Mission Statement

The Society for the Exploration of Psychotherapy Integration (SEPI) is an international, interdisciplinary organization whose aim is to promote the exploration and development of approaches to psychotherapy that integrate across theoretical orientations, clinical practices, and diverse methods of inquiry.

President's Column

A while ago when covid-19 was somewhat controlled and the Japanese government started a campaign called “Go-To-Eat” to re-activate its economy while establishing safety, I had a chance to go out to a restaurant. The experience was engraved in my memory. As soon as I entered the door, my five senses were hit by a myriad of pleasant and exciting stimuli: many layers of aromas of freshly-cooked dishes being carried to tables by waiters, the orchestra of sounds created by utensils, music, people talking, and waiters rhythmically and swiftly walking through tables as if they are performing on a small stage. It felt so nice to see groups of strangers and their smiling faces. I also noticed my curiosity was stimulated by wondering about who they were and what occasions they were there for. All these things came together to make the space alive. A couple of hours at the restaurant felt like a full celebration of everyday life: I felt so much energy and aliveness around me and at the same time I felt relaxed and content. No wonder we long for congregating and gathering, and 3Cs are so hard to resist. We have yearning for closeness, contact, and crowding. There are over 38,000 restaurants in Tokyo where I live. Each must hold different liveliness and create a unique space.

SEPI’s annual meetings that we all love are also full of fascinations: learning cutting-edge work in progress that sparks our inquiring mind, presenting your latest work and getting feedback from colleagues who share the integrative spirit yet hold divergent views, intriguing conversations in sessions and also at coffee breaks, learning creative ways in which its members integrate research and practice, reuniting and catching up with your friends and colleagues, meeting your future colleagues, engaging and relaxing conversations at poster sessions with a drink, Saturday night gala to celebrate our successful meeting and looking ahead, visiting beautiful cities around the world, and the list goes on endlessly. SEPI creates its own unique space like no other. We all play an important part in it bringing unique contributions from all over the world.

The next meeting is set forth. The theme is “Working with emotion in psychotherapy: Clients, diagnoses, Methods”. This theme will probably interest many SEPI members and also almost all psychotherapists and researchers. I have no doubt that we will have very active and stimulating presentations and discussions on the topic.
"I hope that SEPI can make the best out of the current challenge to cultivate and develop some of the important trademarks of SEPI: our dialogue, collaboration and rewarding collegial relationships among its members."

Shigeru Iwakabe

Under the leadership of the program chair and president-Elect Alberta Pos and Local Host Ueli Kramer, we have been working on planning the next meeting, which will be a hybrid meeting permitting both in-person and online access. If the covid-19 situation improves, some of us will be in beautiful Lausanne, Switzerland, and others will join online from wherever they are.

This hybrid meeting is new to us and will not be the same SEPI meeting as we know it. However, we still hope that it will bring us together and we can hold a SEPI space both in person and online and have the two spaces connected.

I hope that SEPI can make the best out of the current challenge to cultivate and develop some of the important trademarks of SEPI: our dialogue, collaboration and rewarding collegial relationships among its members. Our next meeting will be a great opportunity to start exploring how we can cultivate and develop the SEPI spirit online and throughout the year.

This is my last Presidential column of my term. I would like to express my gratitude to the members of SEPI for being a part of this international organization and representing voices of SEPI around the globe. I am grateful to Tracy Prout, the chair for Communication and Publications Committee, who renovated our webpage, created our new logo, Instagram and twitter accounts to connect us better. I would like to thank Alex Vaz who has served as the editor for our newsletter and helped us connect throughout a year. This is the last edition for which he serves as editor.

I am grateful for the SEPI executive Committee as well as the Advisory Board chaired by Marv Goldried and Paul Wachtel. Their wisdom and support helped us keep this organization going. A special thanks to our dedicated administrative officer, Tracey Martin. Finally, I am grateful for representatives of the SEPI Committees. They have worked hard to improve our experience as SEPI members and help the organization grow.

I am grateful for this opportunity to serve as SEPI’s 2020 President. I am full of renewed commitment and appreciation for SEPI. I look forward to seeing you on our next webinars and future meetings.

Shigeru Iwakabe
SEPI Welcomes Ukrainian Regional Network!

We have just welcomed a new Regional Network from Ukraine. The coordinator is Dr. Olha Lazarenko. Olha writes that she would like to interest both students, practicing psychotherapists of all disciplines, and researchers in the activities of the SEPI community. Another goal is to encourage knowledge of other cultures, and scientific activity. Olha is a member not only of SEPI, but also of SPR and APA. She does research and clinical practice, and has a number of publications. As with all applications, the Ukrainian application was reviewed by Tom and Doménica, by the current RN coordinators, and by SEPI’s Executive Committee, with strong support from all. Our Regional Networks come from over 20 different countries, and show the universal importance of psychotherapy integration.

Tom Holman (tom@tomholman.com)
Doménica Klinar (dome.klinar.a@gmail.com)
"The Swiss Network of SEPI is very honored to be selected for the Arnkoff-Glass Regional Network of the Year Award 2019."

By Ueli Kramer, University of Lausanne, Switzerland

The Swiss Network of SEPI is very honored to be selected for the Arnkoff-Glass Regional Network of the Year Award 2019. In this report, I will describe some of our recent activities in Switzerland.

The psychotherapy landscape of Switzerland is marked by a heterogeneity in practice, a favorable context for research, supported by a federalistic and decentralized, political system. The latter yields 26 different health systems on a surface smaller than 50,000 square kilometers, with approximately 8.5 million inhabitants speaking four different languages. So services in mental health, provided mainly by psychiatrists and psychologists, may be quite diverse across a small country, in response to varying contextual factors. Accordingly, the exploration of psychotherapy integration may vary in its focus, depth, method and yield across the country. Like the different tastes of exquisite pralines, Swiss psychotherapists in different corners of the country may be practicing very differently – generally on a high level of competence –, and they may be receiving quite different psychotherapy trainings, also generally on a high level of quality and structure. What may be missing at times is a context which brings these different practices together with the aim of even increasing their effectiveness. A mindful therapist may be asking: what should I do with this particular client when the interaction gets difficult? Has any other colleague had experience with such a particularly difficult situation? What does psychotherapy research have to say? The exploration of psychotherapy integration may offer tentative answers to these questions. While research tends to cut across the singularities of specific therapy approaches, trainings contexts, and delivery methods, it remains a challenge to integrate, in this heterogeneous context, psychotherapy practice with research.

Yet, this is what many Swiss SEPI members are striving to do. Combining the excellence of research with the relevance of clinical practice has been a credo for many Swiss SEPI goers for years, and by the way, this is true not only for members from Switzerland!

I will report on two recent events which represent this challenge in a nice way.

In February 2019, we have co-organized with the Swiss Society for Emotion-Focused Therapies (EFT-CH), the Swiss-French branch of the European Federation of Psychoanalytic Psychotherapy (EFPP), the Swiss Society for Psychoanalysis (Lausanne Center), and the University Clinic of Lausanne a clinical debate on memory reconsolidation in psychotherapy. Featured speakers were Richard D. Lane for the main talk, and Catalina Woldarsky Meneses and Gilles Ambresin for the clinical illustrations from two different perspectives. The model presented by Lane et al. assumes that long-term memories are not only passive records of the past, but also blueprints for future interpersonal transactions.
Under certain circumstances, memories may be updated and changed with new information. This process takes place within a co-activation of episodic and semantic memory structures, along with the essential activation of emotion, substantiated in a neuronal basis implying the hippocampus, the amygdala and specific pre-frontal areas. This hypothesis may be true across psychotherapy approaches. Our two discussants were able to illustrate with clinical material the process of memory reconsolidation from psychodynamic and emotion-focused perspectives. A convincing exploration of a common basis of how psychotherapy works!

In October 2020, together with our Austrian and German SEPI colleagues Markus Boeckle and Johannes Ehrenthal, the Swiss Regional Network co-organized a one-day symposium on deliberate practice in psychotherapy, in German, with an important line-up including (among others) Silke Gahleitner, Franz Caspar, René Reichel and Astrid Riehl-Emde. It was planned to be held in Bregenz (Austria, right at the corner of the three German-speaking countries), but due to the pandemic, it was held online. With this symposium, supported by SEPI, deliberate practice has arrived in the German speaking world as a productive way of enhancing diverse psychotherapy trainings, focusing on the knots and bolts of the therapist effect in psychotherapy, and taking integrative principles of change into account in the training and supervision of psychotherapists. We spent an inspiring day together, and many questions were debated on the characteristics of the development of expertise in psychotherapy through repeated and informed deliberate practice. The implementation of deliberate practice in different contexts (couple's therapy, emotion-focused therapy, trauma therapy, supervision, animal-assisted therapy, online counseling) was discussed. As an example in Switzerland, deliberate practice may inform the debate on the still lacking overall reimbursement policy of psychological psychotherapy with the underlying issue of a truly competence-based psychotherapy.

Last but not least, the Swiss Regional Network is currently working hard on bringing us all together next year at the 37th SEPI conference to be held in Lausanne (Switzerland), from June 10th to 12th, 2021.
Join Us For Our Next Free Webinar!

"Working with Emotions in Therapy the EFT Way"

A Fireside Chat with Les Greenberg, Rhonda Goldman, & Alberta Pos

Tuesday, December 15, 2020
7:00 - 8:30 pm (Eastern)

How can we, as therapists, work effectively with emotions in therapy? In this free-format conversation about emotion in psychotherapy, Drs. Greenberg, Goldman & Pos, trainers in the Society of Emotion-Focused Therapy (ISEFT) will engage in discussion on how we can target the emotions of our clients in a principled, yet integrative, EFT way.

Opening the discussion, Alberta Pos, the incoming SEPI President and Program Chair of SEPI’s Annual Meeting in Lausanne, will introduce the conference theme and describe how broadly emotion work in therapy can be conceived. Following this, Les Greenberg will introduce how integrative EFT treatment offers guidance for clinicians to work emotionally with many populations. He will also discuss new research that offers clinicians new perspectives on working with emotion. Dr. Goldman, is past SEPI President and co-author of several volumes relating to EFT in general and also writes about couples work in EFT. She is also an expert on interpersonal issues related to emotion and how to help couples co-regulate their affect through working with maladaptive emotional patterns. Finally, Dr. Pos will discuss recent research that highlights the importance of emphasizing emotion skills and emotional intelligence with our clients. Audience participation and questions will be encouraged.

REGISTER HERE

Les Greenberg
Rhonda Goldman
Alberta Pos
"Clients show signs of immediate progress when therapists intervene in ways that are ‘plan compatible’."
4. Clients in therapy are typically highly motivated to overcome pathogenic beliefs and achieve their goals, and may work in idiosyncratic ways to do so;

5. Safety is an important determinant of the degree to which clients can regulate (i.e., control) their mental functioning and perform psychological work to achieve their goals (i.e., mastery).

Plan formulation attends to the ways in which the client attempted to adapt to traumas through developing pathogenic beliefs, the ways in which these beliefs impede achievement of personal goals, and potential means for creating safety and corrective experiences to address pathogenic beliefs. After obtaining a history of the client’s difficulties and personal development, the therapist can organize inferences about the plan according to the following plan components: Goals, Obstructions, Traumas, Insights & experiences, and Tests (GOT IT).

Goals refer to the client’s adaptive developmental goals, that is, goals for therapy and for life more broadly. It is often helpful to consider the client’s stated goals whilst being aware that sometimes a client may state a maladaptive goal that actually reflects a pathogenic belief. In other instances, clients may not feel safe enough to become consciously aware of their adaptive goals. Thus, the therapist must infer goals based on an understanding of the client’s history, abilities, and life circumstances.

Obstructions refer to the obstacles that prevent the client from pursuing or achieving adaptive goals. Typically these are considered in terms of pathogenic beliefs, which the therapist may need to infer from the client’s presentation and history. Pathogenic beliefs originally develop to facilitate adaptation to difficult interpersonal circumstances, when children must preserve attachments to parents. A child may, for example, adapt to maltreatment by believing she deserved to be treated badly, thereby preserving an image of a benevolent parent. During adulthood, this pathogenic belief may fuel poor self-esteem and lead to unsatisfying relationships. Another child may infer that being separate will abandon or offend an insecure parent. This pathogenic belief may subsequently inhibit autonomous functioning and lead to excessive guilt and responsibility for others.

Traumas are considered broadly as experiences that interrupt the safety and capacity for pursuing developmental goals. Generally, an experience may be considered traumatic if it led to the development of pathogenic beliefs. Informed by knowledge of psychosocial development, therapists may need to infer potential traumas, as some clients may not feel safe enough to disclose them.

Insights & experiences refer to the kind of knowledge and learning the client may need to obtain during therapy to feel safe, address pathogenic beliefs, and master traumas. This encompasses both verbal, declarative knowledge and experiential, procedural knowledge. In other words, benefit may occur through verbal interventions—promoting new learning about the origins and functions of pathogenic beliefs—and from therapists’ attitudes and behaviours that constitute corrective experiences for that particular client.
Tests are trial actions or scenarios used by the client to acquire a sense of safety and disconfirm pathogenic beliefs. According to CMT, clients test the veracity and appropriateness of their pathogenic beliefs within the therapy relationship. Testing is typically performed unconsciously to learn about and develop alternatives to the pathogenic beliefs that constrict the pursuit of important developmental goals. While testing, the client observes the therapist’s attitudes and responses to determine whether it is safe to proceed in becoming aware of and pursuing forbidden goals. If the therapist appears supportive of the client’s effort to disconfirm pathogenic beliefs, the client is helped toward resuming adaptive personal development. For example, a client may test by proposing a reduced frequency of sessions—‘hoping’ that the therapist will not agree with this proposal and thus undermine his belief that he doesn’t deserve care and attention. Another client may become argumentative with the therapist to test a pathogenic belief that disagreements are intolerable. Yet another client may diminish her accomplishments to test whether others need her to be subordinate. Understanding how such scenarios reflect a particular client’s adaptive therapeutic work, and what kinds of responses would be optimal, is greatly facilitated by a plan formulation. There is no ‘one size fits all’ in psychotherapy, and the Plan Formulation Method provides an elegant framework for integrative, personalized intervention.

References


The race to transforming mental healthcare through cutting edge technologies: Are you on board?

By Ioana Podina  
Senior Assistant Professor, University of Bucharest (UB), Romania  
Chair of the SEPI Research Committee

There has been a lot of turmoil around advancing the research on digital mental health solutions (DMHS) and rushing its uptake in clinical practice in the context of the COVID-19 pandemic. If anything, the current COVID-19 pandemic made it clear that we need viable technological alternatives for instances where in-person treatment becomes unavailable. Though the current COVID-19 pandemic is a good template for this article's topic, there is no need to give it more hype than it has already received and therefore it shall be referred to as “He who shall not be named” (sic) in the following.

The rapidly growing interest for DMHS and future prospects

The global digital health market is predicted to more than double its value by 2024 (Market Data Forecast, 2020; www.marketdataforecast.com) and in its rise, it will push forward mental healthcare solutions. It took almost 20 years for internet-based DMHS to be embraced by practitioners in most countries. This will most likely not be the case in the future. In other words, the combination of the fast pace of technology, the aggressive marketing interests, and the increasing receptiveness of users in regards to readily available solutions means that mental healthcare is transforming whether we - as mental health specialists - are on board or not.

Out of all the future technological prospects, digital phenotyping powered by AI and machine learning forecasts probably the best how mental healthcare will look like in the nearby future. Digital phenotyping stands for moment-by-moment tracking and assessment of the individual-level data that is automatically generated and collected from personal digital devices, such as smartphones and wearable sensors. Below, are some of the clinical and public health uses of digital phenotyping powered by machine learning and AI (more details in Podina & Caculidis, in press).

Firstly, tracking data can be highly suitable for forecasting and preventing relapse. Relapse prevention is chiefly important in mental illnesses such as schizophrenia and borderline personality disorder (BPD). The development of digital phenotyping tools that deliver timely warnings to BPD or schizophrenia sufferers would be highly useful as they find it difficult to self-monitor. Patient behavior anomalies days before a relapse could be used to inform machine learning algorithms and develop smarter digital phenotyping tools.
Secondly, continuous data collection is expected to enable the identification of undiagnosed conditions and/or lead to a susceptibility analysis. Passive detection of phone activity (e.g., GPS tracking) and machine learning is by now used to detect individuals at risk for depression or anxiety. Previous research has also demonstrated the feasibility of machine learning algorithms for natural language processing in training predictive models using Twitter and Facebook content and activity records (Eichstaedt et al., 2018). This could mean that the automatic natural language processing of social media posts will become a progressively more accurate screening method.

Thirdly, another important usage of digital phenotyping is that of tracking treatment growth and treatment choices. Only around half of the depressed patients respond to their first selected medical treatment choice (Rush et al., 2009) with significant time and money resources directed to finding the next best option. Digital phenotyping could reduce these costs by timely tracking user progress and giving access to the level of intervention they require in a stepped care manner (e.g., the Alfred project - www.alfredhealth.com).

Overall, digital phenotyping - in the context of machine learning and AI - is estimated to impact care at all stages stemming from prevention to intervention. Other noteworthy mentions that are set to drive progress in mental healthcare are conversational agents or chatbots, sensors and integrated systems, and big data analytics (here are some present-day projects; Exploring and Modifying the Sense of Time in Virtual Environments; www.virtualtimes-h2020.eu; European Platform to Promote Wellbeing and Health in the Workplace; www.empower-project.eu).

Warranted caution

Therefore, as mentioned before, we need to consider whether we -- as mental health specialists - board a train that holds the promise to be a fast pacing train with no stops. Yet, why most of us aren’t on board yet?

(1) The majority of the current DMHS solutions have been disappointing at best. Indeed, there are several systematic reviews and meta-analyses which end on a positive note, including some earlier work (Podina et al., 2015). Yet on a closer look, when looking at its efficacy against separate control groups, and not against an overall control grouped encompassing mostly waitlist groups, DMHS solutions do not seem to be an alternative to in-person interventions (Fodor et al., 2019), and these result tends to resurface in other fields of healthcare as well (Podina & Fodor, 2018).

On the upside, DMHS options perform well when guided or when preceding or accompanying standard care. For instance, Duffy et al. (2020) recently researched a stepped care model for severe depression and anxiety using internet-delivered Cognitive Behavioral Therapy (iCBT) as a prequel to in-person intervention. The results supported the use of iCBT as a means to reduce treatment delivery waiting times and enhance clinical efficiency.

(2) The second argument is very much connected to the first. There is little funding directed towards improving DMHS solutions and directed at mental health research overall (see www.treat-me.eu/dissemination/official%20documents/white-paper.html). Take for instance the case of serious games. The gaming industry is making groundbreaking steps towards adaptive games that are responsive to a user’s digital input and that are incredibly immersive, yet serious games with therapeutic relevance are facing difficulties to be interactive and immersive due to limited funding.
(3) On account of the 2nd point, DMHS solutions tend to have a high attrition rate and due to the repetitive nature of the tasks they reach a point of limited usage within weeks.

With the new surge of interest in regards to mental health, it is only a matter of time since private funding entities and major players in the IT industry will shape how DMHS will look in the future. Hence, from a technological standpoint, there is no rationale for which to wait another 20 years to go by for practitioners to embrace today’s technological advancements. The biggest concern is that this fast pace of development will disregard research in order to rush the product to a marketing stage. The question is (a) whether professional and national funding bodies and researchers alike will join the race set by technical advancements and seek new ways and regulations to speed-up the research — user uptake process or (b) will approach it cautiously risking for the untested product to reach the prospective patient faster. Nevertheless, this final argument should not be confounded with eagerness to readily translate preliminary research into practice, but rather as an awareness statement to bridge the gap between digital innovation and day-to-day practice.

My take on what to expect in the next 30 years

Considering that it took approximately 20 years for internet delivered interventions for mental health to be embraced by psychotherapy in most countries, I do not expect that by 2050 mental health specialists will be a dying breed. On the contrary, human interaction may be all the more needed in a context where most aspects of life will be digitalized. I do expect, however, that technological advancements, particularly AI, will shape how mental healthcare looks like in the future. Hence, there should be more individuals timely diagnosed, more efficient accessible self-help preventive solutions, and early detectable and reliable markers of at risk individuals that push forward notifications and timely solutions. I expect that the biggest leap in mental health will be made in regards to how accurate our behavioral prediction algorithms will be which will leave more room for preemptive actions and hopefully not for Minority Report Scenario. Most importantly, due to mass digitalization, concern for mental health should become in the future 30 years like a mental fitness mindset which is recurrently exercised and just a hologram away from a mental health trainer. Briefly, I expect that we will continue on the track that we are already on and the pace at which we will choose to embrace new technological developments will have ups and downs.

"I expect that the biggest leap in mental health will be made in regards to how accurate our behavioral prediction algorithms will be."
How can we empirically capture the complexity of human nature and the intertwining variables that make psychotherapy helpful (or unhelpful)? Psychotherapy research is deeply challenging, yet in spite of the challenges, the depth of our knowledge is profound and is a testament to the efforts of many who have approached the work with nuance, compassion, sophistication, and flexibility.

The world of psychotherapy research was born out of a wish to amount empirical evidence for a talking-based treatment of mental illness. For decades prior, support for psychotherapy was limited to theoretical discussions and case studies. Empirical work that unfolded in the years since, aimed to (i) understand, through quantitative, qualitative, and mixed methodological approaches, which factors contribute to patient change over the course of psychotherapy and (ii) test the efficacy of specific treatment approaches (i.e. evidence-based treatments). Nevertheless, the nature of research design, sample size, and statistics often force us to examine one or two key variables at a time, which, as many of us would agree, oversimplifies the experiences of patients in treatment and the range and interactive complexity of processes that account for change. Moreover, and at least as serious, it is essential that our research address more focally the diversity of our patients and their experiences in treatment. As a field we need to broaden and deepen our focus by considering more fully the diversity of life experiences and social locations across patients as well as across therapeutic dyads. Rather than ask about the role of working alliance in psychotherapy, for example, we can test if working alliance functions the same for all patients and dyads, and if not, how it varies.

Another under-examined dimension of psychotherapy research relates to therapists themselves, who are frequently left out of research studies. To the extent that therapists participate in research, they are often used as reporters for their patients’ functioning and for the therapeutic process (i.e. working alliance or techniques employed), or simply included via demographics, such as therapist gender, race, ethnicity, within a broader study. In fact, to the best of our knowledge, there is little work that examines therapists’ own psychological profiles independent of their patients, such as their level of mindfulness, attachment categorization, personality organization, or emotional intelligence and the relationship between these therapist factors on treatment course and patient outcomes.
As a field we are reluctant to define clinicians as “good” or “bad” through quantitative metrics. To do so would force a dichotomy that glides over the complexities of the therapeutic process, waters down the web of factors that make a therapist effective, and neglects ways in which this efficacy shifts depending on the specificities of the patient and patient/therapist dynamic. Still, our hesitance as therapists to become more vulnerable to scrutiny by participating in psychotherapy research, we fear, will create an artificial barrier against further inquiries into psychotherapy.

Our framework is grounded in a two-person model of treatment that holds at its center the intersection of patient and therapist factors, and emphasizes social location and one’s experiences over the life course. It is our opinion that research too often does not reflect this orientation and therefore undervalues how our patient’s lifetime experiences affect how they may progress through treatment. Working alliance, a vital and much-examined construct in psychotherapy research, hones in on the relationship, however this relationship is often conceived of as independent of the variety of other patient and therapist constructs that may moderate it. For example, cultural humility, a newer and less popular area of study, relative to working alliance, places an increased onus on the therapist to acknowledge their bias and assumptions about their patient's lived experiences and held identities. In this vein there is growing evidence that cultural humility may contribute significantly to working alliance, especially among patient-therapist dyads that do not share the same social-location(s) and/or reference group memberships. Further investigations are necessary to form adequate and realistic understandings of why certain treatment processes and certain therapists, themselves, are more effective than others and to better understand for whom these processes and therapists are more effective.

To address the above, three questions guided the development of the Programmatic Evaluation and Clinical Effectiveness (PEACE) program and the ongoing approach to the data (PI: Rudenstine, for more information visit: www.intersectccny.com).

For whom does psychotherapy work?
Psychotherapy has the potential to be effective for anyone. Nevertheless, the underlying assumption here is that psychotherapy is at its best when clinicians consider who their patient is at the onset and tailor treatment to meet patient needs, rather than fitting every patient into the same treatment frame.

What are the mechanisms by which it works?
There are a handful of constructs that have been repeatedly identified as catalysts of change in psychotherapy. While the work on these constructs must continue, we recognize that these constructs explain a very small amount of the variance associated with treatment outcomes. Two avenues of inquiry that we believe are warranted are (i) an examination of additional constructs as potential mechanisms of change, and (ii) an expansion of the current work to test if the variance in treatment outcomes changes across different subpopulations or other psychological profiles. A core assumption here is that the strength of each mechanism of change may vary by patient, by therapist, and by dyadic combination.
What do we mean by “work”?

Research that defines successful outcomes by symptom alleviation, for example, may capture positive or negative change among individuals who present to treatment symptomatically, but may miss the quality of change occurring in an individual attempting to negotiate a career change in their treatment. Patient reported treatment goals are informative data that can be used to examine psychotherapy subpopulations. For example, we have coded patient reported treatment goals into 6 categories and have found, unsurprisingly, that patients who report a psychiatric goal (i.e. reduce anxiety) have significantly higher symptom levels as measured by the Brief Symptom Inventory than individuals who report an intrapersonal goal (i.e. work on self-confidence). Given this finding, it would be misleading to assume the same outcome can measure effective psychotherapy for these two subgroups.

These questions are the foundation from which the PEACE program that was launched in 2015 at The Psychological Center through the Intersect Lab at The City College of New York. For the past five years, we have sought answers to some of these questions, with the goal of applying the psychotherapy research paradigm to a community-based setting with a broad racial and ethnic diversity among patients and therapists, and a plethora of presenting problems, psychological profiles, and therapist variables. As a part of a doctoral program training clinic, we approach treatment planning and conceptualization with the flexibility and openness that accompanies training clinicians. Our research model is based in four-month follow up assessments, and the long-term nature of the treatment that our clinic offers contributes to the nuanced questions that we can both ask and attempt to answer. This model, understandably, is not feasible in many contexts, but our aspirations and questions that aim to explore the complexity of treatments can be applied universally.

The integrated model of SEPI, and the flexibility with which each of us approaches different treatment modalities, allows for inquiries that consider the interactions across a variety of treatment variables and that more fully address the complexity with which clinicians operate, which is rarely captured in the research that has been conducted to date. To be sure, many nuances and realities of therapy will always evade study, but by daring to engage the complexities to which we have been alluding in this piece, we believe that we can make real progress in getting even closer to them.

References


"Empirically supported treatments are more and more including experiential practices, which in the past were mostly confined to non-empirically supported orientations. If you had asked your best friend in your psychotherapy school about guided imagery and rescripting, two-chairs, role-play or experiencing vivid, painful scenes while making the patient follow your fingers or while tapping on their legs, she would have answered: “I have heard they exist, somewhere”. And if she did know them, she sure was not enrolled in either a cognitive or a psychodynamic training. Chances are she was into a humanistic school, gestalt-oriented, or some psychodrama. And, with some exceptions, neither gestalt nor psychodrama could be labelled under the category of scientifically based psychotherapies. So, if you were a self-defined ‘serious’ therapist, your sessions with your patients were all about talking. Unless you were a behavioral therapist, so you gave them exposure exercises, or you learnt hypnosis which, honestly, was a scientific practice long before its pupil, i.e. EMDR.

Well, hypnosis together with emotion-focused therapy (EFT; Greenberg, 2002) and prolonged exposure for PTSD (Foa et al., 2007) were almost the only two practices which: a) were based on a empirically testable paradigm and b) included experiential work, meaning asking patients not just to remember problematic episodes, associate from those, reason differently about those, but also to re-live them in the here and now of the session.

What is happening now? Let me mention a series of empirically supported treatments, beside the aforementioned hypnosis and EFT: compassion focused therapy (Gilbert, 2010), schema-therapy (Arntz & Jacob, 2012), EMDR (Shapiro, 2001), dialectical behaviour therapy for complex trauma (Bohus et al., 2020) and metacognitive interpersonal therapy (Dimaggio et al., 2020). Are they all empirically supported or aiming at empirically support? Yes, they are, but what do they share? They share a large use of experiential techniques: role-play, guided-imagery and rescripting, two-chairs, bodily work.

This means, that if you are at the café with your best friend during the psychotherapy training today, and a colleague of another orientation meets you and asks if you have ever heard of those techniques, you and your friend are now more likely to answer in chorus: “Yes, we do!".
Why is this happening? I can tell what I witnessed over the last 25 years. First, the empirically supported movement was mostly about CBT. And CBT therapists mostly talked, unless when delivering behavioral homeworks. Their main rival was the family of dynamic therapies and sure the latter folks only talked with their clients, and cared very little about empirical testing. With time, empirical support grew for many modalities, and psychodynamic therapies jumped on board. With empirical support came the awareness that success was always limited: the percentage of dropouts, non-responders and partial responders was significant, and relapse was a serious issue. So, therapists willing to deliver something backed up by science realized their work was insufficient, albeit for the majority of their patients.

Second, interest in treating severe clients, like one with personality disorders and complex trauma, grew and again it became a matter of empirical investigation. Clinicians in this area knew since decades that promoting change in these persons was difficult. So, with a more and more tactful regulation of the therapy relationship, they were more able to limit dropouts, but many therapies stalled. DBT, I have to acknowledge, was a game changer in that domain. It included a heavy behavioral element when treating borderline personality disorder, and it made clear that in order to change, these patients had to do something actively.

The third driver of what I am naming ‘the experiential revolution’ is a change in theory. Developmental psychology, neurosciences and experimental psychopathology consistently showed that the largest part of maladaptive cognitive-affective processes unfold themselves at a level which you may name: implicit, tacit, procedural, unconscious (e.g. Bargh, 2017). Patients suffer not just for their maladaptive conscious attributions about self and others, but because of learnt patterns involving behavioral procedures, implicit attributional biases and quick and intense somatic responses involving hyper- or hypo-arousal.

Summarising, to my view such a revolution happened because of the combination of these 3 factors: a) growing impact of the empirically supported therapies movement; b) growing interest in therapies of patients with more severe pathology; c) advancement in basic psychological and neuropsychological sciences.

But the revolution did not come for free, knights of old-fashioned schools raised their barriers, launched their anathemas to the revolutionaries. Their main argument was a concern about safety: experiential techniques are risky, if you use them you are likely not respecting the subjectivity of your clients and their need to be empathically listened. Some considered introducing these practices (e.g. behavioral experiments; Gaylin, 2000) as intrusive. Giving that most of these techniques have the primary effect to let patients’ arousal mount, concerns about safety were expressed with sentences like: “They risk dysregulation”, “They will end up out of their window of tolerance”, “They will dissociate”. Then a more basic criticism: in light of the Dodo verdict, we know that common factors are what you need to play a good game and therefore: why the need to add these “risky” paraphernalia to your toolbox?

These criticisms come to a cost, that is they ignite fear and limit dissemination of experiential practices in psychotherapy. The most striking example is what happens to a heavily experiential treatment, that is prolonged exposure for PTSD (Foa et al., 2007). It has very solid empirical support, but its implementation is largely insufficient (Cahill et al., 2006). As Cahill and colleagues note, among the reasons for insufficient dissemination are concerns that patients will decompensate. Spoiling the finale of my café story: the two friends sipping their espresso know
"We need to work hard in testing these ideas, before concluding that experiential psychotherapies will be more than the new sensation."

experiential techniques, but at least one of them does not apply them. And who knows if the other does?

One may sceptically ask: is there ground to say that experiential therapies are both safe and more effective than talk therapies? Here I have to acknowledge that the question is not solved once and for all. We have not sufficient ground to say that these experiential-based and empirically supported therapies are faster, more powerful and equally safer to non-experiential therapies. The Dodo may still hoover in the air, in spite of its inability to fly.

But data are growing backing up these ideas. I will only report a few examples. Tripp and colleagues (2020) found that exposure did not exacerbate symptoms in a trial on patients with PTSD. In a trial of DBT vs Cognitive Processing Therapy for women with complex trauma, the DBT arm was exposure-based unlike the CPT one. The DBT arm had less dropouts (25% vs 39%) and better symptom response. No concerns about safety could be raised from this study and no Dodo flying in the air, DBT clearly outperformed CBT, non-exposure based. Of note, do not think that exposure therapies ignore the issue of safety. Bohus and colleagues (2020) pay plenty of attention to that, and exposures only starts by session 17-20. But let see that from the other angle: even with a very severe population, therapists did not wait more than 5 months to start with exposures.

Another study compared two experiential-based therapies for adults with childhood trauma: Imagery Rescripting vs EMDR (Boterhoven de Haan et al., 2020). It is a population with intense suffering and, according to theory, with some difficulties in trusting therapist on the ground of their developmental history. Well, dropouts were very low in both groups (7.7% overall), again indicating that treatment was safe and well-tolerated. Treatments were equally effective on all outcomes, not surprisingly as they shared many similarities. In Metacognitive Interpersonal Therapy the experiential element is fundamental, a combination of role-play, imagery rescripting and bodily work. Preliminary studies had very low dropout rates and good outcomes (Dimaggio et al., 2017; Gordon-King et al., 2018; Inchausti et al., 2020; Popolo et al., 2019).

Finally, a couple of studies on the psychotherapy process are promising. Stiegler and colleagues (2018) have found that anxiety and depression changed more in their sample after the two-chair techniques was used, than during the first sessions which were only focused on alliance building, empathic attunement to affect and other common factors. Similarly, Romano and colleagues (2020) investigated a sample with Social Anxiety Disorder. Clients were randomly assigned to 3 conditions, a single sessions of a) imagery rescripting (IR) b) imagery exposure (IE) c) supportive counselling. Only the two imagery-based conditions yielded changes in memory details, which were absent at all in supportive counselling.

Are these studies enough to say that the revolutionaries are right, that therapists in the future have to be and will be trained in using experiential techniques, as they are safe and more powerful? Such an answer is premature. And I have to say that some heavily experiential therapies, like sensorimotor therapy (Ogden & Fisher, 2015) and coherence therapy (Ecker et al., 2012) lack empirical support at all.

We need to work hard in testing these ideas, before concluding that experiential psychotherapies will be more than the new sensation, and we eventually have empirically evidence backing up what evolution said 400 years ago: the Dodo is extinct, with good reasons.
References


Final words from current Editor and introducing our new SEPI Newsletter Editor!

Dear SEPI friends

Stating the obvious: this year did not turn out the way we all expected. So many of our plans got scrapped, so many deadlines missed or postponed (coff coff), and so many opportunities to test our own flexibility. Throughout all this, SEPI persists in getting with the times, having promoted more online content this year than ever before, and taking steps to remain as inclusive as possible (e.g. deciding to go for a mixed format of both online and in person international conference next year).

All good things must come to other new exciting things. In this spirit, I’m very happy to say I’ve had immense pleasure in the luxury of acting as Editor for this newsletter. I want to formally thank everyone that’s helped along the way (unfortunately I’m sure to miss so many, so please consider yourselves included even if you are not here!): thanks so much Catherine, Sasha, Shigeru, Tracy, Jefferey, Tracey, Marv, Paul, Nuno, Tom, Ioana, and many, many others.

I now want to give someone else the same great opportunity I once had: To have an enthusiastic young career psychologist the chance to prepare this newsletter and continue promoting our integrative efforts around the world. I could not be happier to announce Alan Kian, from York University, Toronto, as our next SEPI Newsletter Editor. Alan is a kind, smart and enthusiastic guy (my personal fav combination of qualities). He will make a great Editor! I asked Alan to write a few words about himself, as a first presentation for our SEPI community. Here they are:

"I am a 2nd year MA student studying at York University in Toronto, Canada, under the supervision of Dr. Alberta Pos. I have found that my early career interests in terms of psychotherapy revolve around approaches put forth by Irvin Yalom - an ever-expanding approach revolving around person-centered and existential philosophies. Of course, being a student at York University, I am also particularly fond of EFT and process-based therapy. I have recently started to see clients, and am excited to see how this will develop!

Prior to the onset of the events surrounding COVID, I, along with Dr. Pos, developed a brief online format of a psychoeducational emotional intelligence workshop that she had previously developed and found effective in person. This is the focus of my MA research. Looking forward to my PhD studies, I am looking into developing this further, with added focus on potential side effects of the online format in post-COVID daily life.

I always have on-going personal projects, mostly based around (these days anyway) being a bit more nerdy and finishing up so called "bucket list books". I am currently tackling the beast that is Moby-Dick, so fingers crossed!

Thanks Alan and thanks again to all who continue to make the SEPI dream a reality!

Alexandre Vaz

Alan Kian