President's Column

Happy new year?

No, the question mark is not a typo. Maybe it's just me, but the world feels increasingly anxiety-provoking — a never-ending stream of troubling news about divisions and discord, delivered relentlessly to my phone, which of course I look at much too often. Anticipating a new year can bring more trepidation than excitement.

As cognitive psychologist Steven Pinker (2018) has noted, life is actually getting better in many ways across the globe. According to a number of indices, poverty, famine, and war are declining, and health and literacy are improving. However, I suspect that I am not alone in still feeling that this is a particularly anxious and stressful time.

So what does this have to do with SEPI? We are all familiar with the human stress responses of fight or flight, first introduced by Cannon (1932). I would like to draw attention to another way of responding to stress — what Taylor and colleagues have termed “tend-and-befriend” (Taylor et al., 2000). When we encounter a stressful situation, we have the capacity to seek out ways to care for each other and build stronger networks of social support.

This relates to the theme of our upcoming 2019 conference, which I am also making the theme of my presidential term: building alliances.

The use of the word alliance is in part an allusion to the therapeutic alliance, a robust predictor of treatment outcome across theoretical orientations. However, I would like to expand upon this concept and think about building alliances in a number of different ways:

- **Building alliances across disciplines**: SEPI was initially founded by psychologists and a majority of SEPI members are from the field of psychology. However, the world of mental health care practice and research is larger than psychology, and there is much to be gained from collaborating with practitioners and researchers from disciplines such as social work, mental health counseling, and psychiatry. The SEPI membership committee, led by Paul Wachtel, is actively exploring ways to improve SEPI’s outreach to these other disciplines. One important component of this is ensuring collaboration between disciplines within SEPI: This year, both the membership committee and the program committee include representatives from multiple disciplines.

- **Building alliances with other organizations**: Thanks to the leadership of Mike Constantino, SEPI member and past-president of the Society for Psychotherapy/Division 29 of the American Psychological Association, SEPI is entering into an exciting collaboration with Division 29. For a number of years, Division 29 has...
Remembering Jeremy D. Safran

The Integrative Therapist

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"The theme of our upcoming 2019 conference, which I am also making the theme of my presidential term: building alliances."

sponsored continuing education credits for SEPI conferences. This year, our collaboration will increase in two important ways: both organizations will promote each other’s conferences in our respective conference programs, and both organizations will offer poster awards at each other’s conferences. Specifically, at the SEPI conference in Lisbon, there will be a Division 29-sponsored poster award; at the Division 29 poster session at the APA conference in Chicago, there will be a SEPI-sponsored poster award. Both awards will be named in memory of Jeremy Safran. Our hope is that these cross-organizational awards will increase awareness of and interest in SEPI among Division 29 members, while also helping SEPI members to become more aware of the potential benefits of joining Division 29. By working together, we hope to strengthen both organizations and the benefits to our members.

- Building alliances across generations: This year, we will increase outreach to student members of SEPI by ensuring adequate student representation across committees and identifying ways to increase student input into our decision-making processes.

- Building alliances across countries and cultures: We are working actively with the Regional Networks committee to increase their visibility and to support efforts to ensure that SEPI members from different parts of the world are able to make the most of their experience at the annual conference.

This newsletter, so skillfully edited by the talented Alex Vaz, is itself an excellent example of building alliances within SEPI by fostering connections between different parts of the organization. This issue features highlights from the SEPI regional network committee, an interview with the author of an article from our journal, features highlighting student members and award winners, and an article focusing on the integration of research and practice. In addition, there are articles about approaches to psychotherapy integration that have been developed by SEPI members, as well as an examination of the intersection of psychotherapy and environmental issues.

A very special feature of this edition of the newsletter is a set of remembrances of the late Jeremy Safran, with contributions from a number of his colleagues and former students. Jeremy may be best known for his theoretical and empirical contributions to our understanding of alliance ruptures and repair (e.g., Safran & Muran, 2000), and the theme of building alliances is in part a tribute to him. Jeremy thrived in collaboration: he loved nothing more than to generate and refine ideas in active engagement with others. Focusing this year on building connections, and creating spaces where exploration, engagement, curiosity, and compassion can flourish, is the best way I know to honor his memory.

If you are interested in exploring new ways to tend and befriend with SEPI this year, and would like to get more involved with the organization, please email me (catherine.eubanks@yu.edu).

Here’s to 2019!

Catherine F. Eubanks

References:


SEPI is one of the most international professional associations in psychotherapy. The Regional Network (RN) page on the SEPI website displays our RNs in Europe, the US, South America, Asia, and the Middle East. Each RN has one or more Coordinators. Doménica and Tom chair the RN Committee. We keep in touch with the Coordinators and facilitate communications among the RNs and between the RNs and SEPI as a whole. We compile reports of RN activities, plan and lead the annual RN Committee meeting at the annual conference, and issue a summary report on RN activities. We advocate for the RNs and propose the recipient of the Diane Arnkoff and Carol Glass Award for the RN of the Year, based on end of year reports from the RNs and our communications with the RNs. The first award was given to the Turkish RN, and the second to Argentina.

An example of our advocacy concerns translation. Based on communication with some RN Coordinators, we became aware that many Spanish Speaking SEPI members are either uncomfortable at the annual conferences, or do not attend them. We have engaged in a dialog with the RNs and SEPI to identify ways that translation could be included in conferences, the web site, and other activities.

The best way for SEPI members to learn about the impressive work of our RNs is through their end of year reports. The following are very brief summaries of the reports we received for 2018.

Argentina RN
Beatriz Gomez, Coordinator
1. Annually, 500 students from Argentina and abroad are trained and supervised in Aiglè’s Integrative Psychotherapy Model.
2. Collaboration with universities in Argentina and Valencia, Spain; and the Ackerman Institute for the Family, USA.
3. In 2018 SEPI’s Arnkoff & Glass Award For Regional Network of the Year was presented to the Argentine SEPI Regional Network. The award was used for invited speaker for Seminar on Multicultural Competences in Psychotherapy.
4. Presentations and invited speakers at Latin American Association of Integrative Psychotherapy Conference.

Austria RN
Markus Boeckle, Fritz Betz, and Barbara Kreiner, Coordinators
1. Organizing conference German-speaking SEPI members with Swiss RN; Integrative study group with research group in Vienna.
2. Published report in German on the annual SEPI conference in New York.
3. Published article "Applying Several Theories and Methods for Improving Psychotherapeutic Practice and Research".
### Cyprus: Hellenic RN

**Kyriakos Platrites, Coordinator**

1. Organized annual Hellenic Conference of Integrative Psychotherapy with University of Thessaly (Greece).
2. Two ongoing training programs in Integrative Psychotherapy.
3. Two presentations at SEPI Annual Conference, New York.
4. Programs for substance abuse and compulsive gambling with Government of Cyprus and Cyprus Orthodox Church.

### Cyprus: Turkish Cypriot RN

**Erdem Akgün, Coordinator**

1. Integrative Psychotherapy conference for Eastern Mediterranean University Psychology and Psychological Counseling Students.
2. Integrative Psychotherapy conference for Lefke European University Psychology and Psychological Counseling Students.
3. Weekly supervision activities for psychotherapists.
4. Ongoing social networking pages in integrative psychotherapy.

### Czech Republic RN

**Magdalena Frouzová, Coordinator**

1. Organized International Conference for Integrative Therapy.
2. Two ongoing training programs in Integrative Psychotherapy.
3. Eight weekend workshops in supervision, theory, and training of integrative psychotherapy.

### Ecuador RN

**Lucio Balarezo, Coordinator**

1. Supports the Academic and Research, Publications and Supervision Committees of the Ecuadorian Society of Integrative Counseling and Psychotherapy.
2. Ongoing 2-year training program in three cities of Ecuador.
3. Ongoing research, on development and adaptation of assessment instruments for the integrative model of personality.
4. Courses on integrative assessment and couples therapy.

### Japan RN

**Shigeru Iwakabe, Coordinator**

1. Symposium: “Psychotherapy integration for Japanese chartered psychologists” held at Otsuma University, Tokyo, Japan.
2. Symposium: “Working with Emotion in Psychotherapy” held at Tokyo Seitoku University, Tokyo, Japan, with Dr. Les Greenberg

### Swiss RN

**Ueli Kramer, Coordinator**

1. With Swiss Society for Emotion-Focused Therapy, organized half-day scientific symposium on memory reconsolidation for 70 participants.
2. Ongoing supervision group of Swiss psychotherapists from different orientations.
3. Planning one-day symposium on Deliberate Practice with Austrian and German SEPI partners.

### Turkish RN

**Tahir Özakka, Coordinator**

1. Second National Conference for Integrative Therapy, “From Turkey to the World,” attended by 350 mental health professionals.
2. Ongoing 4 year integrative psychotherapy training program (240 students) graduated its 14th class.
3. Published the Turkish Journal of Integrative Psychotherapy.
4. Translated several important works on psychotherapy into Turkish.
5. Organized meetings with mental health professionals in 10 regional offices around Turkey.
THE SEPI DISSERTATION AWARDEE:
Orrin-Porter Morrison

The SEPI Dissertation Award is an initiative to encourage and support dissertation work related to psychotherapy integration. The 2019 awardee, Dr. Orrin-Porter Morrison (University of Windsor), will present his work this June at the SEPI Conference in Lisbon, Portugal. The Integrative Therapist asked Dr. Morrison to briefly describe his award-winning project.

Sudden gains, or sharp decreases in client’s symptoms between two adjacent therapy sessions, are highly predictive of positive therapy outcome. However, why sudden gains occur remains unanswered with no single process established as consistently predicting the occurrence of sudden gains (Shalom, 2018). To date, studies have examined common client characteristics, external events, therapy approaches, interventions, and the “fit” between client and therapist without a clear indicator for the process of sudden gains. In addition, it is still unclear whether the phase of therapy (i.e., early, working, or late phase) or treatment modality moderates these processes. Only two studies have examined these three phases of therapy (Kelly et al., 2005; Stiles et al., 2003), but these studies highlighted that late phase sudden gains were not related to outcome and early phase sudden were related to outcome. Regarding treatment approaches, the meta-analysis by Aderka and colleagues found that the effect of CBT interventions on outcome measures were significantly greater than the effect of non-CBT interventions. However, the sample size for the non-CBT condition included significantly fewer studies (n = 4) than that of the CBT conditions (n = 14). Additional research is warranted for these moderators of sudden gains.
The focus of the current study is to analyze the processes that arise during sudden gains by examining clients’ evaluations of what events they found to be helpful in therapy. This will be done while considering phases of therapy and treatment approach as moderators.

An archive of weekly therapy session data from clients at an outpatient psychotherapy clinic was obtained. Therapy was provided by advanced graduate psychology students at a partnering university and consisted of either a CBT, EFT, psychodynamic, or an integrative approach. Clients’ presenting concerns ranged from mild (e.g., adjusting to university life) to severe (suicide risk and personality disorders). At baseline and prior to every session, clients completed the OQ-45, a self-report progress monitoring measure that assesses subjective distress, interpersonal functioning, and problems in social role performance. Following each therapy session, clients completed the Helpful Aspects of Therapy (HAT) questionnaire and the Working Alliance Inventory (WAI). The HAT twice asks clients to write about an event they found helpful in therapy while the WAI assesses the client-therapist working alliance. Sudden gains were identified using criteria adapted from Tang and DeRubeis’s (1999) and Kelly and colleagues (2005) requirements. Clients’ written responses on the HAT questionnaire were categorized using a modified version of the Helpful Aspects of Experiential Therapy Content Analysis System (HAETCAS; Elliot, 1988).

Of the original sample (N=294) 23.8% clients (n = 70) experienced a sudden gain with an average magnitude of 24.2 OQ-45 points. The median pregain session (the session at the beginning of the gain) was session 6. Specifically, 19, 46 and 5 sudden gains occurring during the early, working, and late phase of therapy, respectively, and 37 and 33 sudden gains occurring in CBT and non-CBT interventions. Given the few sudden gains occurring in the late phase of therapy, analyses were solely conducted between early and working phases of therapy. There were no significant differences for phase of therapy (early vs. working phase) and treatment approach (CBT vs. non-CBT) related to the frequency of sudden gains, magnitude of sudden gains, or change from pre- to post-treatment (p > .05). The HAT questionnaire had a mean completion rate of 95% for providing a response to the first HAT question and 75% completion rate for the second HAT question. Preliminary findings indicate that clients highlighted alliance building, goal setting, and emotional exploration more often in the pregain session then during prepgain session (a previous session used as a control session). Clients highlighted more insight events as being most helpful during the prepregn (control) session than the pregain session. These initial findings may suggest that the sudden gain does not occur with the onset of the insight but rather as a consequence of it after the client has more fully processed, received validation from the therapist, and set goals. Further analyses comparing phase of therapy as well as intervention modality will be conducted in the coming months and will be presented at the Society for the Exploration of Psychotherapy Integration (SEPI) in Portugal occurring in June, 2019.
explicit shared decision-making around the client's goals for therapy, the constituent therapeutic tasks that need to be accomplished to enable these goals to be attained, and the most suitable methods (activities and interventions) through which task completion can be facilitated. In principle, the client and therapist can draw on any body of knowledge that seems to them to be potentially relevant to the work they are carrying out. Maintaining client-therapist alignment around goals, tasks and methods is achieved through routine use of metacommunication (stepping back from the on-going flow of therapy to clarify therapist or client intentions and experiences), qualitative and quantitative feedback and monitoring instruments, and a process of collaborative case formulation based on visual mapping of the client's concerns, strengths and cultural resources. Further information on how these procedures operate in practice can be found in a series of introductory books and chapters (Cooper and Dryden, 2016; Cooper and McLeod, 2011; Hanley, Winter, Cooper and McLeod, 2017; McLeod, 2017a; McLeod, McLeod, Cooper and Dryden, 2013).

As a model of therapy that has emerged in the last 10 years, the pluralistic approach has been in a position to build on the insights and findings of not only research in psychotherapy but also broader landscapes of inquiry in health care and philosophy. For example, within psychotherapy research, the pluralistic framework for practice is consistent with evidence regarding the importance of client-therapist collaboration, client preferences, culturally adapted therapy, and the use of feedback measures. From medical and health research, the pluralistic approach is informed by research and practice around shared decision-making and the value of everyday healing activities and social capital, such as time in nature, spiritual practice, interaction with animals, and art-making. From the field of philosophy, this form of therapy incorporates ideas from relational ethics, conceptual analysis of the nature of pluralism, and dispositional causality.

At the same time, pluralistic therapy represents a 'grass-roots' movement that seeks to evolve through the creative and innovative contributions of front-line practitioners and by listening to what clients have said – for instance, in qualitative research studies – about what works for them in therapy. From the outset, pluralistic therapy was intentionally conceived as an open, wiki-type system that would continue to grow and change (Cooper and McLeod, 2011). Rather than being a model of therapy that is anchored in a fixed treatment manual, it is better viewed instead as a set of principles that can be expressed in different ways in different contexts.

So far, only a limited amount of research into pluralistic therapy has been published. In an open trial, Cooper et al. (2015) found that pluralistic therapy for depression was equivalent in effectiveness to other approaches, with some indication that it might be associated with higher rates of client retention. There has also been some attention to the possibility of developing feedback tools that offer client more direct ways of conveying preferences to their therapist (Cooper and Norcross, 2016; McLeod, 2017b).

At this stage in its development, it has been important to devise strategies for learning and teaching pluralistic therapy, and clinical supervision. In training programmes for novice counsellors, it has been helpful to identify a set of key competencies, in such areas as basic counselling skills, developing a pluralistic way of thinking, and working collaboratively with clients (McLeod, Smith and Thurston, 2016). At the start of the programme, students are introduced to the concept of pluralism and principles of pluralistic practice. They are then introduced to ideas and methods from a range of therapy traditions, including CBT, psychodynamic and person-centred, and encouraged to regard these established approaches as resources that can be responsively adapted to address specific therapeutic goals of clients. In pluralistic training programmes for more experienced therapists, the focus of training is around how to introduce collaborative procedures and shared decision-making into the pre-existing therapeutic repertoire of the learner. In both types of training, it has been found useful to make extensive use of case-based learning, as a means of honouring the complexity of collaborative work. Recent developments in pluralistic therapy training have started to incorporate ideas from deliberate practice theory, in order to clarify the specific areas in which competence enhancement might take place. An unpublished follow-up study of participants in pluralistic
"The idea of a therapy that is organized around multiple goals and tasks creates a space in which social justice outcomes can be pursued alongside an agenda for individual emotional repair."

counselling training found that trainees were highly satisfied with the degree to which the programme had prepared them for employment as therapists.

A pluralistic framework for practice invites learners, trainers, supervisors, researchers and clinicians to engage with some of the key intellectual and societal challenges being faced by the counselling and psychotherapy professional community. Although there has not been space to expand on the underlying philosophical and conceptual meaning of pluralism in this brief introductory article, it is an idea that has immense implications for anyone who seeks to use it as a guide for practice. For example, commitment to pluralism requires reflection around such questions as the nature of ethical respect for the uniqueness of the other, the ability to make a commitment to dialogue across differences, and the adoption of a “both/and” rather than “either/or” way of thinking. The underlying principle of shared decision-making has multiple points of connection with developments around service-user involvement in care, reconceptualization of professional roles, and the fact that therapy clients are increasingly well-informed about the options that are open to them, based on information available on the internet and through other sources. The idea of a therapy that is organized around multiple goals and tasks creates a space in which social justice outcomes can be pursued alongside an agenda for individual emotional repair. Finally, a pluralistic framework for practice offers a means of bringing together all of the existing models of therapy integration (eclecticism, theoretical, common factors, assimilative, unified) in a form that is robust and flexible at the level of practice, while opening up important new questions and possibilities at the level of research and inquiry.

References

"JPI: In Focus" are exclusive video-recorded talks focusing on a recent published paper on the Journal of Psychotherapy Integration.

In this issue, we talk with Dr. Katie Aafjes-van Doorn (Yeshiva University), first author of the paper "Psychotherapy integration training around the globe: A personal and empirical perspective."

Click HERE to watch our exclusive video interview.
Being a beginner psychotherapist always means being full of doubts. Perhaps even more so, if you are beginning as an integrative psychotherapist. That usually means you don’t receive many manuals or techniques during your training.

That said, we were wondering: After we’ll have finished our training, how do we define the pros and cons of having chosen an integrative approach instead of a specific approach, with a special concern about thoughts and feelings of the trainees? What might be significant in the experience of young beginners in integration?

As the participants of the "Training of integration in psychotherapy", which is a Czech therapist-centered training based on the common factors theory, we have decided to contribute to the research of integrative training in psychotherapy from the participants’ perspective. We have asked all 24 of our colleagues in the final year of the Training of integration in psychotherapy and gathered answers from 13 of them. Most of these thoughts and feelings we can agree with. Even though our sample is not very big, our findings can give us some hints on what might be worth of further research.

We have asked 4 questions within a qualitative research paradigm:
1. Why did you choose the training in an integrative approach?
2. Have you experienced any hardships and discomforts related to beginning as an integrative therapist? Could you describe them?
3. What was (or is) helping you overcome this discomfort?
4. What do you value today on being trained in an integrative approach? What do you perceive as valuable or enriching?

Why integration? Because we fear having to fit in boxes

Of course there were various random reasons for choosing the integrative training, such as knowing the lectors, good references or the training opening for registration just at the right time. Some of the participant also referred they found it hard to choose from different approaches, either because they have liked more of them, or they were worried of making a wrong choice. Integration was a way how to avoid such decision. But as for those who have knowingly chosen integration, the following reasons seem to be important:

- I see freedom in not having to fit in one box.
  I am afraid I wouldn’t fit in one therapeutic approach.

- I like the training to be therapist-centered.
  I like the possibility to create my own therapeutic style, one that fits me.

- Ambiguity is close to my life philosophy.
  I like looking at things from different angles rather than pursuing one truth.

- It seems to me that one approach by itself is not enough, while at the same time there is something useful in each of them.

- Common factors theory makes sense to me.
We might imply a hypothesis that integrative training appeals to those who prefer finding their own ways freely — instead of taking a road that is already tested and proven.

**Perceived hardships? Feeling lost, clueless, uncertain — and underestimated by other therapists**

No clues, no manuals, no tools. Probably all therapists-beginners are uncertain, not only integrative ones, and our colleagues were aware of that. But still, there are some areas of discomfort that seem to be specific:

- I don't have any tools or theory I could hold on to when I feel uncertain. Often I don't know what to do. We create tailor-made therapy for our clients, which has a great freedom in it, but also brings a lot of stress and feelings of responsibility for us.
- I experience frustration while moving on with the training. When will someone finally tell us what to do with the clients?
- It takes time to really understand integration. I get lost in the number of approaches. Some trainees don't truly realize for years integrative doesn't mean eclectic.
- It is hard to stand up for myself in discussions with my colleagues. Even more so at times when I'm not sure what integration is and what do I do with my clients. It's hard to answer the questions from therapists trained in specific approaches and to defend my emerging therapeutic identity.

**What was helping? Common factors theory, support from lectors and trainees, experience and emerging faith in oneself**

As for common factors theory, we have found concepts to hold on to after all. Like the therapeutic relationship, the therapeutic processes “here and now” or regular reflecting after the sessions.

Let's share one inspiring answer: "I was holding on to the finding that it is attention and therapeutic relationship that mediates effectiveness. So when I didn’t know, I was just breathing and building the relationship."

Discussions and shared frustration with our integrative colleagues were also important. And the role of lectors or supervisors seems to be enormous. This is what trainees found helpful:

- Imitating lectors. Using them as role models.
- Trusting lectors. When we felt lost and frustrated, or craving for answers, some colleagues found comfort in trusting that lectors knew what they were doing.
- Being trusted by the lectors. This is what our colleagues found very reassuring and strengthening. Seeing the lectors having faith in us, not only as therapists, but also as human beings who already have what is needed. We therefore felt that their purpose was to help us organize what we already had in our “cabinets” or to allow some chaos to enter what had already been organized to proceed towards balance.

It also took time and practice. But it seems all this led to emerging faith in ourselves. Which leads us to the final chapter — is integration worth all these hardships and all this uncertainty after all?

**What do we appreciate on being integrative psychotherapists? Perceived freedom, ability to mediate different approaches, and a strong anchor in ourselves**

Not having to “put people in boxes” is what lured us into starting with integration. After five years of training, this expectation seems to be met. Not only we don’t need to fit in boxes of different approaches ourselves. We also appreciate not having to put clients in boxes, which gives us the feeling of freedom.
While discussions with our professional colleagues trained in a specific approach were difficult earlier in the training, at the end it seems we are able to moderate them. One of our respondents said it was the openness of our lecturers towards different approaches and opinions that made us less prejudiced, too. Also we feel like it’s easier for us to find a common therapeutic language and common ground. It is easy to see different approaches doing the same while using different words to describe it.

But what trainees describe to be the most important benefit is finding their own therapeutic style. Finding what actually fits us as therapists and what doesn’t. That way we can become more authentic while working, something that can make therapy subsequently more efficient. Integrative therapists describe some kind of inner strength emerging in them. Now at the end of the training they perceive themselves as quite able to tolerate uncertainty.

Some of our colleagues said that the frustration experienced in the training had led them to dig deeper, read more, look for the answers elsewhere. One of our respondents said: “When I realized no one is going to tell us what to do, I also have realized it was up to me to find out. So, now, I can truly know what I do.”

That might be the most important outcome after all. Following uncertainty, frustration and feelings of being lost, a good integrative training can help you find out who you are as a therapist and help you really own your style of work.

Limits of the research and ideas for further research

As we mentioned above, the sample of our respondents was quite small and included just trainees from one training institute. There are at least six different integrative trainings in Czech Republic only, and it could be interesting to compare thoughts and feelings of the trainees from different integrative institutes.

"What trainees describe to be the most important benefit is finding their own therapeutic style. Finding what actually fits us as therapists and what doesn't."

"There is mounting evidence that patient's outcome expectation may transmit its ameliorative effect on outcome by promoting a more positive therapeutic alliance."

"From the Lab to the Clinic" are invited contributions distilling relevant psychotherapy research for the practicing clinician.

Despite their relevance to all psychotherapies, patients’ treatment-related beliefs have been historically under-studied (e.g., Constantino, Ametrano, & Greenberg, 2012). However, there is a growing research literature that compellingly links at least two such beliefs to treatment outcome. The first and most widely studied is a patient’s outcome expectation (OE), or a forecast for the personal effectiveness of a given course of treatment (Devilly & Borkovec, 2000). A recent meta-analysis that included 12,722 patients from 81 independent samples found a small-to-moderate association between patients’ more positive early treatment OE and their posttreatment improvement (r = .18, p < .001, or d = .36; Constantino, Vîslă, Coyne, & Boswell, 2018). Moreover, moderator analyses revealed that the OE-outcome association was stronger for younger vs. older patients, when researchers used psychometrically sound vs. study-specific OE measures, and when therapists followed a fully or partially manualized treatment vs. using no manual at all. Finally, there is mounting evidence that patient OE may transmit its ameliorative effect on outcome by promoting a more positive therapeutic alliance (see Constantino, Vîslă et al., 2018 for a review). This mediational path squares
with goal theory, which posits that people will devote more resources to a goal if they believe that they have a reasonable chance of achieving it (Austin & Vancouver, 1996). In the present context, patients who have a more optimistic OE may be more likely to engage, and/or be more capable of engaging, in a collaborative working relationship with their therapist, which then facilitates improvement.

The second belief variable that is gaining empirical traction, though still less so than OE, is patient-perceived treatment or provider credibility. Perception of treatment credibility refers to how logical, suitable, and effective a given intervention seems (Devilly & Borkovec, 2000), whereas perception of provider credibility refers to how expert, trustworthy, and attractive (i.e., likeable and similar to a patient) a given mental health therapist seems (Strong, 1968). With regard to treatment credibility, a recent meta-analysis that included 1,504 patients from 24 independent samples found a small, but significant, association between patients’ more positive early perceptions of treatment credibility and their improvement \( r = .12, p < .001, \) or \( d = .24; \) Constantino, Coyne, Boswell, Iles, & Visla, 2018). Although this association preliminarily establishes treatment credibility as a correlate of treatment outcomes, the research base remains fairly small and little is known about the conditions under which this variable relates most or least strongly to outcome (i.e., moderators) or the mechanisms through which this variable operates (i.e., mediators). In contrast, research on provider credibility has focused almost exclusively on experimental manipulations aimed at changing perceptions of therapist expertness, trustworthiness, and attractiveness (see Hoyt, 1996, for a meta-analytic review), but with few, if any, direct tests of the effect of such perceptions on treatment outcomes. Thus, more research is needed to determine how perceptions of the provider bear on improvement.

In light of their empirical syntheses, as well as an additional review of process research and experimental work on strategies to influence these belief variables, the authors of these aforementioned meta-analyses offered clinical practice suggestions for effectively assessing and addressing patients’ treatment-related beliefs. I summarize these practice guidelines below for OE and credibility, respectively.

**Therapeutic Practices for OE**

**Patient-Focused OE Cultivation Strategies**

- Assess and appreciate transdiagnostic patient characteristics that might promote low OE (e.g., low psychological mindedness, greater symptom severity, negative previous therapy experiences, and greater general pessimism). Knowledge of these risk factors helps clinicians forecast patients’ negative OE upon arriving at therapy and potentially mitigate their influence (e.g., by matching treatment to a patient’s level of psychological mindedness, discussing past treatments and what did vs. did not help).

- When patients have low early OE, be especially affiliative and supportive, as such a stance may promote better outcomes for these patients.

- Assess patient OE (verbally and/or with a brief measure) throughout treatment, as this belief can be malleable. Such assessment allows therapists to validate their patients’ beliefs and to respond to them prudently, especially when they wane.

- Given that low early OE places patients at risk for reductions in OE following an alliance rupture, early OE level provides a therapist with important risk and relational information. In light of this information, therapists can prepare at-risk patients for possible relationship tensions, invite a discussion of them when they occur, and draw a direct connection between such tensions and OE. Dealing with ruptures explicitly and sensitively might help mitigate their negative effects on patient beliefs.

- Be especially attentive to patient OE when working with younger patients and when delivering a manualized treatment, as OE has a stronger association with outcome under these circumstances.
"Make statements that suggest realistic confidence in the efficacy of psychotherapy and one’s own competence in providing treatment. When making these statements, convey an empathic understanding that patients may not be ready to fully accept this statement at the beginning of treatment."

- Personalize OE-enhancing statements throughout treatment based on patients’ experiences, strengths, and past successes (including at an earlier point in their current treatment).

**Treatment- or Provider-Focused OE Cultivation Strategies**

- Use persuasion tactics that have been shown to increase a patient’s OE for a given treatment and/or provider; for example, deliver a compelling and personally well-suited treatment rationale; describe a treatment as prestigious, supported by research, and broad in scope; provide vignettes of past successful cases; and use some technical jargon when describing a treatment.

- When attempting to increase OE, tread lightly and empathically by using hope-inspiring statements that do not threaten a patient’s beliefs or promise an improbable amount or speed of improvement.

- Make statements that suggest realistic confidence in the efficacy of psychotherapy and one’s own competence in providing treatment. When making these statements, convey an empathic understanding that patients may not be ready to fully accept this statement at the beginning of treatment.

- Provide a non-technical review of the research support for the intended treatment.

**Therapeutic Practices for Treatment Credibility**

**Patient-Focus Treatment Credibility Cultivation Strategies**

- Assess patients’ treatment credibility (verbally and/or with a brief measure) throughout treatment, as this belief can be malleable. This information will provide prognostic risk information, as well as a fuller understanding of the fit between the proposed treatment and the patient’s belief system.

- After proposing a treatment, invite an open discussion about what patients do and do not find compelling about the rationale. When there is a mismatch between the proposed approach and the patient’s belief system, try to identify things that a patient finds credible and consider assimilating those elements into the treatment plan. Also try to identify those things that are less convincing or useful to the patient and consider modifying or eliminating them.

- When a patient’s credibility perception continues to be low (even after offering to modify the treatment approach), try more radical responsive measures, such as offering a different treatment that fits more closely with the patient’s belief system. If a patient’s low credibility perception stems from a poor fit with a given provider, consider offering a referral to a different clinician.

- When possible, attempt to promote early symptom improvement, as such early gain increases patients’ perceptions of a treatment’s credibility.

**Treatment- and Provider-Focused Credibility Cultivation Strategies**

- Given that credibility perceptions are individual- and context-specific, try to personalize the treatment rationale to maximize the degree to which it sounds logical, suitable, and efficacious to a given patient.

- When delivering a rationale, attend to patients’ verbal and non-verbal indicators that it is logical and persuasive. Such attunement will allow therapists to provide additional clarification or to try different strategies for describing a treatment.

- Therapists can also attend to their posture and non-verbal communication, as preliminary evidence suggests that greater forward trunk lean and therapist eye contact are associated with more positive perceptions of a treatment’s credibility.
"When delivering a rationale, attend to patients’ verbal and non-verbal indicators that it is logical and persuasive. Such attunement will allow therapists to provide additional clarification or to try different strategies for describing a treatment."

References


Note

Please see Constantino, Vîslă et al. (2018) and Constantino, Coyne et al. (2018) for a more comprehensive discussion of these empirically-supported strategies, as well as specific references that support them when they are not directly related to the results of the meta-analysis. These strategies are also drawn from valuable collaborations with Michael J. Constantino, Andreea Vîslă, James F. Boswell, & Brittany Iles.
We invited colleagues, students and friends to share their memories of Dr. Safran, recalling the personal and professional impact he had on their lives.

**Remembering Jeremy D. Safran**

The Integrative Therapist presents a tribute series dedicated to the late untimely passing of Jeremy D. Safran (1952 – 2018), former professor of psychology at the New School for Social Research, NY, where he served for many years as director of clinical training. Safran trained extensively in psychoanalysis, cognitive therapy, experiential therapy, and Buddhist mindfulness practice. His pioneering contributions include the in-depth study of the therapeutic alliance and alliance ruptures, innovations in cognitive therapy and relational psychoanalysis, and the co-development of Brief Relational Therapy (BRT) and Alliance-Focused Training (AFT).

We invited colleagues, students and friends to share their memories of Dr. Safran, recalling the personal and professional impact he had on their lives.

**Remembering Jeremy D. Safran with Zindel Segal**

Dr. Zindel Segal is one of the founders of Mindfulness-based Cognitive Therapy (MBCT). During the 80's he worked closely with Dr. Safran on theoretical and clinical contributions to cognitive therapy, such as the development of an interpersonal framework that would take into account early developmental issues and emotional processes in cognitive therapy, as well as a focus on the therapeutic relationship as a means to access and work on various interpersonal schemas. This collaboration culminated in the 1990 book "Interpersonal process in cognitive therapy", considered by many to be a landmark integrative contribution within the CBT literature.

In our video interview, Dr. Segal recalls working with Jeremy and how he always had an "ambivalent attachment" to cognitive therapy.

Click here to watch video interview
Dr. Chris Muran was perhaps the biggest collaborator with Jeremy Safran throughout his lifetime. Together, they developed very influential research studies on the process of alliance ruptures and their repair, and co-authored the now classic 2000 book "Negotiating the Therapeutic Alliance: A Relational Treatment Guide". This text contribution by Dr. Muran was first read at the opening ceremony for the Society for Psychotherapy Research (SPR) conference in Amsterdam, June 20, 2018.

There are so many things I could say about Jeremy, so many things I will miss, but perhaps most of all I’ll miss our talks. Jeremy was so alive in these conversations, like a child in a sandbox where his toys were words. His energy & enthusiasm were electric. Ideas would flow back & forth & appear to multiply exponentially. Jeremy was always at his best in the expression & exchange of ideas. The freedom to articulate with such definition & without inhibition inspired.

When I was in it, it was like being in a zone — where nothing else mattered. When I was out of it, it was like "whoa – that was amazing!" Even when we were frustrated with each other, we could still get in that zone.

There were many hours of musings when we roomed together at many a conference, but often these talks were accompanied by a walk. We were mindfully expressing while mindlessly walking — sometimes just heading to the same restaurant for our weekly Friday lunch — at first an Israeli one… always the same dishes, two years without changing… until at once, we both looked at each other & simultaneously remarked, "I’m sick of that food!" Then we switched to an Italian one… for another two-year stretch. And Jeremy always ordered the same sauce!

These walks were always marked by a place in time, though we were barely aware. There were of course the New York walks, around the Lower Eastside, or up & down the boardwalk in Coney Island, sometimes for just an hour, sometimes for much more. There was that time we walked all over Rome, during an SPR meeting, energized by double expressos, designing & redesigning…

Mostly we discussed theory & research, practice & training, but sometimes we’d go off on politics, history, philosophy or family… & then we would get back to work — we did love to talk work.
Though our talks felt creative, they were not always on target, they did not always make sense - in retrospect. There was one idea, for example, that we would repeatedly look back on & wonder, “What were we thinking? When did we come up with that?? Oh yeah, that was in Rome when we were jacked up on caffeine!” We laughed a lot, we thought we were pretty funny… at least we did!

I will miss these walks. Most of all, I will miss our talks, but I’ll always remember them here [HEAD] & cherish them here [HEART].

J. Christopher Muran

Dr. Leslie Greenberg is a co-founder of Emotion-Focused Therapy (EFT). As one of Safran’s first mentors, they collaborated on a series of papers on the importance of emotional processes in psychotherapy, and critiques on psychotherapy research methodologies. Their collaboration culminated in the 1987 landmark book “Emotion in Psychotherapy”.

In our video interview, Dr. Greenberg recalls the deep personal and professional relationship he had with Jeremy from a very early stage of each others’ career.
"His intellectual landscape seemed boundless – transecting Cognitive Therapy, Emotion Focused Therapy, Psychoanalysis, and Buddhism – all the while, focusing on psychological and interpersonal processes."

"There were several times when he seemed to drop everything in order to respond to last minute requests. He was genuinely committed and fully involved."

Dr. Timothy Anderson (Ohio University) is the main developer and researcher of the "Facilitative Interpersonal Skills" construct. In the last years of his life, Safran collaborated closely with Dr. Anderson in developing and facilitating joint alliance-focused trainings and projects.

Jeremy Safran was a dear colleague and friend. He lived life so fully and left such a great impact on our lives. Jeremy brought amazing vibrancy, original ideas, and zest for discovery to his work. He also expressed himself in a soft, extremely kind, gentle, and engaged manner. His intellectual landscape seemed boundless – transecting Cognitive Therapy, Emotion Focused Therapy, Psychoanalysis, and Buddhism – all the while, focusing on psychological and interpersonal processes. His mind always seemed active and he pursued so many ideas, much of which was innovative and new and often involved genuine psychotherapy integration.

I am deeply grateful to have had the opportunity to have worked with him even though my collaboration with him was relatively recent. My first exposure to Jeremy’s work was his amazing text with Les Greenberg that reconceptualized the view of emotion in psychotherapy (Emotions in Psychotherapy, 1987). Observing Jeremy and Chris Muran co-lead and playfully debate ideas (spar?) at conferences over the past 20 years was as enriching as reading their landmark contribution (Negotiating the Therapeutic Alliance, 2000). Enriching and inspiring were the several walks we took where sometimes Jeremy had a specific topic he wanted to discuss, but at other times we simply wandered. He seemed to blend his personal and professional sides of himself so seamlessly; at least, in my experience he seemed very genuine. I am grateful to Jeremy for helping me think more clearly about completing projects and thinking about the meaning of work. Jeremy as a colleague was multifaceted and included topics of life, parenting, and relationship – “sort of an after-education,” which was Freud’s allusion to how broadly affecting analysis could be.

During the past two years of his life, our New School and Ohio University collaborative team worked closely, and we developed video materials, a training web-site that combined our work, and conducted experimental projects to test the training. While the New School – Ohio University team included several students, we collaborated most intensively with Josh Finkelstein and Caroline Gooch (on training web site design). Matt Perlman and Kate Foley were team leaders in our training studies, and Scott Mimnaugh, Kevin David, and Shelby Martin also played important roles. All of these students were deeply affected by his sudden and tragic loss. Even though I knew he must have been constantly busy with work, he always seemed to be available and giving of his time. There were several times when he seemed to drop everything in order to respond to last minute requests. He was genuinely committed and fully involved.

More specifically, our work brought together Jeremy’s work on repairing alliance ruptures and brief therapist training workshops with my work on identifying therapist Facilitative Interpersonal Skills (FIS). We tested a streamlined integrated workshop that integrated his work on Alliance Focused Training with my work on FIS. We also constructed web-based training materials to accompany the workshop and these included demonstrations by Jeremy of rupture-repair intervention. The manner in which we developed the demonstration videos was novel and involved re-filming our FIS stimulus videos with Jeremy as the therapist. This novel approach to training allowed students to learn from modeling and also provided opportunities for deliberate practice of difficult moments in therapy.
Differences in theoretical schools and traditions did not deter him from jumping into discussion and debate – if anything, it encouraged him! He could also spark disagreement and did not suffer boring discussions easily. He had a penchant for getting to the heart of matters and found ways to have productive and lively differences of opinion. Most of the time, however, it was simply fun to openly explore ideas with him in a free-spirited manner.

I will always remember those times when he laughed heartily after finally understanding the essence of a topic. This joy seemed, to me anyway, even more heartfelt when involving professional discussion that involved different points of view. His laughter at such moments remains forever etched in my memory.

One of my better memories of Jeremy is of him and his dog, Lexi. I had come for a visit to work with him on our projects and after our work, we took his dogs to Prospect Park on a Sunday morning, which was close to his house in Brooklyn. At the park, we tossed the ball and Lexi sprinted for it, but Lexi didn’t simply retrieve it. Instead, Lexi brought the ball to other visitors at the park and would drop the ball at their feet and bark for them to throw it. We were both so entertained at how that dog engaged so many other people in the park. I think we only threw the ball once and Lexi retrieved it and found a new person, dropped the ball at their feet and barked until they threw it. It’s funny what memories really stand out. Jeremy’s collaborations and ideas initiated so much agentic interaction and sharing for so many of us in the psychotherapy community.

Timothy Anderson

It was a hot and humid August day in Toronto, in 1988, when I met Jeremy for the first time. I was an hour early for my job interview as a “psychometrist” (sort of a high-level research assistant) at the Clarke Institute of Psychiatry. A man walked slowly past me as I sat alone in the air-conditioned waiting room: once, twice, and then the third time he paused and asked me if my name was Rose (the woman whose interview slot I was evidently about to scoop). I recall my bemused reaction to his outfit, specifically his Birkenstock sandals and bare feet. He wasn’t dressed as I expected the Director of the Cognitive Behaviour Therapy Unit to be dressed. I explained my unexpected presence and he invited me into his office. We had an engaging and stimulating discussion about psychotherapy, which at that time, I knew very little about. At the end of the meeting, he offered me the job.

Jeremy rarely did anything that would be considered conventional. That was part of his particular charm and his creative genius. It was such a privilege to be involved in the early development of the alliance rupture work. We – Chris Muran, Zindel Segal, Franz Caspar, and a steady stream of graduate students – observed Jeremy’s sessions from behind the one-way mirror and then spent hours discussing each case (as the

Dr. Samstag (Long Island University) collaborated widely and published many co-authored papers with Dr. Safran on the therapeutic relationship, ruptures in the working alliance and other factors that contribute to poor outcome and premature termination.

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"Jeremy’s ideas have lead to seismic shifts in how the therapeutic relationship is considered, that continue to have an impact."

Canadian health care system allowed us to do!), applying different standardized process measures to the transcribed sessions and working out the stages of the first rupture resolution model. Each day was like a master class in conducting psychotherapy. Jeremy was gifted at putting the complex processes between himself and his patients into words. He was most intrigued by those moments when things were not going well in a session, when he and his patient were not on the same page.

Of course, Jeremy’s ideas have lead to seismic shifts in how the therapeutic relationship is considered, that continue to have an impact far beyond that small cluster of offices in the Cognitive Behaviour Therapy Unit. He certainly had a powerful impact on me, shaping the foundation of my thinking about the process of change. I am so grateful to have known and been influenced by him over the past 30 years, first as an influential supervisor, then as a valued colleague, but mostly as a dear friend.

Lisa W. Samstag

Dr. Castonguay (Pennsylvania State University) was a longtime friend and collaborator of Jeremy Safran. He was involved in the development and investigation of new integrative treatments for anxiety and depression that incorporated the pioneering contributions of Dr. Safran on alliance ruptures and repairs.

In our video interview, Dr. Castonguay recalls the many instances where he, as a young researcher, was supported by Jeremy, and the many personal and professional ways in which his influence lives on.

Click here to watch video interview
"This was one of the many things that impressed me about him—that rare combination of theoretical wisdom and sophistication along with organizational and administrative abilities. Many of us in the field have one or the other—far fewer possess talents in all of these areas."

Dr. Kuchuck is the current President for the International Association for Relational Psychoanalysis and Psychotherapy (IARPP). With his lifelong interest in Relational Psychoanalysis, Jeremy Safran had previously served as President of this organization.

There are people in our lives who come along at moments in which time, space and other considerations limit the degree to which we have the opportunity to get to know each other. This despite whatever sense of connectedness, warmth and other such feelings we might experience in the fleeting time we do have. This is how it was for me and Jeremy, and I’d like to believe that the positive feelings were mutual. Of course in the wake of tragedy, we wonder what might have been had we not been robbed of future opportunities that once seemed virtually endless.

Jeremy and I always made it a point to seek each other out at professional meetings or other occasions where our paths crossed. We shared similar sensibilities, collaborated on several projects, and enjoyed some good laughs together over the years. As I know was true for others in our community, Jeremy was my go to person whenever I needed to publicize institute or other events or consult about who in the graduate student community I could turn to for assistance with a professional project. Because of who he was, it gave me great pleasure on those occasions when I could return the favor. Jeremy knew everyone—or so it seemed to me, and he certainly knew how to make things happen. This was one of the many things that impressed me about him—that rare combination of theoretical wisdom and sophistication along with organizational and administrative abilities. Many of us in the field have one or the other—far fewer possess talents in all of these areas. But as I came to learn through the years, these were not the only seemingly disparate areas in which Jeremy excelled.

As others no doubt know as well or better than I do, his theoretical, research, teaching and clinical skills—not to mention the tremendous diversity of his theoretical proficiency—from CBT to Buddhism/mindfulness informed psychotherapy, to psychoanalysis and eventually, Relational psychoanalysis in particular, Jeremy was a true scholar; a passionate learner and teacher. He was also a generous man, freely giving of his time and know-how. I think it was during his tenure as president of the International Association of Relational Psychoanalysis and Psychotherapy (IARPP) that I first came to know Jeremy. I was struck then as I would continue to be by his gentleness and thoughtfulness when he talked about his clinical work, and of course as demonstrated in his interpersonal interactions. These were the early days of my own introduction to and eventual immersion in Relational psychoanalysis. We both came from other psychoanalytic traditions and eventually found our professional homes in Relational thinking and practice. And in his wise, but unassuming and loving way, Jeremy taught me a great deal about my new home, and how to strive to inhabit it with knowledge, warmth, passion and grace. I wish I had told him that.
"He valued a person's ability to speak their mind, even in opposition to his own, more than he valued being "right," a rare quality in a person, let alone in a professor."

Jeremy was a teacher, mentor and supervisor to me; his voice continues to be a defining influence on me as a psychologist and a supervisor. He had a way of convincing me to take steps I was usually uncomfortable with in an effort to create new experiences that I could call upon as I grew up professionally. Whenever I pushed back at presenting research, public speaking or leading supervision groups with him later in my career, he would hold me with that squinty gaze he had, a mix of mischief, warmth and determination of his will and I nearly always agreed.

Jeremy was a character easily remembered: intelligent, witty, honest, angular, gentle, at times both private and transparent and always giving of his time, ideas and energy. I will remember his laugh, a spontaneous eruption of joy and bite. He laughed easily at himself and at others. He had a real sense of what was at play beneath the surface and he enjoyed finding ways to bring that to light. He accepted his own shortcomings and those of others more than anyone I have ever met. I could get ensnared in some sort of negative loop with him, even passionately disagree with his formidable intellect but I always knew I would find my way back to an understanding with him. He valued a person's ability to speak their mind, even in opposition to his own, more than he valued being "right," a rare quality in a person, let alone in a professor.

Jeremy was always the most deeply curious person in any room. He often had the intellectual higher ground because he didn't let a fear of being wrong outweigh his insatiable hunger for a more subtle understanding of any dynamic. He never stopped pondering and was always open to opposing opinions. In fact, he often enjoyed those that challenged his mindset the most. I brought my toughest clinical moments to him because he illuminated the assumptions that I had forgotten to turn over. Seven years ago I was eight months pregnant with my daughter and had a patient who was having a very angry reaction to my pregnancy that was increasingly hard for me to tolerate well as I became more pregnant and, in some ways, more vulnerable. Despite approaching it from every angle I could think of, there I sat in his office feeling frustrated, helpless and exposed about the case. He did not dispense immediate advice or direction. Instead, I remember he leaned forward in his chair, concern visible on his face and shared that he too had experienced frustration and helplessness when he felt under attack at various points in his practice. He didn't have an answer but he tolerated and accepted my struggle as if he were in it beside me, as if he had all the faith that I would find my way out. He neither maximized nor minimized that I felt like I was in a locked interaction that no one could exit; he treated what felt like a dead end as a normal part of a process.
"If anyone could have made sense of his unfair and untimely death, it would have been Jeremy."

"Yet his steadfast encouragement and problem solving allowed me to successfully overcome my doubts and moments of inertia."

"If anyone could have made sense of his unfair and untimely death, it would have been Jeremy."

Medea Elvy

Nearly 9 months have passed since our community suffered the tragic and horrific loss of Jeremy and the process of grieving, remembering, and reflecting on his impact continues to unfold and deepen. I met Jeremy in 2006 when I began the Masters program at the New School for Social Research. I spent the next 7 years of graduate school and the years that followed learning from him, absorbing his passion for a myriad of intellectual and spiritual traditions, and deepening my relationship to him as a mentor. I, along with so many others, have been influenced and affected by the depth of his wisdom, his curiosity, and his authentic love for theory, ideas, and clinical work. It’s been a revelatory process to try to tease apart the ways in which he has influenced my thinking, my clinical work, my spirituality, and my personhood. This is my attempt at capturing some of what I have learned from him. Some strands I have reflected on before and others are newly discovered in just the past few weeks, as the process of reflecting on his impact is ongoing and layered.

Clinically,

The importance of NOW. So many times when I am with a patient I’ve called upon this. What is happening right now? Not what do I think is happening right now? But what do I hear? What do I sense, sensate, feel? And if it’s something unsettling that I can simply try to breathe, stay calm and attempt to approach it in the same way that I would a mediation practice. An empathic action or thought will emerge eventually… And if not it’s ok. In fact it’s better than ok, because things will go out of synch and that can actually help us to move into important dynamic layers of the work.

 Academically,

His persistent encouragement to publish dissertations is known by many students. And it’s with warmth and humor that I remember the many times over the span of 5 years! that I tried to wriggle out of the daunting endeavor. Yet his steadfast encouragement and problem solving allowed me to successfully overcome my doubts and moments of inertia. I was always amazed that he would email me after some time had passed to gently ask “by the way how’s it going with publishing the dissertation?”. And if it wasn’t going, his response would simply be, “How can I help?”. And help is what he always gave when I asked.
"Jeremy encouraged and modeled courage to travel the intellectual and clinical world widely."

"Jeremy broke out a video of his own work, and when the recording was over, he flipped on the lights and prompted with a smile, 'Now, who can tell me what I did wrong, there?'"

Society for the Exploration of Psychotherapy Integration

Jeremy, the Teacher
By Joshua Finkelstein

The Integrative Therapist

Society for the Exploration of Psychotherapy Integration

The first time I met Jeremy Safran was in a crowded lecture hall at Eugene Lang College - though at first, I didn’t see him. He wasn’t seated in any way that would draw attention to him. In fact, he was set down in the middle of the first row of chairs, in a crowd of his students. When the time came for the seminar to begin, a few of the more senior students stood up to introduce him, while Jeremy twisted in his seat to give a soft smile to the audience - seemingly unaware they had gathered to see him. Even after the introductions were complete, Jeremy didn’t move, only sometimes getting up to answer a question tossed out from the back of the hall. He laughed contagiously, words punctuated with a quick, “Ok?” after making a point, checking in with us to make sure he had been understood.

As a teacher, Jeremy was utterly focused on his students. His classes were oriented towards discussion, and Jeremy had a knack for keeping the topic in focus. He would ask questions, prompt in-depth dives, shift gears effortlessly, all while sincerely enraptured by what unfolded before him. He was honest, and never defensive. In a class on psychoanalysis, Jeremy broke out a video of his own work, and when the recording was over, he flipped on the lights and prompted with a smile, “Now, who can tell me what I did wrong, there?” Jeremy was never afraid to be wrong, never afraid to use his experience to help his students grow. His impact as a mentor can’t be overstated. To everyone who had the honor of working with him, even for just a moment, his memory will always be a blessing.

Joshua Finkelstein

Romy A. Reading

Spiritually and intellectually,
He taught me to wed the spiritual and intellectual. This was a revelatory permission-giving message for me to see in action. I also learned that we can wear many hats, and we can jump into and thrive in as many different communities as we are compelled toward. Jeremy encouraged and modeled courage to travel the intellectual and clinical world widely. So for all of this and much more I am intensely grateful to Jeremy. And I will continue to go forward enlivening any feelings of emptiness with memories and reflections of all the ways in which he continues to color and shape who I am and who I am becoming as both a clinician and a person in the world.

Romy A. Reading

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"Jeremy’s contributions resonated with the breadth of his experience and also expressed his sense of humor and his deep interest in living mindfully."

"He was able to draw on his own vulnerabilities and humanity, as much as his research and knowledge."

Dr. Young-Eisendrath is a Jungian analyst, author, and mindfulness teacher. On October 2007, she co-chaired with Jeremy Safran the conference “Enlightening Relationships: Psychoanalysis and Buddhism Meeting in Person”, which was attended by over 550 people.

The loss of Jeremy Safran remains somehow resistant to writing or talking about because it was such a sudden and unspeakable tragedy. Jeremy deeply touched me in many and diverse ways -- as a psychoanalyst, an author, a researcher, a Buddhist practitioner, a teacher, and a human being. It is hard to believe he is gone. In these months since his murder, I continue to “see” glimpses of him on the crowded sidewalks of New York City. His loss is still fresh.

I am writing here, not only for myself, but for the larger community of mental health professionals that Jeremy has influenced in Vermont through his presentations and his research, especially the Vermont Association for Psychoanalytic Studies, the Gibbard Lecture Series at the University of Vermont, and the Vermont Institute for the Psychotherapies where his presentations, writings, and professional relationships have made an enduring impact. Jeremy was an original thinker and a unique leader among Relational Psychoanalysts, not only because he was the rare combination of a serious student of Buddhist and a dedicated psychoanalyst, but also because he had “come over” to the psychoanalytic side after having been a very successful practitioner, researcher, and author in Cognitive Psychology.

Jeremy’s contributions resonated with the breadth of his experience and also expressed his sense of humor and his deep interest in living mindfully. When he took over Hans Strupp’s seminal research on the role of conflict and impasse in psychoanalytic therapy, I was happy because I knew that Jeremy would carry on in the venerable tradition of Strupp. Indeed, Jeremy’s work on therapeutic impasse even exceeded my high expectations for it. It’s still impossible to believe that his work will be carried on by someone else. I remember him talking with us about his results, not long ago, in a day-long program at the University of Vermont.

I don’t recall exactly how or when I met Jeremy, but I believe it was in the late 1990s. He and I began to collaborate and to share our experiences, and very soon, I found him to be a person of great integrity and a scholar of impressive accomplishment. The next thing I recall is that we were meeting regularly to collaborate on putting together the first program of Enlightening Conversations at New York University in 2007. Over 550 people attended that event and, in large part, that success was related to Jeremy working closely with those of us who met as a Planning Board at Tricycle Foundation. Then, Jeremy also came up to Vermont, at my invitation, where he was a keynote speaker for the Vermont Association for Psychoanalytic Studies. Later, he was the presenter of the prestigious annual Gibbard Lecture at the University of Vermont Department of Psychiatry. In all of these capacities, Jeremy was engaged, lively, intelligent, generous, funny, and warm. He was able to draw on his own vulnerabilities and humanity, as much as his research and knowledge.

When he called me up and asked to me to contribute the collection he was editing, called “Psychoanalysis and Buddhism”, I was thrilled to do so because I knew he would put together a first-rate volume. Indeed, when I first read through that collection while I was attending a silent retreat (where we were allowed to read relevant texts), I was very impressed by the range and clarity of the papers. I believe that I read the whole twice during the retreat because there was so much to absorb.
In all the ways I have known Jeremy, and I believe this is true for all of us who have been influenced by his contributions, he has been an extraordinary and talented teacher. He stuck with the things he started and he dug deep into whatever the project meant. May Jeremy be remembered for his dedication, skill, intelligence, insights, and diligence. The space he suddenly vacated is a large one that won’t be filled by anyone else any time soon.

Polly Young-Eisendrath

My name is Howard Steele. I am a professor in the Psychology Dept here at the New School, where Jeremy worked. Jeremy was my colleague and he was also my cousin. The loss of Jeremy has hit our family hard. Jeremy was a first cousin to me, and my two siblings, Tracy Ames and Stephen Steele who live in Vancouver Canada, where we all grew up. Jeremy grew up in Calgary Alberta (and two of his first cousins from Calgary are here today: Jackie Safran and Laura Safran). Jeremy’s mother was the only sibling of my mother, Goldie. Jeremy was very close to Goldie. She was there to comfort him when at the age of 12, Jeremy’s father died suddenly and then when his sister died and later when his mother passed away. He visited my mother often, twice over the last year, and was planning another visit soon.

Jeremy moved on from the challenges he felt in his youth, and carved out a stellar career as a psychologist and psychoanalyst, all before he devoted himself to his own family that he built with Jenny. Jeremy delighted in the births and growth of first Ayla then Ellie. In the last year, Jeremy often remarked to me and Miriam that the happiest times in his life were when Ayla and Ellie were young, and with Jenny, they were a loving complete family – along with their dogs!

My oldest memories of Jeremy are when my family had traveled from Vancouver to Calgary for Jeremy’s bar mitzvah in 1964. Jeremy seemed, big, strong, and remote. Somewhere, somehow, I understood that he had good reason to feel sad, despite the joyous occasion, as his father had recently died. What I remember most from that visit were the tall towers of comic books, 3, 4 towers, each taller than my 5-year old self, reflecting the superhero whose comic book stories were the contents of each tower. Spiderman, Superman, the Hulk, the Flash – Jeremy was animated in telling me about the unique powers of each. Years later, Jeremy loved to tell the story of how he held Marvel DC comic book stock, that was until he and Jenny put a financial planner in charge of managing their stock investments. Jeremy’s Marvel stock was promptly sold – this was some time before Disney bought Marvel comic book rights and the cinematic reign of successful superhero movies that rages on – Jeremy was well familiar with them all. A big smile and laugh would accompany Jeremy’s retelling of his investment that was sold too soon.

After my interactions with Jeremy as a 5-year old, I next recall his moving into my family home when I was 12-years old in 7th grade. Jeremy moved into our house that year, as my parents had reached out after learning...
Jeremy wanted to save money for a caravan trip across America in a VW Bus (it was 1971), and Jeremy had no apparent interest in attending university--adding to his mother’s despair. My mother Goldie told her sister, Jeremy can come live with us and his Uncle Arnold, my father, will find him work. Soon Jeremy was all moved in and started work in a plaster factory where garden gnomes and other sorts of statues were pressed into being. Jeremy would come home at end of the day, exhausted, and covered in white dust, looking rather angelic. My mother insisted he go right to the shower before joining us all for the family meal. This routine lasted through end of May 1972 when I was attending end-of-year ‘graduation’ parties for my middle school or 8th grade class. Jeremy came through for me by agreeing to buy a case of beer, I can still picture those 12 cans of ‘Cool Spring’ (an original ‘light’ beer at 3.9% alcohol). On reflection, I can see how Jeremy was kindly indulging me, while also protecting me. At the time, I was very popular with my friends for having such a ‘cool’ older cousin living in my house. Soon after Jeremy and friends set off for Mexico in their VW bus. When he came back, I celebrated my own bar mitzvah and I recall Jeremy gave me three vinyl LPs that I cherished for years, Jim Croce’s album ‘I got a name’, Jackson Browne’s ‘Saturate Before Using’ and Stephen Stills ‘Manassas’ double-album. The Jackson Browne album turned me into a groupy. I listened again and again to ‘Doctor my Eyes’, ‘Something Fine’, ‘Rock me on the Water’ and the song of love and regret Jackson Browne wrote at the age of 16, i.e. ‘These Days.’ These days, over the 8 weeks since Jeremy was killed, I have been returning to that music as it sums up many of our feelings since we lost Jeremy, perhaps esp. the title of a 1974 song entitled ‘Fountain of Sorrow.’ This fascination I have with Jackson Browne is a long-term, indirect, lingering influence of Jeremy upon me. Each of us will have our own stories of how Jeremy’s influence will stay with us. For me and Miriam, Jeremy will forever be remembered as the cause of us uprooting our family, including three children, to cross an ocean, in order for us to work with him, in the same academic department.

Much has and will be said about Jeremy’s kindness and gentle way of being, but he also had a fierce capacity for holding his ground, and could be very stubborn. This quality of stubbornness was linked in Jeremy to an unrelenting pursuit of professional and personal goals. He was the one who wrote most often to the New School Clinical Listserve, to which all current and hundreds of alumnae depend upon; Jeremy was the only psychology professor to join the Editorial Board of the influential online NSSR Public Seminar, founded by Jeffrey Goldfarb; and Jeremy was the one, together with his close colleagues Lew Aron and Adrienne Harris, who initiated the immensely successful Sandor Ferenczi Center, located it at the New School, which hosts regular public events that profile diverse psychoanalytic approaches to troubling personal, social and political issues.

Jeremy worked tirelessly to promote the well being of our clinical doctoral program, he faithfully served his patients – creatively integrating psychoanalysis and Buddhism --, and zealously mentored and supervised his talented graduate students. Students from all over the world were drawn to his lab with dreams of being accepted into the epicenter of research on ‘rupture-repair’ processes in psychoanalytic research.

Yes, it was directly thanks to Jeremy and his fierce determination that we were recruited to work at the New School, beginning in summer 2004, fourteen years ago. When we moved to NY, with 12-yr old Gabi, 10-yr old Joe and 6-yr old Miki, all because of Jeremy, well... Jeremy was delighted. He said he was happy that there would be some of his family at the large Hunter Thanksgiving dinners! Jenny, Ayla and Ellie indeed have a big and tight family, many of whom are here today, including Ayla and Ellie’s grandparents, matriarch Cathy and patriarch Marvin. I know you both feel deeply the loss of Jeremy.

Many a time, when Miriam served her 7-year term as Director of Clinical Training, Jeremy would text or call at all hours of the day or night, demanding ‘can we talk’. There was a New School crisis looming and Jeremy had a firm idea of how we should proceed. Jeremy: We sure could use your good humor and guidance these days! In conclusion, I want to refer to some special words of comfort and confidence that Jeremy’s maternal grandmother, and so my grandmother too, i.e. Fanny, would frequently say. Fanny was born in 1900 and lived into her 94th year, and often, at the end of a conversation that included the sharing of sad, or difficult-to-talk-about news, she would simply declare: ‘Well... Let’s hope for the best’.

Howard Steele
The effects of our way of life are transforming the planet, way beyond the timescale of our individual lives. Climate change is affecting you and me right here, right now, in the places where we live. How much could we and our clients change (in) the world by approaching ours and their lives as more profoundly interconnected, rather than seeing ourselves and the environment as discrete and ultimately separate entities? To pose such a question may strike as either naive or daunting, but given the challenges facing our world today, this is the kind of shift we need to explore with a willingness to act within the possible.

What if we had more psychotherapists in it for the environment? We are used to help overcoming problems in living. We sometimes help them caring for their little one inside, but aren’t we forgetting about the big one outside? In some contexts, the world is already changing for the better, but it just isn’t changing fast enough. So how do we join the collaborative effort so we can help climate change in time? The number one way can be simply by talking about it. And you guessed it! We actually have a talking profession.

In our profession we have the responsibility to activate resources – it is actually a common factor or even a mechanism of change in psychotherapy. Our work aims at increasing degrees of freedom for our clients. Nobody is really free, if his or her psychological growth does not embrace a more caring relationship to the environment. And what if our clinical decisions here and there make a difference? What if we could slowly build a sustained global movement for sustained living? And we can do this without waiting for instructions or permission, by being vocal about it!

Right there, in-session, why not occasionally dare to inquire directly about the normal stuff our clients did or plan to do? We do work with lifestyle choices, don’t we? What can be new frontiers for greener lifestyles? For example, commuting this way or the other. Buying this or that. Eating this or that. Watching this or that. Saving and consuming this or that resource. Reducing, reusing, recycling, refusing and other R’s. Monitoring personal carbon footprint. In case revamping our client’s life to get a bit more eco-friendly seems overwhelming and difficult, no worries: if there are already apps for that, there must be psychotherapists for that too. In sum, not tolerating gross distraction from simply daily habits that feed into environmental neglect or attack.

What’s happening to the environment is happening because of us. Because of how we live and what we allow and pay for in order to keep our way of life going. Dealing with this significant other can be simple or complex, but definitely rewarding. We need to talk about it. We can talk. Overlooking it is missing an opportunity. Miss a couple but not all.

Greening your psychotherapeutic practice is the act of integrating sub-perceptual or cheerfully explicit doses of interventions, such as self(-involving self) disclosures, affirmations, challenges, negative and positive reinforcements, behavioural experiments, etc., into your weekly routine with your clients for higher levels of personal, professional and environmental growth and sustainability. Theirs and yours. All interconnected. The simple act of letting our theories and decision-making heuristics implicitly and explicitly embrace and include this “big one outside”, the environment, can become a value that guides our practice. Check within your theories and maps and fill in the missing element.

This deep awareness of our interconnectedness can change our practices and contribute to change the world. It can reorient our clinical practices, individually and collectively. It is a project of practicing in accordance with the reality of environmental neglect or attack. It can move us from becoming aware, to understanding, to experiencing, and in the end can become a springboard to psychotherapeutic action.
Be it with rational hope or with conditional optimism, we need a vision of a better future—a future with abundant energy and resources available to all. We do not need to go out and actively look for the hope that we need, that will inspire us to act. We can do it in-session. That’s my line anyhow, and for now I have been experimenting it with my clients and my students more and more often. If you want to share some of your adventures into this realm, drop me line (nunoconceicao@gmail.com).

Nuno Conceição

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**Modern Principles to Undergird Established Theories**

*Jeffery Smith*

SEPI owes its existence to the intuition that all forms of psychotherapy are really accomplishing the same things, and therefore, should be integrated. Yet we continue to struggle with competing theories that confuse clients, stress students, and weaken our profession. Recently, meta-theory has come of age as a way to bring together diverse therapies by building a larger theory to contain them. The purpose of this piece is to suggest a different, more restricted approach, looking at the most basic aspects of psychopathology and change to see how just five foundational mechanisms may be pertinent to all schools of psychotherapy.

It is my intention to show that when we narrow our focus to the bare bones of psychotherapy, modern science can shed new light on those aspects of our understanding where previously, one school’s guess was as good as another’s, and passionate fighting was inevitable. I’ll focus on three areas where we have yet to fully assimilate today’s science.

**Memory**

The exploding field of computational neurobiology sheds new light on the architecture, organization, and functioning of the mind/brain as a structure for behavior control. Where much of the history of psychology has focused on consciousness, we now need to assimilate the humbling fact that around 90% of the calculations made in our mind do not enter the limited window of our consciousness. The largest part of the human mind’s appraisal and anticipation of opportunities and dangers takes place outside of consciousness, as does the formulation of appropriate responses. Furthermore, to a large extent, these functions of appraisal and response take place without the intervention of conscious reasoning. I will argue that this non-conscious function of appraisal and response generation is both the main source of our extraordinary human ability to adapt, and the source of those maladaptive patterns that are the targets of psychotherapy.

While biology has a profound influence on the ways we respond, and biological interventions represent an important part of therapeutics, talk therapy, itself, aims above all at helping patients change patterns of appraisal and response. As psychotherapists, we are there to help our clients trade maladaptive patterns for healthier ones. Recent science has shown that changing patterns of response can lead to lasting changes in...
"Psychotherapy is the art of changing synapses so as to modify old, dysfunctional information or to add new, healthier information. This conclusion may seem trivial, but it will permit us to narrow down drastically the mechanisms by which psychotherapy can produce its benefits."

Evolution

Many authors (among them, Millon, Henriques, and Hayes) have emphasized a need in the field of psychology to fully embrace the idea that the human mind’s design and organization have been shaped by evolution for the control of behavior in order to maximize survival and procreation while expending the least possible amount of energy.

The problems that bring clients to psychotherapy consist of automatic actions, impulses, emotions, and spontaneous or automatic thoughts that can lead to further painful emotions and unhealthy choices. We have already identified these as products of the mind’s appraisal of inputs and generation of reactions, based on stored information patterns. Now let’s look at them from the point of view of evolution. What evolution tells us, is that the mind is unlikely to spend energy doing things unless they have or once had value to the species. In some way, these products can be assumed to be “purposeful.” At some time, in some way, they were aimed at, and are instinctively maintained for, the purpose of enhancing survival or procreation.

Assimilating this principle is relevant to psychotherapy integration. In its early days, behavioral and cognitive therapies largely avoided the question of where and why automatic thoughts and other spontaneous mental products were produced. With a few exceptions, the question of “why” was avoided because, at best, answers were speculative. On the other hand, the same cognitive-behavioral tradition has greatly contributed to understanding what happens once spontaneous products of the mind come to consciousness, that is, how they can be the cause of further dysfunction.

Meanwhile, therapies growing out of the psychodynamic tradition embraced the idea of understanding the purposefulness of non-conscious mental products via indirect inference. Under the influence of the theory of evolution the field of biology has fully embraced the use of inference to understand the survival value of observed phenomena. Recently, cognitive therapy, too, has followed this trend with a willingness to form ideas about the origin and purposes of spontaneous mental products. Now, then, it is time to bring together these two streams of accumulated wisdom: analysis of the purpose of spontaneous mental products and knowledge of what happens after they enter consciousness.

Both groups, cognitive-behavioral and psychodynamic, have laid a lot of track. Let’s recognize that we have at last arrived at Promontory Point. It’s time to drive a golden spike to join the fruits of those who know about the purposefulness of mental productions and those who know about what happens after they enter consciousness.

Emotion

In this last section we’ll look at how contemporary neuroscience provides a helpful model for understanding the precise physiology of one type of maladaptive reaction pattern and how it can be extended to explain diverse pathologies and the action of a wide range of therapeutic techniques.

Learned fear reactions have been shown to involve essentially identical neurophysiology between humans and other mammalian species. In learned fear, appraisal can be seen as a more or less complex process of interpreting signals from the environment and from within. Through associative logic, following a nonlinear path, these inputs follow neural pathways to a common destination. Conditions evaluated as dangerous activate neurons in a relatively small subcomponent of the amygdala. In fact, the mind/brain has no other “definition” of danger than the activation of those neurons. Once they are activated, further synaptic
connections cause a variety of protective reactions ranging from autonomic changes to the conscious awareness of fear.

Studies of learned fear show, so far, just two mechanisms by which existing (maladaptive) fear reactions can be modified. Importantly, both require the same two conditions. First, both pathways require that core emotions (in this case, fear) must be activated. Second, they both require, in close temporal association, exposure to corrective information. When both conditions are met, then existing fear reactions can be suppressed or eliminated.

The first of the two change mechanisms, described by Pavlov, was extinction. Contemporary neurophysiology identifies the precise pathway as cortical learning leading to inhibitory signals being sent to extinguish the fear reaction. This inhibition must be reinforced over time in order to be maintained. The second mechanism, discovered since the beginning of this century, is reconsolidation. Here, synapses that activate those key neurons in the amygdala can be downregulated permanently so the same inputs no longer trigger “fear.”

It is a relatively small step, until proven otherwise, to assume that negative core limbic emotions are the primary mediators between the extraordinarily wide variety of circumstances that can be appraised in humans as danger, and the equally wide variety of maladaptive responses that are the targets of psychotherapy.

What is most interesting about the two known change mechanisms for altering dysfunctional patterns is that they both fit a broad interpretation of Alexander and French’s “corrective emotional experience.” Indeed, the activation of problematic emotions is one of the universal actions of psychotherapy, as is the provision of corrective information, either implied in the therapeutic relationship or provided more explicitly as insight or learning.

But the corrective emotional experience does not explain all of therapeutic action. There are often circumstances where the individual may not have learned a healthy way of coping. The third way that psychotherapy changes information is through new learning, experiential or cognitive, of healthier ways to appraise circumstances and to react to them. Thus, I am suggesting that there may be just three final pathways to psychotherapeutic change.

Conclusion

As we assimilate how the mammalian brain evolved as a behavior control center, how patterns of appraisal and reaction are stored, their purposefulness, and the role of emotion in their modification, it becomes more compelling to think that all effective therapies do the same few things. Diverse schools of therapy are effective because they help clients modify old patterns of coping and add new, healthier ones. Add to that the need to regulate levels of arousal for learning to take place plus the need to support clients’ motivation to engage in the uncomfortable work of changing, and we have a group of five elements that can be seen as undergirding existing theories derived from widely differing schools of psychotherapy so as to bring them under a single roof.

Jeffery Steven Smith

Note: A more thorough presentation of this material can be seen on ResearchGate under the author’s full name.
Final Words from the Editor

Alexandre Vaz

Dear friends,

Thank you for checking out this issue of The Integrative Therapist! It's a very special one for me, not just because it's my first one as Editor, but also and perhaps most importantly because I can, more than ever, feel the excitement of all the great work yet to come. I've written and said multiple times that I think SEPI is just starting, and that its full potential is on the horizon. I'm beyond happy to be part of this vision for a more open, attuned and scientifically rigorous psychotherapy organization that takes seriously into account the genius we continue to inherit from our different therapeutic traditions, as well as a commitment to encourage clinician-researcher collaborations. And indeed, we can all play an important role in this vision!

I'd like to quickly highlight some new initiatives you already saw and can expect in future issues:

- We now have recurring Special Sections: an update on the SEPI Regional Networks; a spot for younger integrationists; an exclusive interview with an author published on the Journal of Psychotherapy Integration; an invited contribution from a researcher to "translate" studies in a practice-relevant manner; and a text bridging psychotherapy and social responsibility issues.

- A new SEPI Youtube page will continue to create and share new and exciting video content for SEPI members and non-members.

- A continued presence of SEPI on social media via our Facebook group.

That's all for now. I love to get feedback and hear your thoughts on any of these issues, so feel free to reach out at: alexmagvaz@gmail.com. Until next time!

Alexandre Vaz

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. 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.

Contributors are invited to send articles, interviews, commentaries and letters to the Newsletter’s Editor, Alexandre Vaz (alexmagvaz@gmail.com)

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