A Profound Challenge, a United Response: Reflections on the Psychotherapy Integration Summit

The recent Summit on the Future of Psychotherapy Integration has left a lasting impression on me, as I hope it has on many of you. In my opening address I focused on the harsh reality of mental health disparities and their linkage to social determinants of health (SDoH) like education, income, and environment before reaching an inescapable conclusion: Psychotherapy is inaccessible to most of the world’s population. We must work together to integrate psychotherapy into the lives of those who need it most. To achieve this, we need to pay closer attention to the role of
SDoH across all aspects of psychotherapy integration -- theory, research, practice, and training. The Summit provided a platform for reflection on keynote addresses, followed by extended discussion.

The Summit began with a focus on the future of theory in psychotherapy integration. Gregg Henriques, former SEPI President, delivered a keynote address arguing for a paradigm shift that integrates diverse mechanisms of change (e.g., therapist responsiveness, emotional processing, patient understanding, neurobiology) to develop a "bona fide general model" of psychotherapy. He challenged us to envision a future where such a model exists. Could this model become an active control condition standard against which new interventions are tested?

The first day concluded by focusing on the future of psychotherapy research. Ueli Kramer, incoming Editor-in-Chief for SEPI's Journal of Psychotherapy Integration (JPI), delivered a keynote address emphasizing the need for research to investigate underlying principles and mechanisms for enhanced integration and efficacy of therapeutic techniques. He offered a vision for the future implications of such inquiries, suggesting they can help identify which patients benefit most from personalized treatment approaches.

The second day explored the future of both practice and training in psychotherapy integration. Chris Hopwood, a published author in JPI, envisioned a future for psychotherapy that departs from categorical diagnoses in favor of dimensional models. Shifting to dimensional models in psychotherapy offers a promising path towards the more personalized treatment approaches that Ueli forecasted the previous day.

Our final keynote address was by Alex Vaz, a former Associate Editor for SEPI's The Integrative Therapist advocated for integrating deliberate practice, a method of
focused repetition with feedback, into experiential psychotherapy training to enhance therapist skills and patient outcomes. He highlighted the advantages of deliberate practice, particularly its ability to equip therapists with the tools and adaptability to provide more effective and personalized care.

A Turning Point for Integration

It was a privilege to welcome to the Summit a diverse audience – seasoned members who laid the foundation (special thanks to Marv Goldfried for his contributions across the discussion groups), mid-career professionals embodying the spirit of integration, and early career psychologists representing perhaps the first generation to identify as integrative therapists from the outset. Discussions, coupled with the deep expertise shared by Stanley Messer and Betty Gomez on an expert panel (moderated by Kristin Osborn, SEPI President-elect Designate), lead me to believe that the Summit might be understood in the years to come as a pivotal moment for shaping the future of psychotherapy integration. Only time will tell, but one thing is certain: Progress requires accepting the challenge.

Based on the Summit, the future of psychotherapy hinges on personalized treatment achieved through a multi-pronged approach:

- **Unifying Mechanisms of Change**: Theory and research are delving deeper into core principles of change that can be integrated into any psychotherapy treatment plan.
- **Shifting Diagnoses**: The field is poised to move away from rigid categories towards dimensional models, allowing for a more nuanced understanding of individual patient needs.
- **Empowering Therapists**: Renewed focus on training methods and processes can equip psychotherapists with the skills and adaptability to personalize their approach for each patient, creating tailored treatment plans that build on a solid integrative core with appropriate and diverse therapeutic techniques.

A United Response for Change

The Summit exposed a crucial truth: A one-size-fits-all approach to psychotherapy is insufficient. We need continuous evolution in our theoretical frameworks, our programs of research, our practice of psychotherapy, and our training of the next generation. We must refine our understanding of the unique challenges faced by underserved communities and adapt our approach accordingly.

As the Summit memories fade, I find myself wondering what specific actions we can take, both as individuals and collectively, to turn these ideas into reality. While individual contributions are valuable, meeting the challenge of ensuring accessible psychotherapy services for all
necessitates a united front. Let’s work together to build a future where high quality, effective psychotherapy is accessible to all. How can you get involved? Consider contributing to The Integrative Therapist, publishing in the Journal of Psychotherapy Integration, developing a panel for the next SEPI annual conference, or hosting meetings for your SEPI Regional Network. SEPI needs and welcomes everyone’s participation. Let’s keep the momentum going by fostering dialogue and exploring new ideas together.

**Gratitude and Moving Forward**

The Summit would not have been possible without Tracey Martin’s leadership and behind the scenes coordination. Jeff Harris and Ken Levy are also appreciated for their insightful moderation and enrichment of our community discussions. Cvent staff provided the technical expertise necessary to bring the Summit vision to life. Additionally, the Summit benefited from a longstanding partnership with the Society for the Advancement of Psychotherapy (SfAP), and Ken Critchfield (SEPI Treasurer) as the SFAP continuing education committee Chair, for providing sponsorship of continuing education credits. I also extend my gratitude to the North Texas Center of Excellence for Reducing Health Service Psychology Workforce Disparities for paying the registration fees of many early career professionals and graduate students via financial support provided by the US Department of Health and Human Services Health Research and Services Administration.

**Looking Towards Istanbul**

Remember, a more equitable future for mental health requires not just our expertise, but also our collective will and an unwavering commitment to bridge accessibility gaps. I hope to learn about innovations and advances from as many people as possible when we join Jeffery Smith (President Elect) and Tahir Özakkas (Local Host and Past President) in Istanbul for the 2025 SEPI conference. We must ensure that the life-changing power of psychotherapy reaches everyone, everywhere. Together, we can make a real difference in the lives of those who need it most. Let’s continue this journey together, fostering a future where psychotherapy is truly accessible and effective for all.
Who Gets Better, Who Doesn’t, and Why: A Summary (and Update) of an Integrative Mind/Body Intervention for Chronic Pain

DOUGLAS GUIFFRIDA
UNIVERSITY OF ROCHESTER, NEW YORK

Chronic pain is an epidemic that affects over 20% of the population, which is more than heart disease, cancer, and diabetes combined. Unlike acute pain, which is short-term and alerts people to injuries that require rest or medical intervention, chronic pain can last for months or years and is often resistant to standard treatment. Recent research, however, has discovered that psychological approaches, including Emotion-Focused Therapy and Mindfulness, can be much more effective than standard medical approaches such as pharmaceuticals and surgery in treating and even curing many forms of chronic pain.

In this article I provide an overview of a chronic pain study my team and I conducted that was published in a recent edition of the Journal of Psychotherapy Integration. This includes providing an overview of the role of the mind/body connection in chronic pain; describing our small group counseling intervention in which we integrated emotion-focused therapy and mindfulness to treat chronic pain; and discussing results of our small, qualitative study that allowed us to discern the conditions under which the approach was most and least effective. The findings not only support the efficacy of the mind/body intervention, but also assist clinicians in identifying patients most and least amenable to the intervention, while also
elucidating possibilities for tailoring the approach to meet unique client needs.

The Mind and Chronic Pain

While connections between the mind and chronic pain date as far back as ancient Greek and Egyptian writings, it was not until the late 1800s that Sigmund Freud and his colleagues articulated a theory for understanding how the subconscious brain can create pain and other physical disorders as a means of avoiding or protecting us from emotions that are perceived as threatening or overwhelming. Additionally, Freud’s psychoanalytic approach to psychotherapy became widely implemented during this time as a talking cure for many forms of chronic pain and other psychosomatic disorders.

Unfortunately, the rise of sophisticated medical imaging in the 1960s, 70s, and 80s caused many in the medical community to abandon psychological interventions for the treatment of chronic pain. These new imaging procedures allowed health care providers to observe what appeared to be structural damage in the shoulders, knees, hips, and backs of people in pain. It was logical, therefore, to shift interventions from psychotherapy, to repairing these damaged body parts.

However, while surgery and other physical interventions have been helpful to many people who suffer from chronic pain, there are many others for whom surgeries simply do not work. It’s estimated that as many as 30% of all knee and hip replacements fail, with patients ending up with the same pain they had before their surgeries. The outcomes for most back surgeries are even more bleak. Spine surgeon David Hanscomb has asserted that back surgeries fail 80% of the time, and that up to 60% of back surgery patients get worse after surgery. Back surgery outcomes are so bad, in fact, that one of the most rapidly rising medical diagnoses is Failed Back Surgery Syndrome.
During the 1980s, a New York University physician named John Sarno noted the limitations of modern approaches to pain treatment through careful observation of his back pain patients. Many of them, he observed, did not improve from back surgery, often becoming worse. Still others who did improve would be back to see him shortly afterwards with similar complaints in other areas of their bodies. He also noted that there appeared to be little to no correlation between observed structural problems and perceived levels of pain. Some patients with no structural abnormalities in their backs experienced severe or debilitating back pain, while others with severely damaged looking backs were pain free. After an exhaustive review of both pain science literature and mind/body approaches to treating pain, Sarno began exploring the psychoanalytic explanations of pain delineated by Freud a hundred years earlier.

Based on psychoanalytic theory, Sarno asserted that many forms of chronic pain were the result of repressed emotions—specifically, repressed rage turned inward—rather than injuries or structural abnormalities. He wrote several books outlining his theory, including *Healing Back Pain*, and he began prescribing his books and lectures as the primary treatment for back pain. While many patients healed simply through education about this relationship between pain and repressed emotions, others with more complicated histories, he found, needed psychotherapy to assist them. For this, he turned to a more contemporary psychoanalytic approach called Intensive Short-Term Dynamic Psychotherapy (ISTDP).

First developed by the Canadian psychiatrist Habib Davenloo, ISTDP is a highly experiential, somatic, emotion-focused approach that assists patients in becoming aware of, experiencing, and expressing painful, repressed emotions. ISTDP is often characterized by its proponents as providing a critical enhancement to traditional psychoanalysis by outlining concrete techniques for accessing and working with unconscious defenses that traditional psychoanalysis lacked; this was stated emphatically by the British Psychologist Dr. David Malan, who was quoted in a New York Times article as stating, “Freud discovered the unconscious, but Davanloo discovered how to use it therapeutically.”

Dr. John Sarno attracted a large following, based primarily on patient testimonials, and his books became bestsellers; it was not until recently, however, that his theory about the relationship between repressed emotions and chronic pain has gained significant empirical support. Numerous studies now show that most people without any back pain show structural abnormalities that are associated with chronic back pain, and that many people with severe back pain show no structural damage. This has led many physicians to conclude that what we once believed to be structural damage in backs, knees, shoulders and other body parts, are most likely normal, healthy structural changes that are part of the normal aging process. Sarno famously likened these structural changes to gray hair, which, like structural changes in the body, does not hurt. Additionally, fMRI research shows that chronic pain looks completely
different in the brain than acute pain and lends support to Sarno’s theory about chronic pain being an emotional issue, not a physical one. Unlike acute pain, which causes areas throughout the brain to activate, patients experiencing chronic pain show brain activation in one area of the brain called the amygdala, which is responsible largely for regulating strong emotions such as fear and aggression.

The relationship between emotions and chronic pain has been supported by several intervention studies. ISTDP, in particular, has shown tremendous promise in curing many forms of chronic pain. To date there have been 18 published studies and a metanalysis supporting the efficacy of ISTDP is curing a wide range of chronic conditions such as back pain, knee pain, headaches, and fibromyalgia. There have also been at least three studies indicating the efficacy of small group, emotion-focused interventions in treating chronic pain, which is important given the time and cost benefits of group therapy when compared to individual therapy. Further, research suggests that integrating mindfulness with emotion-focused work can help participants overcome challenges that many chronic pain clients face when exploring painful or repressed emotions.

While there is a growing body of empirical work supporting the efficacy of emotion-focused and mindfulness-based approaches, research has not, to this point, examined the experiences of clients who participate in these interventions. This type of research is necessary to identify both the conditions that lead to successful outcomes, as well as barriers clients perceive to healing. As I will describe below, the results of our study outline for whom and under what conditions the approach was effective in alleviating chronic pain, as well conditions that yielded little or no benefit to participants.
The Integrative Mind/Body Intervention

We recruited participants from two sites: a family medicine practice and a private physician who works with pain patients. A total of 11 participants participated in one of two pain groups and completed all aspects of the study. Participants suffered from a wide range of chronic pain issues, including back, neck, and shoulder pain; headaches; intestinal/GI issues; chronic fatigue/Myalgic Encephalomyelitis (CF/ME). All of them had suffered for years with these conditions and had failed to find relief from mainstream approaches, including surgery. A more detailed description of each participant, including their medical histories, is included in the original article.

Groups met once per week for 10 weeks with each session lasting 90 minutes. Sessions included psychoeducation about the relationship between emotions and chronic pain, mindfulness meditation, and an experiential approach to emotion-focused work called Emotional Awareness and Expression Therapy (EAET). EAET was developed by Dr. Howard Schubiner and Dr. Mark Lumley and is based largely on the principles of ISTDP. Participants were also assigned homework that focused on mindfulness meditation and emotion-focused reflective writing.

My colleague Jen Farah and I, who both have extensive training in ISTDP and mindfulness, facilitated the groups. After each session, we kept detailed field notes about what occurred during each session. We also had a team of doctoral students trained in qualitative research interview each participant twice, once at the beginning of the intervention and once at the end, to understand their experiences in the groups. All data were analyzed using constructivist grounded theory, specifically, the constant comparative method of data analysis.

The Findings

Our results allowed us to categorize participants into one of three groups based on their assessments of how well the intervention worked in alleviating their chronic pain: Four participants described significant improvement in their physical and emotional well-being, five participants experienced moderate improvement, and two participants described little to no improvement as a result of the intervention. It is important to note the significance of four participants indicating they were nearly or completely pain free at the end of this 10-week intervention. As we outlined in the article, these were people who had suffered from many years, despite participating in a wide range of traditional and non-traditional interventions. More importantly, our analysis allowed us to also identify several common themes shared by participants in each of the three outcome groups that are crucial for understanding the conditions that led to each of these outcomes.
First, participants who experienced significant improvement expressed strong belief in the intervention from the beginning and this belief did not waiver, even if their symptoms flared up as they became aware of repressed emotions. This strong belief was not shared by members of the other outcomes groups: participants in the moderate improvement group expressed a partial belief in the intervention, while noting it was only part of their pain solution; and both participants from the no benefit group expressed strong reservations about the approach from the beginning. This finding supports anecdotal evidence presented by Sarno and other mind/body experts about the importance of patient belief in the intervention. In our article, we also connected this finding to something Ted Kapchuk, a leading placebo researcher, refers to as "client hope," which is a more complicated construct than simply believing in an intervention.

While sharing strong emotions was described as difficult for all participants, one reason those in the significant improvement group may have been able to engage more fully in this challenging process could be due to their strong belief in the power of the intervention. These participants also demonstrated the highest degree of trust in the group leaders and other members, which they attributed to assisting them in disclosing. We noted in our discussion that it is likely that those participants who were the most emotionally resistant could have benefited from what Alan Abbas, a noted ISTDP expert, describes as graded format techniques, which allow therapists to skillfully blend gentle, persistent emotional exploration with supportive recapping to build and strengthen client emotional capacity. Future research, we asserted, should focus on identifying clients who are likely to have the most resistance to emotional expression so therapists can better prepare them for the group through use of graded format techniques.

Third, those who benefited most from the intervention were the most conscientious about attending the group meetings and completing the homework assignments. The homework was crucial in allowing participants to not only prepare for emotional disclosures during our group meetings, but also in helping them to continue to work on issues and themes on their own that arose in the group. Additionally, the homework that focused on increasing mindfulness was likely to have assisted them in building a stronger capacity for experiencing unpleasant emotions. This finding regarding the importance of homework supports the perspectives of eminent mind/body practitioners such as Howard Schubiner.

The fourth theme that emerged related to the role of secondary gain in potentially interrupting the healing process. Secondary gain, which was first described by Freud, occurs when people experience benefits from their symptoms which would otherwise be unattainable. Such benefits can include care and concern from loved ones or medical staff, avoiding unpleasant work, or obtaining medication. While secondary gain has been discussed extensively within the chroni
pain literature, this is the first study that has noted that the participants who demonstrated the most hesitancy in engaging in the intervention were also those who described the strongest secondary gains. It is possible that their concern over losing secondary gains could limit their belief in the approach and prohibit them from actively participating in the intervention.

Conclusions

It is important to note that the intervention was perceived as helpful to 9 of the 11 participants and that 4 of them were nearly or completely pain free after just 10 weeks. This is particularly impressive given the severity and length of their chronic pain. The potential efficacy of this intervention to curing many forms of chronic pain cannot be overstated. The results, however, provide implications beyond just supporting the growing body of empirical support for emotion-focused interventions. The findings also outline the conditions under which healing occurs in emotional focused groups, as well identifying the characteristics of clients who may be the most and least amenable to the treatment. Rather than steering emotionally resistant clients to other potentially less effective interventions, the results point to supplemental strategies that can be implemented, both in preparation for and during group sessions, to assist emotionally resistant clients in more fully engaging in difficult emotion-focused work.

Finally, I want to include an important update about one of the participants that we were unable to include in the article. After the study closed, George, one of the two participants who indicated no benefit from the group, contacted me to request individual therapy. He told me that the ideas we presented in the group about the nature of his pain had continued to resonate with him after the group ended and that he had finally concluded that he was ready to engage in the work in a more meaningful way. He also stated that he thought he would have an easier time engaging in the emotion-focused work in individual therapy rather than in a group. After a few months of intense individual ISTDP therapy with me, George’s headaches and chronic fatigue were eliminated, and he was pain free. Even though I have experienced similar outcomes with many other clients, I continue to be in awe of the healing power of emotion-focused therapy!

Readers interested in learning more about this potent form of group therapy are encouraged to view the documentary titled “This Might Hurt,” which chronicles the experiences of chronic pain patients who participated in a similar group experience with Dr. Howard Schubiner. I also encourage clinicians to consult the Psychophysiologic Association (PPD) website, which contains numerous resources for both providers and patients.
The Leap Towards Deliberate Practice Supervision

JASON BRAND
BERKELEY, CALIFORNIA

There are times in life when I have thought long and hard before choosing a path forward and there are times when I have just leapt. Choosing to become a supervisor and incorporating Deliberate Practice (DP) and the Sentio Supervision Model (SSM) into my approach to supervision was one of those times where I just leapt.

Coming out of the pandemic, I was feeling some burnout. The whiplash shift to online therapy, trying to support my patients and my family during such a confusing time, and the monotony of the days in lockdown altered my perception of my career trajectory. Before the pandemic, my first 15 years as a therapist flew by and I had a sense that I was growing at a pace that kept me curious and engaged. After the pandemic, I became haunted by a question— “Do I have to be a therapist for the rest of my life?” This question was a clear sign that the pandemic slog was leading me towards a mid-career crisis.

As a result of this, I entertained some half-baked notions about finding a new career and let myself float away on a few escape fantasies but my identity as a therapist and my belief in working through moments of feeling stuck brought me back to reality. I realized that, as
opposed to pulling away, I needed to engage and instead of thinking that I was done as a therapist, I needed to grow into a new role.

The answer to burn-out is obviously not to just “do more”. Oftentimes the answer is “do less”. However, I discovered that my struggle was not about the amount I was doing; it was about finding new ways of engaging with my work. With hindsight, I can also see that the pandemic disrupted my comfort, and part of my desire to run away from being a therapist was that I had to face the fact that this new engagement was going to require some hard work.

I have now completed the first half of the yearlong residency program at the Sentio Marriage and Family Therapy MA program. The experiential component of the residency involves providing clinical supervision for two graduate trainees at the Sentio Counseling Center, a low-fee online therapy center that specializes in serving clients with trauma. I use the DP in my work and take part in a weekly supervision consultation meeting where we learn the Sentio Supervision Model. (For a review of the empirical research on Deliberate Practice, see Mahon, 2023.) I offer these early reflections on the experience of incorporating DP Supervision through the SSM into my work as a supervisor and my observations on the models benefits and challenges.

**Community**

Deliberate Practice is often explained through the example of a coach and player rehearsing
skills in a simulated environment (Ericsson, 2003; 2018). This tracks with the supervision that I am doing with my supervisees. We watch their video from the week, I identify a deficit in their intervention and then they rehearse skills based on a learning goal that I create.

I am getting a great deal out of this part of the residency program. However, what the dyadic DP work does not adequately capture is what happens when a group of people come together and decide to adopt DP throughout an organization. Within the Sentio Residency Program, I receive feedback based on how my work fits into the steps of the SSM. This is done by watching the video recordings of my supervision hours in a weekly supervisors group meeting. While it is possible to do DP supervision outside of a community, what it lacks is the rapid growth of a “practice what you preach” environment where both supervisors and trainees are showing their work and practicing skills.

This creates a chorus of sorts. The voice of the whole community, the groups within the community and the individual are amplified and pushed to define. This in turn builds a sense of cohesion on multiple levels and supports rapid individual growth. I feel this multilevel growth in my identity as a supervisor, that of my supervision cohort, my trainees and their clients.

Structure

There is something comical about multi-level video recording that happens within a DP learning community. The sessions between- Client & Therapist, Therapist & Supervisor and Supervisor & Supervision Cohort are all being recorded and reviewed. For all of those videos to not just be a jumbled mess, a good structure is key. I will focus here on the Sentio Supervision Model (SSM) and the structure that it provides for someone learning to improve their skills as a supervisor and learning DP.

On paper, the SSM is simple. It follows a set of 7 steps and reads like a well-organized plan for a supervision meeting. The depth and learning challenge of the SSM can be found in the process of rehearsal. The structure looks something like this- The supervisee comes prepared with a document that describes their learning challenge with a particular client and has chosen places in their video that illustrate this challenge. It is the supervisor’s responsibility to either corroborate or correct the therapists understanding of the clients challenge, the therapist’s deficit, come up with a learning goal and then “do the training” by using the video recording as a rehearsal space. And this all needs to be done in an hour with time at the beginning and end to focus on homework.

A saying that I like describes the SSM in a pithy couple of sentences, “the supervisor isn’t doing the training, the rehearsal is doing the training” (Rousmaniere, 2023, personal communication).
What I like about this quote is how it describes a dynamic process. One that I feel myself learning as I become more proficient with the SSM. When the clinical challenge the trainee is facing is articulated and the deficit is well documented on video, the corrective response is discovered through the repetition of the rehearsal process. This both takes the pressure off the supervisor to “know all of the answers” and creates a dynamic space of play where two people are discovering answers together.

One rather surprising aspect of this process is how much a well-crafted rehearsal can simulate the feeling of a real session for the trainee (e.g., Boswell, Constantino, & Goldfried, 2020; Hill & Knox, 2013). Even though the trainee is rehearsing in front of a recording, when the rehearsal process goes well, the trainee looks like someone who is practicing under pressure and stretching towards learning a new skill. What I appreciate most are the moments of mutual satisfaction when, after multiple repetitions, the rehearsal process yields a result that looks natural for the trainee and is well attuned to the client and clinical challenge that the supervisor identified.

The Challenges

For a clinician settling into the role of DP supervisor, having a community and a well thought out learning structure eases some of the turbulence. While this has made the process smoother, DP Supervision and the SSM are by no means easy to learn. While they provide clear goals and structure, they also challenge many assumptions about what makes for quality supervision. Nowhere has this been truer for me than in having to rethink the role of the Countertransference/Transference (Ct/T) in DP Supervision.

My memories of my own supervision experiences in graduate school are uneven. I remember feeling a sense of being deeply understood by some supervisors or an uncomfortable sense of flailing under a microscope with others. What all these early supervision experiences had in common, is the use of my countertransference
feelings, the transference of the patient and then the supervisor explaining (predominantly psychoanalytic) theory to inform a possible intervention.

In DP supervision and the SSM, the focus, structure and emphasis are on skill development and procedural learning (e.g., Axelsson, Kihlberg, Davis, & Nystrom, 2023; Larsson et al., 2023; McGaghie et al., 2011). This shift in perspective and approach has presented some disorienting challenges. There are three challenges that I will briefly describe— the challenge of the model itself, the disorientation of not working towards a familiar goal of understanding Ct/T and the discomfort of the shift in exposure onto the supervisor.

I described above the wonderful moment when the learning challenge is identified, and the rehearsal process yields results that feel like a fit for the client and the trainee. While this is a wonderful moment, I have only experienced it in glimpses and the majority of my time has been spent trying hard to condense my own big ideas about what is happening on the video into discrete exercises for the trainee to practice. In my early days with DP Supervision and the SSM there is a near constant sense of tripping over my own big ideas and that there is a simpler and more concise way to illustrate and rehearse the learning challenge, but I am just not quite situated in the right spot.

Some of this feeling of not being quite on the right spot has to do with the disorientation of less emphasis on the Ct/T and instead relying on what unfolds through the DP rehearsal process. While my early supervision experiences were uneven, there was a basic understanding that through the deep feelings embedded in the Ct/T that I would develop into a well-trained therapist. While I feel that this was often overstated, I do have concerns that an abrupt shift to being more coach-like in DP supervision bypasses the hard (and sometimes uncomfortable) learning required to sit with the deep feelings stirred up inside of the trainee (e.g., Knox & Hill, 2021).

Furthermore, I can now see that the unevenness of my early supervision experiences was partially due to learning some important lessons through a parallel process about Ct/T. I was experiencing transference feelings towards my supervisors who all modeled different ways of being with Ct/T. While this brought up the discomfort of polarized feelings it helped me to find my way to my own understanding of Ct/T and ultimately how I want to attune to my clients.

In DP Supervision, it has been my experience that the level of self-exposure feels more shared between supervisor and trainee than what I experienced in my own early supervision experiences. Without the use of Ct/T the trainee shares far fewer vulnerable feelings. The supervisor is also not able to locate clinical challenges through the trainees’ feelings and this requires more concrete evidence of what is happening. This can make the supervisor feel a
sense of disorientation that comes from not having the familiar Ct/T tools for navigating the clinical terrain. Finally, there is the fact that DP supervision is recorded, and that supervision is no longer a private conversation between trainee and supervisor. All of this adds up to the supervisor feeling the sense of exposure alongside the trainee. While this has led to some embarrassing moments captured on video, I feel that it has been worth it because of another kind of parallel process which is supervisor and trainee learning together.

Conclusion

All of these challenges do create a steep-learning curve to becoming a proficient DP supervisor and utilizing the SSM effectively. I have found that the challenges are disorienting enough to push me out of my comfort zone but also supportive and intuitive enough where I can still feel myself growing. My advice to anyone considering incorporating DP into their supervision is that they not go it alone, find a community with a well-crafted learning structure that can commiserate and normalize the challenges of and sense of disorientation of getting situated in a very different model. With that structure and support in place there is a real sense in both DP supervision and the SSM of learning a model that provides a rigorous and supportive experience for therapists new to the field.

References


Psychotherapy Unification: A New Approach Views All Therapeutic Action As Specific Types of Memory Modification

BRUCE ECKER
COHERENCE PSYCHOLOGY INSTITUTE, NEW YORK

It is widely recognized that an illuminating and useful framework of psychotherapy unification is needed to alleviate a number of dilemmas of the clinical field. Hundreds of quite different systems of psychotherapy vie for therapists’ attention and use. This kaleidoscopic situation is very rich but also very taxing, unwieldy, and confusing for us therapists. Adequately comprehending such widely differing approaches and wisely choosing between them for best helping a given therapy client are sizable challenges. Being puzzled by how seemingly irreconcilable therapeutic concepts and methods can sometimes be equally effective is in itself a chronic dissatisfaction for many therapists. Furthermore, the profusion of competing therapeutic systems has colored the entire field with an uneasy parochialism as well as the awkward predicament of having no uniform, objective, scientific basis for understanding and comparing their therapeutic action.

I contributed to that situation by co-creating Coherence Therapy, which I was actively promoting in the therapeutic marketplace until 2005, when I learned of neuroscience research findings on the newly identified phenomenon that had been named memory reconsolidation. For me, that changed everything, because it was the beginning of my understanding all
therapeutic action as modification of the state of personal knowledge held in memory. Nearly all of my writing and teaching for two decades now has been focused on developing this unifying mnemonic perspective, including presentations at SEPI annual conferences in 2013, 2018, 2019, and 2021 (with the latter two viewable online here and here).

This work has now developed further in my article published recently online in SEPI’s *Journal of Psychotherapy Integration* titled, “A proposal for the unification of psychotherapeutic action understood as memory modification processes” ([https://doi.org/10.1037/int0000330](https://doi.org/10.1037/int0000330)). This article will be part of a forthcoming special issue on psychotherapy unification edited by Andre Marquis, which will serve as an important compendium of the various approaches to unification. I’m grateful to this magazine’s editor for inviting me to provide an initial glimpse of the new article here.

The article maintains that, thanks to empirical research on memory by neuroscientists, our current knowledge of how new experiences can modify personal knowledge held in memory is now sufficient for us to identify objectively and specifically how any form of psychotherapy does that. This illuminates all forms of psychotherapy in terms of the same conceptual framework and mechanism of change, unifying our understanding of their action and accounting for the full range of observed therapeutic effects, from incremental, relapse-prone, partial symptom reduction to the total, enduring, decisive cessation of symptoms in transformational change.

Viewed in this atheoretical, empirically grounded way, diverse therapy systems no longer seem to belong to different worlds. Rather, their distinctive techniques and methodologies become a rich palette of options for adjusting the contents of memory to produce therapeutic change. This viewpoint enables psychotherapists to understand, respect, and utilize a far larger range of therapy systems than has typically been feasible previously, and to thereby select and apply forms of therapy that are more optimally tailored and effective for each unique person in therapy. It also allows each theoretical camp to explain the therapeutic action of its particular system in objective, universal terms that are readily understandable and meaningful to other camps, dissolving the walls of therapeutic parochialism.

The article defines two fundamentally different processes or mechanisms by which therapeutic processes can change personal knowledge held in memory to cause reduction or cessation of unwanted patterns of behavior, mood, emotion, cognition, and somatic disturbances: competitive change and core change.

In competitive change, the person in therapy acquires (installs in memory) new knowledge of a practice that diminishes or prevents the occurrence of an unwanted response or state. The
internal source of the unwanted pattern is unchanged and remains intact and operational, but the competitive practice interferes with the triggering and/or expression of the unwanted pattern, for symptom reduction. The therapeutic action consists of modifying the contents of memory by installing the knowledge of the use of the interfering practice. Competitive change is essentially the learning and strengthening of a preferred response or state intended to counteract, override, and prevent an unwanted response or state. Strengthening occurs via Hebb’s law (neurons that fire together, wire together) through making the ongoing effort of many deliberate repetitions over time. That learned, preferred response or state then competes against the production of the unwanted response or state. Symptom reduction tends to be partial and uneven, and a relapse occurs when the unwanted response or state is unexpectedly and strongly triggered by current conditions. A truly vast array of therapeutic techniques have this competitive design, such as relaxation techniques to reduce anxiety, exercising, positive thinking, and actively maintaining contact with others to reduce depression, and attending to the breath to reduce distressing or negative thoughts.
In core change, the brain’s mechanism of memory reconsolidation (MR) is utilized to make a fundamental, permanent modification in the memory contents that produce the unwanted response or state, at the level of their neural encoding. Symptom reduction produced in that way persists effortlessly. A person’s “memory” is the stored form of acquired personal knowledge of all types, conscious and nonconscious, verbal and nonverbal. This includes both knowledge of personal experiences (episodic memory) and knowledge of patterns perceived in the world (semantic memory), such as the knowledge that if anyone forms a negative opinion of you, they will communicate it to others and soon everyone you know will turn against you. Both episodic and semantic memory can generate clinical symptoms of behavior, mood, emotion, cognition, and somatic disturbances. Of course, some symptoms are definitely not based in memory (such as the features of Asperger’s syndrome or depression due to hypothyroidism), but memory can be shown to underlie the vast majority of symptoms encountered by therapists in general practice. Therefore, core change via MR is a viable option in nearly all cases.

Facilitating therapeutic MR requires creating a specific set of experiences that have been identified and demonstrated in numerous laboratory studies, and are mapped out in the JPI article. The MR process occurs through a rapid type of neuroplasticity that does not involve Hebb’s law. It allows much latitude for tailoring and creativity, just as, if you were required to induce in a subject the experience of laughter, you could do so in myriad different ways. Importantly, the type of core change produced in the target memory depends on the particular experiences created. In psychotherapeutic application, there are two main types of resulting core change: one that permanently reduces symptoms by grafting or conjoining interfering positive memory contents into the negative target memory, and one that completely eliminates symptoms by experientially disconfirming the underlying target memory so decisively that it is truly unlearned, nullified, and untriggerable because it no longer exists as personal knowledge.

The latter type of core change is the highest possible therapeutic effectiveness, so the article focuses in some detail on this process of profound unlearning and transformational change via MR, including its occurrence in a wide range of therapy systems that seem radically different on the level of technique, yet they all can fulfill this distinct, potent process. (Transformational change via MR is the main focus of the recently published second edition of *Unlocking the Emotional Brain: Memory Reconsolidation and the Psychotherapy of Transformational Change*, which I coauthored with Robin Ticic and Laurel Hulley.)

The JPI article gives a case vignette illustrating the facilitation of each main type of memory modification—competitive, core interference, and core unlearning. Then, having shown that the full range of therapeutic outcomes can be accounted for by known mechanisms of memory modification, the article’s final main section addresses how viewing therapeutic action as memory modification naturally forms a unifying account of the psychotherapy field and
positions therapists to more fully understand and optimally utilize the entirety of the field’s systems and methods. This section defines the main function of this psychotherapy unification framework as being “to identify the mnemonic effects of any given therapeutic process, technique, or methodology in universal, phenomenological terms, completely independently of the theoretical conceptualizations of the various schools of psychotherapy, and without challenging or critiquing those theoretical conceptualizations.” An example consists of the important therapeutic process of facilitating a direct experience of emotion that was previously kept suppressed out of awareness, and shows how to identify the type of memory modification caused by that process. Also, it is proposed that the many mechanisms of therapeutic change that have been identified, studied, and described in the clinical literature all achieve their therapeutic effect by feeding into the mechanisms of memory modification.

The article (and this one too) ends with this paragraph: “Out of intense complexities intense simplicities emerge’ wrote Winston Churchill. From Oliver Wendell Holmes, Sr.: ‘For the simplicity on this side of complexity, I wouldn’t give you a fig. But for the simplicity on the other side of complexity, for that I would give you anything I have.’ Whether Holmes—not being a psychotherapist—would have been inclined to give anything in exchange for [this unification] framework seems unlikely, but I am hopeful that its value for psychotherapists will be significant.”
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akian@yorku.ca
jeremy08@yorku.ca