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Society for the Exploration of Psychotherapy Integration

SEPI

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WHAT'S INSIDE

Continued...

President's Column

JEFFERY SMITH

Dear SEPI Members,

We have opened our new website for registrations to the SEPI-2025 Annual Conference in Istanbul, October 10-12, 2025. And we have closed the portal for submissions. As a new innovation, made possible by the launching of our new website platform, registration fees are divided by geographical area to encourage attendance from around the world. The conference is shaping up to be a celebration of ideas and foundational principles that contribute to a view of psychotherapy as a whole with many parts. As a follow-up to last year's summit, we bring together a wide range of fresh thought about what we love to do.

Here are some highlights.

- Richard Lane and Hanna Levenson will connect theory and practice in a joint keynote highlighting memory reconsolidation and memory-emotion interactions as key features of a broader framework for psychotherapy integration based on neural systems and computational mechanisms. I can't wait.
- Richard Hill, co-founder and managing editor of Australia's Science of Psychotherapy, will be taking a fresh look at how the client is really the guiding force in therapy, with therapist sensitivity and responsiveness becoming watchwords.
- We are privileged to welcome George Silberschatz and colleagues from the San Francisco Psychotherapy Research Group, with four presentations focused on their foundational model conceptualizing the targets of psychotherapy as specific maladaptive patterns rather than what I think of as "disorderly" collections of symptoms.
- Eric Plakun is the Founder of the American Psychiatric Association's Psychotherapy Caucus, a senior leader among psychiatrists, and author of the "Y Model" of psychotherapy training, in which the stem represents factors common to all therapies. He will be talking about making training efficient and effective.
- Kenneth Critchfield, Sepi's Treasurer and a leader in psychotherapy research brings discussion of the Structural Analysis of Social Behavior (SASB) framework for analyzing interpersonal dynamics in psychotherapy.
- Ueli Kramer, Editor of SEPI's Journal of Psychotherapy Integration and focused in his prolific research on what leads to change in personality disorders.
- Connor Adams, SEPI's current Secretary and colleagues from Stanford come to share a unique trans-theoretical approach to formulation and treatment planning with an emphasis on modern teaching techniques as well as integrating DEI considerations.

- Nuno Conceição, former President of SEPI, and colleagues from Portugal bring thoughts on the temporal phases of psychotherapy from both research and clinical perspectives.
- Tahir Özakkaş, our local host and Director of the Psychotherapy Institute of Turkey, brings his extraordinary breadth of interest and thought to examining the role of culture in evaluating and understanding various therapy modalities. In addition, his leadership in Turkish psychotherapy is inspiring multiple presentations from students and colleagues bringing the same kind of innovation and thoughtfulness to multiple areas of psychotherapy integration.

Oh, yes, and Hanna Levenson and I will each be presenting a pre-conference workshop, titles to be announced.

For the many I have not named and the many countries that represent SEPI's worldwide reach, we welcome you and look forward to celebrating your contributions to a remarkable gathering and incubator of ideas, taking place at the fulcrum of today's world.

Jeffery Smith MD

Bridging Research and Practice: Advancing Routine Outcome Monitoring to Strengthen Mental Health Systems in Latin America

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The mental health crisis in Latin America demands an interdisciplinary approach, with psychotherapy research playing a key role in addressing this challenge. International organizations, including WHO, emphasize the importance of investing in standardized data collection and research as a foundation for evidence-based mental health policies and for reducing disparities in care through effective monitoring and evaluation. In this article, we propose Routine Outcome Monitoring (ROM)—a systematic process of collecting client-reported outcome data throughout the course of treatment—as a suitable strategy to achieve these goals, as it is a cost-effective strategy to track changes over time, guide treatment adjustments, improve clinical decisions, and generate contextualized evidence to inform local public policy and support personalized care. However, its implementation in the Latin American context requires careful consideration of local challenges.

Understanding the scale and impact of the mental health burden in the region is essential to contextualize the relevance and urgency of implementing strategies like ROM. An estimated 160 million people in the Americas live with a mental health condition, contributing substantially to disability and premature death. Mental, neurological, and substance use disorders, along with suicide, account for over one-third of all years lived with disability and one-fifth of all disability-adjusted life years (DALYs). The Americas report the highest prevalence of anxiety disorders and the second highest of depressive disorders among WHO regions. In 2019, 15.6% of the population had a mental health disorder—the highest rate globally (FP Analytics, 2023; PAHO, 2018).

In response, several Latin American countries have introduced mental health reforms aimed at strengthening community-based care, expanding outpatient services, and enhancing professional training in primary mental health care (Caldas De Almeida, 2013). Despite these reforms, there is still limited clarity on how effectively these policies have been implemented or whether they have translated into meaningful improvements in population mental health (Trujillo & Paz, 2020). Outcomes vary across Latin American countries, largely influenced by differences in governance and national decision-making processes, highlighting the urgent need to generate systematic, high-quality data to guide public policy.

This aligns with the priorities outlined in the Comprehensive Mental Health Action Plan 2013-2030 (WHO, 2021), which emphasizes the need to strengthen information systems and research capacity as a foundation for improving service delivery and reducing disparities. These priorities reflect the recognition that strengthening information systems and research capacity is critical to improving mental health service delivery. This includes generating and using data on service availability, financing, and effectiveness, while also producing context-sensitive evidence that captures cultural, social, and structural factors—such as ethnicity, gender, socioeconomic status, and geography—that shape disparities in access and outcomes across the region (WHO, 2021; PAHO, 2023). Achieving these goals requires greater investment led by local professionals, ensuring that policies are informed by the realities and needs of each country in the region.

In this context, implementing ROM systems emerges as a strategic means to operationalize priorities in mental health in Latin America. ROM refers to the systematic use of outcome measures to track patient progress during treatment in real-world settings (Howard et al., 1996). More than just measurement, ROM is a dynamic process that captures mental health changes over time, identifies meaningful trends, and guides tailored treatment adjustments. By integrating ROM into practice, clinicians gain actionable insights to address critical questions in psychotherapy research while fostering precision in care. This iterative feedback loop not only refines clinical decision-making but also empowers clinicians and mental health professionals to deliver interventions that align with each client's unique needs, embodying the core principles of psychotherapy integration and of context-sensitive mental health delivery.

Given that research shows ROM can significantly improve outcomes and reduce risks among vulnerable populations, its relevance becomes even more pronounced in Latin America, where poverty, violence, and systemic inequality deeply affect mental health and create substantial barriers to care. Its use enables the generation of extensive context-specific data drawn from routine practice and utilizes technological tools to enhance service delivery. Incorporating ROM into regional mental health systems can help establish consistent records, improve care quality, and provide evidence to support locally adapted public policies. Additionally, it offers

a way to uphold clinical standards and reduce inconsistencies in service provision (Fernández-Alvarez et al., 2024).

ROM represents a critical tool for generating a comprehensive and contextually grounded understanding of mental health services in Latin America, by capturing users' characteristics, treatment responses, and the social realities that shape both. This is particularly vital in a region where mental health and research remain chronically underfunded, and where a culture of systematic monitoring and data collection is still in its early stages. With most existing data originating from the Global North, where mental health systems benefit from greater institutional support and where outcome measurement is a routine practice (McAleavey et al., 2024), there is an urgent need for locally generated evidence. Implementing ROM in Latin America is not only a valuable tool but an essential strategy for designing improvement efforts that are both evidence-based and responsive to the region's unique structural and cultural contexts.

While the implementation of ROM in Latin America faces challenges that may resemble those encountered in the Global North, such as resistance to measurement or logistical barriers, these must be understood and addressed through the lens of the region's unique health system structures and user population characteristics. Simply replicating models from the Global North is insufficient; instead, tailored strategies that reflect the diversity and complexity of local health systems and user populations are essential.

ROM implementation places significant demands on organizational resources, requiring sustained logistical, technical, and behavioral changes. However, its success hinges not only on internal capacity or leadership support, but also on the region's profound diversity. Social, economic, and political contexts directly influence how mental health services are organized and delivered, underscoring the need for strategies that are not only adequately resourced but also contextually responsive. Governance structures and health system capacities

vary widely, not only between countries but also within them, creating stark contrasts between well-equipped urban areas and under-resourced regions. Therefore, for ROM to be effective and equitable, its implementation must be flexible and adaptive across multiple levels, aligning national objectives with local realities to address structural inequalities and meet the specific needs of diverse communities (Paz et al., 2025). Technological disparities further complicate ROM adoption. While urban services often have the infrastructure and staff to support advanced systems, rural and underserved areas face persistent barriers such as poor connectivity, limited equipment, and lack of technical support. Addressing these gaps requires innovative, context-sensitive solutions (Paz et al., 2025).

Another challenge is posed by patient-related factors such as low literacy, cognitive limitations, language diversity, and culturally specific views on mental health, which complicate self-reporting and the use of standardized tools. The limited availability of culturally adapted measures and a still-nascent culture of systematic evaluation also hinder integration. Organizationally, high workloads, scarce training opportunities, and fears that ROM will be used for performance appraisal contribute to clinician resistance. In many settings, ROM training is uncommon, and its value remains unclear to professionals who may perceive it as intrusive or bureaucratic.

To respond effectively to these multifaceted challenges —technological, cultural, and organizational—targeted strategies must be adopted that not only address structural limitations but also engage those at the core of clinical delivery. Paz et al. (2025) emphasize the importance of clinician engagement as a cornerstone of successful ROM integration. When professionals are meaningfully involved, ROM is more likely to be viewed

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as a tool that enhances clinical work rather than as a form of external monitoring. Presenting ROM as a means to improve patient care and clinical outcomes, rather than as a performance monitoring tool, can also help reduce resistance and foster trust. Incorporating feedback from both clinicians and patients into the development and implementation of ROM systems ensures these tools are aligned with everyday clinical realities and perceived as valuable and relevant.

Once clinician support is established, implementation should proceed gradually using a stepped-care model. Piloting programs in selected services enables testing of different ROM measures, data systems, and assessment schedules (e.g., baseline, pre-post, or session-by-session), while also identifying and addressing any early technical or ideological challenges. As successful outcomes emerge from these pilot initiatives, such as improved transparency, clinical utility, or cost-efficiency, larger-scale implementation becomes more feasible. Positive results, such as improved care quality, transparency, and cost-effectiveness, can then support broader rollout. Embedding ROM into collaborative, team-based care models helps distribute responsibilities across clinicians, non-specialist providers, and administrative staff, easing individual burdens and promoting service continuity. Coordination with health authorities ensures alignment with existing policies and infrastructure, while partnerships with academic institutions can facilitate the development of culturally appropriate tools and robust evaluation methods.

In this context, collaborative networks play an increasingly important role in facilitating cross-disciplinary research, particularly within the field of psychotherapy in Latin America. The Consorcio Latinoamericano de Investigación en Psicoterapia (CLIP) stands out as a key actor in this landscape by fostering regional collaboration, promoting the co-development and validation of culturally sensitive ROM tools, and facilitating knowledge exchange between researchers and clinicians across countries. CLIP's initiatives support the creation of shared infrastructure for ROM and the training of mental health professionals in ROM use and interpretation. Through its network, CLIP enables the implementation of multicenter studies, generates local evidence, and strengthens research capacity across institutions, all of which are essential for advancing evidence-informed mental health practices.

Implementing ROM in Latin America holds significant potential to address the region's mental health burden by narrowing the gap between research and clinical practice. When supported by structured systems and cross-cultural collaboration, ROM fosters a culture of systematic data collection that generates context-sensitive, real-world evidence to inform public policy and improve service delivery. Moreover, it promotes socially relevant, interdisciplinary dialogue and aligns with the core principles of psychotherapy integration—encouraging collaboration across therapeutic models and enhancing multicultural exchange. In doing so, ROM not only strengthens clinical effectiveness but also advances the development of psychotherapy in the

region by moving beyond isolated theoretical frameworks and embracing diverse perspectives on treatment outcomes.

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Student Perspective on Integrating Psychology & Spiritual Care

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On the first day of my doctoral studies in clinical psychology, members of my cohort took turns introducing themselves by sharing their names and their most salient identities. As my turn rapidly approached, I found myself hesitating to share that I am religious (Episcopal, to be exact). Having spent the previous four years working as a hospital chaplain and my career to that point in religious and spiritual spaces, I was suddenly in a strikingly secular one. Was there space for my spiritual and religious identity and perspective in psychology? Could I bring to psychological practice the ways my theological education and training in spiritual care have shaped how I understand the human experience? Three years later, as I continue with my doctoral studies, these questions are still very present and have inspired my clinical and research interests.

As a hospital chaplain, I experienced the ways in which a diverse array of individuals, amid immense pain and suffering, found meaning, comfort, strength, connection, and hope through their religious and spiritual beliefs, practices, and communities. I also experienced how these same beliefs could add to one's suffering – leaving one full of conflict, anger and sadness lamenting about where the sacred was in their suffering. Having seen firsthand how the spiritual and psychological often collide, I came to psychology interested in studying the intersection of religion, spirituality, and psychological distress, with a particular interest in how

greater understanding of these relationships may contribute to integrative clinical practice. I was also particularly interested in demographic shifts in the United States around religiosity, regarding the rise of the spiritual but not religious (as high as 30% of the population). I wondered how these shifts may impact the need for psychotherapists to engage religion and spirituality (r/s), as fewer people come to religious leaders and communities with existential and spiritual concerns. Where and how might there be a need for and space for spiritual care in psychotherapy and clinical practice? How do spiritual care and psychological care overlap and diverge in theory and practice? What would integration of the religious, spiritual, and psychological look like in today's age, for today's population? Lastly, how might we further equip and empower psychologists to engage the spiritual and religious dimension of their patients' identities and lives?

These questions first led me to conduct an exploratory research study on religious and spiritual struggles within an outpatient community mental health clinic in Harlem, New York, NY, where I am a clinician in residence. Through the use of the Religious and Spiritual Struggles Scale (Exline et al., 2014), we examined the kinds of r/s struggles our help-seeking population experienced, including 1) divine or supernatural struggles; 2) demonic struggles; 3) moral struggles; 4) interpersonal struggles; 5) doubt struggles; and 6) ultimate meaning struggles. We

also examined links between r/s struggle and psychiatric distress across different demographic variables, including religious/spiritual affiliation, race, ethnicity, gender, and sexuality, as well as lifetime experiences (change in religious/spiritual affiliation and holding a different spiritual/religious affiliation than parents). Among our sample of 240 help-seeking individuals, we found that r/s struggles were moderately correlated with probability and severity of depression and anxiety. Interestingly, a slight majority of our sample (54.7%) identified outside of religious institutions, including as Agnostic, Atheist, non-religious, "spiritual but not religious," and "unsure or exploring." While all religious and spiritual identities experienced all six kinds of r/s struggle, with no significant differences as between them, notably, individuals that identified as Atheist, Agnostic and spiritual but not religious had the highest levels of Ultimate Meaning struggle. Overall, this illustrates an important finding within a diverse, urban clinical population supported by the wider literature: r/s struggles are not solely experienced by religious individuals but in fact reach beyond traditional religious identities.

While solely an initial exploratory study, our study confirms that r/s concerns, distress, and struggles do exist within diverse, help-seeking clinical populations, across those who hold religious/spiritual identities and those that do not. These findings, while not surprising, highlight the need for clinicians to be aware of the possibility of r/s struggles within both religious and non-religious patients. In the United States, where I live, a 2025 survey found that 70% of American adults state that religion is an important part of their lives, and 92% of Americans hold one or more spiritual beliefs, with 86% believing in a soul or a spirit in addition to a physical body (Smith et al., 2025). While many people identify as both religious and spiritual, over the past two decades a growing number of Americans (as high as 30%) have started to identify as spiritual but not religious, leaving behind their affiliation with religious institutions. However, the most recent surveys of Americans reveal that this trend appears to have slowed down, and perhaps halted (Smith et al., 2025). Researchers are just beginning to explore the causes of this shift. Americans are also changing their religions at a higher rate than previously known, reflecting a shift in how individuals engage with religion and religious communities. Thirty-five percent of individuals surveyed had changed their religion since childhood (Smith et al., 2025). In short, religion and spirituality are here to stay, and their roles in the lives of individuals and contemporary society continue to foster new, unanswered questions.

Despite the centrality of r/s in many people's lives, and its connection with both well-being and distress, historically, psychology and religion have shared a relationship marked by skepticism and tension - on both sides. I felt this tension within my initial moments in my doctoral program. However, over the past three years, among my cohort and colleagues, I have sensed a shift, which may or may not reflect wider trends across psychologists. While many do not identify as religious or spiritual, they appear to have an openness and curiosity towards engaging the r/s

dimension of their patients - as well as significant hesitations and fears around doing so ethically and professionally. Most feel unprepared, given their lack of training related to working with spiritual and religious concerns. They don't seem to want to leave spirituality and religiosity out of the room but want help in how to bring it into the room in ethical, culturally attuned, sensitive, authentic, and effective ways.

Witnessing this dynamic within my peers has inspired my interest in how we can equip future clinical psychologists to engage the spiritual and religious dimensions of their patients. Considering how important religion and spirituality are in many people's lives, their connection to well-being and distress, and their evolving roles in U.S. society, I think it's an especially exciting time to engage these questions. These questions will guide my future research, as I explore the views, attitudes, perspectives, and experiences of the next generation of psychodynamic clinicians towards religion and spirituality. The hope is that greater understanding may guide the development of further training that promotes ethical, culturally attuned, and clinical effective engagement and integration of r/s in clinical practice.

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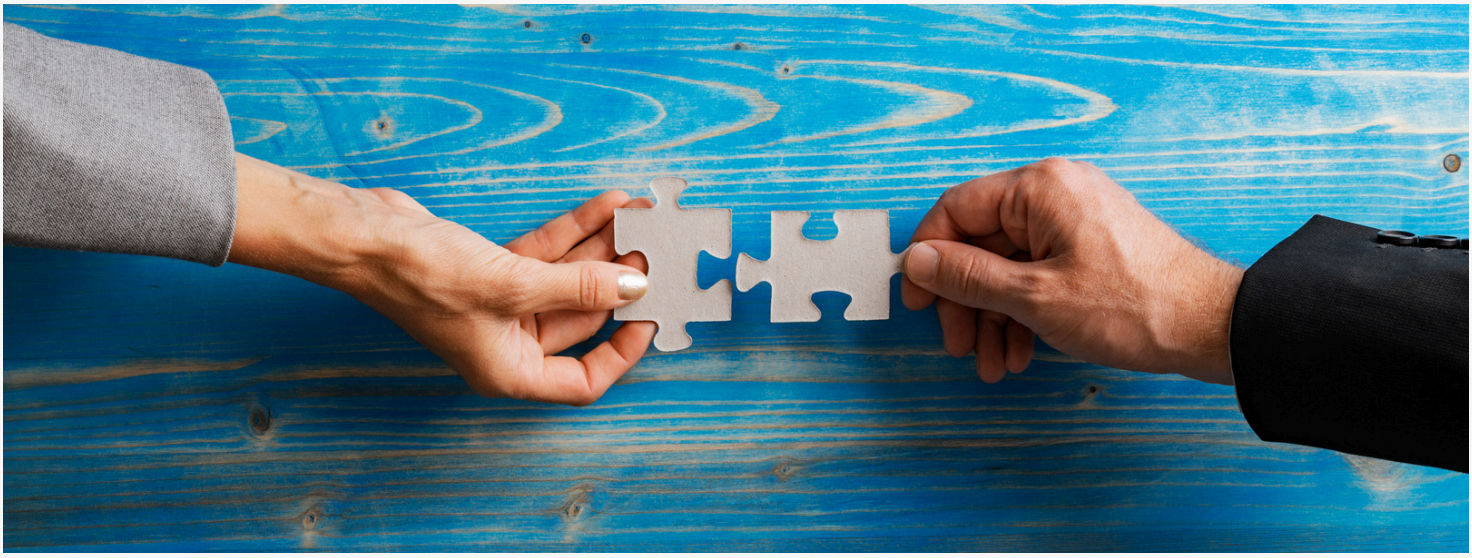

Therapists' Responses to Cultural Ruptures: A Pilot Study of External Ratings of Multicultural Orientation

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Cultural ruptures are moments of misattunement, disconnection, and/or conflict in the therapeutic relationship that are related to salient cultural processes that have implications for therapeutic processes and power dynamics within the therapeutic dyad. Cultural ruptures may be subtle or overt, and they may occur when therapists and clients have similar cultural identities and backgrounds and/or when they differ significantly. Effectively navigating cultural ruptures is a transtheoretical skill that may be crucial for therapists to develop given that they are likely common and may have implications for therapy processes and outcomes. Despite this, there are challenges to training therapists to address cultural ruptures, including limitations of relying on therapists' self-report, ethical concerns regarding therapists practicing cultural rupture skills with actual clients, and the lack of opportunity for feedback.

With this is mind, this study created, piloted, and tested a system of four video vignettes portraying distinct types of cultural ruptures, using and externally-rated coding system to evaluate responses. The video vignettes were created in consultation with experts in the multicultural orientation framework (MCO; Davis et al., 2018; Owen et al., 2011; Owen, 2013). This framework emphasizes cultural comfort, cultural humility, and cultural opportunities as

three primary processes therapists can embody with clients to improve the therapeutic alliance and facilitate effective multicultural practice. The videos were also meant to draw upon the general rupture and repair framework that have received empirical support over several decades (Eubanks et al., 2018; Safran, 1993; Safran & Muran, 2006). Specifically, we sought to create videos that would display four types of ruptures across two dimensions: task or bond related ruptures with withdrawal or confrontation responses. Along the first dimension, experts contend that ruptures may be task-related, which occur when therapist and clients encounter conflicts or impasses related to the work of therapy, or bond-related, which occur when the emotional connection between the therapist and client is strained. On the other hand, clients may exhibit withdrawal responses, marked by pulling away from the work of therapy and/or the therapist and shutting down, or confrontation responses, marked by the client expressing their discontent with the rupture. The cultural ruptures videos developed in this study, therefore, utilized a 2x2 framework with the first video portraying a bond-related cultural rupture and a withdrawal response, the second portraying a task-related cultural rupture and a confrontation response, the third showing a task-related cultural rupture and a withdrawal response, and the last showing a bond-related cultural rupture and a confrontation response. The videos varied in terms of the salience of the cultural content. That is, some ruptures portrayed were more overtly cultural in nature, while others were more subtle.

The aim of this study was to create these videos and test the feasibility of training coders to rate participants' responses in terms of the three pillars of MCO. These videos were tested with a pool of 88 participants all of whom self-identified as white and all of whom were enrolled in training programs in psychology, counseling, or another helping profession at the time of

participation. This initial study focused on testing these videos among white participants to explore race as one potential cultural factor that could be salient in these cultural rupture vignettes; however, the vignettes are meant to be flexible and used to assess a variety of types of cultural ruptures. Secondly, the aim of this study was also to explore the extent to which participants were accurate in their own self-ratings of their effectiveness in responding to the vignettes in comparison to coder ratings.

Results suggested that coders were able to reliably rate participants' responses for cultural comfort, cultural humility, and cultural opportunities, with evidence of good interrater reliability. This lays the groundwork for using external ratings for multicultural skills and processes, rather than relying on therapists' self-reports alone. The feasibility of this type of system may be pertinent for multicultural training and research, especially in light of the secondary finding of this study, which suggested that participants tended to over-estimate their effectiveness in comparison to coder ratings. This aligns with previous research showing that therapists may over-estimate their skills (Constantino et al., 2023), with this study showing that the same may apply to therapists evaluating themselves in terms of multiculturalism.

This article provides a transtheoretical framework to assess trainees' multicultural capacities, specifically their cultural comfort, cultural humility, and cultural opportunities skills within the applied context of responding to video vignettes. Given that the results of this study suggest that the system can be reliably coded and that using self-reported measures alone could lead to over-estimation, this cultural ruptures video vignette and coding system can be implemented in several ways. First, it may be useful to employ this video vignette system in research as a way of measuring therapists' multicultural skills. Second, these videos and the coding system may be useful in training in that they allow therapists to practice their multicultural skills and receive feedback without negatively impacting actual clients. Finally, while not included as a part of this study, future studies may be able to test whether engaging with this type of video and coding system may actually improve therapists' multicultural skills and practice. In summary, the cultural ruptures video vignettes and coding system offers a transtheoretical framework that can be feasibly used in the effort to improve multicultural research, training, and practice.

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