goldfried: It may have, but it may not be operating at a certain point in time. Exposure may not be the way of treating it. They may need to learn another way. They may need to learn much more about the consequences

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of their action, and they may need to learn more empathic skills. The therapist who is empathic, may serve as a role model, and they may not have these role models.

There was an interchange between Albert Einstein and Niels Bohr. Einstein said, “Alas, our theory is too poor for experience.” To which Niels Bohr said, “No, no, experience is too rich for our theory.”

I don’t think it explains all. I know that there are some people that are talking about affect phobia. But the thing that really gets to me, Jeffery, is that somebody comes up with an idea, suggests that it explains all human behavior, and then they start a school.

I remember seeing a patient who had panic attacks, and I was trying to simulate panic symptoms within the session by means of hyperventilating or exercising, because some CBT therapist said this is what should be done. But it didn’t work.

However, when the client started talking about his brother, who was living in his apartment and was refusing to move out—which was at great inconvenience to the patient—he had a panic attack. And I said okay, what went on here? He says, I don’t know. I got this strange feeling. It just came out of nowhere. And I said, well I’m not sure if it did. And we traced it to his being angry. I said, “Tell me about anger.” He says, “Oh anger is terrible.” He was raised in South America by Jesuit priests, who told him when he was a little boy, that if you’re angry it means the devil is inside you.

Panic coming from anger is not in the CBT literature. Therapists from orientation that are not CBT might not be surprised by this example. Human behavior is very complex, and we can benefit from approaches. But it is so hard to have a discussion with people of different orientations using words, because we use different words.

Smith:   It certainly is, absolutely. Yes.

Goldfried:   I think you’d appreciate this. Some years ago, I founded a journal called In Session. I don’t know if you know about that? It’s now Journal of Clinical Psychology/In Session. And it’s designed to provide clinical information and relevant research evidence that could be read by therapists of any orientation. So the editorial policy was that you could not write in jargon.

Smith:   Wow, good!

Goldfried:   And authors would have to go back and translate things. One author just couldn’t do it. However, she had a teenage daughter. I said, show it to your daughter, and if she doesn’t know what certain words mean, explain it to her and use that to edit. With many of the journal issues, this was my policy at the time. And it was very, very interesting how people from different orientations were talking about very similar things. So Kernberg had to edit his stuff on treating borderline personality disorder. Marsha Linehan also had to edit her stuff. And when they did, it was very interesting. They didn’t seem to be that far apart.

You know, as long as therapists are in good contact with reality, they’re probably likely to see the same things, even though it’s distorted by their theory. And the extent to which it’s distorted by their theory and they still see it, well then there is something there. It’s a very robust phenomenon.

Smith:   Very well put. That’s fascinating about language. I really appreciate that.
Overview of my reaction to the Structured Interview

Giancarlo Dimaggio  
Center for Metacognitive Interpersonal Therapy, Rome, Italy

I surely agree that therapy needs to be emotion-focused and that dysfunctional attempts at regulating emotions are one key aspect leading to suffering and behavioral dysfunction. To my view a universal protocol needs to include an understanding of human motivation. I mean: emotions arise when humans evaluate, both in nonconscious and conscious ways, the matching with the needed state of the environment and their goal. If I long for a beer and I see a beer in the fridge I am excited and happy (I hasten to say that I do not suffer from alcohol addiction). If I am tired and I need my partner to cook me a warm meal and she is not available because she is late from work, I can be sad or disappointed. Suffering, in the view of many evolutionarily based psychotherapists, such as Joseph Lichtenberg, Paul Gilbert and Giovanni Liotti, comes from the anticipation that basic goals shaped by evolution will be unmet. These goals include, among the others, attachment, social rank, group inclusion/affiliation, autonomy/exploration and so forth. So mental health problems do not come from emotion regulation alone, but by a set of expectations about the possibility that basic goal will be met vs. unmet.

**Question 1:** Regarding the possibility of a common view of emotional healing (“bottom up therapy”).

This is a very timely topic. Together with my own colleagues, we are more and more including bottom-up techniques in our own model, which is in itself an integrated approach (Metacognitive Interpersonal Therapy, Dimaggio et al., 2015). Our consideration that bottom-up techniques are really necessary for the change process comes from two sources. One is the emergence of the paradigm of embodied cognition. Humans, in this perspective, do not reason in an abstract ways on the world, but they reason while interacting with it when trying to reach a personal goal. We strive towards our desired objects and relational states. In the act of anticipating how we will feel in the desired state we form our ideas about the external world. Put simply, we are not primarily interested in the mental processes passing through the mind, but may notice them while searching for a certain kind of relationship, be it cooperative, sexual, or of asking for and giving care. In such a way, in order to change our ideas, we need to change how the body and the mind relate to that person. This is why experiential techniques are so important. I use a clinical example in order to explain the idea. A woman with dependent personality disorder in her 40s suffered because she felt inadequate, unworthy and she thought that if she acted in order to fulfill her goal she would hurt others. She remembered that her adoptive parents were harsh and stern and did not offer much praise when she went to school. She grew up with the unmet goal of being appreciated. She oscillated between having a sense of personal worth, because she had very good marks at school, and feeling inept, which was her dominant self-image, filled with negative emotions.

I asked her to perform a guided imagery exercise. She went back to a moment in which she failed answering a question during an end-of-the school show when she was 11 years Old. The nun said she could not have the drawing she was longing for because she did not correctly list the 7 kings of Rome. She knew them, but just forgot to name the first one. When she went back to her place her father said, “You shouldn’t have tried.” During the re-experiencing of the episode she felt ashamed for having failed and guilt for having caused disappointment and frustration for her parents. I then invited her to try imagery rescripting. I asked her first to think, “I love that drawing, its colors are so vivid”. Thanks to that

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she felt happier and motivated to give the correct answer and she felt confident that she could. In the last part of the re-
scripting I invited her to say to her father: “It is important to know that you appreciate me. You can’t always criticize 
me.” She find this difficult to do, but this led to experiencing moments of self-confidence, pride and freedom from the 
tyranny of harsh judgment.

I think this is a very nice and powerful way to have people change their minds and their schemas about self and others. 
It is not a matter of saying: “You think you are unworthy but maybe this is just a maladaptive false or irrational belief, 
let us seek for evidence against that belief.” It is a matter of contacting, at both experiential and emotional levels, differ-
tently emotionally charged self-representations and letting them guide behavior. Once people experience their body and 
mind doing different things their beliefs about the self and world are more likely to change.

Question 2: Regarding work with conscious thoughts and behaviors, aimed at changing

This is simple: any therapy needs to help patients rewrite their ideas about the self and the world, and without top-
down work this is just impossible to achieve. To me it is not a matter or bottom-up vs. top-down, both are fundamental 
aspects of therapeutic work. It is more about integrating bottom-up work in the clinical work and have revision of be-
liefs (top-down) following experiential work, instead of being a mere abstract reflection.

Question 3: Regarding the universality of affect avoidance as a cause of pathology:

I partially disagree that affect avoidance is a central element. I mean, this is sure important for many patients, but in a 
vast array of cases, the problem is not just affect avoidance, but poor awareness of affects. This does not come from 
avoidance only. In the tradition of mentalizing therapies, adults are more or less able to name their affects and let them-
se themselves be guided by them. When they have this ability it is mostly because they have been guided in validating, recog-
ning, labeling and using feelings during development. If a child is reared in an environment where feelings were 
neglected, he or she will not develop a rich and nuanced emotional language, nor will he or she learn that emotions are 
relevant for our decisions. So, as an adult, emotions will be not recognized, considered and used as a reliable instru-
ment for meaning-making. So the process is more a kind of new learning, that is learning that emotions exist, have 
names, arise under certain conditions, are a central part of human experience, and give us the most basic clues about 
our wishes, aspirations, setbacks and hopes. This aspect is central in some therapies such as mentalization-based 
therapy (Bateman & Fonagy, 2004) and my own, above mentioned, approach, metacognitive interpersonal therapy 
(Dimaggio et al., 2013). The idea is that we do need to help patients overcome affect avoidance, but only when they 
actually avoid affects. In other situations it is more about helping them know what they actually experience. For many 
other patients the affect is there, but they do not know the eliciting factor. They are sad or angry and do not know why. 
Or they do not know that certain aspects of experience are driven by affect. For example, they are unaware that stom-
achache is a sign of anxiety or that declining the invitation to a party is because they are ashamed and not because they 
endorse a negative, moralistic view of parties.

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
McWilliams: Let me first say I think this is a worthy ideal. And I’m glad you’re doing it. Most of my reservations about it involve my longstanding interest in individual differences. That it’s very hard to describe one basic psychotherapy process when some people come because they’re overwhelmed by their affects, and other people come because they don’t feel them and get into trouble in various ways.

And to try to talk about a process that embraces the whole range of patient—that is very daunting, but very—I’ll say it just got me reflecting about affect. I was a student of Silvan Tomkins many years ago, and he was very critical of the psychoanalytic tradition, which was the main clinical tradition then.

McWilliams: Now I’ve been kind of waiting for the CBT group to start calling themselves cognitive behavioral affective therapists because everybody seems to be converging on affect.

Smith: I agree.

McWilliams: Yes. And from what we’re learning about the brain, it does seem that affect precedes cognition.

Smith: Yes. In the diagram I put affect between two kinds of conscious and unconscious cognition, first, appraisal then mind’s function of shaping a reaction to the appraisal.

McWilliams: Yes. Yeah. I think it’s a pretty good diagram of what is recognizable to any experienced clinician as the possibilities. Even the top-down vertical metaphor is kind of interesting to me ‘cause we’re probably talking more about different systems in the brain.

**Question 1:** Regarding the possibility of a common view of emotional healing (“bottom up therapy”).

McWilliams: I think the Stern example is quite beautiful. I’ve been very interested in the work of Rainer Krause in Germany. I don’t know if you know his work.

Smith: No I don’t.

McWilliams: It hasn’t—mostly it hasn’t been translated to English, but he and his colleagues have been videotaping patients and therapists. The therapists are of different orientations, but they’re all experienced. And the patients are real patients. In fact, they’re treatment-resistant patients who’ve kind of flunked a couple of previous therapies. In those therapies in which both the therapist and the patient agree that significant progress happened, what the video shows is that most therapists, the successful ones, respond with what Krause calls “abnormal affect,” meaning that in normal affect we match. If you’re yelling at me, I’m quickly yelling at you.
"...it seemed that the patient was learning there's a different way to feel about this.”

"Like the mother who briefly matches the distress of an infant facially and then changes to a happy face...”

"...the people studying dissociation and trauma are talking about ways of trying to help people deal with overwhelming affect...”

"What is so exhausting about clinical work is all the toxic affects you have to allow into yourself in order to understand and help the patient."
My husband works with schizophrenic patients, and he does psychotherapy with them combining CBT for psychosis with a kind of Kleinian understanding psychotic process. And he finds that CBT for psychosis is a very good method of slowly showing the patient that they have a false belief. And then they get curious about why they develop that false belief. But psychosis is a lot more than false belief [Laughs].

Smith: Yes.

McWilliams: There’s all kinds of affects—and repetitive thoughts and behaviors that go into psychosis. And at the point where the person gets curious, then my husband will move into exploration of the more psychoanalytic kind. He’s writing a book on this now, and he’s also doing the chapter in the next edition of Kaplan and Sadock on psychotherapy for psychosis. So I’ve been watching this develop over a while. He talks about CBT being very good at establishing the literal falsity of a belief. And psychoanalytic work being very good at helping the person understand the metaphorical truth of their delusions, what their delusions were saying about them.

And eventually they get a narrative that makes sense of their life that is something that seems to me goes above and beyond the concepts that are in question two. But I’m not sure. Maybe there’s a way to be inclusive about that.

Smith: I’ve kind of struggled with that because I believe in narrative, too. I do it, but I’ve had a hard time figuring out quite where it goes. I agree with you that there’s something unique and special about narrative.

McWilliams: There’s some way that people’s suffering often involves an element of a kind of desperate not knowing why they do what they do or feeling pushed around by things they don’t understand. And they do need some kind of coherent story about who they are.

Smith: Absolutely. So I agree that’s a little bit of a lump in the elegance of this scheme.

McWilliams: [Laughs] People are so complicated and so different in what they come to us for, too.

Question 3: Regarding the universality of affect avoidance as a cause of pathology:

Smith: I do think that when we look at the origin of the problems we work with in therapy, the thing that they all have in common is that you can boil them all down to avoidance of painful and overwhelming affects.

McWilliams: Yes. I think that’s very elegant.

Smith: Good [Laughs].

McWilliams: It is about time we put affect at the center.

McWilliams: Yes. I am still a little bit uncertain about affect avoidance as the unifying principle because there are some people that get overwhelmed with affect, that act it out, that justify it, that it’s not exactly that they avoid it. They can’t contain it.

Smith: Right. But one could say the pathology is about controlling overwhelming affect.

McWilliams: Yes. And first of all, I love the fact that you’re trying to get us off this horserace model of which treatment is better. When I work with some patients, I can slowly help them get rid of certain defenses against affect. And then they can feel the affect. With other patients, especially people with paranoia, I find I can’t do it that way because they feel too humiliated by it. So I find other ways of trying to detoxify the affects that I think are underneath their need to disown something and see it outside themselves.

When affects are deeper and more threatening, you can’t exactly address them. You have to somehow model a different attitude towards those affects. With many patients, I find that over time they get a lot
“...you can’t exactly address them. You have to somehow model a different attitude towards those affects.”

“But I still want to be sure that models like these keep open some kind of not knowing in the therapist.”

“We’re all looking at the same suffering animal, and there should be a way of putting everything together.”

Smith: I think there’s a very important principle here. Biology has found a single paradigm. It’s gone from a pre-paradigmatic science to a “normal science” by adopting the idea that evolution produces purposeful functions in the organism aimed at survival and procreation. And if we slide under that umbrella in psychology, at least as far as psychotherapy goes, then we come to the idea that the way the brain fulfills that function of ensuring survival and procreation is by tagging dangerous behaviors and circumstances with negative affects a tagging positive ones with positive affects. And the affects then drive our behavior.

McWilliams: Yes.

Smith: So using that overall umbrella, if we could develop a consensus about that, then allows us very neatly to slip in with biological science by saying that the kinds of psychological dysfunction treatable in psychotherapy are where the brain learns certain ways to control our thoughts and behavior for survival and procreation that don’t meet fully the needs of the complexities of the world.

For example, if you adapt to an unhealthy family environment and then later your life gets better, those adaptations are often dysfunctional.

McWilliams: Yes. I have no problem with embracing that. I think that’s a statement of what we all see every day in our offices. But I still want to be sure that models like these keep open some kind of not knowing in the therapist. An explorative element.

Smith: I hope the diagram does that. The internal and external circumstances we perceive are infinite and our appraisal of them is infinitely complex. In the same way, the outputs of the system, consisting of our reactions, are also infinitely complex. But in between, feelings are positive or negative and those are what drive our reactions. And when it comes to pathology, it is mainly negative emotions that are behind those reactions that are maladaptive.

McWilliams: Well, I’m really glad you’re doing this [laughs]. It shouldn’t be impossible. We’re all looking at the same suffering animal, and there should be a way of putting everything together.

Smith: Any thoughts of things that we haven’t talked about or that you’d like to add?

McWilliams: Not really. Just when you said what you just said, I was thinking of Jaak Panksepp’s work on mammalian affect and how central that’s been to some of my own understanding lately.

Smith: Me, too, I think he’s right on the money [laughs]. Thank you so much for this conversation.

McWilliams: My pleasure. 🤗
Response to Questions by Jennifer Davidtz

Dennis Greenberger
Co-author of Mind Over Mood

Question 1: how do you think about emotion in your work as an expert cognitive therapist?

“It is a truism that, the richness of human experience is a blend of feelings and emotions. Without the free play of emotions there would be no thrill of discovery, no entertainment over humorous situations, no excitement at seeing a beloved person. Human beings would operate purely at a cerebral level, devoid of the feeling tones that make their lives vibrant rather than mechanical.” Beck (1979; p. 34)

Barlow et al (2011) describes the primary underlying principle of the Unified Protocol (UP): (bold added below for emphasis)

“The main premise of the treatment is that individuals with emotional disorders use maladaptive emotion regulation strategies—namely attempts to avoid or dampen the intensity of uncomfortable emotions—which ultimately backfire and contribute to the maintenance of their symptoms. Thus, the UP is an emotion-focused treatment approach; that is, the treatment is designed to help patients learn how to confront and experience uncomfortable emotions, and to respond to their emotions in more adaptive ways.”

Despair, crying, joy, panic, elation, anger, anxiety, guilt, shame, and jealousy are central to the work of excellent therapists and excellent cognitive behavior therapists. Most people come into therapy because of some type of emotional problem. Whether or not patients are satisfied with the outcome of therapy is largely dependent on whether or not they feel better — whether or not there has been a mood or emotional change.

The traditional CBT model recognizes that there is reciprocal interaction between, emotion, behavior, cognition and physical functioning.

“CBT, like all good therapies, utilizes all the non-specific psychotherapy factors that we know are beneficial.”

Question 2: to what extent do you think it is necessary to address emotion directly in cognitive behavioral therapy?

In CBT emotion is directly addressed beginning in the first session. CBT, like all good therapies, utilizes all the non-specific psychotherapy factors that we know are beneficial. Empathizing with a client's distress, validating their experience, forming a positive and trusting therapeutic alliance, accurately reflecting and deepening client's descriptions of their experiences are all ways of directly responding to our client's emotions. Our client's emotions are responded to when we respectfully work at the speed they are ready to work at.

In addition, emotion is often directly addressed in CBT when the therapist notices an emotional shift during a therapy session. It would not be uncommon for a CBT therapist to inquire about the shift in emotion, to find out what had occurred experientially and to inquire about what thoughts had accompanied that emotional shift. What had been triggered in the conversation? Did the patient have a thought, a perception or misperception, about something that the therapist had just said? Directly asking about these emotional shifts can lead to productive therapeutic moments.

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Another example of addressing emotion directly in CBT can be found in the treatment of panic disorder. Although the treatment of panic disorder has many different dimensions (increased tolerance of distressing physical sensations, increased acceptance of ambiguity, anxiety management training, cognitive restructuring, overcoming avoidance, decreased reliance on safety strategies, etc.) one central feature is exposure therapy or panic induction. In this part of the treatment the therapist will induce a panic attack via hyperventilation, spinning in a chair, or exposure to cues such as a small elevator, which are likely to induce a panic attack. This is an example of where, in CBT, emotion is directly addressed in order to make therapeutic progress. Research and clinical experience have demonstrated that there can be a significant reduction in the frequency of panic attacks and that patient's maladaptive appraisals of anxiety (“I won’t be able to tolerate this,” “I’m going to have a heart attack,” “I’m going to have a stroke,” “I’m going to die”) change via this process.

Exposure therapy is a central feature in the CBT treatment of anxiety disorders including posttraumatic stress disorder, generalized anxiety disorder, panic disorder, health anxiety, etc. In this treatment the patient is directly exposed to the anxiety that they have been avoiding. It is generally accepted in cognitive behavior therapy that it is necessary to directly address the anxiety/panic via exposure in order to reach the treatment goals of eliminating panic attacks, reducing the frequency/severity of anxiety, or reducing the impact that the anxiety has on one's life.

Traditional cognitive behavioral therapy will teach patients to identify, evaluate and alter the thoughts or behaviors associated with their mood problems. Emotions are directly addressed via the thoughts or behaviors associated with them. For example, the depressed patient who thinks that they are a failure, worthless and unlikeable can be taught to identify when the depression and those thoughts are activated and then learn strategies to respond differently to those thoughts and moods when they occur. These new coping strategies have proven to be effective in terms of lowered frequency and severity of depression.

Similarly, 50 years of research has demonstrated that behavioral activation is an effective treatment for depressed patients. Inactivity, avoidance, and decreased social interaction often characterize patients suffering from depression. In the context of a warm, trusting, caring therapeutic relationship patients can be taught to recognize the correlation between their inactivity and their depression. In CBT patients learn to “experiment” with increased levels of activity, especially doing things that gives them a sense of pleasure, mastery, control, purpose or meaning. This often results in a decrease in depression and a movement towards therapeutic goals.

Excellent CBT therapists (and I suspect excellent therapists regardless of orientation) will be flexible in their approach and will utilize interventions that work for each individual patient and will discard interventions that don’t work. Good therapists work from a therapeutic model, are flexible in their approach, and are committed to their patients improving. This question asks “to what extent do you think it is necessary to address emotion directly in cognitive behavioral therapy?” The more pertinent question for a cognitive behavioral therapist might be “what is the most efficient and effective way to address emotion or the therapeutic targets?”

**Question 3: how do you conceptualize and address the avoidance of emotion or affect in psychotherapy?**

In cognitive behavior therapy conceptualization is always an individualized process based on the CBT model. Avoidance, like any behavior, can be understood both in terms of the function that it serves and the cognitions that it is connected to. Avoidance of emotion may serve different functions for different people. Someone with depression and an alcohol problem may drink in order to emotionally anesthetize themselves and to avoid experiencing their depression.

In this example drinking serves the function of avoiding sadness. Someone with germ OCD may believe that the only way to not become contaminated or ill is to wash their hands repeatedly. The hand washing can be conceptualized as a response to the thought “I’ll become contaminated and ill” and temporarily reduces or avoids the associated anxiety.

In order to understand avoidance it is important to look at the function it serves as well as the cognitions associated with it. For some people, it may also be important to understand the developmental and family experiences that led to their avoidance of emotion. Individualized conceptualization, taking into account developmental experiences is important in cognitive behavioral therapy. Avoidance of emotion may be a learned behavior that was adaptive at some point in time. In a CBT framework a learned behavior can be unlearned and replaced with new learning and more adaptive responses.

There may be underlying beliefs that contribute to emotional avoidance. Beliefs that could lead to emotional avoidance include “If I feel love then I will be hurt,” “If I feel anxiety then I will be overwhelmed,” “If I feel anger then I won’t be...”
“For some people, it may also be important to understand the developmental and family experiences that led to their avoidance of emotion.”

“If I feel despair then I will sink into a black hole and never get out.”

“As a young psychiatrist Aaron T. Beck, M.D. was a psychoanalyst.”

“Cognition is explicitly focused on as a way of managing emotion—as a means of emotion regulation.”

able to control myself,” “If I feel despair then I will sink into a black hole and never get out.” Working with these underlying beliefs and simultaneously learning to be more accepting and embracing of these emotions may be part of the CBT therapy and a way to work with the avoidance of emotion.

Question 4: what are your thoughts about the assertion that cognitive therapy might collude with the “intellectualizing defenses” and pathological avoidance of affect of some patients by focusing so much more explicitly on cognition?

This is such an interesting assertion as it is so discrepant from my experiences in therapy. I am not aware of any evidence or data that supports this idea.

As a young psychiatrist Aaron T. Beck, M.D. was a psychoanalyst. Through observation of his patients he noticed that there was a negative theme to the thinking of his depressed patients. Further observation and careful research led to his formulation of the negative cognitive triad. The negative cognitive triad recognizes that depressed people tend to think negatively about themselves, about ongoing experiences and about the future. Prior to this time there was no clear articulation of the role of cognitions in psychological problems and no systematic way of attending to the cognitive correlates of mood problems. Dr. Beck’s formulation led to treatment interventions that have been more thoroughly researched than any other form of therapy. “Focusing so much more explicitly on cognition” was a therapeutic paradigm shift as earlier models of psychotherapy did not explicitly focus on cognitions.

Although cognition is explicitly focused on in CBT this does not mean that affect is avoided or ignored. Adding cognition to our conceptualization and formulation enriches and deepens our understanding of our patient’s experiences. Usually clients enter into therapy because they feel too much—too much depression, too much anxiety, too much anguish, too much shame, etc. Cognition is explicitly focused on as a way of managing emotion—as a means of emotion regulation.

If it is determined through evaluation, history and case conceptualization that there is problematic intellectualizing or “pathological avoidance of affect” then it is likely that the treatment plan would include strategies to overcome this avoidance. These strategies may include exposure, response (avoidance behaviors) prevention, acceptance, and cognitive restructuring.

I appreciate the opportunity to answer these questions. I will end with additional questions for the reader to consider?

A – How do you currently incorporate cognitions and behavior into your integrative treatment planning?

B – How could integrative therapists work more directly with cognitions and behaviors?

C – What would be the advantages and disadvantages of integrative therapists working more directly with cognitions and behaviors?

References
“In the present case the phenomenon of interest is psychotherapy’s ‘emotional healing component,’ which begs the question as to what emotional healing exactly means.”

“...this interaction strikes me as blending a strong therapeutic alliance with elements of a corrective emotional experience...”

“...the infant’s initial emotional reaction (‘surprised, but not really hurt’) occurs in the context of experiencing a setback (‘falling’) in striving to achieve a distinct goal...”

Response to the Structured Interview

Jack Anchin
Medaille College

1. My answer to this first question is prefaced by two caveats. First, to identify features that compose the prototype of a given phenomenon, there needs to be some consensus as to what that phenomenon refers. In the present case the phenomenon of interest is psychotherapy’s “emotional healing component,” which begs the question as to what emotional healing exactly means. Material contextualizing the three questions posed seems to answer this question by more or less equating emotional healing with emotion regulation. The latter is indeed a rich and highly robust concept capturing different processes, one or more of which are often highly pertinent to meaningful clinical change; however, the question is open as to whether a consensus exists that emotion regulation sufficiently captures all forms of emotional healing in psychotherapy. Second, it is important to note that Gross (2015) makes a distinction between intrinsic emotion regulation and extrinsic emotion regulation, the former referring to regulatory processes “activated in oneself” (p. 359) and the latter to regulatory processes “activated in someone else....[that is,] interpersonal emotion regulation” (p. 359). Stern’s illustration primarily represents the latter, and as such, my response reflects mapping this particular form of emotion regulation onto the notion of “emotional healing.”

This said, I experience mixed feelings about adopting this interaction as a unifying prototype for the emotional healing process in psychotherapy; in my view it illuminates several potentially viable features of such a prototype, but I also see certain limitations.

On the “positive” side of the ledger: Cast as a metaphor for the clinical situation, this interaction strikes me as blending a strong therapeutic alliance with elements of a corrective emotional experience insofar as a therapist’s expressed empathy vis-à-vis the client in a heightened (negative) emotional state is likely to induce or activate some degree of salutary down-regulation in the intensity of that state—and perhaps facilitate a shift towards a more positively-toned state. This empathy-based healing facet of the relational process is transtheoretically fundamental and inherent to psychotherapy, and thus to my mind would be an important feature to include in a unifying prototype of psychotherapy’s healing component.

In addition, paralleling Mother vis-à-vis her 12-month-old infant, a therapist’s responsiveness invariably provides the client with a “wider perspective” by virtue of the fact that not only are the therapist’s verbal and nonverbal reactions, like a mirror, reflecting back to the client the latter’s internal experiences, verbalizations, and overt actions, but crucially, these “reflections-back-to-the-client,” like Mother’s response to her infant, are inescapably colored by the therapist’s interpretive meanings. In turn, the latter become assimilated and blended into meanings the client consciously and/or tacitly gives to those experiences, verbalizations, and actions, with beneficial consequences for emotion regulation potentially ensuing. This is a process of information exchange whose perspective-widening effects and their emotion-regulatory implications stem from the fundamentally hermeneutic, interpretive nature of psychotherapy, irrespective of therapeutic approach (see Anchin, 2006). I perceive this process to be another transtheoretical feature of psychotherapy, thus constituting another viable prototypic feature of psychotherapy’s emotional healing effects.

A more implicit facet of Stern’s vignette—that is, the source of the infant’s emotional reaction, which is also the central focus of Mother’s empathic understanding and response—may be a third feature warranting inclusion in the unifying prototype under discussion. Specifically, the infant’s initial emotional reaction (“surprised, but not really hurt”) occurs in the context of experiencing a setback (“falling”) in striving to achieve a distinct goal (“learning to walk”). Smith and Lane (2016) concisely captured the process at play here: “Emotion involves an assessment of the extent to which needs, goals, and values are met or not met in a given situation...” (p. 219). Recognizing the potential impact of moderator variables, perceiving and experiencing oneself as effectively navigating toward or attaining a desired goal state tends to be associated with positive emotional states, whereas negative emotional states tend to be associated with perceiving and experiencing discrepancies between a valued goal state and one’s actual circumstances. In this illustrative situation, in which the infant is striving to achieve the developmental milestone of walking, the valence of her/his initial
...her overt response governs whether this initial emotional reaction moves in a positively or negatively valenced direction.”

“A prototype will also need to make room for the client’s development of intrinsic emotion regulation.”

“...we tend to encourage the client to reflect on our input; to ‘try on’ what is being taught or realized; to determine and decide what resonates...”

“I prefer the terminology of—and conceptualization embedded within—‘insight’ and ‘action.’”

Surprise upon falling is uncertain; however, more evident is the fact the infant’s emotional reaction is bound up with felt-meanings associated with unexpectedly encountering an obstacle to attaining a goal. At the interpersonal level, Mother’s empathy would seem to be a mixture of implicit or explicit attunement both to the fact that her infant is attempting to achieve a highly desired goal and the fact that she/he is experiencing an emotional reaction to the setback; her overt response governs whether this initial emotional reaction moves in a positively or negatively valenced direction. These dynamics suggest that when the client’s emotional healing is induced by the therapist’s interpersonal emotion regulation, another operative prototypic feature is the therapist tacitly or explicitly understanding—and conveying this understanding—that the client’s painful emotions are directly or indirectly tied to having encountered obstacles to, setbacks in, or perceived failures in attaining one or more subjectively important goals. Parenthetically, these may be goals especially associated with (and as well illustrated in Stern’s vignette) strivings for agency (motivation centered on developing a coherent, differentiated, and integrated self-characterized by effectiveness, control, and mastery in one’s world), communion (centered on developing and maintaining satisfying relationships with others), or a mixture of both (e.g., if, by successfully walking, the infant is also wanting to please Mother and garner her affection and approval) (see Magnavita & Anchin, 2014).

Two particular considerations underpin the concerns I have about Stern’s interaction serving as a unifying prototype for the emotional healing component of psychotherapy. Specifically:

Per Gross’s (2015) distinction defined above, to the extent that a unifying prototype of emotional healing in psychotherapy is defined only by extrinsic (interpersonal) emotion regulation, as in Stern’s example, it is incomplete. Such a prototype will also need to make room for the client’s development of intrinsic emotion regulation. These capacities are often fostered through therapist interventions which, depending on the therapeutic approach, in one way or another equip the client with specific strategies and methods for regulating problematic emotions. Initially acquired in session and subsequently activated through cuing by the therapist (e.g., “What are your options for managing this kind of feeling?” or “What can you keep in mind that could help you emotionally in this type of situation?”), the goal ultimately is for the client to self-activate these tools in her/his naturalistic, day-to-day circumstances (transitioning from interpersonal to intrinsic emotion regulation). Features of a comprehensive unifying prototype for the healing component of psychotherapy would thus incorporate processes and effects deriving from both interpersonal emotion regulation by the therapist (e.g., through empathy, fostering insight, and so forth) and intrinsic emotional regulation on the part of the client.

In addition, we know from empirically supported dual process models of the human mind that reactions to events occur through automatic (e.g., out of awareness and rapid) processing, deliberative (e.g., conscious and relatively slower) processing, or an interaction between the two (see Anchin & Singer, 2016). In the interaction described by Stern, the infant’s emotional reaction (one of healing if Mother responds with a smile) occurs through automatic processing: she/he sees Mother’s reaction and within milliseconds experiences and expresses an emotional reaction that accords with her response. However, a considerable amount of the emotional healing that occurs in effective psychotherapy, certainly with adults and adolescents (and perhaps by children past a certain age), is mediated by a client’s deliberative processing; whatever therapeutic methods and interventions a therapist may use in fostering effective emotion regulation, we tend to encourage the client to reflect on our input; to “try on” what is being taught or realized; to determine and decide what resonates; to apply in vivo the emotion regulatory skills and insights emerging in sessions; and to process with us the consequences of these efforts. An intimately related consideration here is the therapeutic importance of respecting and encouraging the client’s autonomy. In Stern’s interaction, the infant “looks to the mother,” born of her/his considerable dependence on the latter and integral to the power of her influence on the infant’s emotional reaction. And while our adolescent and adult clients also “look to us,” and their healthy dependence on us helps grease the wheels of psychotherapy, we also take into account and seek to build the client’s capacities for autonomous emotion regulation—to not just “look to us,” but, in ways described above, to also process and work with what we offer them and make it their own. A comprehensive unifying prototype of the emotional healing component of psychotherapy would thus also recognize the important role and contributions of both automatic and deliberative processing in the healing process—and placed within the interpersonal context in which these occur, it would reflect mindfulness of the dialectic between client dependence and autonomy as healing processes unfold.

2. This conception of therapy’s principal modes of action contains some appealing elements, but on the whole my reaction is mixed. I do believe that two particular modes of action and their interaction are central to therapy’s effectiveness, but rather than characterizing these as “top down” and “bottom up” work, I prefer the terminology of—and conceptualization embedded within—“insight” and “action” (Wachtel, 1987). To my mind, there are points of overlap between these two conceptions, but also meaningful differences.

Distilled to its essentials, I view insight as a process of gaining awareness and understanding of different components of the client’s dysfunctions and the nature of interrelationships between these components, whereas the “thinking (and talking!) together” integral to “top down” work is the process through which insight is fostered and achieved. Thus, in the “proposed map of psychopathology and therapeutic intervention” on which this inquiry is based, a major form of “top down” work entails the therapist and client collaboratively identifying the client’s maladaptive appraisals of
“Appraisals entail interpreting and in turn giving meaning(s) to a given situation or life circumstance, with resulting emotional, physiological, and behavioral consequences. To my mind, in and of itself, the psychoeducational process of helping a client understand that appraising, interpreting, and giving meaning to circumstances is something she or he does imparts knowledge that fosters the client's insight into an important aspect of her or his psychological processes. Similarly, helping the client understand that certain of her or his interpretations entail distortions and that the distortions she or he engages in are characteristically of certain types (e.g., catastrophizing; black-and-white thinking; discounting the positive) is to foster additional insight. And of course, in the same way, helping her or him understand that these distortions give rise to negative, subjectively painful emotional states (and physiological concomitants), and that self-defeating, maladaptive behavior follows from these cognitive and affective processes, is to foster still further insight. The point is that explaining this “interacting systems” (Westbrook, Kennerley, & Kirk, 2011, p. 6) conception to the client and collaboratively applying it to specific situations or life circumstances to help her or him understand the nature of her or his functioning is “top-down” work whose effectiveness in contributing to the process of change derives from the insight it produces.

The proposed map also depicts “maladaptive… patterns of reaction” (my emphasis) as a second focus of top-down work. However, here again—whether this translates into helping her or him understand that there is a predictable relationship between appraisals with “this kind of content” (e.g., some form of catastrophizing), the particular emotion she or then tends to experience (anxiety), what she or he experiences physically (e.g., sweating), and her or his ensuing behavior (e.g., avoidance), or whether it entails sharpening the client's awareness of the recurrent nature of this constellation across different situations—collaborative top-down work that illuminates for the client the existence and nature of her or his patterns ultimately moves the change process forward through enhancing the client's self-insight.

Paralleling my view of “top-down” work as the vehicle through which insights are fostered, I view “bottom-up” work as encompassing processes that effect action—that is, directly fostering adaptive changes in specific covert and overt components of the client's dysfunctionality being brought to the fore and increasingly understood through insight-oriented work. With regard to the proposed map's characterization of “bottom up” work as “emotion centered,” I agree with this if by “emotion centered” we mean that a fundamental metagoal of the therapeutic endeavor is to bring about change in negative, painful affectivity to more positively-toned or otherwise salubrious affective states, and that “bottom-up” work is essential to achieving this metagoal. However, the systems principle of equifinality, which holds that there are multiple pathways to achieving the same goal, figures prominently in my approach to action-oriented work; consequently, achieving explicit emotion centered goals can be pursued through bottom-up interventions directly focusing not only on particular emotions and emotional processes (e.g., emotional experiencing; emotion regulation), but also on other components revealed by insight-oriented work to be functionally related to the client's dysfunctionality and resultant pain. Depending on particular idiographic considerations, this bottom-up work may entail, for example, fostering more accurate and realistic appraisals of current situations or life circumstances; changing meanings attributed to particular historical events, situations, or experiences, particularly to the extent that these continue to influence current affectivity; developing acceptance; modifying self-relational processes (e.g., critical self-reactions); changing the nature of interpersonal actions and reactions in specific relational contexts; and/or modifying the nature and/or particular dimensions of agentic and/or communal goals. Amplifying both the use of strengths and targeted enactment of healthy processes in the client's repertoire are often additional bottom-up, action-oriented strategies.

I see psychotherapy, then, as a continuous interplay between working from the top-down to foster insights and from the bottom-up to cultivate constructive changes in covert and overt actions…”
“...experiential avoidance is a powerful dynamic in perpetuating an array of psychological disorders.”

“...experiential avoidance is likely only one among other ‘functional diagnostic dimensions’”

“...we teach students about the importance of the ‘4 Ps’—predisposing, precipitating, perpetuating, and protective factors...”
An Interview with Jeffery Smith

Leslie Greenberg
York University

Smith: If you look at that diagram, the essence of what I'm asking about is your views regarding the idea that emotion is an essential mediator between experience and the things we do, a basic motivator for thought, behavior, and feelings.

Greenberg: Right. Right.

Smith: In addition, I'm trying to boil things down to psychotherapy's two most basic actions. The first is what I'm calling “bottom up,” the things we do to take the visceral, painful sting out of emotions. And then on the other side, we do things from the top down to help people voluntarily change their thoughts and behavior, which then reverberate back into the area of emotion.

**Question 1: Regarding the possibility of a common view of emotional healing (“bottom up therapy”).**

Smith: I wonder how you feel about Stern's image of the toddler who has fallen, as a metaphor for the emotional healing aspect of therapy, and if you think that that kind of prototype might actually be a good way to describe it?

Greenberg: In general, yes, but I think this quote from Stern is missing one aspect; that the child does actually have a self-experience. So I mean it could be misread as the mother's face will TOTALLY determine what you feel. Stern uses the visual cliff, you know, to describe this and I mean the issue is that the child looks down the visual cliff and has a fear response. So that's where it starts. It doesn't start with looking at the mother's face. But then, in the context of having the biologically based emotional response the child begins to make sense of it by using such a reference. So I mean I agree with it and I think it brings to light that for me in therapy it's the relationship that is healing emotionally in this way, but it's not the only form of working with emotion, because emotion exists within the organism independent of how it's being treated from the outside.

Smith: Can you say a little bit more about other ways you see emotion being worked with in therapy?

Greenberg: Well, through awareness of your own bodily feeling and symbolization of it, it’s not all relationally dependent, but if the relationship is safe and trusting you can give more attention allocation to what it is you actually experience in your body, because you’re not monitoring the safety in the environment. So the reduction of interpersonal anxiety through empathy and trust allows you to tolerate more intrapersonal anxiety. Then you can turn inwards and actually pay attention to what you feel. I think the relationship is a part of the emotion, but there’s also an internal process. So I don’t think everything is relational. It’s a dialectical synthesis between biology and culture, between emotion and language and the inner and the outer environment.

Smith: Yes. So let’s say somebody who’s been traumatized comes to you with trepidation about re-experiencing the emotions around their trauma and they feel enough safety in the therapeutic environment to go ahead and recount their traumatic experience. So I think you’re saying that they’re able to actually examine and experience the emotion and the fact of doing that then transforms it.

*Continued on page 25*
Greenberg: Yes. Yes.

Greenberg: I’ve talked about it. I mean, I believe there are certain processes. It’s not MERE exposure that leads to the transformation, but the first step is being able to experience it and be aware of it and so on.

Smith: Are you talking about reconsolidation and that sort of thing?

Greenberg: Yes, that, but also I have this principle of changing emotion with emotion. I mean it clearly involves reconsolidation of memory. We need to have a new experience of a new emotion in order to change that old emotion.

Smith: And the new emotion comes from the other person or from within?

Greenberg: From both. More predominantly from within, but it can come without, so it could be either. It depends on the emotion and the circumstance, but I think to some degree it’s important that it comes from within.

Smith: Do you see this process of emotional healing or processing as one of the primary things that goes on in psychotherapy?

Greenberg: Absolutely. I see it as the primary thing for enduring change.

**Question 2: Regarding work with conscious thoughts and behaviors, aimed at changing**

Smith: The second question is about all of the things that we do to help people trade in maladaptive behaviors for healthier ones and maladaptive thinking for healthier thinking and I think I’d add to that, changing unhealthy non-verbal schemas for healthy ones as well. How do you feel about seeing that as the other half of psychotherapy?

Greenberg: Yes. I agree. It depends exactly how we think about this “top down.” I mean, I think a piece of it that’s missing is that some of the major top down work is creating meaning. So it’s not all modificational, yeah, although that’s contained in your statement. I think you’re not implying that we use our thinking in order to change our thinking or our behavior, but we’re using it to create meaning.

Smith: How do you see the creation of new meaning as transformational?

Greenberg: For example, I think when you feel empowered anger that transforms maladaptive shame, then you get to a new, truly novel experience of self, which is, say, confident, or forgiving. Then you create new meaning from that. Meaning is a consolidating process that makes sense of what you are feeling.

Smith: Uh-huh. I like that. What about where do you put corrective emotional experiences?

Greenberg: I think a corrective emotional experience is an example of a relational way of changing emotion with emotion. So I think there really are corrective interpersonal emotional experience, which is when you experience shame, but you find respect, let’s say. So that’s an interpersonal corrective emotional experience. But as I said, I think you can also have corrective emotional experiences that are not interpersonal where you generate this new emotion within yourself and that changes the old emotion. So one of them is interpersonal, the other is more intrapsychic.

**Question 3: Regarding the universality of affect avoidance as a cause of pathology:**

Smith: A lot of different people have identified affect avoidance as a major source of maladaptive patterns. For example, character disorder patterns can be seen as learned ways to avoid uncomfortable feelings in early life. I’m tempted by the thought that affect avoidance is the source of essentially all of the pathology that we treat in psychotherapy. I wonder what you think about that.

Greenberg: I struggle with it, I lean towards it, but I think any single factor theory of dysfunction is oversimplified. So I think they’re also different, so my answer is no. I think it’s more complicated. I think affect avoidance is an essential piece, but I think that if I avoid, say, my core shame, avoid my core insecurity, and then if I face it, that in itself is not transformative or change producing. Its only a first step. Now it has to change.
Smith: Right.

Greenberg: So therefore, avoidance of it is not the only cause. I mean that shame itself, even if I accept my shame, is pathogenic.

Smith: Right. Are those what you call secondary emotions?

Greenberg: No. Those are called maladaptive emotions, primary maladaptive emotions. The thing is we usually avoid our primary maladaptives because they’re so painful. Overcoming the avoidance is a step on the path to change. If I accept that I feel like a worthless piece of garbage it’s still pathological.

Smith: Absolutely. Yes.

Greenberg: So it has to change. So it’s not only avoidance, I think these are over simplified, you know? I mean the thinking of behaviorists, such as Barlow, and Hayes, and people like that. So unlocking this kind of affect is oversimplified. But it’s a very important step.

Smith: The internalization of a negative attitude towards the self could be seen as a mechanism of avoidance of something even more painful, which is loss or the fear of loss of the relationship.

Greenberg: I understand, but you see, that suggests everything occurs around fear of loss of the relationship and I don’t think all psychopathology is basically based on attachment or only relational. I mean a lot is. So, for example, I mean let’s say you’re traumatized or your father is killed in front of you. I don’t think that’s fear of the loss of the relationship.

Smith: I see what you mean.

Greenberg: So I think learning has a place; where you have certain experiences of emotion and you learn that something is dangerous, or frightening, shaming, and then that becomes your primary response to complex cues that evoke that kind of feeling. So I just don’t feel it’s all on the relationship, you know? Identity is not all dependent on attachment.

Smith: Yes.

Greenberg: So, you know, these are all differentiations, but I mean basically I agree with a lot of the things you’re saying, but I think there are these distinctions.

Smith: One of the thoughts in terms of convergence of theory is to try to help us move under the framework of evolution. From that point of view I think it would be very helpful for us to embrace the idea that the brain as a control mechanism, an organ of behavior control that’s evolved to ensure that we do the right things and that pathology is a result of that complex system not always getting things right.

Greenberg: I’m not sure I feel we can reduce it all to biology, but I think incorporating a biological—I mean a neurobiological perspective is helpful.

Smith: The thing that I think maybe has the most potential in here is the thought that with mammals, what mediates between perception and reaction is emotion; that emotion drives behavior.

Greenberg: Yes.

Smith: And then we could adopt the same idea, that emotion drives our behavior and our thought, and mediates between perception and reaction.

Greenberg: Absolutely. I mean, you know, that’s my hope that that will happen. Then we should eventually get an emotion focused, cognitive, behavioral therapy.

Continued on page 27
“Sometimes people grow up in environments where affect is not labeled. So you’re not actually avoiding the emotion, you lack a skill.”

“...they fear their emotions, because they fear not the pain of the emotion, but they fear that they will disintegrate or that they won’t be able to function.”

“The rage in borderline, let’s say the anger, is deregulated, but actually, underneath that there’s fear of abandonment or shame.”

But you know, I just think that avoidance alone is an over simplification and it also tends to be thought about in learning theory terms. So just in my view, sometimes people grow up in environments where affect is not labeled. So you’re not actually avoiding the emotion, you lack a skill, right?

Smith: Yes.

Greenberg: And other times you have painful emotions, which you don’t feel for safety reasons and so on. But at other times you have very negative feelings and you learn, so it’s not only avoidance. Then the fourth thing is you create meanings and that meaning system can be dysfunctional in some way. So although avoidance is very major, it’s not the only thing.

Smith: The whole area of lack of skill, experiences that haven’t been had and skills that haven’t been acquired is definitely a big part of what we work with.

Greenberg: Right. Right. Right. And then I favor a notion of protection rather than avoidance so that this brings in an agent who is doing something and they fear their emotions, because they fear not the pain of the emotion, but they fear that they will disintegrate or that they won’t be able to function. So then I have two students who are currently studying interruption and avoidance, which we prefer to call protection, so that I see people as actively trying to protect themselves, because they feel the feeling will overwhelm them. They feel they will die or they will be sucked into a vortex, or they won’t survive. So they’re actually protecting themselves.

Smith: Mm-hmm.

Greenberg: So it’s not a simple kind of learned avoidance as in learning theory. And you know, the problem with Barlow’s system as I see it is that affect disregulation is seen as the core problem, but I don’t think it’s simply a matter that, you know, the amygdala overreacts, although that’s one of the processes. So jumping onto affect disregulation is another mechanism. Avoidance is one. But affect disregulation is another.

Smith: Right.

Greenberg: And so then we’ve got to ask which affect is dysregulated and often it’s a secondary affect in my view that’s dysregulated. The rage in borderline, let’s say the anger, is deregulated, but actually, underneath that there’s fear of abandonment or shame. So there’s disregulation. There’s a protection or avoidance. There’s learning. So you know, but I think once we start focusing on affect we’ll get a more complex understanding.

Smith: Yes, you have outlined a good deal more complexity and detail. Are there other things that you’d like to say?

Greenberg: No. But I applaud the effort and the notion that if we could come together around emotion as leading to cognition, and behavior, and their interaction, then we’d have a fully integrated theoretical framework.

Smith: Exactly. Then we would have two aspects of one process instead of two competing approaches.

Greenberg: Right. Exactly.
Response to the Structured Interview

Richard Lane
University of Arizona

Question 1 has to do with detoxifying negative affect that has been generated. The example you have given, however—the baby is trying to figure out what to feel and the mother indicates to the baby how it should feel—in my mind falls into the category of the appraisal processes that generate the emotion. The Shachter-Singer model of emotion—the idea that the combination of non-specific arousal and a cognitive appraisal of the situation together determine what emotion is generated—is a very plausible model of how specific emotional responses are generated. The example from Stern seems to fit that—the baby is aroused by the fall but the valence of the response is determined by the mother’s reaction (reflecting her own appraisal) which then influences the baby’s response. The Stern example is not one in which the baby has a negative reaction and the mother soothes the baby to feel better. It is easy to imagine that phenomenon as well, but that would require a slight change to the example. This may seem like hair-splitting but from an affect science and neuroscientific perspective the differentiation between these different component processes is important.

Question 1: Do you see here a possible unifying prototype for the emotional healing component of psychotherapy?
Answer: Yes, but not in a way that matches up with the diagram. I think the example you give fits well with the component of therapy that refers to appraisal processes, which in the model is labeled as “top down.” I don’t see this as an example of bottom-up therapy seeking to detoxify activated negative emotions. Of course, soothing negative emotions is an important component of therapy (see below) but in my mind it is not captured by the example that you gave, given the other components of the model as you have outlined them. In general, I very much agree with the basic processes described on the left side of the diagram and believe that focusing on emotion as the central target of psychotherapeutic interventions is correct. What I have tried to do with the model that I have proposed is to add the element of emotional learning: we respond as we do based on previous emotional learning (captured nicely by the example you gave) and psychotherapy constitutes a context for updating and improving (i.e. making more adaptive) that previous learning.

Question 2: Regarding work with conscious thoughts and behaviors, aimed at changing maladaptive appraisal and patterns of reaction (“top down therapy”)—Do you agree that most therapies include some form of “top down” work, and that this thinking together, along with emotion centered “bottom up” therapy, describe the two primary actions of psychotherapy? If not, why?
Answer: Embedded in this question is a fundamental distinction between emotion, which is described as bottom-up, and thinking, which is described as top-down. Top-down here refers to thinking about conscious thoughts and behaviors. In very broad outline, from the 30,000 foot level, I agree that psychotherapy involves working with emotion and thought to bring about change. However, I do not think that the top-down component consists mainly of conscious thinking about conscious thoughts and behaviors. I think that people come to psychotherapy because of problems in their lives that have to do with implicit schemas that were learned in childhood that were adaptive in that context but are maladaptive later in life. These implicit emotion schemas generate behavioral patterns that are problematic. In my view the first component of the change process is to activate these old patterns in real time. This first component also includes activating the old feelings—becoming consciously aware of the emotions driving the behavior and identifying the associated needs inherent in the hidden emotion. What I am describing is a process of transforming affective responses so that instead of being implicit/unconscious they become explicit/conscious, which then permits the client to consciously experience and reflect upon these experiences. So I would say that while the top down component can and...
“A second component of the change process is having corrective emotional experiences, in which the therapist responds to the client and his/her circumstances in unexpectedly helpful and soothing ways.”

“...my view is that the maladaptive schemas that bring people to therapy are emotion driven, and the purpose of these schemas is to avoid the very emotions that were previously experienced as unbearable.”

Response to the Structured Interview, continued from page 23


What I Have Learned

Jeffery Smith
New York Medical College

Creating the Structured Interview and receiving so many thoughtful responses has made it possible to develop a revised statement of the theory. Some things were abandoned because they were hard to define, including “top-down” and “bottom-up.” I also realized that it is rarely good to make absolutes like “every” and “always.” On the other hand, I am impressed at how many respondents saw value in the idea of affect avoidance as a major driver of pathology. Most of the objections came from the fact that I had omitted the very important area of new learning, which I have corrected in this version.

This new statement of principles is a reach. I am going as far as possible, hopefully within the bounds of the opinions expressed in this issue, to formulate a specific and explanatory theory of psychotherapy that might prove acceptable to a majority of SEPI members and others representing fields ranging from neurophysiology to traditional and more recent schools of psychotherapy. To the extent that this exercise is successful, a consensus theory of psychotherapy could help move us a step further in the direction of “normal science.”

Ten Unifying Principles

1. The human central nervous system evolved under the influence of natural selection. This history, favoring survival and procreation, is reflected in its functioning as an organ of behavior control. Also, the bulk of human information processing takes place outside of consciousness.

2. Inputs to the human brain (from without and from within) are infinitely varied and complex. Appraisal of these inputs is also highly variable and yields activation of emotional and motivational brain circuits. These, in turn, lead to production of infinitely varied and individual responses in forms that include thoughts, feelings, behaviors, and impulses to act.

3. Each individual’s unique experiences give the mind’s appraisals and reactions a range and complexity that makes psychotherapy an art as well as a science.

4. Currently, understanding of the emotional and motivational links between appraisal and the production of conscious and/or observable responses is in its infancy. A consensus exists that emotion and motivation are closely linked and stand between appraisal and response. Furthermore, emotion and motivation, tend to be organized into positive and negative valences associated with approach and avoidance behaviors. (for further discussion, see LeDoux, 2012, Panksepp, et al., 2016)

5. Emotion and motivation tend to have parallel valence and intensity. These attributes are largely assigned automatically and are importantly influenced towards what is or was, in the course of evolution, related to survival and procreation. Consequently the valence and intensity of emotions can be viewed as a proxy for the mind’s version of survival value. As in all of evolution, greater weight is placed on avoiding threats than on approaching opportunities.

6. A major source of clinical pathology consists of reactions that can be viewed as derived from mechanisms of avoidance of painful, uncomfortable, or overwhelming negative emotion. A second major source of pathology (or non-acquisition of adaptive skills) is failure to learn adaptive patterns either due to an absence of modeling or to observing maladaptive behavior in others during development.

Continued on page 31
7. Those maladaptive patterns of appraisal and reaction that are resolvable in psychotherapy are held in memory structures known as neural networks. These include both procedural memory and semantic memory. While Psychotherapy can and does affect biological parameters such as hormone production and gene expression, it is primarily directed at augmenting or modifying information stored in neural networks.

8. Studies of therapeutic change in those forms of stored information representing maladaptive responses have so far shown that two conditions must be met for change to occur. The first is that the relevant memory structure must be in a state of activation. The second is that corrective information must simultaneously be presented. This finding applies, so far, to the known change mechanisms of reconsolidation and extinction. In humans activation of emotion is usually synonymous with the conscious, visceral experience of affect.

9. Active maintenance of maladaptive patterns is often observed in psychotherapy. One frequent contributor to this tendency is the conscious or unconscious avoidance of negative emotional experience. A second source of maintenance of maladaptive patterns is the inertia of habit.

10. Among primary objectives of psychotherapy are: 1) The activation of memory structures associated with maladaptive emotion, thought, and behavior, 2) The simultaneous provision of corrective information, and 3) The introduction and assimilation of new and healthier coping skills. Additional therapeutic objectives, which may derive from the primary ones listed above, include development of a new life narrative, encouragement of conscious awareness of emotions and other aspects of mental life, the use of the therapeutic relationship to create a corrective context, and the practicing of novel behaviors in a manner that simultaneously activates memory structures and provides corrective information.

Taken together, these principles form the outline of an explanatory theory of psychotherapy. The outline is meant to be broad enough to achieve consensus, yet sufficiently specific to have explanatory power. It is designed to leave ample room for multiple techniques and conceptualizations and to encourage elucidation of the many details left unspecified.

To the Reader: We want your opinion via an online survey
Please go to: SurveyMonkey-theory-principles where you will find a brief questionnaire asking your reaction to each of the ten principles and a place to indicate your reservations and suggestions.

References
“...as graduate students, they are pressured to choose the school or camp that will forever define their professional identity.”

“...achieving theoretical unification in support of psychotherapy integration means that all of these special interest groups lose authority and membership...”

Integrative Psychotherapy

Warren Tryon
Fordham University

Psychology is currently characterized by competing schools and camps. This is clear to students who take courses such as Theories of Psychotherapy and Theories of Personality and is further emphasized when, as graduate students, they are pressured to choose the school or camp that will forever define their professional identity. Students are also expected to join the pertinent professional groups that promote their chosen approach to psychotherapy. These groups compete for members and resources on the basis that their approach to psychotherapy is superior to all others. Philosophical differences and the lack of a common language fuel serious unresolved theoretical schisms that lie at the core of clinical psychology; they are forces for separatism. By contrast, achieving theoretical unification in support of psychotherapy integration means that all of these special interest groups lose authority and membership—which is why they do not and will not support meaningful psychotherapy integration via theoretical unification.

The issue of professional identity becomes acute when students apply for internships. The Association of Psychology Postdoctoral and Internship Centers (APPIC) application requires applicants to rank order up to three theoretical orientations to which they subscribe. Most internship sites feature a particular clinical orientation and favor applicants who express their desire to specialize in that form of psychotherapy. Applicants who identify as integrative may be labeled “eclectic” which can be viewed as jacks of all trades but masters of none. Or they may be perceived as not wanting to declare their true allegiance, as in “whose side are you really on?”

Contemporary “integrative” psychotherapy consists mainly of using different methods derived from competing and often contradictory clinical orientations at various times with specific patients with particular presenting issues. This approach is heavily promoted on the basis that meaningful theoretical unification is not possible (Tryon, 2016). But how does one go about making these selections? Clearly some unifying perspective is needed to guide clinical practice, which brings us to the need for theoretical unification.

A Way Forward: Theoretical Unification

Tryon (2016; in press) noted that clinical orientations are more general than the underlying theories that authorize them are. For example, one need not accept everything that every psychodynamic therapist believes in order to have a psychodynamic clinical orientation. Tryon (in press) identified critical core concepts associated with the six most prominent clinical orientations: a) cognitive, b) behavioral, c) cognitive-behavioral, d) psychodynamic, e) existential, and f) pharmacologic. The first five of these clinical orientations are already unified in that none of them can explain how or why their therapies work. They all lack mechanism information but can be unified given common mechanism facts.

Theoretical unification requires that we focus on what all psychology shares in common. Fundamentally, that would be learning and memory. Without the capacity to take in new information and store it as memory, psychotherapy, regardless of the clinical orientation, would not be possible. Tryon (2014) focused the attention of psychotherapists on mechanism information regarding how clients learn and remember that derive from neuroscience-based neural network models. This information is fully consistent with all six clinical orientations mentioned above. It provides a core theoretical basis for integrative psychotherapy. This mechanism information currently consists of 15 psychological principles that are neural network properties formulated as empirically supported psychological principles. Their empirical support comes from both psychological science and neuroscience. Collectively, these principles constitute an Applied Psychological Science (APS) clinical orientation that is based on a Bio-Psychology Network explanatory system. I present four of these principles below to show their relevance to psychotherapy integration through theoretical unification.

Continued on page 33
Unconscious Processing Property/Principle

Neuroimaging has clearly revealed that we have a default mode network that communicates unconsciously among several neural networks when not interrupted by an external task. Unconscious processing is now referred to as stimulus independent thought. Considerable social psychological evidence supports Unconscious Thought Theory. All neural network models begin with activations that spread unconsciously across one or more neural networks. Psychological properties of learning and memory emerge from these network cascades in ways that avoid the mind-body problem (see Tryon, 2016). This unconscious processing principle provides a basis for the theoretical unification of all six clinical orientations mentioned above but is especially useful for integrating behavioral and psychodynamic clinical orientations.

Priming

Repetition priming refers to the fact that repeating a word or phrase predisposes us to behave accordingly. Unlike computers that remain unchanged by the processing they do, neural networks are modified by the processing that they do via experience-dependent neuroplasticity mechanisms. This explains why repetition priming predisposes people to process and behave in predictable ways. This principle provides another basis for the theoretical unification of all six clinical orientations mentioned above.

Part-Whole Pattern Completion Property/Principle

I refer here to the ability of people to recognize a friend with just a glimpse of them and to eye witness testimony that includes post-event information to make a better story; to form a gestalt from partial features or elements. Neural network models excel at pattern completion; gestalt formation. This principle is central to my explanation of PTSD (Tryon, 1999). It provides yet another basis for the theoretical unification of all six clinical orientations mentioned above.

Dissonance Induction/Reduction Property/Principle

This principle explains how and why exposure and response prevention therapy works for treating anxiety disorders (Tryon, 2005) and depression (Tryon & Misurell, 2008). Exposure procedures induce dissonance, which automatically activates experience-dependent neuroplasticity mechanisms that modify synapses across neural networks that physically changes the brain in therapeutic ways that show up on brain scans. Exposure procedures are incremental and analogous to orthodonture (See Tryon 2014, p. 585). This principle provides another basis for the theoretical unification of all six clinical orientations mentioned above.

Anticipated Opposition

One dynamic that opposes psychotherapy integration via theoretical unification is that our profession is in dialectic conflict over integrative psychotherapy. On the one hand we favor integrative psychotherapy because we intuitively understand that all clinical orientations have something of value to offer and that we limit our ability to help people if we ignore or disregard this information. On the other hand our professional identity derives from our choice to become a particular kind of therapist. People are naturally conflicted about changing their identity and that is problematic. Meaningful psychotherapy integration requires adopting a more inclusive clinical orientation such as the APS clinical orientation identified above.

A second dynamic that opposes meaningful psychotherapy integration via theoretical unification is our heavily promoted current consensus that theoretical integration is not possible. This approach permits specialized, contradictory, and competitive approaches to psychotherapy to persist and even flourish on the basis that their methods can also be used by integrationists. This approach to psychotherapy integration is promoted by ignoring publications concerning theoretical unification such as my article on transtheoretic transdiagnostic psychotherapy.

Fortunately, the recognition, approval, and support of psychotherapy integration via theoretical unification by our current “leaders” is not necessary. It is decisions that young professionals in training make that are crucial to the future of integrative psychotherapy. When faced with a choice between building effective integrated psychotherapies on a solid empirically supported theoretical foundation versus cobbling together methodological bits and pieces from various conflicting, competing, and often adversarial clinical orientations I believe that the choice that most young professionals will make is evident.

Figure 3.1 in Smith's excellent practical guide to psychotherapy arranges all of the major psychotherapies around the perimeter of a donut where the hole in the middle represents what we do not know about the mechanisms responsible for how these therapies work. The 15 empirically supported principles identified above supply much of this missing information. They transform the donut image into a wagon wheel with the APS clinical orientation at the hub and explanatory spokes extending to each and every psychotherapy.

Continued on page 34
A third factor that impedes integrative therapy is that the term “integrative” is not specific or captivating. It does not have the same punch that the terms behavioral and psychodynamic have. I therefore identified my integrative clinical orientation as *Applied Psychological Science* because: a) science has punch and b) this clinical orientation is based on 15 empirically supported scientific principles. There is no ownership of scientific principles (see, Tryon & Tryon, 2011). Basing one's professional identity on scientific principles precludes the special interest schools and camps that stand in the way of meaningful integrative psychotherapy.

**References**


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**President's Column, continued from page 4**

The tripartite ubiquity of integration, conflict and in some cases dissociation brings to mind a title of a chapter by Sandra L. Paulsen and Ulrich F. Lanius: “Seeing That Which Is Hidden: Identifying and Working With Dissociative Symptoms.” They were specifically addressing phenomena in structural dissociation of the personality or fragmented self-states whereby the fragmented sensory channels of experience remain unintegrated and separate from ordinary consciousness. Integration of that which had been dissociated is the path to psychological wellbeing for many, from the extreme trauma-related conditions like dissociative identity disorder, complex trauma, and personality disorders, to those more common conditions that result when attachment/developmental milestones couldn’t be successfully navigated by an unaided child.

What about our sometimes-fragmented personal and professional selves and shelves? Which of our members’ needs are we satisfying? Which of our members’ problems are we helping to solve? What bundles of knowledge value, services and products are we offering to each member segment? Younger and older members, as well as members in one or in another geographical area might have as many similar as many different needs. Let’s aid the different folks in successfully navigating the contemporary integration maze.

Finally, about the topic of theoretical convergence, I am slightly phobic to words like unifying, as I am not a fan of stop exploring nor of single paradigms—actually, as some of you know, I am more for paradigmatic complementarity. Yet, I love visual representations that frame decision paths. It seems to me that the framework under discussion in this issue, strengthens the opportunity for another enthusing dialogue around our understanding of how memory is stored (in neural networks) and how therapeutic work can best facilitate its transformation, when desired by those of us seeking professional help, when mentally injured. A number of dual-process accounts have been put in the psychology arena and this one follows that same thread. It appears to offer several good enough neuropsychologic- and psychological-level reasons for taking the idea of unconscious emotion seriously. It’s about time, Seeing That Which Is Hidden! I believe an important implication of the framework is that methods used to analyze and transform those conditions associated with unconscious emotion beget applied clinical contexts of both short term and longer term nature. And let’s not forget that even pleasant emotions get frequently avoided or even dissociated. Or will you all come to Denver? 🎪
The Society for the Exploration of Psychotherapy Integration (SEPI) invites you to attend the 33rd Annual Conference to be held in Denver, Colorado USA May 19-21, 2017 (with preconference workshops on May 18th). The conference site will be the Sheraton Denver Downtown. Please view the Sheraton's website at: https://www.starwoodmeeting.com/Book/sepi2017 for more information about the hotel, downtown Denver, or to make room reservations.

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

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

Sincerely,

Nuno Conceicao                           Lavita Nadkarni                       Lynett Henderson Metzger
Program Chair                             Local Organizing                     Local Organizing
Committee Co-Chair                        Committee Co-Chair

Clinical Decisions at Work
Navigating the Psychotherapy Integration Maze

with pre-conference workshops on Thursday, May 18th