A Word From the Editor

Jeffery Smith

Dear Readers,

Once again the Annual Meeting in New York City was exhilarating and heart warming. I hope you savor this year’s photo essay as a reminiscence for all who were there, and a temptation for those who were not. Thanks especially to the many attendees who contributed photos, especially Hilde Vleugels, a talented artist and winner of this year’s Photo Contest.

But there is much more to this issue than images. The last symposium in the Grand Ballroom, organized by Paul Wachtel was the highpoint for me. The Integrative Therapist asked the presenters from the symposium to contribute written versions of what they said. Reading their contributions, as well as one from Bruce Ecker, I hope you will agree with Marvin Goldfried that “the corrective experience may be a principle of change about which we can agree.” Amen To me this is exactly Marv’s “mid level abstraction between theory and technique” around which SEPI can build a truly integrative way of thinking about psychotherapy. Don’t miss these great articles.

Our next issue is scheduled for September on training and education. Please think about what you might want to contribute.

Jeffery Smith

President’s Column

Stanley Messer

Dear SEPI Members,

Having just experienced the SEPI conference that took place in New York City May 31-June 2, 2018, I would like to offer my reflections on it. I have also reviewed the contents of a survey about the conference conducted by the editors of the Newsletter and will present some of the respondents’ reflections.

In terms of attendance, the conference was a great success, with 396 attendees from 23 countries. Both numbers are considerably above average, especially for a North American SEPI conference. Because of the large number of submissions, only 60% could be accepted despite there being seven simultaneous presentations in each time slot (except for the three plenaries), in addition to the two 40-poster sessions. When people complained to me that there were such difficult choices to be made as to which session to attend due to their attractiveness and high quality, I suggested that they be sure to come back next year to hear those presenters whom they missed this year.

The NYC venue was certainly an important part of the big draw, but the excellent...
From Our New Associate Chair of the SEPI Regional Networks

Doménica Klinar Alfaro
Psychotherapist in
Buenos Aires, Argentina
Aiglé Foundation

Dear SEPI colleagues,

As someone who is passionate about her career not only as a Psychotherapist, but as teacher and researcher, I am very honored to be co-chair of the RN Committee, and have the chance to work with Tom Holman, who I believe is very committed to his job and motivated. I am sure I will learn a lot working with him.

In this year’s SEPI Conference, I had the chance to meet people from different countries, and share ideas about integration in Psychotherapy. It was very nice to see so many countries represented, and be able to listen to what they are doing regarding integration in their countries. It is so important for different countries to be represented and to share how they teach, work and think about integration.

This type of exchange allows technical knowledge and learning from experiences not only from the scientific point of view, but also from different culture’s outlook. In order to psychotherapy keep growing, the possibility of sharing research outcomes and both clinical practice and training experiences is fundamental, and this year’s conference was a great example of the developments in our field.

I look forward to working with different Regional Networks, and I am thrilled to be part of the SEPI Family.

NEW YORK 2018, A PHOTO REMINISCENCE

Jeffery Smith

SEPI members and friends came to New York for the Annual Meeting from all over the world. Some of us took the train from the suburbs. Photo by JS

Continued on page 4
program, so ably planned and executed by Daniel Fishman and assisted by Alexandre Vaz, was another key factor contributing to its success.

From what I could tell, there were four major theories represented: psychodynamic, cognitive-behavioral, experiential/emotion-focused, and couples and family systems; and various combinations or integrations thereof. Within these domains I discerned some distinctive groupings or emphases:

1. Experiential-dynamic therapy, which encompasses short-term dynamic psychotherapy, accelerated experiential dynamic psychotherapy, and affect phobia therapy.
2. Unified theory, which ranges over the biological, psychological, social and cultural domains in an effort to bring them together under one conceptual roof.
3. The important clinical and research knowledge contained in the single, systematic case study; and the associated role of case formulation, which focuses on individualizing therapy. It typically draws upon more than one theory in conceptualizing a client and his or her associated treatment plan.
4. Interpersonal theory and therapy from an integrated perspective.
5. The area of training and supervision with an integrative slant, which was also represented this year in a pre-conference workshop.

Turning to the survey, to date there are 30 responses, some of them from students. Thanks to Jeffrey Smith and Alexandre Vaz for conducting and collating the survey and making it available to me. Here are the redacted comments:

1. Great appreciation for videos and a wish for even more of them.
2. Liked the spirit of open discussion across both theoretical models and generations of therapists.
3. Sessions were open, flexible and accessible; congenial spirit.
4. A need for more audience discussion, perhaps limiting sessions to three speakers.
5. A need for more processing time between sessions.
6. Case study presentations were a highlight for some.
7. Feeling a strong sense of belonging as an integrative therapist was invaluable and intellectually stimulating.
8. People attending for the first time finding a home for their integrative outlook.
9. Appreciation for the sessions/workshop on technological advances in clinical practice.
10. A request for a session for newcomers to meet each other and get oriented to SEPI and the conference.
11. There should be a time set aside to meet in small groups with colleagues to process the sessions and to get to know each other.

And from another informant, conveyed to me by email: “Every presentation that I attended was engaging, informative and collegial. The warmth and energy of the conference reflected the spirit of SEPI. I left the conference with a sense of momentum that I would like to see built upon as we look forward to next year’s conference in Lisbon.”

And to that I say, Amen    😊
For many, Grand Central is the portal to New York City. Photo by JS

The first day, it was rainy and tall buildings were shrouded in mist. Photo by JS

But most coped with jet lag from their cozy hotel rooms. Photo by Eduvigis Cruz-Arrieta.
When registered, Tracey’s crew gave out this year’s cool SEPI bag. Photo by Hilde Vleugels.

One of many Plenary sessions. Photo by Eduvigis Cruz-Arrieta

Dan Fishman, the Program Chair (left) introduced John McLeod for the keynote how “Systematic Case Studies Can Enhance Integration in Psychotherapy.” Photo by Eduvigis Cruz-Arrieta

Tahir Ozakkas was here as always, reminding us of the importance of the regional networks and of to what extent psychotherapy integration is international. Photo by JS
Stanley Messer, President, speaking from the audience.  
Photo by Hilde Vleugels.

Gregg Henriques spoke on the nature of depression.  
Photo by Hilde Vleugels

Stephen Holland gave a case presentation: The client says, “The bottom line is you suck at conversation.”  
Photo by JS
Under the guidance of Jack Anchin, trainers and trainees spoke of their experience. (left to right, Alice Coyne, Rachel Hershenberg, Edward Watkins, and Christopher Fisher).

Photo by JS

And here’s Jack Anchin, guiding the session. Photo by JS

Timothy Anderson on Facilitative Interpersonal Skills.

Photo by Hilde Vleugels
Alexandre Vaz and Nuno Conceição shared their energy with attendees after their talks.  
**Photo by JS.**

Hilde Vleugels of Antwerp was the one who took up the invitation to try her hand at street photography. Her artistry won her first prize in the photo contest. Following are some of her works.

**Contest Winning Photo:** Look closely, this is actually a selfie of Hilde. The atmosphere it captures is amazing. All three judges, Art Bohart, Ken Critchfield, and Pamela Li Vecchi, the Winner in Dublin, agreed unanimously that this was the top contest entry.
NYC Street photo #4
by Hilde Vleugels

NYC Street photo #5
by Hilde Vleugels

Ken Barish added atmosphere to the Welcome and Poster Session with his trumpet and band. Photo by JS.
Franz Caspar of Bern.  
Photo by JS.

Daniel Baumruk,  
Czech Republic.  
Photo by JS.

Patrick Love.  
Photo by JS.

John Norcross deep in conversation with Christoph Flückiger.  
Photo by JS.
Poster sessions with wine and music are much more fun. Photo by JS.

James Boswell & Paul Crits-Christoph, leaders in the research community. Photo by JS.

Josephine Ibisagba. Photo by JS.

Shigeru Iwakabe & David Kealy. Photo by JS.
Grainne Martin Ward, Marcella Finnerty, and Frankie Brown of Dublin. Photographer unknown

Does it look like Greek? Coding symbols from Cyprus by Kyriakos Platrites. Photo by JS.

Caroline Gooch & Matthew Perleman. Photo by JS.

For all who wonder about the inner workings of SEPI, this leaked photo shows Stanley Messer opening the annual in-person meeting of the Executive Council. Photo by JS.
Catherine Eubanks, President Elect and Kristin Osborn, Secretary at the Executive Council Meeting. Photo by JS.

Beatriz Gómez receives the Arnkoff & Glass Award for Regional Network of the Year. Photo by Tom Holman

After long days, some went out to photograph New York at night. Photo by Eduvigis Cruz-Arrieta
Always near, the World Trade Center.  
Photo by Eduvigis Cruz-Arrieta

And back to the work of learning yet more. Paul Crits-Cristoph presents. 
Photo by Eduvigis Cruz-Arrieta

Paul Wachtel and Laurie Helgoe, who provided this image.
Beatriz Gómez with members of the Buenos Aires contingent. Doménica Klinar Alfaro on the right is the new associate chair of Regional Networks for SEPI. Photo supplied by Doménica Klinar Alfaro.

Theodore Ellenborn came with members of his group, Alicia MacDougall, Jordan Stewart, Rosie DeVincentis, Monique Bowen, Nancy McWilliams, Chad Lazzari. Photographer unknown.

Three World Financial Center. Photo by Eduvigis Cruz-Arrieta.

Doménica Klinar Alfaro was up early sightseeing from the Brooklyn Bridge
One World Trade Center,
Photo by Eduvigis Cruz-Arrieta

The World Trade Center Memorial,
Photo by Arthur Bobart

And a shot of the Trinity Church on Wall Street. Photo by JS.
Sometimes we just needed to sit down and relax.
Photo by Tom Holman.

Kyriakos Patrites, Cyrus; Angelo Compare, Italy; Tahir Ozakkas, Turkey; Gulsum Ozakkas, Turkey.
Photo by Tom Holman.

Stephen Holland speaks with Robert Leahy on the left and Paul Wachtel on the right.
Photo by Eduvigis Cruz-Arrieta.
To me this session on the corrective emotional experience summed up the conference. The articles in this issue of The Integrative Therapist tell the story. Giorgio Alberti, Paul Wachtel, Marvin Goldfried, Diana Fosha, Photo by Eduvigis Cruz-Arrieta

And finally, it was time for the Gala.
Photo by Eduvigis Cruz-Arrieta
The Gala was a joyful and tasty event. Photo by Martina Belz

Hilde Vleugels put her street photography skills to work to capture yours truly, Jeffery Smith
On the Corrective Emotional Experience

Giorgio G. Alberti
Milan, Italy

I not only believe that corrective experiences (CE) are essential change factors in most or even all psychotherapies, but I also maintain that in order to promote change they should be facilitated as much as possible, and that integrative psychotherapy is the best way to do that.

Since Alexander’s original proposal, important progresses have been made not only in discovering CEs embedded in diverse therapies (Alberti 2012; Castonguay & Hill 2012), but also in highlighting new ways for bringing about ECs by stimulating the patient in different ways.

The traditional view of the corrective experience

According to the traditional conception, as formulated by Alexander in 1946, CEs are brought about by the disconfirmation of maladaptive expectations generated by dysfunctional aspects of the patient’s personality. Dysfunctional expectations, on their turn, regard either the therapist, whom the patient perceives on the basis of previous (mostly negative) experiences, i.e. transference, or somebody in the outside world who, inadvertently or not, does not confirm them.

In this perspective CEs come up spontaneously and unpredictably. The therapist, or the person outside therapy, is mainly passive. The therapist has to wait until CEs come up. CEs don’t refer to the patient but to another person, thus being relational phenomena.

Extension of the conception of corrective experience

In the last decades clinical experience and research have extended the conception of CEs in the following directions. The first pertains to how CEs are generated in psychotherapy. As Goldfried (2012) hypothesized, the global CE regarding the therapist and differentiating him from projected inner representations, results from repeated disconfirmed expectations - I called “micro-CEs” - cumulating in time, reciprocally confirming each other, until the patient has sufficient confidence that the therapist is no new version of somebody from his past.

This has been rigorously shown by the San Francisco Group, whose therapist’s “pro-plan responses” disconfirming patients’ dysfunctional cognitions, are identical with “micro-CEs”. Explaining his theory, Weiss (1993) writes “… that the patient seeks corrective emotional experiences through his testing, and that the therapist should provide the patient with the experiences he seeks” (p. 23).

Confirmation of this summing up of “micro-CEs” in therapy came recently from Ecker’s (2012) studies on memory reconsolidation, a process consisting in the temporal association of a (usually unpleasant) memory and an emotionally intense disconfirming actual experience. In this case too, disconfirmations should be repeated in order to bring about a permanent therapeutic effect.

The other extension of the concept of CE is that it can be promoted by certain interventions, instead of being waited for according to its unpredictable “popping up”.

Actively Promoting Corrective Experiences in Integrative Therapy

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Actively Promoting Corrective Experiences in Integrative Therapy

Giorgio G. Alberti
Milan, Italy
On the Corrective Emotional Experience (continued)

One way is advising the patient to behave in a more adaptive manner. Cognitive-behavioral clinicians (Castonguay et al. 2012) have observed CEs arising when the patient discovers that by changing behavior something unexpected happens, modifying his/her self-with-other image. The second direction in promoting CEs regards intervening on the patient directly in session, which can happen in three different ways.

First, as anticipated by Alexander (1950), by adopting a suitable attitude, differing from the patient’s expectation as well as from how significant persons in his/her past behaved. The usefulness of this type of intervention has been confirmed by other psychodynamic clinicians, as e.g. Wachtel (2008).

Second, by promoting previously avoided emotional experiences, whose intense perception equals the discovery of a denied aspect of self, disconfirming a long adhered to representation of the patient’s self. Usually this process is activated by experiential therapist, like Davanloo (1978), Fosha (2000) and Greenberg (2002).

Third, CEs can be brought about by confronting the patient on incongruences in the very moment they come up in session. By making him/her aware of contradictions between statements, between statements and feelings, between declared feelings and bodily expressions etc., the therapist unveils his/her inconsistent self-representation (Safran & Segal 1990; Golden 1978).

It should be noticed that the last two ways for promoting CEs are different from that intended by Alexander, inasmuch as they don’t regard the therapist but the patient. Although the final result is the same - a change in the relational scheme of “self-with-other” - the process bringing to this result is more immediate and unquestionable.

Implications of the extended conception of the corrective experience

A first implication is that the new ways for promoting CEs allow overcoming the traditional limits of therapist passivity and of CEs’ indefinite latency and unpredictability. This implies that the therapist can better guide and modulate the change process.

To this end it is better to dispose of an ample array of techniques. As the new ways for promoting CEs correspond to techniques of different origins, dynamic, experiential, cognitive, behavioral, integrative psychotherapy is the best approach for promoting CEs with different patients, maladaptive patterns, and situations.

An hypothesis

I have the impression that CEs aroused by actively disconfirming expectations in session have a more intense and rapid effect than CEs occurring spontaneously during the whole therapy course.

The reason for their higher intensity could be that such CEs directly touch patients’ feelings, behaviors, and thoughts, not being mediated by the perception of another person sitting across or probed by the patient. Higher intensity experiencing could also explain why just one or a few such «micro-CEs» can be sufficient for changing maladaptive functioning.

In order to show the effect of single micro-CEs in session I chose the following case example, in which two interventions, made already in the 3rd session, i.e. the promotion of emotional experiencing and the affect-laden simulation of an action contrasting a dysfunctional habit, brought about a CE within less than one hour.

Livia’s Case

Livia, a medical student aged 33, had problems with her mother, 52, a picture restorer with a borderline personality disorder: egocentric, stubborn, intolerant and possessive, she had rage outbursts whenever Livia didn’t follow her advice. It soon became clear that Livia emotionally complied with her mother’s aggressions, while inhibiting adequate self-protective reactions. By promoting emotional experiencing the therapist evoked her denied healthy aggressiveness, then inviting her to simulate with him how to tackle her mother’s aggressions. These interventions were followed by Livia spontaneously imagining to “press mother’s head on a table”, a fantasy she interpreted as the will to stop her raging mother and to become independent. This was a turning point: in the following months Livia progressively grew in autonomy, acting more and more freely and independently.
On the Corrective Emotional Experience (continued)

References


Is there a Consensus that the Corrective Experience is an Agreed-Upon Principle of Change?

Marvin R. Goldfried
Stony Brook University

Since co-founding SEPI with Paul Wachtel in the early 1980s, my hope has been that we would be able reach a consensus about how therapy works—a consensus that not only cuts across theoretical orientations, but is also supported by both clinical observation and empirical research. I am beginning to get a sense that the corrective experience may be a principle of change about which we can agree.

Some years ago (Goldfried, 1980), I suggested that a fruitful way in which we might find commonalities across the three major orientations—psychodynamic, behavioral/cognitive behavioral, and experiential/humanistic—might be to look for common principles of change. Rather than comparing the theories associated with these orientations or the techniques involved in each, there might exist common principles that could be found at a mid-level of abstraction between theory and technique. In searching the clinical literature within different theoretical approaches to therapy, it became evident that some commonalities reflecting the corrective experience could be found.

“I am beginning to get a sense that the corrective experience may be a principle of change about which we can agree.”
For example, the psychoanalyst Otto Fenichel (1941), on the topic of fear reduction, noted that:

“When a person is afraid but experiences a situation in which what was feared occurs without any harm resulting, he will not immediately trust the outcome of his new experience; however, the second time he will have a little less fear, the third time still less” (p. 83).

Albert Bandura (1969), using very different language in describing a behavioral orientation, reached the very same conclusion:

“Extinction of avoidance behavior is achieved by repeated exposure to subjectively threatening stimuli under conditions designed to ensure that neither the avoidance responses nor the anticipated adverse consequences occur” (p. 414).

Within an experiential approach to therapy, Polster and Polster (1973) spoke about the importance of having clients experience change through “directed behavior,” the goal of which is to provide the client with

“the opportunity for relevant practice in behaviors he may be avoiding. Through his own discoveries in trying out these behaviors, he will uncover aspects of himself which in their turn will generate further self-discovery” (p. 252).

Having different theoretical assumptions and using different techniques, these three examples reflect a common principle: the corrective experience—where they suggest that having clients doing something that they may have been avoiding can be therapeutically helpful.

The concept of the corrective emotional experience was introduced some years ago by Alexander and French (1946), who shocked their psychoanalytic colleagues by suggesting that there can be instances where patients could change even if they had not resolved their underlying conflicts. Alexander and French were referring to the healing quality that existed between therapist and patient, whereby a more accepting and understanding therapist could provide patients with an experience unlike what they may have had earlier in life, indicated that the nature of the therapeutic interaction in and of itself may contribute to change. Although they called this a “corrective emotional experience,” it was also cognitive and behavioral as well. Rather than referring to it as the “corrective-emotional-cognitive-behavioral experience, the short-hand term “corrective experience” seems to be less cumbersome.

Practicing therapists can detect the presence of a corrective experience as occurring during breakthrough events a client may have during the course of therapy. This happens when clients are in a situation where they have anticipatory thoughts and concerns, expecting that if they said or did something, things would not turn out well. However, upon taking a risk and doing what they had typically been avoiding, their unrealistic expectations were not forthcoming. In fact, the outcome might be positive, allowing them to get what they wanted and experience a positive feeling about themselves.

In an edition of the journal Cognitive Therapy and Research that dealt with commonalities across different theoretical orientations, (Brady et al., 1980), a diverse group of well-known therapists of different orientations acknowledged that the corrective experience was a core principle of change. Thus, such therapists as Brady, Davison, Dewald, Egan, Frank, Gill, Kempler, Lazarus, Rainy, Rotter and Strupp described these new experiences from within their varying orientation as being “essential,” “basic,” “crucial,” and “critical.”

Depending upon one’s particular theoretical orientation, the method for implementing a corrective experience might vary. For a relationally oriented therapist, the corrective experience might consist of the interaction with the therapist. The between-session exposures encouraged by CBT therapists with fearful clients is a different way in which the corrective experience may occur. And regardless of orientation, the successful resolution of an alliance rupture between client and therapist can be corrective in nature, indicating that relationships can continue, even after a disagreement has occurred.

Whatever the specific method of bringing about the corrective experience, it represents an important principle of change. The importance of corrective experiences has not only been recognized by therapists. As Eleanor Roosevelt,
On the Corrective Emotional Experience (continued)

who grew up shy but became an outspoken force for human rights once indicated: “You must do the thing you think you cannot do.” For a more detailed discussion of the corrective experience from a theoretical, clinical, and empirical point of view, see Castonguay and Hill (2012).

Other common principles of change can be found across different orientations. Indeed, common principles, rather than the more abstract theoretical orientation or specific techniques, is where we may find consensus across schools of therapy. The rationale for this has been stated elsewhere:

“To the extent that clinicians of varying orientations are able to arrive at a common set of strategies, it is likely that what emerges will consist of robust phenomena, as they have managed to survive the distortions imposed by the therapists’ varying theoretical biases” (Goldfried, 1980, p. 996).

As suggested above, the specific interventions used by these different orientations for implanting a principle of change may differ, and which method is more effective might be thought of as an empirical question. Thus, general principles of change may be used as a starting point for research efforts—and also as general guidelines for clinical training and practice.

In looking at the middle level of abstraction between the theoretical explanations of different approaches to therapy and their specific clinical techniques to find commonalities, it may be possible to identify the following principles of change:

1. Expectation that therapy will help and having motivation to change
2. Presence of an optimal therapeutic alliance
3. Helping patients become better aware of themselves and their world
4. Encouraging corrective experiences
5. Facilitating ongoing reality testing

A discussion of how these principles operate in clinical practice, and how they can facilitate the therapeutic case formulation, may be found elsewhere (Eubanks & Goldfried, in press).

References (Complete set of references available from author)


On the Corrective Emotional Experience
(continued)

The rejection of Alexander’s concept of the corrective emotional experience was likely the single biggest misstep in the history of psychoanalysis, and it took decades for psychoanalytic thinkers and therapists to recover. There were many reasons for this rejection—some, according to various accounts, having to do with Alexander having had an abrasive personality, some related to the politics and economics of psychoanalysis at the time, some related to an ideological commitment to insight as the crowning glory of the psychoanalytic method and hence to an aversion to Alexander’s point that insight often follows change, that it was the icing rather than the cake.

A more serious critique had to do with ways in which Alexander could be read as “manipulating” the patient, as taking a stance counter to that of the parents in a simplistically mechanical way rather than as an organic outgrowth of the relationship and the perception of the patient’s needs. But as the presentations by my fellow panelists make clear, that is not a necessary implication of the concept. Most ideas in our field need to be refined over time. As Erik Erikson said about Freud’s libido theory, “True insight survives its first formulation.” Part of the rigidity of the psychoanalytic establishment was that even as they repeatedly argued for increasingly sophisticated understandings of the essence of Freud’s ideas, they insisted on a static, literal and constraining understanding of Alexander’s as a justification for their continuing rejection of his dangerous heresy.

As my fellow panelists highlight in different ways, deep therapeutic change depends not so much on what is put into words as what is learned in a directly experiential way. This does not make words and verbal learning irrelevant. Psychotherapy remains in important ways “the talking cure.” Even in the vast majority of cognitive-behavioral therapies, if one looks at what is going on, the two people are talking. Human linguistic capacities are not checked at the door of the consulting room like guns in the saloons of some western movies. Those capacities are essential to even identify and define the nature of the problems to be addressed. They are essential to establishing the relationship that is at the heart of the corrective emotional experience. And they help consolidate and extend the largely nonverbal emotional and relational learning that the corrective emotional experience generates. But it also the case that both in traditional psychoanalytic practice (especially in the older versions that preceded contemporary more relational models) and in aspects of cognitive therapy, there is an overemphasis on and an overvaluation of words. Put differently, both place too much emphasis on declarative, explicit learning and insufficient emphasis on procedural or implicit learning (which contemporary neuroscience shows us constitutes the vast preponderance of what our brain does).

But it is essential to be clear that the learning is not only procedural but contextual. We rarely learn lessons that apply everywhere and at all times. Put in the terms of learning theory, both stimulus generalization and stimulus discrimination are universal attributes of any successful species. Without being able to generalize something learned from the specifics of the context in which it is originally learned to a broader set of cues, learning will be ineffective and of little use, and adaptation becomes almost impossible. But species that survive are also able to discriminate between situations, to learn where opportunities are present or absent and where it is safe or unsafe. Without that ability, survival for very long is also impossible. But many approaches to psychotherapy—in virtually all the major theoretical orientations—are problematically overweighted toward generalization. They implicitly assume that the relearning that occurs in the session will automatically be applied throughout the person’s life space. In essence, they assume that the relearning is context-free, that when the patient has had a deep and powerful disconfirmation of problematic assumptions in relation to the therapist, that lesson will now be applied in all contexts and all relationships. What gets short shrift is the importance of corrective emotional experiences with people other than the therapist—and the range of further therapeutic efforts and skills required to ensure that this happens.
On the Corrective Emotional Experience (continued)

There are several reasons why it is easy to lose track of the importance of this dimension of the change process. To begin with, in recent years, it has become increasingly apparent that the therapeutic relationship in itself is a key element in therapeutic change. In formal studies, it often accounts for more of the variance in whether change occurs than does the therapist’s theory or the specific techniques used. In addition, the experience with the therapist in the room is particularly vivid, and so easier to track, notice, and work with. And in recent years important concepts such as Safran and Muran’s conception of rupture and repair in the alliance and the Boston Change Process Study Group’s work on now moments and moments of meeting have further illuminated how events transpiring in the therapeutic relationship can have a direct impact on therapeutic change.

But more fundamentally, these and related developments point to not only the importance of the therapeutic relationship per se but of the relational nature of personality more generally. Our personality is not monolithic or just “in our head.” We experience ourselves differently in different relational contexts. We are not like machines needing to be structurally repaired and then simply able to leave the shop and function. We are sensate, interacting, meaning-making creatures, and our experience must always be understood in relation to the people and events that inhabit and define our lives. When we conceptualize change as deriving substantially from corrective emotional experiences, rather than exclusively from insights or cognitive restructuring, we are building on that relational foundation.

When we learn, from interactions with the therapist, that things can be different, we have learned a relational lesson, a contextual lesson. And more often than is appreciated, the (unverbalized) lesson ends up as “wonderfully, in here it is safe to be myself, to express my deepest yearnings or my most unpleasant thoughts or demands; but outside of this room things remain as they were.” The therapist may be struck by the vivid evidence of the patient changing right before her eyes, and this shiny object may obscure that in the rest of the patient’s life he remains largely the same. The discrimination the patient makes between the “safe” confines of the consulting room and the “not so safe” contexts in the rest of his life can lead him to act outside the room the way he always has—and thus to evoke the same responses from others, and thereby to “prove” to himself (again mostly without words, or even focal awareness) that what happens in the consulting room is different from what happens in the rest of his life. The self-perpetuating vicious circles in the patient’s daily life must be interrupted and modified if the change the patient entered therapy to achieve is to become an enduring reality in his life. What happens with the therapist is a crucial part of the process; but working to ensure that corrective emotional experiences occur with others as well is the key to generating the change for which the patient has come in the first place.

Memory Reconsolidation Research Confirms and Advances the Corrective Experience Paradigm

Bruce Ecker

For adherents of the corrective experience paradigm, the findings of memory reconsolidation research by neuroscientists might seem too good to be true. That research, launched in 1997–2000, has developed explosively since I began closely studying it in 2005. According to some of the clinical field’s longstanding, ingrained assumptions about change, these lab findings aren’t even possible.

For example, Hebb’s law—“neurons that fire together, wire together”—underlies the assumption that in order for healthy new beliefs, behaviors and states of mind to replace old, unhealthy ones, it’s absolutely necessary to enact repetitions of the new pattern for months. The preferred new pattern competes against the unwanted pattern, which remains retriggerable and retains its own memory encoding. The myriad repetitions build up the preferred new pattern to win that competition.
On the Corrective Emotional Experience (continued)

That’s what I term the counteraactive process of change. It requires the ongoing effort of choosing and enacting the preferred pattern. However, a decisive, stable change proves elusive through this counteraactive process, as therapists know too well. Relapses occur because the old, unwanted pattern is rooted in potent, subcortical emotional learnings that are influenced little, if at all, by the preferences of the neocortex (the conscious personality).

Therapists also know—because we have witnessed it in clients and in ourselves—that a very different process of transformational change exists, manifested as three unambiguous markers: a long-term pattern of distress or problematic behavior completely ceases to occur in the situations that had reliably evoked it; the accompanying emotional activation or distressed ego state likewise disappears; and those two changes persist permanently and effortlessly. This liberating, relatively sudden shift brings unprecedented well-being.

The corrective experience (CE) paradigm is essentially the quest to identify the critical ingredients and process that produce such transformational change. What could be more important to the psychotherapy field than fulfilling that quest, enabling therapists everywhere to produce such results with regularly?

Alexander and French first gave that quest firm form in 1946 and, based on clinical observations, identified specific factors for inducing transformational change. Then Goldfried in 1980 recognized the universality of those specific factors across therapy systems and also across all experiential channels, beyond the “emotional” channel emphasized in 1946. Many others have continued to develop the CE paradigm.

Transformational change clearly is not governed by Hebb’s law. What is the neurological mechanism of change that does govern it, and what induces that process?

We now have empirical answers to those key questions. Memory reconsolidation is the brain’s innate process for transforming what was previously learned and is now carried in memory. In particular, it allows a target emotional experience of the reactivated target learning, plus an experience of perceiving that the world is not as the target learning knows and expects. That combination of experiences is referred to as memory mismatch and also as ‘prediction error’ by neuroscientists.

Nearly a century of extinction research appeared to show that wasn’t possible. Researchers finally happened to do exactly what the brain requires for neurochemically changing the neural encoding of an emotional learning from its stable, “consolidated” state in long-term memory, to a destabilized, de-consolidated, labile state that is susceptible to immediate re-encoding by a contradictory, disconfirming experience.

However, if the target learning is not in a de-consolidated neural state when the disconfirming experience occurs, there is no re-encoding of the target learning. Then the contradictory experience merely creates its own separate encoding and competes against the unwanted target learning. Sound familiar? Yes, that’s counteraactive change, and that’s why guiding our clients to learn and build up preferred states, beliefs and behaviors tends to be only counteraactive and is not a reliable pathway to transformational change.

The discovery of an innate process of de-consolidation was an upheaval in the neuroscience of learning and memory. It was found that the de-consolidated state lasts for about 5 hours, after which the neural encoding re-consolidates automatically. That’s why this process was named memory reconsolidation (MR).

It took neuroscientists four more years, until 2004, to identify the specific experiences required by the brain for triggering de-consolidation. The MR process is neurological, but it is experience-driven, controlled in a top-down manner by behavioral experiences. It was Héctor Maldonado’s group in Argentina that first demonstrated, in an animal study, that de-consolidation is triggered by the simultaneous occurrence of two subjective experiences: the experience of the reactivated target learning, plus an experience of perceiving that the world is not as the target learning knows and expects. That combination of experiences is referred to as memory mismatch and also as prediction error by neuroscientists. De-consolidation is almost immediate after mismatch occurs. The mismatch requirement was subsequently confirmed many times (see references online: https://bit.ly/2b8lHuH). Those studies decisively falsified the pre-2004 notion that de-consolidation occurs from reactivation alone, and from every reactivation. That misconception still shows up in the literature.

Do these lab findings apply to psychotherapy? The fact is, the necessity of a mismatch experience for inducing
On the Corrective Emotional Experience (continued)

transformational change was detected by psychotherapists long before neuroscientists recognized it: The both-at-once experience of the reactivated target learning and a disconfirmation of it is a specific ingredient called for by Alexander and French. Now we have rigorous, empirical confirmation of that requirement from brain science.

We call it a juxtaposition experience in Coherence Therapy, which I co-developed with Laurel Hulley for focusing from the first session of a new client on facilitating juxtaposition experiences with efficiency. We and colleagues in the Coherence Psychology Institute have published many case examples showing the three markers of transformational change ensuing from juxtaposition experiences, for a wide range of presenting symptoms (references listed at https://bit.ly/2tKX0yX). Neuroscientists regard those three markers as strong evidence that MR and erasure have occurred. In many cases, powerful, lifelong emotional learnings completely wither immediately, sometimes as early as the client’s first or second session. In other cases, the target learning does not immediately lose all force in response to a juxtaposition experience because it is entangled with other potent schemas not yet disconfirmed.

From extensive clinical experience with this process, it’s clear to us that the brain is always equipped for unlearning and nullifying its longstanding, negative emotional learnings. That is an innate, profound resilience. The fact that target learning reactivation is required explains why emotional arousal has been found to have a strong, positive correlation with effective therapy: While not all of a person’s implicit learnings are emotional, the ones involved in therapy almost always are, so reactivation naturally entails experience of that accompanying emotion. The task of skillfully guiding the emotional process can therefore loom large in therapy, even though the MR process does not itself inherently involve or require emotion, as shown in many lab studies using non-emotional target learnings.

To utilize the potency of MR, therapists have to meet the brain’s requirements by facilitating a disconfirmation that is both experiential and highly specific to the client’s unique target learning. Specificity of disconfirmation is critical. That’s another key guideline for therapists. For example, the therapist’s empathy and kindness can disconfirm the emotional learning maintaining a client’s symptom if that emotional learning was created by interpersonal mistreatment, but not otherwise; and not every type of interpersonal mistreatment creates learnings disconfirmable by a client-therapist relationship. In Coherence Therapy we’ve mapped out a methodology for finding potent disconfirmations of any target learnings.

It is momentous that the psychotherapy field now has an empirically confirmed process of erasure (ECPE), the set of specific experiences that the brain requires for transformational change. The ECPE is defined transtheoretically and independently of any procedures or methods for inducing those experiences. No type of therapy is privileged (though not all facilitate the ECPE equally). We’ve been examining case examples of transformational change from diverse therapy systems and have found that the steps of the ECPE are detectable in every case scrutinized so far (ten different systems; see https://bit.ly/15Z00HQ). In that way, support is building for our hypothesis that the ECPE is always the cause of transformational change and unifies the panoply of psychotherapies.

Also, by providing empirical confirmation that specific factors are necessary for transformational change, the MR findings are a direct refutation of non-specific common factors theory. That does not mean non-specific factors are unimportant for effective therapy. The point, rather, is that transformational change results from certain specific factors required by the brain.

A comprehensive, rigorous account of all this good news and more is provided in my recently published journal article, “Clinical Translation of Memory Reconsolidation Research,” downloadable here: https://bit.ly/2Mmmvg1.

“From extensive clinical experience in this process, it’s clear to us that the brain is always equipped for unlearning and nullifying its longstanding, negative emotional learnings.”
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.”

Call for Contributors: SEPI's Practice Advocacy Committee

The Society for the Exploration of Psychotherapy Integration’s Practice Advocacy Committee is looking for professionals mostly involved in clinical work to represent and give voice to the needs of our integrative community. If you’d like to know more, collaborate and be part of this Committee, please submit your interest and CV to the Committee’s Chair, Jeffrey J. Magnavita, at magnapsych@gmail.com