A Word From the Editor

Jeffery Smith

Dear Readers,

First I want to welcome Alexandre Vaz, Associate Editor to our staff. As a researcher and clinician, he brings to this issue an emphasis on therapist factors in the success of psychotherapy. With questions slanted in that direction, simply reading this issue is an education on the ferment going on in thinking about psychotherapy and psychotherapy research. Stanely Messer, in his Presidential Letter brings up the promise of carefully done single case studies, especially in their ability to focus on the subtleties of what therapists can and do bring to the interaction. Tony Roussmaniere talks about Deliberate Practice, involving serious self-examination and training akin to that of an athlete. And Steven Hayes highlights the concept of improvement in psychological flexibility as a measurable abstraction relevant to successful psychotherapy. Taking the time to click on the link to our survey responses, now ensconced in the SEPI Archives, will take you on a tour of subjects like trauma, emotion, neurobiology and especially the importance of common factors and the therapeutic relationship. Clearly, in our thinking, we are beyond the RCT horserace, and are ready to pursue the quest for improvement in results by understanding how therapists and patients interact. And then there are the politics and economics of research. How will the field find the support needed to pursue the directions so well highlighted in this issue? So we’ll put out a call for articles for coming issues on how to meet the challenge of getting the kind of research support we so clearly need.

Jeffery Smith

President’s Column

Stanley Messer

Dear SEPI Members,

As this issue of the SEPI Newsletter is devoted to research, my letter will describe what I view as important developments in furthering SEPI’s aim of integrating research and practice. Those of us who have been in the field for some time grew up with the idea that the randomized clinical trial or RCT was the gold standard in conducting psychotherapy research. While it still retains preeminence because it allows one to maximize internal validity and make causal inferences about the value of a particular approach, it is now recognized that it falls short in being maximally useful to the practitioner. Among other drawbacks, it is subject to researcher allegiance effects, which refers to the strong association between a researcher’s preferred therapy model and the therapy that was judged to be more successful. In addition, many patients are excluded from RCTs, such as those who are dually diagnosed, so that they typically include rather select patient samples, making them less applicable to normal practice. Many patients drop out of RCTs and only about 40% gain

Continued on page 4
From Our New Associate Editor

Alexandre Vaz

Maybe disappointment is the fear of no longer belonging to a system. So I could put it like this: he is very happy because he was finally disappointed.

Clarice Lispector, in “The Passion According to G.H.”

Dear SEPI colleagues,

An introduction is in order, or so I was told! My name is Alexandre Vaz and I’m a young clinical psychologist and researcher from Lisbon, Portugal. My very early psychotherapy heroes were Carl Rogers and Albert Ellis. Try to integrate that, SEPIans! Soon after, binge reading led me to stumble upon Jerome Frank's “Persuasion and Healing” when I was 21 years old. A card-carrying integrationist was born.

My first SEPI meeting experience was absolutely memorable. Suddenly, I was surrounded by my bookshelf protagonists in the flesh. It's an amazing feeling when the people you grew up with intellectually are actually kind, friendly humans. From that meeting, one experience stands out: doing a live roleplay session with Rhonda Goldman. I’d be embarrassing her if I told her how much that experience shook me up. So, let's let her know in the safe space of an internationally available newsletter. In one 40-minute unscripted session, I probably felt more I and Thou-ed than during most of the 5 years I was in psychoanalytic psychotherapy. What a way to start an adventure.

I feel strongly that psychotherapy interventions, models, studies and communities are only as ambitious as the people behind them. As Paul Wachtel noted in a past issue, “bland ecumenical platitudes, tamely integrative thinking, can dull the cutting edge of our movement.” While SEPI is definitely a safe space for many of us, I doubt integration should feel too safe. Which leads me to another point…

I honestly believe SEPI is just starting. As a community, it has all the potential to be at the vanguard of psychotherapy practice and research. Besides trying my best to provide valuable content, I am sensitive to the importance of creating yet another integrative bridge within SEPI, namely, a generational one. In an era where I see many of my peers not so turned on by reading, SEPI can either reminisce on the past glory of literate students (if that was ever a thing), or adapt in such a way as to make younger professionals intrinsically excited to find out more, debate more and contribute more. I see this newsletter as an absolutely necessary means to that end, as well as an ongoing investment in new audiovisual content, social media presence, and the like.

Carl Sagan, in his amazing “The Demon-Haunted World”, wrote: “Not explaining science seems to me perverse. When you’re in love, you want to tell the world.” That’s how I feel about SEPI. So, thank you to Jeff Smith and the Executive Board for appointing me associate editor of The Integrative Therapist. Our work is just starting—full speed ahead! 🚀
Starting as a Young Integrative Therapist

First of all, I would like to thank SEPI for the initiative to listen to young therapists that are starting their practice without a single theoretical and practical orientation. I hope this can inspire future research and discussion to attend to our present growth pains and needs. I would also like to thank all the contributions that have allowed me to grow as an integrative therapist since such an early stage.

Early in my life, I felt curious about human being's mind and behavior. While being a psychology student and future therapist, I wondered how psychotherapy could respectfully embrace its richness and complexity. At the beginning of my academic years, this question didn’t seem to be totally answered by the theoretical and practical orientations that were exclusively presented. Separately, they seemed just pieces of a complex puzzle that didn’t allow me to see and play with the whole picture. Therefore, the perspective of having more than a unique instrument in my therapist toolbox brought me comfort and relief, through my acquaintance with experienced Portuguese integrative psychotherapists and integrative literature (e.g., routes to integration, common factors, integrative models). The idea of being able to notice, focus, and work with different psychological levels and dimensions made me believe, as a future therapist, that I would be more prepared to respond to patients’ singularity and to different instances of a single self. However, as soon as I started my clinical practice I realized that integration in psychotherapy was still just a good theoretical idea and much needed to be learned about how to be integrative in practice.

Being a beginner is, per se, a frightening situation marked by inexperience, disorientation and a low sense of competence. However, I believe that part of the anxiety I often experience at this starting point is also triggered by the apparent incompatibility between the desire to develop an integrative practice and the simultaneous need for structure and its underlying perception of organization and guidance. It’s at a decision clinical making level that I find most of the challenges as a wannabe integrative. Frequently I find myself sailing through a deep ocean of effective and significant therapeutic options/approaches, without knowing for certain when and how I should consider each – where should my attention lie on? Is there any priority work? Which situations, phases of the therapeutic process or moments of a psychotherapy session, will benefit from the use of a specific approach? Sometimes the desire for a structure makes me wonder if it’d be easier to start with a single approach and progressively assimilate other psychotherapies. At the same time and for these same reasons, I conclude this would be taking the risk of starting biased or create the habit of putting the my need for secureness in front of the patient.

Although I believe restrictive structures in psychotherapy might decrease the opportunity to develop unique therapeutic processes centered on the person and collaborative therapeutic relationships, I miss having specific guidelines towards an integrative psychotherapy (early) practice. The integrative models that I’ve been in contact with inspire my thinking and practice. Nevertheless, I wonder sometimes if, controversially, these tend to develop as new single models. It would be interesting to highlight on a single map which situations, phases and moments of the therapeutic process might benefit from the specific approaches already developed and its respective literature, audiovisual support, and training.

Starting as an integrative psychotherapist presupposes a lot of autonomy but also the responsibility of using the huge amount of the available knowledge. I truly believe that an integrative thinking and practice can indeed increase responsiveness in psychotherapy and promote structural and lasting changes. However, I acknowledge that more empirical evidence is needed in order to guide clinical decision making of young integrative therapists that are starting this long and challenging psychotherapeutic path.
TYPICALLY NOT CONSIDERED ARE PATIENT CHARACTERISTICS SUCH AS CULTURAL BACKGROUND, PSYCHOLOGICAL MINDEDNESS AND MOTIVATION FOR TREATMENT, AS WELL AS LIFE CONTEXT, THE THERAPEUTIC ALLIANCE AND THERAPIST FACTORS OR THEIR INTERACTION WITH PATIENT VARIABLES. ALL OF THIS AND MORE LIMIT THE USEFULNESS OF RCTS AS GUIDES TO PRACTICE (MESSER, 2016).

WHAT IS THERE TO REPLACE OR AUGMENT THE RESULTS OF RCTS? I WOULD ARGUE THAT CASE STUDY RESEARCH HAS COME OF AGE AND PROVIDES AN EXCELLENT BRIDGE BETWEEN RESEARCH AND PRACTICE, SUPPLEMENTING WHAT WE LEARN FROM TRADITIONAL RCTS. RESEARCH HAS SHOWN THAT PRACTITIONERS ARE MORE INFLUENCED BY CASES THAN BY DATA FROM RCTS, REGARDLESS OF THEIR THEORETICAL ORIENTATION (STEWART & CHAMBLESS, 2010). THERE ARE ALSO MIXED METHODS THAT INCORPORATE RCTS AND SINGLE CASE COMPARISONS, WHICH INCLUDE QUANTITATIVE AND QUALITATIVE DATA. ONE OF OUR KEYNOTE SPEAKERS FOR THE UPCOMING SEPI CONFERENCE IN NYC (MAY 31-JUNE 2, 2018) IS JOHN McLEOD (2010) WHO HAS PUBLISHED A FORWARD-LOOKING BOOK FOCUSING ON THE VARIOUS WAYS TO CONDUCT RIGOROUS CASE STUDY RESEARCH. HE SHOWS HOW CASES CAN BE PRESENTED IN SUCH A WAY AS TO PROVIDE RELIABLE AND VALID EVIDENCE RATHER THAN BEING PURELY ANECDOTAL OR ILLUSTRATIVE. HE EMPHASIZES FOUR FACTORS THAT MAKE CASE STUDIES RELEVANT FOR BUILDING A SOLID PSYCHO THERAPY KNOWLEDGE BASE: (1) A NARRATIVE WAY OF KNOWING, (2) COMPLEXITY OR THICK DESCRIPTION, (3) A FULLER CONTEXT FOR THE VARIABLES OF INTEREST, AND (D) BEING ABLE TO OBSERVE PRACTICAL EXPERTISE IN ACTION.

WHAT ARE SOME OF THE WAYS THAT HAVE BEEN DEVELOPED TO CONDUCT RIGOROUS CASE STUDY RESEARCH? THESE ARE KNOWN AS THE PRAGMATIC CASE STUDY METHOD (FISHMAN), N=1 TIME SERIES CASE ANALYSIS (KAZDIN; MORGAN & MORGAN), THE HERMENEUTIC (OR ADJUDICATIONAL) SINGLE CASE EF FICACY DESIGN (BOHART; ELLIOTT), THEORY BUILDING CASE STUDY (STILES), NARRATIVE CASE RESEARCH (ETHERINGTON), AND TEAM-BASED CASE STUDY METHOD TO ENABLE PRACTITIONERS AND STUDENTS TO CONDUCT SYSTEMATIC CASE STUDIES (MCLEOD). THIS IS NOT THE PLACE TO ELABORATE ON THESE APPROACHES BUT SUFFICE IT TO SAY THAT THEY ARE WORKS IN PROGRESS, EACH WITH THEIR OWN ADVANTAGES AND DRAWBACKS.

IN A RECENT BOOK EDITED BY FISHMAN, MESSER, EDWARDS AND DATILLIO (2017), FOUR RCTS OF DIFFERENT KINDS OF THERAPY ARE PRESENTED AND, ALONG WITH EACH, TWO OR THREE CASES FROM THE RCTS—USUALLY A SUCCESS AND A FAILURE CASE. EACH CASE IS PRESENTED IN NARRATIVE FORM BUT IS ENHANCED BY THE QUANTITATIVE DATA THAT WERE COLLECTED AS PART OF THE RCT. WHEREAS THE RCT GROUP RESULTS ARE NOT ABLE TO DESCRIBE HOW OR EXPLAIN WHY SOME CLIENTS ARE SUCCESSFUL AND OTHERS NOT, THE CASE COMPARISONS DO EXACTLY THAT. THIS IS KNOWN AS THE MIXED METHODS MODEL AS IT MAKES USE OF BOTH QUANTITATIVE AND QUALITATIVE DATA.

WHAT DO CASE STUDIES ADD TO WHAT IS LEARNED FROM AN RCT? IN A REVIEW OF THE FISHMAN ET AL. VOLUME IN PSYC CRITIQUES, ART BOHART SUMMARIZED SOME RELEVANT POINTS NOTED BY THE EDITORS, CHAPTER AUTHORS AND COMMENTATORS:

- Identifying therapist and client factors that may help determine success or failure
- Identifying extra-therapeutic factors such as the role of parents
- Examining how mismatches between client and therapy can affect outcome
- Determining the role of culture
- Examining how the process of a specific therapy works

IN ADDITION TO SEPI'S TRADITIONAL ROLE OF STUDYING COMMONALITIES AND DIFFERENCES AMONG THEORETICAL AND CLINICAL POSITIONS, I BELIEVE THAT IT HAS AN IMPORTANT ROLE TO PLAY IN NARROWING THE GAP BETWEEN RESEARCH AND PRACTICE. SYSTEMATIC AND RIGOROUS SINGLE CASE STUDIES ARE ONE VERY PROMISING VEHICLE FOR ACHIEVING THIS GOAL.

REFERENCES:


Structured Interviews on Research

Homing in on key issues in research, the Integrative Therapist has asked a group of leaders in the research field to respond to five questions designed to bring out trends, opinions and questions at the cutting edge of the psychotherapy research.

Nine members of SEPI (and beyond) have kindly offered the responses that follow.

Michael Constantino

1. Psychotherapy research seems to point towards a greater variability in outcomes between therapists than therapies. How can this research on “therapist effects” inform clinicians and their real-world practice?

It's probably now safe to say: “research robustly indicates,” vs. “seems to suggest,” that psychotherapists vary in their efficacy, thus rendering a pressing need to think less in terms of what interventions work best for whom, but more in terms of what therapists and therapist-level characteristics/behaviors work best for whom ... and when/how? To be practically useful, clinicians need to first acknowledge the existence of this global therapist effect, which may not be easy given that most therapists report being more generally effective than the average clinician. Despite these self-perceptions, clearly not all therapists are highly effective generalists.

Moreover, research indicates that therapists possess relative strengths and weaknesses within their own practice depending on their patients’ presenting problems; that is, many clinicians may have unknown specialist tendencies. To make therapist effects’ knowledge actionable, therapists also need to work toward ‘knowing thyself’ by measuring their own variable efficacy in treating different types of patients and problems. Only then can this information be harnessed; for example, by treating only the patients that they are reliably good at treating, or by getting additional training in treating the types of patients for whom they are less effective.

2. How can the field of psychotherapy integration, specifically, benefit from recognition of the importance of therapist effects?

Psychotherapy integrationists would benefit from understanding that to explain between-therapist differences in patient outcomes inherently requires knowing something about the person of the therapist and/or therapists’ differential abilities to facilitate important in-session processes. To do this requires disaggregating the total correlation into its between-patient and between-therapist components, and appreciating how failing to do so can result in false empirical and clinical conclusions. To me, routinely incorporating therapist-level analysis into our research can go a long way toward defining far more precisely clinician expertise. This focus on the therapist, I would argue, is inherently integrative, as it crosses theoretical orientations. Moreover, delving into the therapist as a research “participant” can also cross scientific disciplines. And not only can the field of psychotherapy integration benefit from recognizing the importance of the therapist effect, but perhaps integrationists, with their open-minded approach to treatment delivery, are best situated to conduct this type of research and model its translation to the therapy room.

As one example, we know that routine outcome measurement and related feedback, both inherently integrative practices, can facilitate patient improvement. However, although such feedback improves outcomes for a given case, research has shown that receiving such feedback does not, over time, improve overall therapist-level effectiveness. This may be because we are giving therapists valuable patient-level feedback, which improves patient-level outcomes, but we are almost never giving therapists true therapist-level feedback, which could, theoretically at least, impact therapist-level outcomes. To me, this level of feedback is an important focus of future integrative research.

Continued on page 6
“...training all therapists to do similar things to deliver treatment “competently” would be training them to do something that patients will ultimately see very differently.”

“Any research that parses and provides appropriate therapist-level implications is very important for practitioners.”

3. Funding for psychotherapy research has generally gone for the study of particular models applied to the treatment of specific disorders. Meanwhile, much of the research suggests that who provides the treatment is more important than which treatment is provided. Going forward, what can research programs do to deal with this tension?

The optimist in me believes that if the reality of therapist variability is accepted, there need not be a tension. The realist in me, though, understands that many persons will remain loyal to the faithful delivery of treatment brands. Consider, though, the notion of competence in delivering a treatment manual — it may be something on which we can train therapists to the point of seeing no between-therapist difference in performance indices. However, if you ask patients to rate their therapists on perceived competence, there could be immense variability, which would suggest it is something about the patient or the unique dyad that affects perceptions of competence. In this case, training all therapists to do similar things to deliver treatment “competently” would be training them to do something that patients will ultimately see very differently; thus, it would be an attempt to affect a therapist-level predictor of a patient-level process, which is an inherently flawed conceptual and statistical assumption, though still the basis of many studies/trainings on empirically-supported treatments.

To me, parsing efficacy effects at differential levels holds the most promise for addressing this tension, especially if we can articulate the clear training and practice implications that derive from parsed effects. For example, if you have a fully between-patient effect on a treatment process, then understanding determinants of that effect is most promising in helping you to personalize treatment for a given patient/dyad. As an example of this extreme, it would be like learning that patient comfort relates to outcome, and all variability in comfort is between patients. We may then learn via research that (a) one between-patient predictor of low comfort is being a man, and (b) what predicts more comfort for men is sports memorabilia on the walls. The implication for therapists is that to best affect comfort (irrespective of potential brand loyalty) would mean seeing their male patients in a room with sports memorabilia. As there were no between-therapist effects, the key to improving comfort would not be in changing something about therapists themselves, or how they deliver treatment.

But, at the other extreme, if we found a wholly between-therapist effect on a process, then understanding determinants of that effect can help harness it and teach therapists to consistently foster it across their patients. For example, we might find that warmth is a between-therapist predictor of between-therapist patient comfort levels. The implication here would be for therapists to try to be warm with all of their patients. This type of result is the most likely path to discovering a true therapist-level competence, and it need not create tension, especially when the determinant (like warmth) represents something that can be applied to any type of intervention.

4. Speaking of funding, would you rather be doing psychotherapy research in Europe or in the US, and why?

Having only ever lived and conducted research in the US, I have no direct basis for comparison. So, I will simply say that research on therapist effects, wherever conducted, should hone in on determinants of such effects. I applaud early work on this topic, which has revealed therapist facilitative interpersonal skill and deliberative practice as promising determinants of why some therapists consistently outperform others. We need to keep up this type of discovery in all countries, as identifying trainable therapist-level behaviors should become a focal point for evidence-based training.

5. In your opinion, of relatively recent research findings, what are the most important for clinicians?

Any research that parses and provides appropriate therapist-level implications is very important for practitioners. Again, if a between-patient variable (say therapist empathy perceptions) fully explained between-patient variability on an outcome, it would be near impossible to base our clinical trainings on the generic idea of improving therapist empathy, as such differences in empathy perceptions would have everything to do with the patient or dyad. However, we might also learn that while there could still be variability within a therapists' caseload on ratings of their empathy, it could simultaneously be the case that Therapist B is consistently better across all of her patients than Therapist A at promoting empathy, which may also relate to more improvement for Therapist B's patients. We would then want to understand determinants of these empathy perceptions that systematically differ between therapists' caseloads. Let's say that therapist verbal fluency explained much of the variability in patient empathy ratings, with more verbally fluent therapists being perceived, on average across all of their patients, as more empathic than less verbally fluent therapists. In this case, harnessing this determinant by helping clinicians become more verbally fluent across patients could become a training centerpiece. However, if we found something like therapist interpersonal trauma to be a strong therapist-level predictor of between-therapist differences in treatment process and outcome, this might have to be the basis of therapist selection (given that training cannot undo trauma). As should be clear, the clinical implications are quite different based on the results of these different levels of analysis.
1. Psychotherapy research seems to point towards a greater variability in outcomes between therapists than therapies. How can this research on “therapist effects” inform clinicians and their real-world practice?

Research on “therapist effects” can be useful for clinicians in several ways given the strong personal involvement that the role of therapist implies. Research can help clinicians develop a more refined personal care and personal preparation strategies for the task. In this sense, the proposals to apply self-reflection and self-practice (Bennett-Levy) can be very useful. On the other hand, this research can help practice in the real world to the extent that it helps knowing the way in which the role of therapist modulates the potential scope of settings and therapeutic techniques.

2. How can the field of psychotherapy integration, specifically, benefit from recognition of the importance of therapist effects?

Undoubtedly, knowing better the effects of therapists can be very useful for the field of integration in psychotherapy, insofar as this may allow formulating more individualized therapeutic treatment plans and more idiographic interventions. However I think this can be applied to the whole field of psychotherapy.

3. Funding for psychotherapy research has generally gone for the study of particular models applied to the treatment of specific disorders. Meanwhile, much of the research suggests that who provides the treatment is more important than which treatment is provided. Going forward, what can research programs do to deal with this tension?

The research programs that can deal with this tension will be designs that can cross a great diversity of treatments x therapists in order to overcome the dissociated estimation of both components.

4. Speaking of funding, would you rather be doing psychotherapy research in Europe or in the US, and why?

We have many years of work in Latin America and the conditions in our region are not those of USA and Europe, therefore we have no arguments to respond, but the interesting thing about the question is that it restricts research to these regions since there are other regions where research is conducted. We understand that a good alternative would be to include the contributions of Latin America, and the development of international collaboration programs.

5. In your opinion, of relatively recent research findings, what are the most important for clinicians?

These are: a) identification of the sources of failure in psychotherapy (drop outs, harmful effects, etc.), b) empirical studies linked to supervision in psychotherapy (especially linked to the effects of supervision on the therapeutic outcome of patients), c) the use of new technologies (ethical issues, cross-cultural issues, implementation standards, comparative outcomes).
“We all know that half of the clinicians are below average but we all secretly believe that we are in the top half. That’s a delusion.”

“I think you can bring these two ideas (therapists matter; methods matter) together by considering what the actual processes are that mediate outcomes among our various therapies.”

Steven C. Hayes

1. Psychotherapy research seems to point towards a greater variability in outcomes between therapists than therapies. How can this research on “therapist effects” inform clinicians and their real-world practice?

If you look at the literature on common core processes that have to do with therapist’s characteristics, a weakness is that the literature doesn’t tell you enough about what you can do as a therapist in order to be among those who are particularly effective. There’s a small literature of that kind, but I don’t think it’s very powerful and the head to head experimental tests are not there to my knowledge. I will propose a good way to do it later.

When I’m discussing this with clinicians, I usually ask how many people think that therapist factors and the therapeutic relationship are critical to outcomes in psychotherapy. About 99% of the people in the audience raise their hands. I then ask them whether or not they think they can do a reasonably good job of producing powerful working alliances. About 95% of the people in the audience then raise their hand. I then ask how many people think that they live in therapeutic Lake Woebegon, where all the therapists are above average, and a nervous laughter goes through the room. We all know that half of the clinicians are below average but we all secretly believe that we are in the top half. That’s a delusion.

If you ask clients to indicate characteristics of their therapists, or features of their relationship with their therapists, they see things that are useful and helpful, but that should not be taken to substitute for an adequate scientific analysis. There could well be (actually, I think there are … I will describe some in a moment) third variables accounting for the empirical relationships and the lay public would not know what those are. Just trying to produce characteristics that clients point to, may not be effective. It takes experimental science (not just correlational science) to explain the features of therapists and the relationship that matter, to give them theoretical meaning, and to develop means of teaching practitioners methods for producing the critical features that matter.

I’ve seen this question balloon into the idea that techniques and methods do not matter, and that is to my mind is a bit bizarre. It is just so obviously untrue. Take the entire literature now on interventions based on books, website, apps, and so on. You can readily show effects without any therapist involvement,¹ and you can show differential outcomes based on the methods that are included.¹

We know methods matter, at least sometimes. I sometimes hear the most extreme versions of this line of thinking from some of the very folks who claim to be the most interested in the profession of psychotherapy, but they do not seem to realize that the end point could well be to de-professionalize psychotherapy. If only therapist factors matter, why all of these training programs? Why pay therapists like professionals? Why not just screen for socially supportive and credible people and call them therapists?

A weakness in the literature that is underneath your question, in my opinion, is that the ways that we have characterized therapies are not very useful. Techniques can be applied competently or incompetently, of course, but the much more important part of techniques and methods are the processes of change that they engage. Labeling something by a technological or protocol name is a very shallow way to categorize things. If the method does not move the intended change process, what good is that technological label? It would be like categorizing heart valve replacement under the label “moving a scalpel” and then claiming that how you do heart valve surgery does not matter to health outcomes, citing evidence from a study that included surgeons who claimed to be doing heart valve replacement but never replaced the valve: they just moved the scalpel.

I think you can bring these two ideas (therapists matter; methods matter) together by considering what the actual processes are that mediate outcomes among our various therapies, and then focusing on what best produces those
You can do a quick personal assessment of this idea by thinking of somebody who was profoundly empowering to you in your life, and then asking yourself these questions: did you feel accepted for who you really were by this person? Did you feel constantly judged by this person, or was judgment and criticism far away? When the person was with you, did they seem to be present, or were they constantly looking at their watch, or talking about things that didn’t have to do with this moment of being together? When you look that person in the eye, did you see consciousness there, and could you see that you yourself were being seen as a conscious human being? Or did you see dead eyes, the eyes of a person who is only half present? When you were together with that person, did what you care about matter to them, or would they easily ride over your deepest concerns without a second thought? Could you be together in a way that fit the situation and fit the possibilities and what you cared about, or was it always one way, my way, or the highway? 

Those six questions ask about acceptance, defusion, flexible attention in the now, a perspective taking sense of self, values, and actions linked to values, which are the six defining features of psychological flexibility. If you answered the way I would guess you did, then this summary might make intuitive sense to you: empowering relationships are psychologically flexible. I’d personally be happy to call “ACT” any therapeutic method that is focused on and has been shown to move psychological flexibility. It’s the model and processes that matter, not the techniques and protocol.

We’ve tested this idea by the way. If you put in the working alliance it mediates outcomes in ACT, but so too does psychological flexibility. If you let the two compete in a multiple mediator model, the working alliance is weakened, and is sometimes no longer significant. That is not because the relationship is not important. I think it is because if the client does not internalize what the therapeutic relationship is modeling, it does not matter that much. Said in another way, the relationship is a means to an end – a change in important psychological processes. But those same processes can also be targeted by techniques and methods: the relationship and therapist factors are only one way to do so. It’s a “both and” situation, not an “either or.”

I think the future of therapy is not therapies considered solely as a set of techniques, but therapies as intervention strategies that move the mediators of change. If you had to pick a single set of processes that mediate outcomes across a wide range of human problem areas, and even therapeutic methods, I think you could not do much better than to nominate psychological flexibility as such a target. It can be moved by many methods. Thus, if you take a more process-based focus, you can use a lot of different therapeutic techniques, whether analytic, humanistic, existential, cognitive, behavioral, systems, or what have you, but always be doing evidence-based therapy in the sense that the processes of change being moved are evidence-based.

2. How can the field of psychotherapy integration, specifically, benefit from recognition of the importance of therapist effects?

We need to rethink what psychotherapy integration really means in the context of a more process-based approach. It seems to me that we should be using evidenced-based procedures to change evidence-based processes, for the purposes of fostering the prosperity and solving the problems of people. That does mean that we’re integrating methods, but it does not necessary mean that we’re integrating theories.

Of course, we need to get on with the business of softening the division between broad traditions. There’s no mature science or profession that divides itself into such silly divisions as psychotherapy does, or indeed much of the psychological and behavioral science. The analytic wing; the behavioral wing; the existential wing; the cognitive wing; and so on. Oh please. That’s obviously just a temporary transition in the development of our field and eventually will pass away.

We can find what’s useful inside our various psychotherapy traditions by subjected them to careful examination of the moderators and mediators of change for both positive aspirations and the amelioration of negative problems; that is, both for people who need mental and behavioral health assistance, as well as assistance in the areas of work, or relationships, or sport, or what have you. Therapist’s effects, when scientifically understood, can point to manipulable processes of importance. I emphasized psychological flexibility in that answer above, but I could have talked about the importance of social support, or attachment issues, or learning good relationship skills, and so on—and these different models can be tested and compared. I think in the mature era we’ll eventually get to, we will let go of our attachments
to schools, and instead hold on to the best that Western science can give you in the development of coherent model of processes of change, both in diagnosing complex human problems and issues and in altering their trajectories.

3. Funding for psychotherapy research has generally gone for the study of particular models applied to the treatment of specific disorders. Meanwhile, much of the research suggests that who provides the treatment is more important than which treatment is provided. Going forward, what can research programs do to deal with this tension?

I'm not sure I agree with your characterization, especially in the context of the changes inside the United States funding system, in which the NIMH is greatly reducing funding for psychotherapy research as it applies to mental health problems. Meanwhile medication use is soaring. Thinking of it as a matter of who provides the treatment versus which treatment is provided is a very limited way to think about it, and frankly is unlikely to change these trends in funding or use. I don't mean that there's not an issue inside that distinction, I simply mean that that distinction is not the right way to think about that issue, as I've argued above.

The correct way, in my opinion, is to focus on the process of change, and the processes that moderate them. If you did that, you could include therapist effects, as long as you had good means of altering them, along with other processes — and we could get beyond this sad era of protocols for syndromes. That era is already passing. We need to move toward a view of evidence-based psychotherapy that is inherently integrative in the sense that we will take whatever processes are available that moderate or mediate change.

We need models to help bring order to the myriad change processes. I think the model that very likely will eventually underlie psychotherapy research is the same model that underlies all the rest of the life sciences: evolution science. My guess is that you will see over time that the mediators of change in psychotherapy will line up pretty well with processes that encourage healthy variation, that fit variation to context, that allow people to select and retain variations in psychological adjustments that are successful while letting go of those that are not, and that focus on the right dimension (e.g., emotional, cognitive, over behavioral) and level of selection (e.g., sub-organismic, organismic, social).

4. Speaking of funding, would you rather be doing psychotherapy research in Europe or in the US, and why?

I've mostly done research in the United States, so I don't have a strong opinion on that beyond an appreciation for a greater interest in the theories and processes of research in certain parts of Europe. It has always seemed to me that understanding basic processes, even if it required that clinicians do the basic science work that allow us to have effective processes in hand that can apply to human complexity, is by far the most progressive empirical approach, as opposed to simply randomized control trials linked to protocols for syndromes, which I always thought was unlikely to be very important, even though I felt forced to do it in order to put important ideas into the conversation. My own research has always included laboratory and basic science elements as a result. You see that breadth of focus in the Contextual Behavioral Science community—the group that has arisen to guide the development of ACT and related parts of the research program. CBS folks are about as interested in evolution science or a basic science of cognition (especially, Relational Frame Theory) as they are ACT.

5. In your opinion, of relatively recent research findings, what are the most important for clinicians?

The most important research findings by far, in my opinion, are mediational data. Mediators are not causes, but they are functionally important targets of change that are more proximal than the targets of change that will emerge without guidance by science.

If you went out to your backyard and shoot baskets for an hour a day, you'd get better, but not if you wore blindfolds. You can go to your clinic and see six clients a day for years on end and not get any better. Most clinicians don't believe that, but the data are clear. Psychotherapy is one of the few areas of human functioning in which experience doesn't correlate very well with competence. That only happens when feedback is poor.

We have gone through an era in which we have focused on signs and symptoms, which gives us very poor feedback on true progress, and on the success of our practice. We also focus on the degree to which our clients are pleased with us, which is also is a very poor substitute for indications of real change. If you focus on mediators, you have a chance.
If you can forgive a bit of self-focus, let me use the mediational evidence on psychological flexibility in ACT and allied methods as an example of what I mean. The data on the mediational role of psychological flexibility is one of the strongest sets of mediational data available in the psychotherapies, in terms of the breadth of application and the consistency of the result. Those data allow me to tell practitioners to take psychological flexibility very seriously. When they see their clients becoming more emotionally and cognitively open, more centered in the present moment, with more flexible attention to the now; and more able to align their behavior with their chosen values. If you can see major progress in therapy sessions in those areas, you’re very likely witnessing a life being liberated. Metaphorically, when you see transformations like that you are seeing a ball that went through the hoop. Chase that effect—let that feedback shape you as a clinician—and it seems likely you will have a better chance to get better over time as defined both by being able to move the mediator and also by client outcomes produced.

It’s a very testable hypothesis in any case, and there we come full circle back to your originally question.

The same should be true of any broad and flexible set of mediational results. You should be able to the same experimental study with well-crafted measures of the working alliance for example, and it would allow feedback systems to be tested head to head from various models. That would be a progressive step in fostering a science and practice of integrative therapy.

Footnotes and References

1 Foundation Professor, Department of Psychology, Behavior Analysis Program, Mail Stop 296, University of Nevada, Reno, NV 89557-0062


7 You can see what that community is up to at www.contextualscience.org


10 You can see a list of some of the ACT mediational studies here: https://contextualscience.org/act_studies_with_mediational_data
Structured Interviews on Research, continued

Scott D. Miller

1. Psychotherapy research seems to point towards a greater variability in outcomes between therapists than therapies. How can this research on “therapist effects” inform clinicians and their real-world practice?

For me, at least in two ways. The first is that, given the variability of performance, we need to be monitoring our work on an ongoing basis, both in our ability to connect with the individual client but also our outcomes. The second one is how we determine whether or not we are developing professionally. There’s overwhelming evidence that therapists value professional development activities, as well as an identity consistent with the idea that they are getting better with time and experience. The data indicates that they don’t get better with time and experience. And so, the variability of individual performance gives us a window to look through to understand why some are better than others, consistently so. And, it turns out, some evidence exists that the differences are attributable to the amount of time spent in an activity called “deliberate practice.” In 2007, our team introduced this concept to the broader psychotherapy audience, and began looking at how therapists who were better spent their time. On average, top performers spend two to four times as much time engaging in activities related to improving their outcomes, outside of performing psychotherapy—meaning, they’re engaging in deliberate practice. I think those are really the two areas.

2. How can the field of psychotherapy integration, specifically, benefit from recognition of the importance of therapist effects?

Well, I think one of the chief integrative variables is the therapist. Sol Garfield was pointing this out nearly two decades ago, suggesting the field look into the contribution made by the clinician to outcome. Instead, our profession, in my opinion, took a detour developing treatment models and approaches, believing that training therapists in those approaches would lead to superior outcomes and superior performing therapists. I think the outcome of that choice has proven unhelpful, the opposite direction of what was predicted. So, one chief integrative variable should be the professional development of clinicians. To me, the variability between providers gives us evidence on what we might focus on.

3. Funding for psychotherapy research has generally gone for the study of particular models applied to the treatment of specific disorders. Meanwhile, much of the research suggests that who provides the treatment is more important than which treatment is provided. Going forward, what can research programs do to deal with this tension?

I think there are so many things that could be done. Whether or not they will happen is an open question. The current way research is thought about and funded has been mastered and driven by those in university settings. Changing the dominant approach to thinking and researching is likely, as is true of change in general, to prove difficult. So, I’m not particularly sanguine about the prospects of researchers changing their view and adopting a different way of thinking about the field and how we do research. I also think that much of the research continues to be funded by organizations led by physicians and the medical model. Sorry to be pessimistic, but I think it’s very unlikely that those organizations (e.g., NIMH, NICE) are going to foster change in a new direction. What’s more likely to happen is what’s been happening for the last 30 years: psychology will try to emulate medicine, and if it wants money to do research it will have to treat psychotherapy as an analogue to prescription drugs.

Continued on page 13
4. Speaking of funding, would you rather be doing psychotherapy research in Europe or in the US, and why?

If the question is where I’d rather be practicing psychotherapy, I would say in Europe six ways ‘til Sunday. The reason is I think Europe has a much larger social consciousness and safety net. The US has a distinctly different culture. More, much of the practice is driven by reimbursement economics. I don’t know enough about how psychotherapy research is funded in Europe to comment about research there to argue convincingly one way or the other. For the reasons I stated in the previous questions, research funding is very difficult for someone coming from a contextual rather than medical paradigm.

5. In your opinion, of relatively recent research findings, what are the most important for clinicians?

In terms of effectiveness and professional development, I think some of the most intriguing results are about individual therapist’s differences. It is also, at present, the “Wild West.” We don’t really have a good definition of what therapists need to practice in order to get better. Even those of us hailing from a contextual paradigm are unclear at this moment about what might be the best protocol for professional development. At the same time, I think there is emerging evidence that deliberate practice includes a number of essential elements. The first is, monitoring the outcome as well as engagement level of clients in your therapy practice. Doing so will aid in identifying performance improvement opportunities—where we show deficits in our outcomes, for example.

The Integrative Therapist: Call for Content

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

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

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

Submission Deadlines and Publication Dates

December 1 deadline for January 15 Issue
March 1 deadline for May 15 Issue
June 20 deadline for July 15 Issue
September 15 deadline for October 15 Issue

Specifications

- The preferred length of submissions is 1,250 words or less
- Block style, single spaced with an extra space between paragraphs
- No paragraph indentations, page numbering, headers or footers
- Use subheadings and bullet points freely
- Bare Minimum references should be single spaced, in approved APA-style format
- Please include a photo of the author or authors, minimum 50K file size each.
- Photos should be submitted as separate JPEG, TIFF, GIF, or BITMAP files.

All submissions should be sent in the body of an email to jsmd@howtherapyworks.com with the subject line “Contribution to Integrative Therapist.”
Structured Interviews on Research, continued

Jan Roubal

1. Psychotherapy research seems to point towards a greater variability in outcomes between therapists than therapies. How can this research on “therapist effects” inform clinicians and their real-world practice?

The recently growing, research based emphasis on the psychotherapy relationship role in the change process can support psychotherapists in exploring, how to be with the client in an effective way. It seems to me that it is not so much important what we do with our clients, rather how we are with them. Attuning well in a specific way to every individual client, moreover in every specific moment of our meeting, seems to be one of the key points for the psychotherapy effectiveness. Psychotherapy and neuroscience research can help practitioners to reflect and cultivate this competency.

2. How can the field of psychotherapy integration, specifically, benefit from recognition of the importance of therapist effects?

It seems to me that many interventions, which therapists do with the intention to help their clients, work to a great extent for therapists themselves to cope with their own experiences of anxiety, uncertainty, or helplessness. The key psychotherapist’s competency would be then the ability to cope with their own experiences while being at the same time available to the meeting with client. Such a competency is inherently integrative, because it is genuinely human. Our human experiences and abilities to meet the other human being do not differ according to the different psychotherapy approaches we were trained in.

3. Funding for psychotherapy research has generally gone for the study of particular models applied to the treatment of specific disorders. Meanwhile, much of the research suggests that who provides the treatment is more important than which treatment is provided. Going forward, what can research programs do to deal with this tension?

I find it very promising to focus on exploring psychotherapists’ own experiences, together with their strategies for coping with such experiences, with different specific populations: with clients who experience psychosis, depression, borderline phenomena, panics, etc.

4. Speaking of funding, would you rather be doing psychotherapy research in Europe or in the US, and why?

I am lucky that I can be more focused on the topic of my research than on the funding resources.

5. In your opinion, of relatively recent research findings, what are the most important for clinicians?

I recently found very inspiring to study research on psychotherapists’ countertransference (in the broad meaning, nicely summarized and introduced by e.g. Gelso & Hayes, 2007; or Wolf, Goldfried, & Muran, 2013) in the light of the neurocognitive mirroring concept, and of the neuroscience research in general (aptly linked to psychotherapy by e.g. Siegel, 2012; or Cozolino, 2016). Again and again, I am astonished by how little the psychotherapy change process is consciously controlled by the therapist, and so how important is that therapists humbly do not get in the way of the healing potential of human meeting with its own, often hidden, dynamics and wisdom.

References:

Continued on page 19
“...to me, the scientific headline is not the modest therapist effects but the lack of treatment approach effects.”

“Clients tend to have similar positive outcomes because all treatments offer a wide range of tools and therapists have learned how to use them appropriately.”

William B. Stiles

1. Psychotherapy research seems to point towards a greater variability in outcomes between therapists than therapies. How can this research on “therapist effects” inform clinicians and their real-world practice?

Differences in effectiveness among therapists are not large, except at the extremes, but they are bigger than nothing, which is roughly the difference among therapies. I suppose an implication for individual clinicians is: to be effective, concentrate on doing a good job of what you do and don’t worry about which treatment approach you use.

2. How can the field of psychotherapy integration, specifically, benefit from recognition of the importance of therapist effects?

As I said, to me, the scientific headline is not the modest therapist effects but the lack of treatment approach effects. This is the familiar Dodo verdict: “everybody has won and all must have prizes.” If we understood this, we might have start on understanding what does make a difference.

How can so many demonstrably different treatments all be about equally effective? To come at this question a bit sideways, I think a clue is that in routine practice, treatment duration doesn’t predict outcome either. Using several large practice-based datasets gathered in the British National Health Service, we found that clients averaged similar amounts of pre-post change regardless of how many sessions they attended. Those who attended two or three sessions did as well as those who attended twenty or thirty sessions. Others have replicated this finding too.

Finding that short and long treatments have similar outcomes may seem surprising if you think of treatment duration as an experimental manipulation. But it is more plausible if clients and therapists are considered as responsively regulating treatment duration. That is, we speculated, participants regulate how much therapy they get in response to their needs and circumstances. Clients have varied requirements and resources; therapists do too. They monitor benefits and costs as treatment proceeds, make progress at different rates, and end treatment when they’ve had enough, however many sessions that is. So the clients tend to have similar outcomes because they all get about as much therapy as they need or can afford.

The Dodo results could have a similar explanation. Perhaps clients and therapists responsively make the best use they can of whatever type of treatment is being offered. They use the tools of the offered treatment to address emerging requirements. Clients tend to have similar positive outcomes because all treatments offer a wide range of tools and therapists have learned how to use them appropriately. This sort of appropriate responsiveness (doing the right thing as needs and circumstances change) is characteristic of any human interaction, and of course it is emphasized in clinical training, but it is overlooked in the simple causal models that get tested in experimental paradigms like randomized trials.

So how does all this bear on therapist effects? Perhaps therapists differ in appropriate responsiveness. That is, perhaps they vary in their ability or tendency to do the right thing. Of course, the right thing to do is different in different circumstances, so appropriate responsiveness is not easy to measure. Choosing the right intervention at any moment depends on just about every treatment variable you can think of: diagnosis, severity, age, gender, ethnicity, intelligence, language, culture, type of treatment, stage of treatment, client personality, therapist personality, history of the relationship, and so on and so on. Perhaps the more effective therapists are better at making these complex choices. As a result, they may show better empathy, form stronger alliances, and have more positive outcomes.

Continued on page 16
3. Funding for psychotherapy research has generally gone for the study of particular models applied to the treatment of specific disorders. Meanwhile, much of the research suggests that who provides the treatment is more important than which treatment is provided. Going forward, what can research programs do to deal with this tension?

This looks pretty hopeless to me, at least in the short to medium term. Funders are fixed on the question of what works, or which is the best treatment. The received wisdom is that randomization is necessary to establish causality, and hence for secure knowledge about whether a treatment works, or works better than an alternative. To put it another way, high quality research is understood to require a condition that can be manipulated as an independent variable, and treatment approach is about all we’ve got.

It would be possible, of course, to randomize clients to therapists, and this could establish therapist effects more firmly in a particular instance. But it would be hard to convince funders to pay the huge costs involved for a randomized clinical trial that, at best, could show one particular therapist was more effective than another.

4. Speaking of funding, would you rather be doing psychotherapy research in Europe or in the US, and why?

European funders have been relatively more friendly toward a wider variety of types psychotherapy research, including process research and qualitative research. It’s hard to know if that will continue.

5. In your opinion, of relatively recent research findings, what are the most important for clinicians?

In line with the foregoing discussion, I think an important recent finding is the Pybis et al. (2017) report that outcomes for CBT and generic counseling for the treatment of depression were comparable in a very large (N > 33,000) British sample. (Counseling in the UK is usually an integrative treatment approach.) In this study, the familiar observation that different treatment approaches had equivalent outcomes occurred in the context of a highly-publicized and well-funded program called Improving Access to Psychological Therapies, or IAPT, which involved special training for the CBT therapists aimed at improving efficiency and outcomes in these practice-based NHS settings. To extend the earlier line of thinking, it appears that the responsive regulation that yields equivalent outcomes across different treatment types and durations may be robust to specialized training of therapists. Outcomes may still depend on participants making appropriate responsive use of what is offered.

References

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


Structured Interviews on Research, continued

Ladislav Timulak

1. Psychotherapy research seems to point towards a greater variability in outcomes between therapists than therapies. How can this research on “therapist effects” inform clinicians and their real-world practice?

First of all, while we know that some therapists’ clients have better outcomes than others, we do not know that much about what qualities in those therapists might be responsible for those outcomes. If we knew what therapist qualities might be responsible for those outcomes, we could see whether we could foster those qualities more.

2. How can the field of psychotherapy integration, specifically, benefit from recognition of the importance of therapist effects?

I am not sure. We only know that clients of some therapists have better outcomes. We only indirectly infer the qualities of those therapists that may be responsible for those differences. I think we need more theoretical work done that would frame what we know about the therapist qualities that may be important for ‘therapists’ effects’. Once we had a clear line of research supported by a plausible theoretical framework, then we could start to get more clarity on this phenomenon. Only then could we think of applications for training and/or practice.

3. Funding for psychotherapy research has generally gone for the study of particular models applied to the treatment of specific disorders. Meanwhile, much of the research suggests that who provides the treatment is more important than which treatment is provided. Going forward, what can research programs do to deal with this tension?

I am not sure whether the claim in this question is actually true. We only know that the clients of some therapists have better or worse outcomes (as opposed to being in the mainstream ‘average’ therapist effect). We actually do not know much about who are those therapists whose clients do exceptionally well (or badly for that matter). Therefore I would be careful in making such a claim. As outlined above, I believe we need more theoretically driven research into the qualities responsible for better outcomes with particular therapists’ clients.

4. Speaking of funding, would you rather be doing psychotherapy research in Europe or in the US, and why?

I live in Ireland and my sense is that Ireland is friendly to psychotherapy research. I’m basing this judgment on my line of successful bids. I am not that familiar with the situation more broadly in Europe, UK, or US. My sense is that mental health is more and more recognized by governmental bodies, which is reflected in opportunities for obtaining funding. It is possible, however, that my view is over-optimistic, anecdotal and based on my local experience.

5. In your opinion, of relatively recent research findings, what are the most important for clinicians?

I was particularly influenced by studies on emotional processing sequences stemming from the work of Antonio Pascual-Leone and others in various theoretical orientations. I appreciate that the work is theoretically elegant, predictive and applicable to a variety of contexts, approaches, and client presentations. I think we do not have that many sequential theories of change and corresponding multi-step sequences of therapist strategies/interventions. It is interesting to see, for instance, that hopelessness can be differentiated into a sense of being unloved/unlovable and that through the articulation of an unmet need (e.g., to be loved/accepted), the client may access adaptive experiences of feeling loved or deserving whilst also grieving for the times when that connection was not available.
Structured Interviews on Research, continued

“While traditional continuing education is focused on models, and clinical consultation is usually focused on clients, Deliberate Practice is focused squarely on the unique developmental path of each therapist.”

Tony Roussmaniere

1. Psychotherapy research seems to point towards a greater variability in outcomes between therapists than therapies. How can this research on “therapist effects” inform clinicians and their real-world practice?

This research could help guide clinicians towards more effective clinical training. Traditionally, clinical training has focused largely on learning new treatment models, without much consideration for first assessing each therapists’ individual strengths and weaknesses. While treatment models are valuable, they are best learned in the context of each therapist’s personal growth edge: interpersonal skills and psychological capacity just beyond the therapist’s current ability. For example, can you imagine putting 20 random people through a marathon training without first assessing each person’s fitness? The focus on the individuality of the therapist can build on the finding of therapist effects and add an important dimension to clinical training. While traditional continuing education is focused on models, and clinical consultation is usually focused on clients, Deliberate Practice is focused squarely on the unique developmental path of each therapist.

2. How can the field of psychotherapy integration, specifically, benefit from recognition of the importance of therapist effects?

The field of psychotherapy integration can benefit by increasing the research focus on what leads some therapists to be more or less effective than others. Which clinical skills or personal attributes impact clinical outcome the most? When these are identified, we can then do research more precisely targeted clinical training. This same plan could also be done for supervisors.

3. Funding for psychotherapy research has generally gone for the study of particular models applied to the treatment of specific disorders. Meanwhile, much of the research suggests that who provides the treatment is more important than which treatment is provided. Going forward, what can research programs do to deal with this tension?

Researchers conducting clinical trials of models should assess therapist effectiveness before doing their clinical trials, and this data should be used to screen which therapist to include in clinical trials. For example, there could be a clinical trial for CBT or psychodynamic therapy for therapists who have been found to have low, medium, or high clinical effectiveness. Screening therapists will help researchers customize the clinical training provided in trials, and also lead to more valid and generalizable findings regarding which practicing clinicians will benefit from those models. I personally think we should aim for more effective clinical training for therapists at the lower and mid-range of the effectiveness curve, as that could benefit clients the most.

4. Speaking of funding, would you rather be doing psychotherapy research in Europe or in the US, and why?

I haven’t been involved in grants yet.

Continued on page 19
5. In your opinion, of relatively recent research findings, what are the most important for clinicians?

One promising new trend in research is studies that examine trans-modal therapist characteristics. For example, a few recent studies have suggested that trainees’ and therapists’ interpersonal skills and self-reflective functioning are associated with better clinical outcomes (e.g., Anderson, McClintock, Himawan, Song, & Patterson, 2015; Cologon, Schweitzer, King, & Notle, 2017; Schöttke, Flückiger, Goldberg, Eversmann, & Lange, 2016). This raises the exciting possibility that trainees and therapists may be able to improve their interpersonal skills and self-reflective functioning through the use of Deliberate Practice. This would be a therapist-focused method of clinical training, and may more reliably improve clinical outcomes, when compared to a model of training that focuses primarily on treatment models.

References

SEPI Questionnaire on Research

Alexandre Vaz

Ladies and gentleman, it’s time for us to continue our (very recent) tradition here at the Newsletter and present our newest Survey results! The many answers we got from SEPIans from all over the world truly highlight what a diverse bunch our dear community is. We asked you on psychotherapy research and its impact, and we got practically every psychotherapy topic represented plus the kitchen sink! You can now browse through all the survey answers in our archive.

[Research Survey Link]

To open your integrative appetite, feast your pluralistic mind on the answers provided by SEPI’s most senior member, the inimitable Zoltan Gross:

Q1 — What research findings, if any, have made you rethink or significantly reconsider previous ideas you held on psychotherapy practice?
Research on the importance of the therapeutic alliance and on the fact that some therapists are better than others. Both of these have had an impact on psychotherapy and more research on these variables should be done.

Q2 — What research findings have most influenced your thinking on how to improve as a therapist?
None that I know of.

Q3 — What researchable question on psychotherapy would you most like to see addressed (or be addressed more thoroughly)?
Much more research on the emotional intelligence of therapists is needed.

Q4 — If you are a researcher, what is your top priority or suggestion in order to make the research field more relevant for real-world clinical practice?
The different metatheoretical languages of research and clinical practice needs integration.

Q5 — Please identify yourself and year of graduation (unless you wish to remain anonymous).
Zoltan Gross, Ph.D. 1952
SEPI XXXIV
ANNUAL MEETING
New York, New York, USA
May 31 – June 2, 2018
www.sepiweb.org

Drawing on Multiple Theories and Methods to Enhance the Integration of Psychotherapy Practice and Research

The 34th Annual Conference of the Society for the Exploration of Psychotherapy Integration will be held in New York City, Thursday, May 31 – Saturday, June 2, 2018, with pre-conference workshops on Thursday morning.

The Conference will be held at the New York Marriott Downtown (Battery Park).

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Join us in New York City—the largest and most exciting city in the US—for what promises to be an stimulating and interesting program of learning and fellowship.