sepi

Society for the Exploration of Psychotherapy Integration

NEWSLETTER

Volume 5, No. 1
March 1987

Editors:

Marvin R. Goldfried
Paul L. Wachtel

IN THIS ISSUE

* *

1987 CONFERENCE

Our 3rd Annual Conference will be held at the Orrington Hotel in Evanston, Illinois, May 1-3, 1987. The chair for this year's Program Committee is Doug Powell, who has been ably assisted by Lee Birk, Mary Fitzpatrick, Iris Fodor, Richard Halgin, Jay LeBow, Perry London, Jeanne Phillips, and John Rhoads. In addition, Diane Arnkoff and Carol Glass, bringing to bear their wisdom in putting together last year's conference, have served as consultants.

The theme in this year's conference involves the practice of integrative psychotherapy. As a means of facilitating this theme, senior clinical presentations will be offered, panels involving the clinical practice of integrative psychotherapy will be held, and workshops have been planned on a wide range of topics, including the human change process and theories of psychotherapy integration. Other program highlights include topical breakfast discussions, a wine and cheese gathering, and group lunches to be included with the price of the registration fee. Conference brochures, which include the entire program and other details, will be mailed out in early March.

We eagerly look forward to seeing you in May.

CLINICAL-RESEARCH DIALOGUE

With this issue, we initiate a new feature for the Newsletter. The dialogue between David Orlinksy (primarily a therapy researcher) and Jeffrey Young (primarily a clinician), which begins in this issue and continues in the next, was

SPECIAL ADDENDUM

PLEASE NOTE: The blue announcement you have received or will shortly receive regarding "SEPI III," our annual meeting in Evanston on May 1, 2, and 3, has an important omission. It omits the special rates for students. Student pre-registration rates are $35 for registration, $50 if they want to attend the Friday night dinner as well. If you know any students who are interested in attending, please inform them of this special discount rate.

If you have any further questions about student rates, please contact Doug Powell at 617-495-2042.

arranged to permit a format for an exchange of views between clinicians and researchers. We hope it will be the first of many such dialogues to appear on the pages of this Newsletter. The dialogue format seems a particularly fitting one for an organization such as ours, whose avowed aim is to foster communication across the various gulfs that divide our field. Many of those great divides are between competing "schools" of therapy, but an equally significant one is that between researchers and clinicians. Like our two initial dialoguers, many of SEPI's members have worn both hats in their careers, but clearly there is considerable diversity among our membership with regard to how each of you identify yourself. SEPI is an organization with a strong commitment to meeting the needs of both clinicians and researchers, and we hope that this dialogue will be a step in promoting greater communication and mutual stimulation.

It is our intention that the dialogue not be limited to the words of Orlinsky and Young. Another feature which we hope will be a regular part of the Newsletter is a "Letters to the Editor" section in which the membership can express views not only about what appears in the Newsletter but about any issue that is of relevance to SEPI and its membership. We would like to initiate that section with your responses to this issue's dialogue. If you have something to say, it would be helpful if you could send us a letter fairly promptly so that we might be able to include it in the next issue while the topic is still hot.

We would also like to invite you to suggest further topics for dialogues in future issues and/or future individuals whose views it would be interesting to explore in this format.

In attempting to focus the dialogue, Orlinsky and Young were asked to address the following questions during their discussion: What do researchers feel they have found thus far that should be of interest to the practicing clinician? What kinds of questions would clinicians like researchers to address?

Orlinsky:: Let me begin by suggesting that the movement for psychotherapy integration in some ways depends on and can be facilitated by research, because a great deal of what separates therapists of different schools is at an ideological or semantic level. There are various languages that the different schools have, and if you talk their language you're one of them; if you don't talk their language, then you're not really the right kind of therapist. But research necessarily undercuts that level of differentiation.

Young: In other words, if you look at what therapists are actually doing, they're not as much different as what they say they're doing.

Orlinsky: Well, not so different as their theories seem to suggest. Research forces people to get down to the level of actual operations. In research, everything has got to get very

concrete. I think it is that concreteness which can really contribute to mutual understanding.

Young: This is an interesting dilemma because I think that, on the one hand, one positive aspect of research is that it does force you to specify what you're doing in sessions. Because researchers study the tapes of sessions, you actually have to be sure you're doing what you say you're doing. On the other hand, I think that if you look only at what happens in a sampling of sessions you often can't see the direction of the therapy over time, which may be a function of the conceptualizing going on in the head of the therapist. While it may be easier to study a single session by making it concrete, I'm not sure that it's easier to study what's going on over time by being concrete. One of the problems with research is how to be sure that it is taking into account both what's happening at an overt level in a session and also what's guiding the therapist to make decisions at different points in time.

Orlinsky: From my point of view, research should include the subjective experiences of the participants including the therapist. When I say concreteness, I don't mean just overt behavior; I include the thinking and the feelings of the therapist and of course the thinking and the feelings of the patient as part of the data to be collected. My own research involvement for 20 years has been all driven in that direction in order to counteract and complement the predominant behavioral approach which has stressed the taping of therapy sessions and the study of therapy processes only from an external observer's viewpoint. From that viewpoint the thoughts and feelings of the participants are not accessible. Ken Howard and I chose to go the other way round.

Young: I agree with that focus. On the other hand, I also appreciate the outcome research I participated in for two years. To me, that's useful, too, in that it is testing a particular approach, and there are definite ways of measuring whether there's progress or not. What I have trouble with are the in-between research strategies. I like research that examines how both the therapist and patient view the therapy and what's helpful to each. I also like research that's geared toward what works and what doesn't work within particular classifications of patients. However, the type of process research that tries to take sessions and break them down into small elements and categorize them does not seem at all useful to me as a clinician. I don't know if you have found that too, and if you have ideas about why that is.

Orlinsky: Part of the problem has been with researchers. People have studied what was easily available for study, rather than what, as therapists, they sensed was important. Abraham Kaplan called that " the law of the instrument."

Young: The methodology determines what you end up doing.

Orlinsky: Right. Give a child a hammer and everything will

become a nail. There are too many things that don't yield to that approach. But I want to go back to the point you raised about the very small-scale, microscopic focus of process research.

Young: That's what I was going to talk about too, so go ahead.

Orlinsky: One of the issues, I think, that's greatly neglected in thinking about research is the time-scale of the observation. You can study segments of therapy sessions; you can study whole therapy sessions; you can study sequences of successive sessions, for example looking at "phases" which clinicians talk about. Then you can look at whole courses of treatment, the whole set of sessions from beginning to end. Obviously its easiest to look at segments of sessions, especially if your approach is based upon tape recorded sessions; that methodology almost constrains you to do second-by-second microanalysis of process, and everything else gets neglected. There has not been a great deal of sophistication in terms of being aware of how research methods constrain observation, and shut out lots of things that clinicians would want to learn. The questions that clinicians have are probably much more macroscopic.

Young: Yes, that's how I feel too. The clinician part of me wants to look at the entire course of therapy, or at least to focus on one issue until it's resolved or not resolved. Research should at least focus on a unit of measurement where either there is some resolution, or the client and therapist agree that there is no resolution.

Orlinsky: What would be an example of such an issue? A problem that a patient brings in?

Young: Sure.

Orlinsky: Or what the patient and therapist come to agree as the real problem?

Young: Yes, the research focus could be a set of symptoms that both the patient and therapist agree are important symptoms to change, like depression or anxiety. You would keep following the course of therapy until that symptom is relieved. Or it could be a problem focus. For example, both the therapist and patient could agree that the patient is out of touch with her feelings, and for research purposes the course of therapy would continue until the patient and therapist both believe that the patient understands what she feels. Or it could be a focus on relationships. The patient and the therapist might both agree that the patient tends to get into destructive relationships, and the course would then be for as long as it takes for the therapist and patient to agree that the patient's relationships are more adaptive, or that they have reached an impasse and there is no way to resolve it.

Orlinsky: Now, if you have a study of that sort, granted that that's interesting (and it would be very interesting and informative to have a study like that) how would it be of

interest to you specifically as a clinician, rather than to your general interest as a researcher?

Young: Well, for me as a clinician, what I'd like to do is to have many analyses of many different patients with similar kinds of problems, using different kinds of approaches and also different therapists, and start to get a sense from comparing what goes on during treatment.

Orlinsky: So one case study wouldn't be very informative?

Young: Right. Its not one case, but an accumulation of comparative case studies. The ideal would be to select clients with very similar problems, to the extent that you could identify similar problems, assign them to different therapists, and watch what happens to them over time. Of course, you never have perfect controls.

Orlinsky: Right. There are various questions coming up in my mind. Would you, for example, in a study like this, think it valuable to try to control the kind of therapy which these different therapists were applying to these similar problems, or would it be more valuable for understanding what was happening to let therapists work in the way that is most comfortable for them.

Young: I'd rather let each therapist work in his or her own way. For example, I feel that this was one of the failings of the NIMH Collaborative Study on Depression. We tried to take "random" therapists and train them to do cognitive therapy. Most of these therapists were not trained as cognitive therapists originally, and their main bent was not toward cognitive therapy. In a sense an attempt was made to control for the therapist variable by training everyone to do the same approach.

Orlinsky: They were trained to criterion?

Young: Right. But the problem is that you have therapists who are not doing what they are naturally most gifted at and most comfortable with. So you end up getting some sessions that barely meet criterion, some that exceed criterion, and some that don't meet the criterion at all. You haven't really had a fair assessment of the therapy. What you've got is a fair assessment of what happens when you take many different therapists and impose a treatment on them that they don't necessarily want to be using.

Orlinsky: That brings up an interesting theoretical problem, the degree to which the therapy is independent of the therapist. There is a line by Yeats, "How can one tell the dancer from the dance." It's very apropos, I think, but many researchers and clinicians who are advocating a particular treatment model say "Here is this treatment model, this is the right way to do therapy". They write manuals which try to define how to handle different situations, as if that is really independent of the therapist, supposing that any therapist with good will and interest could pick it up and do it equally well. Do you think

that is a viable procedure?

Young: I don't believe it is. I think that's a major problem.

Orlinsky: That's interesting, because you come from a background in cognitive therapy. I could imagine the experiential therapists saying, "No, its not plausible"; but cognitive therapy has tended to be defined in a way that is rather focused on technique, and in that sense similar to the behavioral therapies more than it is to the psychodynamic or experiential therapies.

Young: I support the idea of a well-defined technology of therapy, but I think you have to have a therapist using it who wants to use it, for whom it fits, not a therapist to whom it feels dissonant. I think that if you have a therapist who's drawn to cognitive therapy and feels comfortable with it after a little bit of practice, then it's wonderful that there is a technology and a definite way to do it, as long as there's some flexibility in the way they use it. But I think it's a mistake to believe that anyone, regardless of their talent, orientation or interest can be taught to use any therapy well. Similarly, if you tried to take many cognitive therapists and teach them gestalt therapy, they might be able to use the empty chair technique and other imagery techniques mechanically, and yet still not be good gestalt therapists. By their nature, what they're comfortable doing interpersonally and the way they conceptualize are really at odds with what the technology is telling them to do.

Orlinsky: For me, this comes back to the issue of psychotherapy integration, because I think the recognition that there's some core interdependence of therapeutic procedures and therapist personality defeats the notion that any one particular therapy represents the "Truth". Like, the right way to do therapy for depression would be cognitive therapy, or interpersonal therapy, or psychoanalysis or gestalt therapy. If that were so, then only certain therapists would qualify; we'd have to throw everybody else out.

Young: I take an in-between position on this issue. I think the first step is to find homogeneous subgroups of patients, but not necessarily based on DSM-III diagnoses. I don't mean subgroups as broad as "depression", but somewhat more specific, such as "depression where separation is the primary issue," or "depression where low self-esteem is the primary issue," or "panic attacks where fear of losing a job is the primary issue." If we're being that specific, I believe we could eventually reach a point where we could say that some therapeutic approaches are simply more promising with that subgroup than are other approaches. Then it's a question of channeling the patient to the therapist who's comfortable with that approach. There are going to be other types of problems where you need a blending of approaches, and then you're going to have to find therapists who are comfortable blending.

Orlinsky: So as you see it there's hope for the future in terms

of greater specificity of treatment design.

Young: Right. Greater specificity of patient types and of therapist assets and talents.

Orlinsky: But then you're again pointing to "therapist assets and talents" rather than a particular type of therapy.

Young: Well, I'm including that as one of their assets. In other words, consider a borderline woman with separation issues who's also depressed. We may find through research of the type I was talking about that they tend to respond faster and better with therapists who are able both to use cognitive techniques and to analyze transference.

Orlinsky: Even if we found that, the fact that such patients did better faster with such therapists might not be due to the fact that they were practicing that particular form of technique; it might be due to the other things about the therapists which happened to be reflected in their predilection for a particular form of therapy.

Young: Right, and I would say that would have to be included among the list of the therapist's assets and talents.

Orlinsky: Gestalt therapists like to confront feelings directly, and push them to the fantasy level.

Young: Right.

Orlinsky: Cognitive therapists confront feelings, but from a greater distance, let's say. Not to intellectualize it, but to put it into a conceptual model; feelings are "hot cognitions" or something like that, and it really resolves into the underlying beliefs that the people have. So the difference may be in the style of dealing with feelings.

Young: Exactly. And that would be one of the therapist's assets that would have to be a part of his or her list.

Orlinsky: And in a sense it would be incidental to the theory of the therapy that's being done.

Young: Well I think you'll have a good deal of overlap because a therapist who's that way is going to be drawn more to one approach than another.

Orlinsky: Let me pick up again on this notion -- you said that there's got to be a "fit" between the therapy that the therapist does and something about the therapist personally. What intrigues me particularly as a research issue, and I think a research issue with a lot of clinical implications, is what it is about the therapist that the therapy either fits or doesn't fit. What is the protuberance on the therapist's soul that either meshes with the therapy or doesn't? I mean, what is it about me as an individual that leads me to feel that one particular combination

of therapeutic procedures works best, and you to feel that another combination of procedures, which may or may not overlap with mine, works best for you?

EDITOR'S NOTE: Because of space limitations -- but also to add a little suspense to the dialogue -- Young's response to this question and the remainder of the interaction will be continued in the next Newsletter.

T R A I N I N G O P P O R T U N I T I E S

In response to our request for information regarding training opportunities in integrative approaches to therapy, we received a variety of descriptions, ranging from single courses, to general training programs that have an integrative component, to programs specifically oriented around integrative themes. What follows is a summary of the material sent to us. We have made no effort to judge as to quality or appropriatness or just how "integrative" each program is. All of the programs listed were regarded by those who responded to our request as relevant to the aims of SEPI. If any of these sound of interest to you, you can contact the name listed with each:

1) M.Sc. in Psychotherapy at the University of Warwick, Coventry CV4 7AL, England. This is a two-year part-time post-qualification course accredited by the British Psychological Society. This comprehensive training program "aims to help trainees develop their own personal models for eclectic and integrative practice." For further information contact Dr. John D. Davis in the Department of Psychology.

2) A variety of programs are offered by The Contextual Therapy Center, 2550 Ninth Street, Berkeley, CA 94710 and by Contextual Affiliates of New York, 22 Riverside Drive, Apt. 11A, New York, NY 10023.

3) The Short Term Psychotherapy Center at Beth Israel Medical Center offers an introductory course in Brief Dynamic Psychotherapy. Contact Theresa Sporing, Beth Israel Medical Center, First Avenue at 16th Street, New York, NY 10003.

4) Weekend workshops in cognitive-analytic psychotherapy are offered by Dr. Anthony Ryle, United Medical and Dental Schools, St. Thomas' Hospital, London, England SE1 7EH.

5) The training program in the Mental Health Service of the Harvard University Health Service (open to advanced graduate students and post-docs) blends psychoanalytic therapy with

behavioral treatment and includes both psychoanalytic and behavioral supervision and an ongoing eclectic therapy seminar. Contact Doug Powell at the Health Service (75 Mt. Auburn Street, Cambridge, MA 02138).

6) In connection with the research and clinical activities of the Geriatric Research, Education, and Clinical Center of the Palo Alto V.A. (3801 Miranda Avenue, Palo Alto, CA 94304) psychology interns and post-docs working with a geriatric population receive training in a variety of treatment approaches. The Center does not offer a specific integrative therapy training program but presents a considerably more integrative approach than one finds in most places. Contact Larry Thompson or Dolores Gallagher.

7) The Ph.D. Program in Clinical Psychology at Temple University (Philadelphia, PA 19122) is a theoretically diverse program with an intentionally eclectic faculty and a scientist-practitioner emphasis. Contact Philip Kendall, head of the division of clinical psychology.

8) The Center for Family Studies/Family Institute of Chicago at Northwestern Memorial Hospital and Northwestern University Medical School offers two long-term training programs in integrative psychotherapy. The one year Clinical Training Program (a second year can be arranged) combines didactic, supervision, and clinical experience in Integrative Problem Centered Therapy. The Two Year Program centers on marital and family treatment and is open to professionals in practice. Contact Jay Lebow at the Center (666 North Lake Shore Drive, Chicago, IL 60611).

9) John Norcross (Psychology Department, University of Scranton, Scranton, PA 18510) offers a graduate seminar in Eclectic and Integrative Psychotherapies at the University of Scranton and a one-week version in the summer at the University of Rhode Island, as well as individual and group supervision in Scranton, PA.

10) A seminar for experienced therapists using an integrated approach that is primarily behavioral is offered at the Payne Whitney Clinic of New York Hospital. Contact Herb Fensterheim at 212-889-7290.

11) Susan Heitler (Suite 360, 4545 East 9th Avenue, Denver, CO 80220) provides consultation for therapists in the Denver area looking to expand from traditional individual therapy to more eclectic work with families and couples. Participation in an ongoing group of psychologists who meet weekly to discuss diverse approaches might also be possible.

12) The Centre for Psychological Services is a training and research unit in adult clinical psychology affiliated with the School of Psychology of the University of Ottawa. It is the only APA approved bilingual program, and can accomodate up to 20 interns for the practicum or Ph.D. internship. For further information, contact Pierre Baron, Centre for Psychological Services, University of Ottawa, 275 Nicholas, Ottawa, Ontario, Canada K1N 6N5.

B O O K R E V I E W S

Wachtel, E.F., & Wachtel, P.L. (1986) Family dynamics in individual psychotherapy: A guide to clinical strategies. New York: Guilford Press.

Individual and family therapy are most often viewed as alternative, rather than complementary, approaches to the conceptualization and psychotherapeutic treatment of behavioral and emotional problems. In this book, Ellen and Paul Wachtel depart from this traditionally narrow view and present a creative, pragmatic approach to the integration of family systems ideas and techniques into the process of psychodynamically-oriented individual psychotherapy. The book is a superb, trail-blazing contribution to the field of psychotherapy. It has a great deal to offer to both individual and family therapists, as well as those of us who are already convinced that such rigid distinctions are limiting and counterproductive.

The theoretical foundation for the authors' integrative approach is laid down in the first two chapters. Initially, there is an excellent presentation of Paul Wachtel's cyclical psychodynamic model of the relationship between intrapsychic and interpersonal dysfunction. This is followed by a comprehensive review of family systems concepts and their relevance for individual psychotherapy. In these two chapters, and throughout the remainder of the book, the theoretical concepts are richly illustrated with clear, concise, and illuminating clinical examples.

Following the initial theoretical chapters, the focus of the book shifts to the pragmatic level of clinical assessment and therapeutic intervention. Here, the authors first describe a variety of ways to ask questions that "reveal the family system" by inquiring about the patient's interpersonal problem-solving strategies, the reactions of others to the patient's functional and dysfunctional behaviors, and the overall structure of the patient's family system (enmeshed, disengaged, etc.). There is also a discussion of the use of exploratory role-playing as a means for clarifying the nature of problem-maintaining vicious circles.

The second of the two assessment-oriented chapters contains

a description of Ellen Wachtel's innovative methods for using the genogram as a vehicle for both information-gathering and psychodynamic exploration. With concise explanations and highly illustrative clinical examples, the techniques of genogram administration and interpretation are clearly spelled out.

The remainder of the book is devoted to therapeutic intervention. Initially, the focus is on systems-oriented interpretations, which are defined as statements by the therapist which heighten the patient's conscious awareness of the effects of his or her behavior on the interpersonal context in which that behavior is embedded, and/or the effects of the interpersonal context on the patient's feelings, thoughts, and behaviors. Such interpretations may relate to the structure of the patient's family system, the significance of the patient's problems for the system, or the nature of the interpersonal and intrapsychic vicious circles that maintain the problems. The roles of reinforcement, shaping, reframing, and positive connotation in the interpretive process are also discussed.

From interpretations, the authors then move to a delineation of the role of more active interventions -- e.g., tasks, skill training, and paradox. As before, clear and concise description of technique are combined with excellent clinical examples to produce a wealth of therapeutically useful information.

In the final two chapters, the use of conjoint interviews with the patient and his/her family are described. These interviews are limited to one or two sessions and are viewed as opportunities to enrich the work of individual therapy, rather than a transformation of individual therapy to family therapy. A detailed rationale for this approach is presented, and the specific techniques for preparing for, conducting, and processing the results of the conjoint interview(s) are described. These chapters represent the most radical departure from the traditional structure of individual psychodynamic psychotherapy and will undoubtedly arouse the most resistance from traditional individual therapists. In contrast, many family therapists will probably object to the limitations placed on the conjoint interviews and will question why the authors don't "go all the way" and move from individual therapy to family therapy. These resistances and objections are cogently discussed and the authors' rationale for proceeding as they do is clearly and compellingly delineated.

The final brief chapter is a coda on Psychotherapeutic Practice and American Individualism. Here, the authors stress that while they regard the "dignity and worth" of individuals as a fundamental value for both psychotherapy and society, it is "only in concert with others" that individuals can achieve internal harmony.

In this book, Ellen and Paul Wachtel have presented a model for the conduct of individual psychotherapy that integrates the interpersonal context in such a way that the possibilities for achieving intrapsychic and interpersonal harmony are markedly

each of these contributors complete freedom to discuss those aspects of integration that mattered most to them as individuals; and third, by setting up a format of essay, critique/comment (by one of the other contributors), and finally rejoinder to the critique. This latter feature especially seems to have led to a very meaningful, unusually stimulating richness of thinking that is the hallmark of the book, and a tribute to all the contributors: the two editors, plus Paul Wachtel, Meir Winokur, Thomas Schacht, Michael Mahoney, Alan Kazdin, Eric Mendelsohn, Lloyd Silverman, Merton Gill, John Rhoads, Cyril Franks, and Leon Salzman.

In sum, this is a very well-conceived, well-executed book which is highly evocative of rich and richly interconnected thought about the nature of integration and of psychotherapy itself. I consider it such an excellent book that it would be hard to imagine a SEPI member who looked at it and would not want to read it cover to cover, and preferably own it.

Reference

Birk, L. (1986). The demise of dogma in psychotherapy. Contemporary Psychiatry. 5:2, 107-110.

Lee Birk, M.D.
Learning Therapies, Inc.
Newton, MA

A B S T R A C T S O F T H E L I T E R A T U R E

Haaga, D.A. (1986). A review of the common principles approach to integration of psychotherapies. Cognitive Therapy & Research, 10, 527-538: This paper reviews the common principles approach and suggests that commonalities identified so far represent neither meaningful consensus nor adequate guidelines for research. Instead of researching common principles to obtain consensus, we might do well to conduct therapy research within existing orientations but with flexibility in regard to what techniques are studied.

Mikulas, W.L. (1986). Self-control: Essence and development. The Psychological Record, 36, 297-308: So far, the growing interest in the integration of different therapies in mainstream Western psychology has primarily consisted of combining a couple of traditional Western therapies as they apply to specific problems. What is needed is integration of a wider range of therapies, including Eastern psychologies, and the consideration of sequential and hierarchical relationships among therapeutic approaches. One way to pursue such an integration is by following general themes that cut across many domains and

levels, such as self-control.

The following are abstracts of articles that have appeared in the International Journal of Eclectic Psychotherapy, 1986, Volume 5, Number 2:

Messer, S. B., & Winokur, M. Eclecticism and the shifting visions of reality in three systems of psychotherapy: This paper outlines the visions of reality - romantic, ironic, tragic, and comic - which thread their way through psychoanalytic, behavioral, and humanistic forms of treatment. Although these three systems of psychotherapy have traditionally intersected the visions in quite different ways, certain developments in psychoanalytic therapy and behavior therapy have brought about increased overlap between them in the ironic and comic modes, while humanistic therapy continues to focus on and deepen its romantic vision. The paper discusses the trade-offs involved in the kind of eclecticism that accompanies the shifting visions of reality.

Murray, E.J. Therapeutic integration and visions of reality: A questionnaire containing tragic and comic therapeutic visions of reality was administered to 79 practicing psychologists. The major finding was that there was little or no difference among psychodynamic, behavioral, humanistic, and unaligned psychologists on tragic and comic visions. Most endorsed the comic vision and rejected the tragic vision.

Prochaska, J.O., & Norcross, J.C. Exploring paths toward integration: Ten ways not to get there: This brief article presents a nonexhaustive list of 10 methods which impede the development of integrative psychotherapy: pretending we are there; pretending we cannot get there; integration without accommodation; integration without representation; translation is not integration; mergers miss much; mindless combinations miss more; integration without documentation: I and II; and organization over integration. The intention is "to set ourselves free" to explore more productive paths toward sophisticated integration/eclecticism.

Powell, D.H. Spontaneous insight associated with behavior therapy: The case of Rex: This case illustrates a little discussed phenomenon in eclectic psychotherapy - the spontaneous recognition of psychodynamic factors associated with symptom formation, occurring as a result of behavioral treatment. After four visits in which a speech anxious client was taught several behavioral techniques to reduce his anxiety, he became largely symptom-free. During this period, he suddenly became aware of the origin of his anxiety, and the remainder of treatment addressed the familial causes of his overdriven strivings. This appeared to solidify the gains attained by the behavior therapy.

Thompson, J.K., & Spana, R.E. An interpersonally based cognitive-behavioral psychotherapy: The present paper presents an integrative psychotherapy which attempts to combine humanistic and cognitive-behavioral tenets and techniques. It is argued

that the core relationship factors identified by Rogers -- genuineness, nonpossessive warmth, and accurate empathy -- can play a central role in the efficacy of cognitive-behavioral interventions. Specific aspects of assessment and treatment are discussed and illustrated with regard to the therapeutic integration of the two approaches.

The remaining abstracts have appeared in the International Journal of Eclectic Psychotherapy, 1986, Vol. 5, No. 3:

London, P. Major issues in psychotherapy integration: This article reviews the themes that dominated the first annual SEPI conference. Problems of integrating theoretical positions were paramount. While attempts to find a single unifying theory of psychotherapy are no longer common, there was considerable concern over how to translate the terminology of different psychotherapies into a common language and how to separate scientific theory from metatheory. Training in psychotherapy also occupied much of the conference, with opinion divided on the relative merits of concentrating early training on a single therapeutic orientation or on teaching several approaches at once.

Hariman, Jusuf. Prescriptive Psychotherapy: This paper shows that Prescriptive Psychotherapy lays down the blueprint for a complete defense of eclectic psychotherapy from theoretical, empirical, moral (social) and legal points of view. It sets out five requirements for the fruitful growth of knowledge of psychotherapy, and deals with a number of other economic and legal issues relevant to therapy.

Norcross, J.C., & Napolitano, G. Defining our journal and ourselves: This article summarizes the results of an IJEP survey, in which 60 editorial board members and consultants responded to a mailed questionnaire concerning journal matters and definitional issues. There was a consensus that the journal title should be amended to include the "integrative" and that the term "international" should be dropped. Over 90% of the respondents expressed support for a new Forum section, and the vast majority considered the synthesis of therapy modalities as well as the integration of psychopharmacology and psychotherapy to be legitimate parts of integration/eclecticism. Opinions regarding definitions of integrationism and eclecticism and their interrelationship are also described.

DiClemente, C.C., McConnaughy, E.A., Norcross, J.C., & Prochaska, J.O. Integrative dimensions for psychotherapy: One of the promising new approaches to integrating the psychotherapies is to identify core dimensions of change that can occur across diverse systems of psychotherapy. DiClemente first discusses processes of change or how people change; McConnaughy provides an overview of stages of change or when people make particular changes; Norcross describes levels of change or what people attribute their problems to and what and what they try to change; and Prochaska shows how the transtheoretical approach attempts to synthesize the processes, stages, and levels of

change into a three-dimensional model of integrative therapy.

L O C A L N E T W O R K S

At the September 20, 1986 meeting of the Greater New York local SEPI network (coordinated by Steven Katz, Ronald Murphy, and Elliot Seligman), Leigh McCullough of Beth Isreal Medical Center's Brief Psychodynamic Therapy Program presented videotapes of her work. These tapes and McCullough's commentary illustrated integrationist aspects of Davanloo's methods from several perspectives, including behaviorial and gestalt. Herbert Fensterheim and Kenneth Frank added a perspective from the behavioral and traditional psychodynamic perspectives, and a lively interchange followed with members of the audience. Anyone who would like to receive announcements of future meetings can write to Dr. Ronald Murphy, 110 East 82nd Street, New York, NY, 10028.

B U L L E T I N B O A R D

SEPI members may be interested in attending the upcoming Seventh International Congress on Personal Construct Psychology, to be held August 4th-9th, 1987, in Memphis, Tennessee. The theme for the Congress will be "Integrative directions in personal construct theory," with special presentations (by Marvin Goldfried, Michael Mahoney and others) focusing on the potential for cross-fertilization between construct theory and other traditions in psychology. Although the conference program will cover a broad range of topics in personality, social, developmental and applied psychology, a large proportion of the workshops, symposia, paper sessions and posters will have a clear clinical/psychotherapeutic focus. SEPI members interested in attending the Congress or participating in the program are encouraged to write Robert A. Neimeyer, Ph.D., Department of Psychology, Memphis State University, Memphis, TN, USA, 38152.

Brunner/Mazel Publishers has inaugurated an Integrative Psychotherapy Book Series, and is interested in receiving proposals from prospective authors. Anyone contemplating a book project in this area should write to: Dr. John C. Norcross, Psychology Department, University of Scranton, Scranton, PA 18510-2192, U.S.A.

Needed: Transcripts of psychotherapy sessions, any modality, for purposes of content analyses. This is a research project of David McClelland's human motivation research group. The purpose of this project is to identify, through content analyses, commonalities in the sequence of diverse forms of psychotherapy. For further information about what is needed,

contact: Joel Weinberger, Henry Murray Research Center, Harvard University, 10 Garden Street, Cambridge, MA 02138, U.S.A.

A peer supervision group based on the SEPI model, composed of four clinicians, is seeking a fifth person with a gestalt background. Meetings are held Tuesdays from 9 - 10:30 A.M. in New York City. Contact Elliott Seligman at (212) 532-5312.