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I have a dream: Integrative systemic transdiagnostic and transtheoretical approach in psychotherapy and mental health treatments

Imam sanje: Integrativni sistemski transdiagnostični in transteoretični pristop v psihoterapiji in obravnavah na področju duševnega zdravja

Abstract

Medicalization is a global trend in the societies of late capitalism and the biomedical model dominates in the mental health system. Despite its many shortcomings and harms and despite the categorical ICD and DSM diagnostic systems of mental disorders have been criticised from professional and scientific point of view, dimensional and transdiagnostic approaches to psychopathology and treatment are still relatively underdeveloped and neglected.

Over the last hundred years the differences between the biomedical and the biopsychosocial/contextual approach gave rise to and still drive 'the great psychotherapy debate'. The biomedical approach emphasizes the dualism of body and mind, defines health as the absence of disease and places the origin of disease in the body. Diagnosis is based on a specific identification of this bodily cause and is the basis for planning and implementing a specific form of therapy. In contrast, the biopsychosocial/contextual approach emphasizes holism, and explains both health and illness as the result of an interplay of biopsychosocial factors in a multicausal manner. Diagnostics or assesment takes into account the individual in the historical, social, cultural, and economical context. Common factors theory, contextual model and CARE-Model of mental health treatments, that were developed in the tradition of biopsychosocial approach, promote the Dodo bird verdict, the diversity of therapists, emphasize the idiographic nature of therapeutic methods, client-centered perspective and individualised, personalized evidence-based practice.

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Complexity science is already offering the transtheoretical frame as well as the technologies to realize the integrative systemic transdiagnostic and transtheoretical approach in psychotherapy and mental health treatments. If the starting point on the level of theory is the transtheoretical frame of synergetics as well as the mathematical formalism of the theory of complex dynamic systems, then the Synergetic Process Management (SPM) as a generic system enables the optimal and appropriate use of specific therapeutic methods and techniques according to the therapeutic process (e.g. resource-focused interview, idiographic system model, individualised process questionnaire for daily online monitoring, regular therapeutic sessions with feedback on basis of the current data-profile, and Synergetic Navigation System (SNS)), and can therefore contribute to the effectiveness of any psychotherapeutic approach or method. SNS is a highly flexible, generic internet-based system for data acquisition, time-series analysis, and visualisation of various questionnaires and coding systems. It enables real-time monitoring of the dynamic characteristics of biopsychosocial self-organizing processes.

The context of the great psychotherapeutic debate can also help us to understand the current public confrontations on the psychotherapy law in Slovenia, and to dream about psychotherapy as an independent profession and autonomous scientific discipline. It is a dream about more diversified, flexible, accountable, highly cost-effective, client- and context-tailored mental health treatments.

Key words: biomedical model, biopsychosocial model, categorical diagnosis, transdiagnostic, complexity science, Synergetic Process Management, integrative systemic psychotherapy

Povzetek

V družbah poznega kapitalizma je medikalizacija postala globalni trend, tako da tudi na področju duševnega zdravja prevladuje biomedicinski model. Kljub številnim pomanjkljivostim in škodljivosti ter kljub temu da sta kategorialna MKB in DSM diagnostična sistema duševnih motenj deležna obsežnih strokovnih in znanstvenih kritik, ostajata dimenzionalni in transdiagnostični pristop k psihopatologiji in obravnavi relativno nerazvita in zanemarjena.

V zadnjih sto letih so razlike med biomedicinskim in biopsihosocialnim/kontekstualnim modelom spodbudile in še vedno poganjanjo t.i. 'veliko psihoterapevtsko razpravo'. Biomedicinski pristop poudarja dualizem telesa in uma, definira zdravje kot odsotnost bolezni in umešča izvor bolezni v telo. Diagnoza temelji na prepoznavanju specifičnega telesnega vzroka in predstavlja osnovo oz. izhodišče za načrtovanje in izvajanje specifične oblike terapije. Po drugi strani pa biopsihosocialni/kontestualni pristop poudarja holizem in tako bolezen kot zdravje razlaga z vidika večvzročnosti in interakcije biopsihosocialnih dejavnikov. Diagnoza ali ocena upošteva posameznika v zgodovinskem, socialnem, kulturnem in ekonomskem kontekstu. Teorija skupnih dejavnikov, kontekstualni model in CARE-model v obravnavah na področju duševnega zdravja, ki so se razvili v okviru tradicije bisopsihosocialnega pristopa, poudarjajo razsodbo ptiča Dodo, raznolikost terapevtov, idiografskost terapevtskih metod, na klienta usmerjeno perspektivo in individualizirano, personalizirano, na znanstvenih izsledkih utemeljeno prakso.

Znanost o kompleksnosti že relativno dolgo ponuja tako transteoretični okvir kot tudi tehnologijo za uresničevanje transdiagnostičnega in transteoretičnega pristopa v psihoterapiji ter obravnavah na področju duševnega zdravja. Če na ravni teorije vzamemo za izhodišče transteoretični okvir sinergetike in matematične formalizme teorije kompleksnih dinamičnih sistemov, potem je Sinergetično procesno upravljanje (SPU) generični sistem, ki omogoča terapevtskemu procesu optimalno in primerno uporabo specifičnih terapevtskih metod in tehnik (npr. intervju usmerjen na vire, idiografski sistemski model, individualizirani procesni vprašalnik za dnevno spremljanje, redno povratno informiranje o zajetih podatkih na terapevtskih srečanjih in Sinergetični navigacijski sistem (SNS)). SPU tako izboljšuje učinkovitost kateregakoli psihoterapevtskega pristopa oz. metode, SNS pa je izjemno prožen, generični medmrežni sistem za zbiranje podatkov, analizo časovnih vrst ter vizualizacijo različnih vprašalnikov in kodirnih sistemov. Omogoča spremljanje dinamike samoorganiziranih in samoorganizirajočih se biopsihosocialnih procesov.

Okvir velike psihoterapevtske razprave nam lahko tudi pomaga razumeti trenutne javne polemike o psihoterapevtskem zakonu v Sloveniji ter sanje o psihoterapiji kot samostojnem poklicu in avtonomni znanstveni vedi. To so sanje o raznolikih, prožnih, družbeno odgovornih, stroškovno učinkovitih ter klientu in kontekstu prilagojenih obravnavah na področju duševnega zdravja.

Ključne besede: biomedicinski model, biopsihosocialni model, kategorialna diagnoza, transdiagnostika, znanost o kompleksnosti, Sinergetično Prosesno Upravljanje, integrativna sistemska psihoterapija

1. The medical model nightmare

In Slovenia, where I live and work as a psychiatrist and psychotherapist, the biomedical model dominates in the mental health care system. Medicalization and medicamentalization[2] are steadily increasing, which is not only a Slovenian phenomenon but a global trend in the societies of late capitalism (Conrad, 2007; Sadler et al., 2009; Wyatt, 2009; Slatnar, 2012; Thangadurai & Jacob, 2014; Sadler, 2016; Yovanov, 2018). The medicalization of mental health care with its many disadvantages, both for the patient and for the society, is manifested in:

- encouraging the reification of psychological problems and viewing them as unchanging rather than dynamic (Lahey, 2021);
- misdiagnosing and excessive diagnosing because of lowered thresholds for diagnosis (Muller, 2007; Thombs et al., 2019), e.g. depression (Blazer, 2005; Shorter, 2013), ADHD (Asherson et al., 2010; Whitely et al., 2019), bipolar disorder, autism spectrum disorder, PTSD (Paris, 2015);
- spreading of new psychiatric 'disorders' and iatrogenic diseases (Moynihan & Cassels, 2005; Watters, 2010; Rapley et al., 2011; Cassels, 2012);
- excessive prescribing, use and side effects of psychiatric drugs (Breggin, 2001; Whitaker, 2004, 2010; Moncrieff, 2013; Paris, 2013, 2017; Gøtzsche, 2015; Makovec, 2019; Shorter, 2021);
- assumption that neuroscience has all the answers for psychiatry and mental health problems (Paris, 2013, 2017);
- discrimination and stigmatization and defining persons with psychological problems as being fundamentally different from others (Barham & Hayward, 1995; Read et al., 2006; Corrigan, 2007);
- ignoring the unique needs of the individual patient (Lahey et al., 2022);
- imposing decisions about how to describe and classify a person's behaviour and experience as an objective fact, rather than shared in a transparent and open manner (Terkelsen, 2009):
- suboptimal expenditure and loss of public or private money (Verhaeghe, 2014).

In my clinical practice I daily encounter children and adolescents who do not have access to publicly funded psychotherapy, because waiting times are one to five years, and who have been labelled with psychiatric diagnoses and over-prescribed and overdosed with psychiatric drugs by biomedically indoctrinated doctors and psychiatrists. It seems I am living in a medical model nightmare.

2 For example, the consumption of antidepressants in Slovenia increased threefold between 2002 and 2015 (Srebrnjak, 2016) and the upward trend continues to the present day (Kostnapfel & Albreht, 2023).

Since Mesmer's time, the tremendous technological progress has made the biomedical approach a veritable Goliath, compared to which other approaches to the treatment of physical ailments are like David. Around the world, however, it also prevailed in the field of mental health care, where it is based on objectivist assumptions:

1. that the categorical diagnosis of mental disorders is the key starting point for treatment;
2. that mental disorders are the result of disorders in the functioning of the brain; and
3. that the key to recovery is drug treatment that is supposed to be specifically effective (e.g. antidepressants for depressive disorders, anxiolytics for anxiety and antipsychotics for psychotics).

Although all three of these assumptions are tenuous (Duncan et al., 2004), in the second half of the twentieth century they contributed to the exponential growth in the use of psychotropic drugs and to the glorification of the methodology of randomized clinical trials (Timmermans & Berg, 2003; Schiepek, 2008; Leichsenring & Steinert, 2017; David et al., 2018ab; Leichsenring et al., 2018), which became the gold standard for determining the effectiveness of drugs (Healy, 1990, 1996, 1997, 2006, 2008, 2012; Meldrum, 2000).

However, despite many criticisms of the medical model in the field of mental health, which have been voiced for decades and have escalated in the last ten years, both theoretically and epistemologically as well as on the level of practical application (e.g. Engel 1977; Lewis, 2006; Schiepek, 2008; Ule, 2009, 2013; Deacon, 2013; Enache-Tonoiu, 2013; Elkins, 2016; Verhaeghe, 2014; Miškulin, 2016, 2017; Možina, 1998, 2019ab, 2020a; Možina & Barnes, 2020; Tramonti et al., 2020), it does not seem that its primacy will diminish in the near future. The profits of the pharmaceutical industry are too great to call into question the reductionist medical model, despite the fact that it is now clear, based on extensive research and systematic outcome reviews, that psychotherapy is more effective than pharmacotherapy for a wide range of mental disorders (e.g. Barlow et al., 2000; Keller et al., 2000; Barlow, 2004; DeRubeis et al., 2005; Butler et al., 2006; Coldwell & Bender, 2007; Dutra et al., 2008; Hofmann & Smits, 2008; Fairburn et al., 2009; Hall, 2016; Možina, 2016b) and cost-effective (e.g. The Centre for Economic Performance's Mental Health Policy Group, 2006; Byford et al., 2007; McHugh et al., 2007; Domino et al., 2009; Miklowitz & Scott, 2009), and despite the fact that clients also consistently prefer psychotherapy over pharmacotherapy (Healy, 1990; Mitchell et al., 1990; Hofmann et al., 1998; Hazlett-Stevens et al., 2002; van Schaik et al., 2004; Feeny et al., 2009; McHugh et al., 2013).

Olfson and Marcus (2010) in their study on the representative sample about trends in outpatient psychotherapy in the United States in the decade from 1998 to 2007 on a background of increasing pharmacological treatments, found a decreasing proportion of mental health outpatients received psychotherapy, and those who did received fewer sessions. Over the course of a decade that witnessed substantial growth in outpatient medical expenditures, spending on outpatient mental health care underwent little change, and spending on psychotherapy significantly declined. During the same period, a large and growing number of mental health outpatients received psychotropic medications without psychotherapy. These changes have helped to redefine outpatient mental health care in the United States.

The anomalies in the application of the medical model are not only the result of its epistemological narrowness, but also of the "cancerous growths" in the health care system, as Verhaeghe (2014, pp. 130-133) described them. They result from the neoliberal trend, which is turning healthcare into a profitable business. Continuous structural 'improvements' lead to increasing control over employees and everything is sacrificed at the altar of measurability. There is less and less time to deal with patients, and less focus on the work itself and more on administration, management and control. With constant pressure to cut costs, ever-increasing sums of money are being spent on things that serve no purpose related to care. The explosion of rules and regulations creates an increasingly opaque system of control, and the growing administrative burden stifles creativity and lowers productivity. As the rules are increasingly being determined by health insurance companies and the management of institutions, clinical and academic independence is also increasingly being lost.

2. The nightmare of psychiatric categorical diagnostics

Although the categorical ICD and DSM diagnostic system of mental disorders have even been criticised professionally and scientifically by some of the world's most prominent psychiatric associations and renowned authors (e.g. The British Psychological Society, 2011, 2013; Royal College of Psychiatrists, 2019; Timimi, 2013; Cuthbert, 2014; de Beurs et al., 2018; Cuijpers, 2019; Stein et al., 2022; Wampold & Flückiger, 2023), dimensional approaches (Helzer et al., 2008; Moreland & Dumas, 2008; Zachar et al., 2014; Appelbaum, 2017; Lahey, 2021; Lahey et al., 2022), and transdiagnostic approaches to psychopathology and treatment (Nolen-Hoeksema & Watkins, 2011; Liu et al., 2018; Fusar-Poli et al., 2019; Dagleish et al., 2020; O'Driscoll et al., 2022; Imperiale et al., 2023; Lutz et al., 2024; Zhu et al., 2024) are still relatively underdeveloped and neglected.

Despite a dramatic growth of knowledge about mental disorders in recent decades, understanding of their components and processes remains rudimentary. Artificial intelligence, machine and deep learning research (e.g. of patients' lived experiences to learn about psychiatric diagnostic categories), while promising to create a paradigm shift in the current practice in diagnosis, prognosis, monitoring, and treatment of mental disorders, is also in its infancy (e.g. Chen et al., 2022; Ghosh et al., 2022; Iyortsuun, et al., 2023). While "soft" transdiagnostic approaches preserve the underlying diagnostic classification and seek to clarify etiopathology or develop interventions that have relevance to one or more of traditional diagnoses, "hard" transdiagnostic approaches dispense with the diagnostic system altogether and try to characterize mental ill health in new ways (Dalgleish et al., 2020).

In 2009, the National Institute of Mental Health initiated the Research Domain Criteria (RDoC) project to improve the ICD and DSM classifications. RDoC provides a framework that emphasizes integration of basic behavioral and neuroscience research to deepen the understanding of mental disorders (Joober, 2013; Cuthbert, 2014; Cuthbert & Insel, 2013). The vision is to study all causal factors together and to break researchers away from studying a few relevant factors in isolation. It is intended to facilitate the study of brain-behavior relations across developmental and environmental contexts. Major functional aspects of behavior and mental operations, e.g. fear, executive functioning, and social attachment, and the neural systems that implement them were specified. The first aim of RDoC is to »develop a comprehensive literature about the convergent and interacting roles of neurodevelopment and the environment as well as their relations with biological, psychological, and social variables in the onset and course of impairment in various functional domains. For the present, the RDoC approach sets aside issues related to definition and classification, as well as how best to describe patients' current status in the context of their development and past and current environments. It is anticipated that RDoC will be able to offer relevant data to address these issues as it accrues information that can guide and be incorporated into future iterations of ICD and DSM« (Clark et al., 2017, p. 99).

Kotov et al. (2017) beside emphasizing that the expansiveness of psychiatric diagnosis is increasingly pathologizing people's everyday mental health problems, also point to diagnostic instability, to frequent blurred boundaries between disorders and comorbid conditions, and to heterogeneities within individual disorders resulting from arbitrarily accepted distinctions between psychopathology and normality. The authors see the weaknesses of the traditional taxonomy as mainly:

a. the imposition of a categorical conceptualisation on widespread phenomena, leading to a significant loss of information and diagnostic instability;
b. the limited reliability of traditional categorical diagnosis, since in a clinical test of diagnostic criteria for mental disorders defined in the DSM-5, 40% of them were found not to meet even mild reliability criteria, although the same disorders often showed excellent reliability when operationalised dimensionally;
c. attempting to address the heterogeneity of pathological processes by defining subtypes of disorders that are defined arbitrarily rather than on the basis of structural research findings, making it impossible to delineate between subgroups;
d. high comorbidity of existing mental disorders, which complicates research design and clinical decision-making, as comorbidity distorts study results and affects treatment. At the same time, high comorbidity suggests that some single conditions have been subdivided into multiple diagnoses, which consequently often co-occur, indicating the need to redefine the boundaries between disorders;
e. the fact that many patients, despite signs of obvious distress or impairment indicating a need for care, do not meet the criteria for any mental disorder, with significant implications for their status and treatment.

Although the World Health Organization (WHO, 1946) after the World War II defined human health as the state of physical, mental and social wellbeing and not merely as the absence of disease or infirmity, and although the development of psychosomatic medicine led to the point where in 1977 George Engel conceptualized the "biopsychosocial model" (Engel, 1977), biomedical determinism in the medical clinical practice has prevailed to this day. Although the aim of WHO's definition that for preventive, curative and rehabilitation measures the basic unit is a *human being in the environment*, because, like any other living organism, human beings are inseparably embedded in the evolution of nature and socio-cultural nurture, we still haven't prevented the dominant reductionistic medical discourse and the aberrations of decontextualized medical approach. Most often, the complexity of biopsychosocial human existence is reduced to the simple linearity of molecular mechanisms. As well expressed by Sturmberg (2015), the target of most physicians shifted from the subjectively felt dis-ease to an objectified disease.

Likewise, there was a gradual shift in the research approach from the subjective and existential to the objective. The experience of the person receiving mental health treatment was dismissed and the focus on the pathology of the patient prevailed: "The development of the randomized design displays

a transition from a close relationship between the experimenter and those experiencing a stimulus (viz., Wundt and his students) to the physician-patient relationship (viz., the French physicians and their 'subjects') to the subject as a stranger (viz., British empirical investigations of mental faculties) to the double--blind design. The British social statisticians also introduced the notion of using a continuous distribution of a trait to designate abnormality, which forms the basis of most clinical trials in psychotherapy in which symptoms measured on a continuous scale constitute the outcome measure" (Wampold & Imel, 2015, p. 31). This represents a change from examining concepts of self in relation to the ideal self and changes in personality, which were an integral part of the first empirical investigations in the humanistic tradition (see Rogers, 1942ab, 1951ab, 1957). The notion of mental health treatment as an opportunity to grow or as an opportunity to make meaning is not considered in any substantial manner in the current empirical investigations.

In their review article, Lebowitz and Appelbaum (2020) have pointed to another negative side of the medical model, namely the harmful consequences of biomedical explanations of mental disorders as medical diseases with neurobiological and genetic roots that have become increasingly dominant in the new millennium[3]. Such explanations of psychopathology are often assumed to be beneficial for reducing negative attitudes toward people with mental disorders by casting them as blameless victims of a medical disease. Although there is evidence that biomedical explanations do reduce the extent to which people are blamed for their own psychiatric symptoms, these explanations can also have negative effects, such as:

a. engendering essentialism, which can create or exacerbate the impression that mental disorders are relatively immutable or unlikely to remit, and causing pessimism about patients' prognoses;
b. reducing clinicians' empathy for patients and lead clinicians to appear less warm, potentially interfering with therapist - patient relationships;
c. affecting treatment preferences, leading to increased confidence in pharmacotherapy and decreased confidence in psychotherapy, and
d. reducing people's confidence in their own ability to overcome their difficulties.

3 At least in the United States, the advent of direct-to-consumer advertising for psychiatric medications and other prescription drugs has contributed a lot to the widespread adoption of biomedical conceptualizations of mental disorders. In 1997, the US Food and Drug Administration allowed the widespread promotion of pharmaceuticals via broadcast media and commercials for antidepressant medications in particular quickly became commonplace. Often, advertisements advance biochemical explanations for the etiology of depression to encourage people with depressive symptoms to request a medication from their doctors, which is presented as a means of correcting a supposed chemical imbalance (Lebowitz & Appelbaum, 2020, p. 559). Indeed, research has also demonstrated that patients' requests for prescription medications - including requests that mention an advertised antidepressant by name - can significantly influence doctors' prescribing decisions (Kravitz et al. 2005).

3. The great psychotherapy debate between the biomedical and biopsychosocial/contextual approach

In 2001, Bruce Wampold published a book entitled *The Great Psychotherapy Debate* (Wampold, 2001b) and followed it up with an updated edition in 2015 (Wampold & Imel, 2015), in which he challenged the belief, based on a wealth of research, that psychotherapy can best be understood through a medical model. Through a balanced and careful selection of research, he has re-justified the contextual model, which, compared to the medical model, provides entirely new insights into the workings of psychotherapy (Table 1). He pointed out the weaknesses of the overemphasis on empirically supported psychotherapy (EST) methods based on the medical model and called for further research into the common factor theory from which the contextual model grew in the 1960s[4] (Frank, 1961, 1971; Frank & Frank, 1991).

Table 1
The differences between the biomedical and the biopsychosocial/contextual approach, which gave rise to and still drive the great psychotherapy debate.

THE GREAT PSYCHOTHERAPY DEBATE	
BIOMEDICAL APPROACH	BIOPSYCHOSOCIAL, CONTEXTUAL APPROACH
development of modern medicine (from the middle of the 19th century)	development of broader cultural currents, traditional healing practices and humanism
mind-body dualism	holism
biomedical model	biopsychosocial model, contextual and CARE-Model of mental health treatments
objectivism; positivism; scientific monism	constructivism; relativism; dialogical pluralism; systemic, hermeneutic and transformative epistemology
decontextualization	contextualization
disease/health dualism, health as the absence of disease	health as the state of physical, mental and social wellbeing, health as the ability to coexist with disease, increasing the possibility of survival and evolution

4 At the same time, it should be emphasized that the great psychotherapy debate is not only about scientific and philosophical/epistemological polarization between researchers, but also about intense political conflicts concerning the financing of psychotherapy services (Možina, 2010; Laska, 2012), the normative regulation of psychotherapy (Možina & Bohak, 2008; Možina et al., 2018) within health and social care structures, and the inclusion of psychotherapy as a scientific discipline within academic educational structures (Pritz, 2011; Laubreuter, 2012, 2018; Fiegl, 2016; Možina, 2016a).

THE GREAT PSYCHOTHERAPY DEBATE	
BIOMEDICAL APPROACH	BIOPSYCHOSOCIAL, CONTEXTUAL APPROACH
linear, somatogenetic, monocausal explanations/etiology – disordered biochemical and/or neurophysiological processes	circular, biopsychosocial, multicausal explanations/etiology
emphasis on pathology, pathogenesis and deficit	emphasis on salutology, salutogenesis and difference – resources, resilience, empowerment of clients
symptom as text without context	symptom as punctuation and metaphor about a larger context
the tendency to trivialize complex systems	considering the non-triviality of complex systems (complexity science)
specificity of diagnosis	contextualized process – outcome assessment (feedback-informed treatment)
specificity of treatments	commonality among treatments
the goal of medical treatment is to reduce symptoms and eradicate pathogenic factors	in addition to reducing acute symptoms, the goal of contextual treatment is to increase the quality of life and coevolution with pathogenic factors
subspecialization and fragmentation of treatment	integration of treatment
successful mitigation of acute symptoms	more suitable for solving chronic problems and for understanding acute symptoms as part of a longer, context-dependent process of evolution
superiority of one psychotherapeutic approach/ method	Dodo bird verdict
psychotherapy technique is crucial	common factors theory: crucial are client factors, therapist factors, and therapeutic relationship/alliance
nomothetic	idiographic
empirically supported treatments RCT design	evidence-based practice and practice-based evidence
standardized manuals	tailoring treatment for each client
somatic interventions predominate	dialogical interventions predominate
bag of tricks, emphasis on techniques	wisdom, emphasis on holistic treatment
knowledge as a virtue	curiosity and not knowing (awareness of limited knowledge) as a virtue

3.1. The biomedical approach

The biomedical approach began to take hold with the development of modern medicine from the mid-19th century onwards, with its emphasis on the dualism of body and mind (spirit). Health is defined as the absence of disease and the origin of disease is in the body, and in the case of mental disorders it is mainly a disruption of biochemical and/or neurophysiological processes. Diagnosis is based on a specific identification of this bodily cause and is the basis for planning and implementing a specific form of therapy. On this basis, there has been an excessive subspecialisation and fragmentation of the various forms of treatment and an advocacy of the superiority of certain forms of treatment over others. The methods and techniques of treatment are said to be crucial, as they have a significant impact on the outcome of treatment. They should be validated by controlled studies (RCT design) and their implementation should be based on standardized manuals (Schiepek, 2008).

In his historical overview of 150 years of the great psychotherapy debate, Wampold outlined (mainly focusing on a historical account of psychotherapy development in the United States) the key developmental currents of medical and contextual models. The first, which dominated and still dominates the scientific discourse on psychotherapy, is linked to the development of modern medicine from the middle of the 19th century onwards. The other, which is more intertwined with broader cultural currents, traditional healing practices and humanism (Wampold, 2001ab, 2012) and which the common factors theory and the contextual model are part of, remains in the background despite its long tradition and the fact that it could serve as a core and key source for the development of modern psychotherapy science.

The 19th century was marked by the scientific and technical revolution which legitimized the materialistic worldview. Although Mesmer found that he could modify the course of physical symptoms through what we now call hypnotism, his work was criticized and largely ignored by the medical scientific community. “The mind-body schism spread widely and the ultimate soma became the cell. The healthy cell was conceived as the source of health, the diseased cell the source of disease” (Martin, 1978). The progress of medicine only reinforced such a monocausal materialistic conception: for example, Pasteur’s discoveries, which were followed by preventive vaccinations, or Virchow’s cellular pathology, which

became the root of modern pathology[5], or Koch’s discovery of the causative agent of tuberculosis and cholera, as well as the discovery of the causative agent of syphilis in 1905 (Bohak, 2022). In this materialistic frame psychiatry primarily became neurology, and the explanation of mental disorders also emphasized exclusively somatogenetic etiology and denied everything that could not be proven by physical and chemical methods.

Crucial for the development of modern science and modern medicine is Cartesian concept of the world as a great machine and the human body as a precise mechanism, and division into the body and soul, reason and emotions. Scientific medicine is, like modern science, fully devoted to the systematic search for the objective knowledge. As in many other sciences the subjective, the human, was thus eliminated sphere of experience. Cartesian dualism, on which all modern science is based, is a fundamental part of the modern ideology of control and domination over nature and mankind. This image made a deep impression on the development of modern science, including modern medicine (Ule, 2012).

Due to the great importance the natural laws of science have in medicine and due to the demand for scientific objectivity, modern medicine hardly admits the existence of psychosocial dimensions of health and illness, which are not captured by medical technical diagnostics. In such medicine there is no place for the intuitive methods that were the basis of traditional healing arts. In the mechanistic model of human body there is no place for intuition or intuitive knowledge. Although modern medicine cannot deny these treatment effects, which manifest themselves in placebo effects, publicly rejects anything that does not conform to the mainstream mechanistic understanding of natural science directed medicine and what cannot be explained by its strictly defined conditions.

In such medicine, the patient is not treated as an individual, but as a case, as an object on which certain methods and rules are applied, and which are justified with different specific scientific models. This can only function as long as the subjective dimensions of the disease are separated from the its ‘objective’ signs and as long as the disease can be treated as something ontologically independent

5 It is interesting that the famous German physician Rudolf Virchow (1821-1902), who is today mostly known as the father of modern pathology (Borisov, 1985), was not biomedically narrow-minded. Namely, he was also the founder of social medicine and he laid the foundations of public health in Germany, elevating the economic and social conditions of the poor and cleaning up living conditions in certain cities. He proposed the concept of sociomedical causation, emphasising the role of social and environmental factors in the etiology and prevention of diseases. In his seminal report of a typhus epidemic in mid-19th century Germany, he established a connection between the epidemic and poverty and living conditions. He proposed radical social reform and stated that “medicine is social science and politics nothing but medicine on a grand scale” (Lange, 2021, p. 149). In his middle age, he became increasingly interested in anthropology and became one of the leading anthropologists of the 19th century.

of patient's subjective experience. The persistency of the dualistic medical model is all the more surprising, when we consider that even the modern discoveries of natural sciences oppose the positivistic/objectivistic paradigm. For example, observations of 'hard' science as physics testify about the disappearance of the boundaries between the objective world and subjective awareness of the world, and they note that natural science does not describe nature as it is, but in relation to the observer (Heisenberg, 1971). Similarly, we can say that what scientific medicine observes, is not the disease itself, but a condition constructed by medical questions. But because modern medicine is based on science and objectively verified treatment methods, on research achievements and studies, and because its knowledge is mostly incomprehensible to laymen and directed at therapeutic goals, the medicine has gained a privileged position and major influence compared to other authoritative social institutions, like the law and the church (Ule, 2009).

Foucault (2009, 2018) deserves the credit that he recognized how changes in forms of medical knowledge about illness are linked to forms of power. According to his opinion, question such as, what is illness, is closely related to the question of what the function of medical knowledge is in contemporary social contexts and in the contexts of medical professionalization. The language of the physical symptoms of the disease already contains a judgment of what is desirable and what is undesirable, and the medical profession has a lot of institutional power and leverage in modern societies to determine what is normatively acceptable, what is a quality life and what is not. Diseases are sensitive to the relationship between nature and culture, but they are also sensitive to class and gender relations. By placing the symptoms of disease with nature, we inadvertently conceal the influence of medical knowledge on everyday life and the connection of medical knowledge with prevailing social values at all levels from the micro- to the macro-level of social life.

3.2. The biopsychosocial/contextual approach

In contrast, the biopsychosocial/contextual approach has evolved from broader cultural currents, traditional healing practices and humanism (Wampold, 2001ab). It emphasizes holism rather than mind-body dualism (Smuts, 1936) and defines health as a state of physical, psychological and social balance (Engel, 1977, 1979; Borrell-Carrió et al., 2004; Anchin, 2008; Tramonti et al., 2020). It explains both health and illness as the result of an interplay of biopsychosocial factors in a multicausal manner. Instead of categorical psychiatric diagnosis, it develops ways of assessment and diagnosis that take into account the individual in his or her social and cultural context (Duncan et al., 2017). It seeks to integrate

subspecialized and fragmented forms of treatment. Rather than seeking the superiority of a particular psychotherapeutic approach and method, it refers to the results of meta-analyses, which have confirmed the so-called ‚Dodo bird verdict' that different psychotherapeutic approaches are generally equally effective due to the operation of ‚common factors', the key factors being the client's factors, the therapist's factors and the therapeutic relationship and alliance (Duncan, 2017). Instead of controlled studies and RCT designs, the psychotherapy model promotes evidence-based practices (EBP) (APA, 2006; Norcross & Wampold, 2011) and practice-based evidence (PBE) (Barkham & Margison, 2007; Schiepek, 2008; Barkham et al., 2010; Green & Latchford, 2012; Cook & Cook, 2016). And instead of using standardized manuals, psychotherapists in this model tailor each therapy to the needs and characteristics of each client. The common factors theory promotes the diversity of therapists, emphasizes the idiographic nature of therapeutic methods and individualised, evidence-based practice (Littel, 2010). Just as different clients with different problems need different therapeutic methods and different therapists, therapists also need to have the results of different studies at their disposal. Thus, they can choose those that make sense for them and correspond to their worldview and self-image. In this way, they help them improve their performance within their theoretical model.

The contextual model opens a meta level, so that the objectivistic, positivistic approach is not abandoned, but integrated into a larger, contextual frame, in which the ordinary dichotomies, like quantitative/ qualitative and nomothetic/ idiographic are resolved on a new, more integrative level (Možina, 2021a). On the scientific, conceptual level, such a shift from "deficit" to "difference" does not imply an either–or dichotomy, but that the medical model can be integrated, on a new level of abstraction, into the constructivist/contextual model (Možina, 2021b), very much like the shift Heinz von Foerster proposed from *analytical clarity* to *trust* and from *objectivity* to *responsibility* (von Foerster in Kordeš, 2005), and Bradford Keeney's "cybernetic complementarities" (Keeney, 2005), as well as Varela's non-dualistic sense of "trinity": "By trinity I mean the contemplation of the ways in which pairs (poles, extremes, modes, sides) are related and yet remain distinct [...] For every Hegelian pair of the form, A/not A, there exists a more inclusive [form], where the apparent opposites are components of the right hand side." (Varela, 1976, pp. 12, 62, 64)

In the case of a medical objectivist–constructivist pair where a symmetry of opposites is proposed, one can always reframe this pair as part of a more encompassing cybernetic complementarity. Such a complementarity involves different orders of recursion (which we can imagine as nesting Russian dolls). The pure medical objectivist perspective remains at the level of recursion that

does not include the awareness that it is only one kind of construction, i.e., the construction under objectivist rules and premises. By contrast, the constructivist/contextual perspective can include both the awareness of objectivism as one possible way of construction and the awareness of constructivism as another possible way. So, the constructivist/contextual perspective can be understood not only as the Hegelian opposite to the medical pole, but as a more encompassing level of recursion, as a larger Russian doll that contains the smaller, medical doll. This recursive leap from medical to constructivist/contextual understanding avoids being stuck in medical technical and control approaches to the treatment of people with so-called "mental disorders".

With this shift, medicine, psychiatry and other mental health disciplines turn into a discursive, dialogical (and polylogical) activity, which accepts its epistemological responsibility (Miškulin, 2016, 2017). This responsibility includes taking into account context dependency, historical variability, circular, multicausal explanations with the inclusion of the observer (participatory position), and "dialogical pluralism" (Gelo & Pritz, 2020).

4. Modern transdiagnostic and transtheoretical psychotherapy based on the tradition of biopsychosocial/contextual model

During the last 25 years the common factors/contextual wave in psychotherapy science and practice has created an integrative vocabulary and framework for the operationalization of psychotherapeutic clinical practice irrespective of what particular approaches and models the individual psychotherapist might belong to (Duncan et al., 2010). A psychotherapist can use any technique, strategy, and theory as long as they reinforce one or more common factors (client, therapist, therapeutic relationship, client's feedback and general and specific effects of models/techniques) and make sense to the client. This 'client-centered perspective' points out that the effectiveness of interventions depends primarily on the use of client resources, strengths (resilience), hopes, expectations, goals and their 'theories of change' (Duncan & Miller, 2000a).

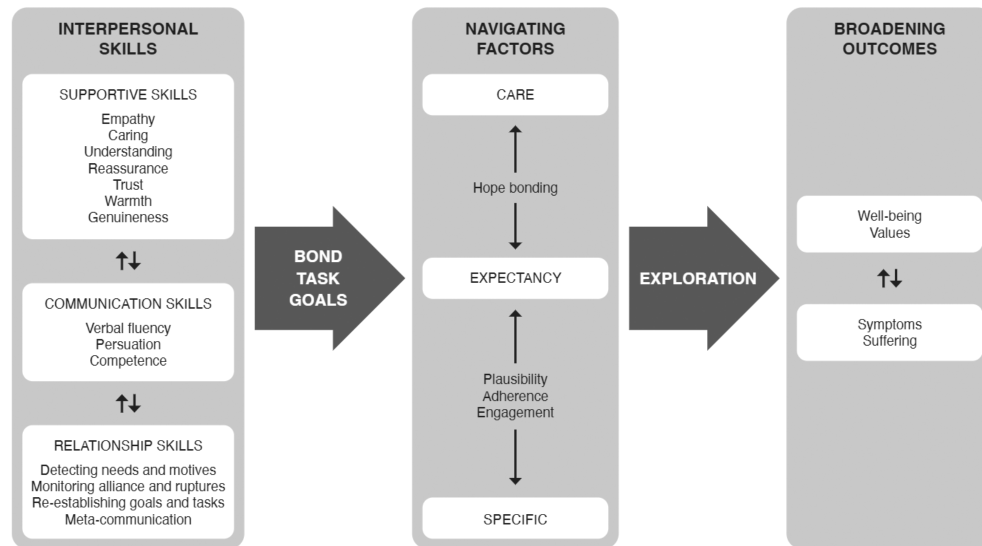
According to the contextual model, on the basis of trust and understanding between the therapist and client and the therapist's expertise (the key here being that all three are positively evaluated by the client) therapy works through three mechanisms: a) real relationship, b) (co)creation of expectation through explanation and c) some form of treatment and specific ingredients (tasks/goals, therapeutic actions) (Wampold & Imel, 2015). Unlike the medical model, the basic premise of the contextual model, which is transdiagnostic, transtheoretical

and transcultural, is that specific components do not act directly on a particular disorder or deficit, but indirectly through (co)creation of positive expectations and encouraging the client to actively develop healthy and functional patterns of thinking, feeling, behavior and relationships.

According to Lutz and Rief (2024) such a transtheoretical perspective »offers a new framework for integrating evidence-based psychological treatment techniques that can have theoretical roots in different theories. Thus, it represents an umbrella that encourages the consideration of all research results and evidence-based treatment proposals, and a fruitful stimulation of insights *across* traditional orientations. Transtheoretical psychotherapy aims to use findings from mechanisms, outcome, process, and feedback research as conceptual frameworks for clinical practice and training« (p. 1). They understand transtheoretical as a broader concept, as originally introduced by Prochaska and Di Clemente (1982), because they include an orientation towards evidence-based treatment procedures and strategies as well as multimethod and multidimensional diagnostic concepts and data-informed decision tools, which can form the basis for transtheoretical and evidence-based clinical training and practice in the future.

As an extension of the contextual model, Wampold and Flückiger (2023) proposed the CARE-model as an evidence-based transtheoretical as well as transcultural model with three pathways to the benefit of all mental health (as well as physical health) treatments: The CARE pathway (caring, attentive, real, empathic), the EXPECTANCY pathway, and the SPECIFIC pathway (Figure 1). This model integrates the effects of relationship factors and specific ingredients, making it important for various healing domains, including psychotherapy, psychiatry, and medicine. Although research and clinical attention have mostly focused on the alliance between a clinician and a patient in face-to-face interactions, there is preliminary evidence concerning the alliance between patients and other clinic staff, systems of care, or the program in Internet-mediated services.

Figure 1
The transdiagnostic, transtheoretical, transdisciplinary and transcultural CARE-Model for treatments of mental and physical health problems (Flückiger et al., 2024, p. 8)



Based on extensive meta-analytic evidence for contextual model and CARE--model, Flückiger et al. (2024, p. 1) propose four relevant implications for future training and practice in transdiagnostic and transtheoretical psychotherapy: 1) the development of a transtheoretical legal framework for psychotherapeutic treatments, 2) the formulation of evidence-based transtheoretical interpersonal skills, 3) an orientation toward transtheoretical therapeutic factors, and 4) the exploration of comprehensive psychotherapy outcomes.

5. Integrative systemic psychotherapy as a transdiagnostic and transtheoretical approach in psychotherapy

In accordance with biopsychosocial/contextual, transdiagnostic and transtheoretical approach in psychotherapy and the four implications formulated by Flückiger et al. (2024), Schiepek and colleagues (2015) developed so called 'integrative systemic psychotherapy'. It is not a new systemic psychotherapy school or a new school of integrative psychotherapy (like, for example, Richard Erskine's relational integrative psychotherapy or Hilarion Petzold's integrative gestalt psychotherapy) (Petzold, 1992; Erskine, 2015), but a meta model of integration. It is on a different, transdiagnostic and transtheoretical level of recursion

compared to the level of recursion of existing psychotherapeutic schools or approaches. It is based on complexity science and "contains the paradox that as long as its assumptions are valid (e.g., non-linearity, dependence on initial conditions and minimal fluctuations or interventions; critical instability by breaking of symmetry, etc.), the dynamics and systemic structure of individual cases will have to come into focus precisely because of their general (nomothetic) laws" (Schiepek et al., 2015, pp. 75-76).

This meta conceptualization of integrative systemic approach in psychotherapy connects different levels, as listed below, in accordance with the structuralist interpretation of theories (Stegmüller, 1973; Westmeyer, 1989) (Figure 2):

- the level of transtheory or scientific paradigm with mathematical formalization, simulation and modelling techniques;
- the level of field-specific theories (e.g. psychotherapy, neurodynamics) and knowledge about phenomena (e.g. therapeutic change, process and outcome);
- the level of acquisition (measurement), data analysis and data presentation, which includes propositional knowledge[6] and competences for multidimensional orientation, multiperspective assessment and diagnostics, which is not only tied to psychiatric diagnostics or a specific psychotherapeutic approach; and
- the level of experiences and findings of different psychotherapy schools and of clinical practice studies, which, in accordance with the PBE model, participative procedures and ecological validity, includes operational (procedural) knowledge and operational competence for the implementation of methods and techniques of various psychotherapeutic approaches, principles for organizing the therapeutic process (generic principles), real-time monitoring of the realized system dynamics and outcome assessment (feedback-informed treatment), and gathering of quality documentation for quality management (quality control).

6 The term propositional knowledge used here means information or understanding that can be represented in a highly formal language such as mathematics and propositional logic. Its synonyms are descriptive or declarative knowledge in contrast to tacit or procedural knowledge.

Figure 2
An expanded concept of integrative systemic approach in psychotherapy that connects different levels: the level of transtheory, the level of scientific findings and knowledge about phenomena, the level of multidimensional acquisition (measurement), analysis and presentation of data, and the level of experience and results of studies from clinical practice (adapted according to Schiepek et al., 2003, p. 241).

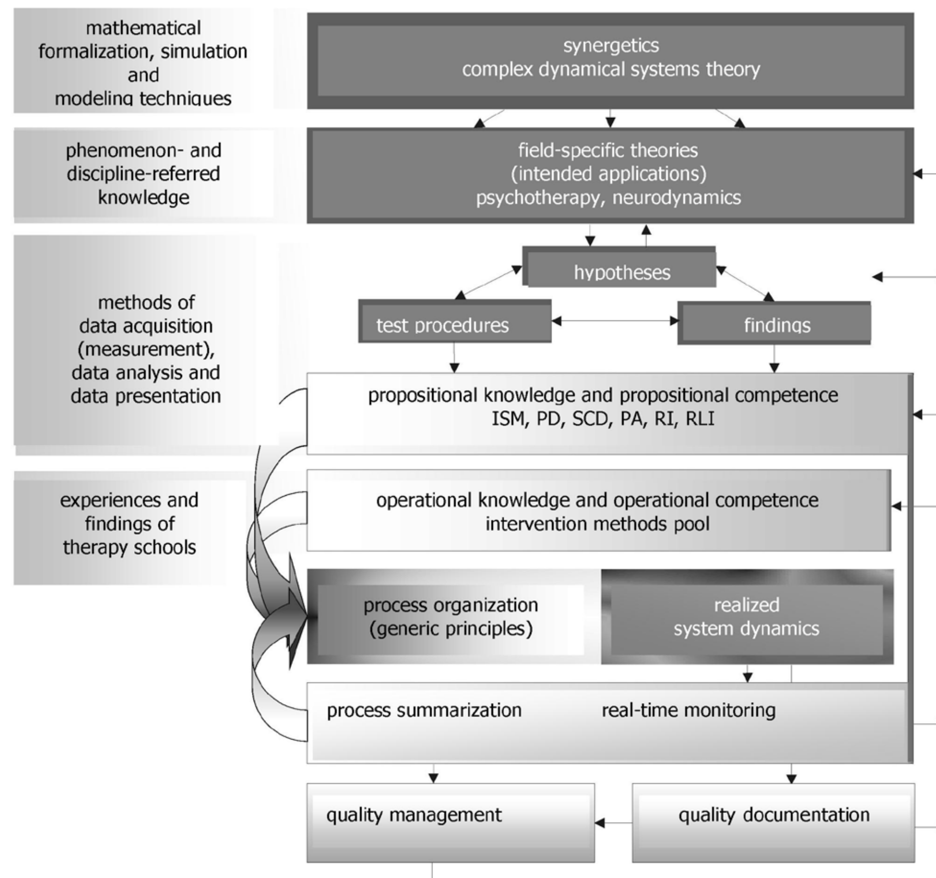


Figure 2 also shows the connections between the levels that enable the integration of psychotherapy science and clinical practice and the expansion of the concept based on findings of practices that are no longer context-independent. This means that 'results' or 'evidence' for (possible) efficacy is not attributed in a decontextualized way to the intervention or therapeutic program itself, but has to be justified and, if necessary, changed on the basis of real-time monitoring, taking into account feedback on a case-by-case basis (this depends on the context) (Schiepek et al., 2016).

This meta concept of integrative systemic approach in psychotherapy creates a space where psychotherapy can be considered as the management of self-organization processes co-created by the therapist and the client. The starting point on the level of transtheory is the transtheoretical frame of synergetics as well as the mathematical formalism of the theory of complex dynamic systems (top of Figure 2), which synergetics refers to and uses (Haken & Schiepek, 2006). In order to produce concrete specifications of the formal synergetic transtheoretical frame for its application to psychotherapeutic change processes or neurodynamics, access to phenomenon-specific knowledge is necessary. After a phenomenon-referred extension of the transtheoretical frame, the derivation of hypotheses is possible, which can be tested with adequate operationalizations and measurements. Data should be produced in real-world settings through active cooperation with subjects (practitioners, clients, or members of social networks). As for the arrangement, representation and analysis of data, which, with real-time monitoring, are obtained in the form of time series, a spectrum of methods for linear and nonlinear time series analysis is available.

5.1. Synergetic process management

The contextual approach has shifted the whole centre of gravity of diagnostics and treatment so that the client has much more importance and influence than in the biomedical approach. The diagnosis and treatment is co-created by the client and the therapist. Meta-analytic outcome research has shown that what clients think about their problems and suffering, resources and solutions, and what clients think about what kind of a procedure could be helpful for them correlates much more with the therapy outcome than the therapist's explanations and solutions (Wampold, 2015). If the therapist doesn't follow the client and doesn't include the client's understanding about the problem, resources and therapy process, then what the therapist thinks, does or selects as a possible helpful procedure, correlates much less with positive therapy outcome.

Diagnostics, which is based on psychotherapy theories, is more important for the therapist than for the client (Barnes, 2008; Carta et al., 2021). Therapists' diagnoses tell more about the therapist than about the client (Možina & Barnes, 2020; Možina, 2020d). Therefore the advocates of 'client-directed perspective' acknowledge that the client is the expert by experience, the main hero of therapy and the engine of therapeutic change (Duncan & Miller, 2000ab; Duncan et al., 2004, 2010; Miller & Duncan, 2012; Miller et al., 2005). So therapists should ask clients about their expectations and hopes, their experience of therapeutic relationship, therapy process and change in a systematic way (feedback-informed treatment).

Based on this client-directed or client-centered perspective Günter Schiepek and his coworkers developed the integrative systemic transdiagnostic and treatment approach called the The Synergetic Process Management (SPM) which entails (Haken & Schiepek, 2010; Schiepek et al., 2015, 2016): resource-focused interview, idiographic system model, individualised process questionnaire for daily online monitoring, regular therapeutic sessions with feedback on basis of the current data-profile (continuous cooperative process control), and Synergetic Navigation System (SNS).

SPM is not a new school of psychotherapy, but a generic system that allows for the optimal and appropriate use of specific therapeutic methods and techniques according to the therapeutic process, and can therefore contribute to the effectiveness of any psychotherapeutic approach or method.

SPM uses a set of procedures, which enable the presentation of network structures and their functioning in the systems involved. In Figure 2 they are assigned to practitioner's propositional knowledge and competence. Examples in Figure 2 comprise: idiographic system modelling (ISM) (Schiepek, 1985; 1991, 2019, 2020ab), process documentation (PD) (for example, Therapy Process Questionnaire – TPQ) (Schiepek et al., 2019), stability and coherence diagnostics (SCD)[7], methods of plan and schema analysis (PA) (Caspar, 2010), configuration analysis (identification of 'States of Mind') (SM) (Horowitz, 1987), resources interview (RI) (Schiepek & Cremers, 2003), and rating inventory for solution-focused interventions (Ratinginventar Lösungsorientierter Interventionen) (RLI) (Honermann et al., 1999). These procedures are used to identify and describe clients' cognitive-emotional-behavioral patterns in their living environment or in their interaction with the therapist. What is crucial for the case conceptualizations is to understand the extent and the borders of the observed and changeable system, the time and space of modelling resolution and the observed system level(s) (e.g. biological, psychological, social-interactional level). Of course, the choice of which assessment and diagnostic set to select is open: it can be tied to psychiatric diagnostics or a specific psychotherapeutic approach or not, and the one presented here and connected to SPM is only a possible choice.

A resource-oriented interview (RI) (Schiepek & Cremers, 2003) has several advantages. First of all, it is a positive counterbalance to classical psychodiagnostics, which focus almost exclusively on pathology. Many clients experience the positive atmosphere and focus of such an interview as a relief and a reminder to

7 Diagnostics of stability and coherence (in the German original Stabilitäts- und Kohärenz-Diagnostik), which includes the analysis of multiple time series in order to discover the degree of stability or instability of the process and the degree to which different time series of subsystems are synchronized.

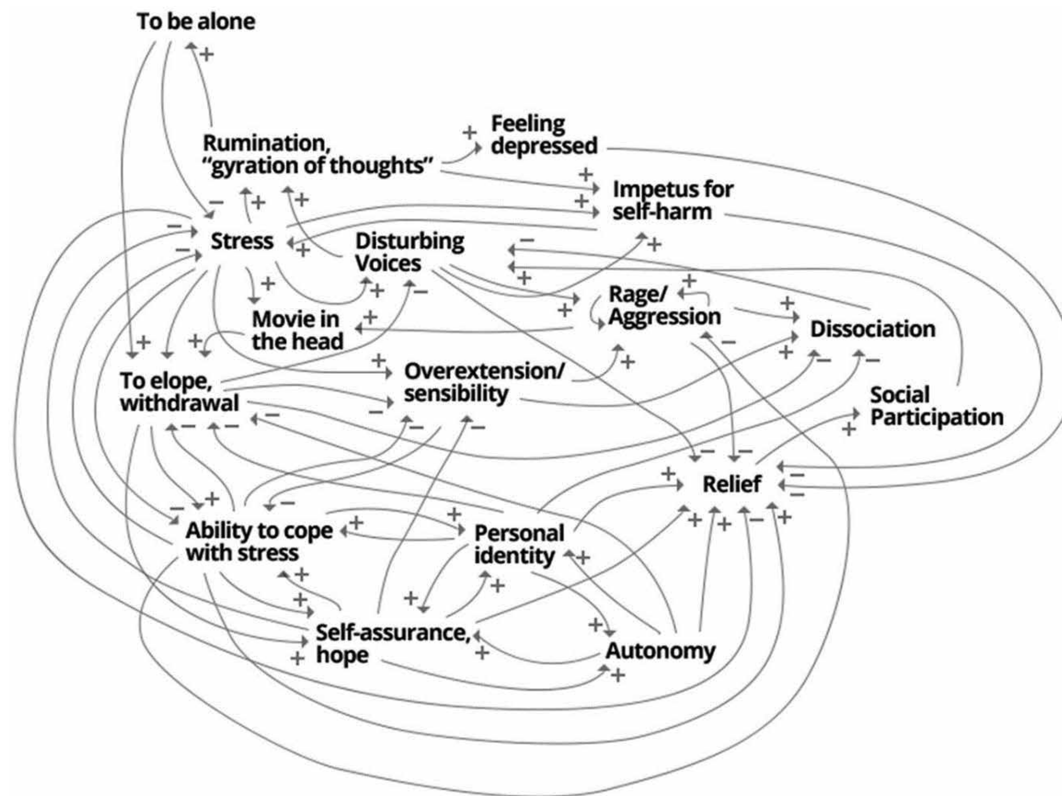
remember their abilities and strengths and to have a positive mental attitude. Another advantage of this open-ended, loosely structured interview is that it is a prelude to the next step of the SPM - idiographic systems modelling.

5.2. Idiographic System Modeling (ISM)

After the resource interview, in the second interview the therapist tries to make a list of the client's relevant psychological and social issues. He starts with questions to get a general picture of the client's life in the last months, while making notes on the client's psychological problems, problem-solving methods, coping strategies, the impact of interpersonal relationships, etc. These notes then form the basis for the creation of an Idiographic System Model (ISM) (Matschi & Schiepek, 2015; Schiepek, 1985; 1991, 2019, 2020ab; Schiepek et al., 2008, 2016; Stöger-Schmidinger et al., 2016). Any content that is relevant to the client can become part of the interview and later be included in the ISM together with the therapist. The therapist should aim to capture as many expressions as possible as uttered by the client in order to develop a shared understanding and design a model tailored to the client. At the end of the interview, they double-check all the key concepts together, both terminologically and conceptually, so that the client really has a sense that these are his/her concepts. It is also important that they are designed in such a way that they can change over time. Ideally, the therapist and the client use the list of key concepts to cover all the important biopsychosocial aspects of the client's life - cognitions, emotions, motives, behaviours, psychological states, etc. - by using the client's vocabulary.

This is followed by drawing interconnections between the concepts or variables to create a map of the personal landscape with the important aspects of the client's mental functioning - an idiographic system model. On a whiteboard or larger piece of paper, the therapist (or the client) writes concept A and checks which other key concepts it is related to. Once they have chosen concept B, they link them with an arrow and a + sign for a positive link (increasing A leads to increasing B and decreasing A leads to decreasing B) or a - sign for a negative link (reverse effect: increasing A leads to decreasing B and decreasing A leads to increasing B) (Figure 3).

Figure 3
The idiographic system model, a synopsis of psycho- and socio-dynamical aspects of the client's experiences (Schiepek et al., 2016, p. 3)



ISM is based on a co-creative process between the client and the therapist, producing a network model of the mental and social functioning of the client. Conceptual components of a system model are 'variables' that change over time and represent intra- individual or interpersonal components of a complex system (e.g. cognitions, emotions, motives, and behaviours). This is a new kind of client-centered diagnostics where the client in collaboration with the therapist makes his or her own individualised process questionnaire to follow the therapeutic process and outcome based on her or his particular ''map''.

Idiographic models show interactions, loops between variables, or recursions of a variable to itself (autocatalytic effects). The cross-linking of the variables makes it possible to see connections that were previously unnoticed or were only considered as unilateral cause- to- effect relations ('x is to blame for y'). After completion of the modelling, therapist and client create an individualised process questionnaire for monitoring and data collection. During the

therapeutic process, the therapist and client can refer to the model and to the time series of the change dynamics. Beyond the identification of a spectrum of outcome criteria, that is, the variables of an idiographic model, the system model provides an impression of the network structure of the clinical pattern. This means that the evaluation (a) considers changing variables and changing structures of the important system or network, (b) makes use of multiple time series and its changing patterns and connectivity, and (c) contributes to the

reflection and cooperative decision- making during the psychotherapeutic process. An important aspect of this personalised outcome evaluation is that it places greater emphasis on the client rather than the general question of treatment effectiveness (e.g. is this type

of treatment effective for this type of disorder?). At first, no generalisation to any population is intended, but in a second step, classifications and aggregations of completely individual, highly complex, non- ergodic and unpredictable trajectories of change can be realized (Schiepek et al., 2022).

The use of ISM, as it is shown in this book, is expanding from the field of psychotherapy (individual, couple) to different disciplines, such as coaching, counselling, social work, team development, and can be applied different settings, such as outpatient and day clinics.

5.3. Synergetic Navigation System (SNS)

An important aspect of propositional competence consists of acquiring information about the dynamic characteristics of self-organizing processes. This is possible with the Synergetic Navigation System (SNS), which can be used to identify critical phases and non-linearities of the ongoing self-organization processes (Schiepek, 2020a). SNS is a highly flexible and generic internet-based system for data acquisition, time-series analysis, and visualisation of various questionnaires and coding systems. Data can be entered and results can be checked by most web-compatible devices, including PCs, notebooks, tablets, or smartphones (ubiquitous computing).

As a practical impact of real-time monitoring, SNS opens psychotherapy to science-based process-outcome-research. Models of change processes (e.g., sudden gains) can be tested but also used as an interpretation frame of idiographic results. In everyday practice SNS enables the evaluation of different conceptualizations of extratherapeutic factors, enhances transparency, self-efficacy of clients, and supports the motivation to change. Compliance of clients is usually high, and the data show sufficient validity (Schiepek & Aichorn, 2013).

SNS analysis tools allow for stability and coherence diagnostics of a dynamic system (SCD) (Schiepek, 2003). The sensor within the therapy process dynamics

does not need to be limited to subjective estimates gathered with the therapy process questionnaire (Schiepek et al., 2019). Other information (e.g. from the therapist or from the client's social environment), physiological data or immune parameters are just as detectable and analysable. Procedures of computer--based real-time monitoring are the heart of SPM, since they enable data-based navigation through the turbulences of the system's self-organized development processes.

Needless to say, therapists must be competent in a range of intervention methods and specific therapeutic techniques, acquired with adequate training and advanced studies. Techniques are used to implement generic principles and enable the practitioner's freedom of navigation and choice within the functional equivalence of several techniques for the realization of a particular principle. This freedom of choice of methods and techniques allows SPM to be independent of therapy schools without having to resign valuable experiences and findings of various treatment methods as they were developed within particular schools. The independence of the SPM from classical therapy schools stems from the fact that synergetics as a general theory of change processes is more general and abstract than customary psychotherapy theories.

The available intervention possibilities are considered and examined against the background of generic principles in order to achieve a client-tailored therapeutic treatment, i.e. a treatment suitable for the client's current development and system condition (Schiepek et al., 2000; Možina, 2023). Generic principles serve as filters and criteria for continuous, adaptive indication decisions. In Figure 2 the filter and screening function of generic principles is symbolized with arrows running from real-time monitoring, clinical diagnostic system modelling (propositional knowledge on the basis of applied assessment procedures) and from the available intervention methods pool towards the generic principles.

The client is actively included in the process feedback and the evaluation of process analyses. Thus, a partner collaboration develops, in which the client becomes an independent process designer and gradually takes control over the process. This has a positive effect on their self-efficacy experience and their sense of self-esteem as well as on the therapeutic relationship.

The SNS may also enhance the collection of process documentation, and the continuous process analysis also offers the option of therapy evaluation. At various time points questionnaires can be applied, and social-demographic and therapy-referred data gathered (e.g. on first contact before the beginning of treatment, at the beginning of treatment, at the end of treatment and at catamnestic intervals). The evaluation results can flow into the practice quality

management (e.g. in a stationary or outpatient clinic) and become the basis for further optimizations of processes and outcomes. The SNS produces a complete record of the treatment process and outcomes of each individual therapy, the individual case data being aggregated and summarized into group statistics. Thus, process-outcome research is possible in a more ecologically valid way within an actual practice setting. The results and experiences from the feedback system can be used for further practical improvement of various model components and levels, quality control, as well as research development (feedback arrows in Figure 2).

6. Integrative systemic approach in psychotherapy beyond psychotherapy schools and beyond biomedical/contextual dichotomy

Schiepek et al. (2015) point out that the proposed concept of integrative systemic approach in psychotherapy as feedback-aided support to processes of self-organization offers a synthesis of the classical dichotomy between the biomedical and the contextual approach. It is possible to integrate these two approaches "if patterns and structures relevant for changes find systemic explanations as dysfunctional processes of self-organization or as structural 'condensates' of such processes, or if changes can be explained systematically and triggered by feedback – in the sense of providing conditions for therapeutic self-organization" (p. 74).

A psychotherapy model of self-organization implies that:

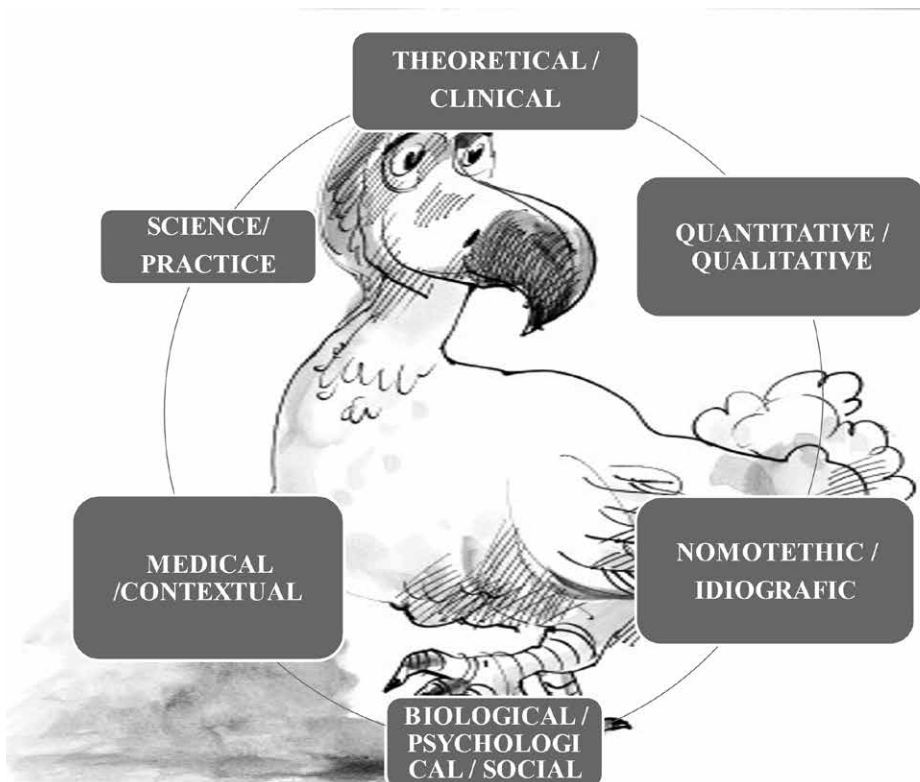
- therapy is providing support for self-organization processes;
- non-specific factors become specific because they can be clearly defined theoretically (e.g. as generic principles);
- the assumption of input-output mechanisms is theoretically outdated;
- it is possible to explain the systemic processes of reorganization scientifically with models of complexity science and self-organization, and to explicitly support them by means of process monitoring and feedback (ibid.).

Therefore, within the Schiepek's concept of integrative systemic approach in psychotherapy, Dodo bird with his verdict came to the possible resolution of the great psychotherapy debate between the medical and the contextual model. As I described, Dodo's long journey through the winding paths of psychotherapy research (Možina, 2020c, 2021a), which began in 1936, when Rosenzweig used the allegory of the Dodo bird verdict (Rosenzweig, 1936), has brought him to the point where the possibilities for achieving integration of different polarities are opening up.

Moreover, the integration of the following dimensions beyond psychotherapeutic schools is also included in Schiepek's concept: science and practice (practitioner-scientist model); biological (especially nervous), mental (psychological) and social dimension; quantitative and qualitative methodologies; nomothetic and idiographic; theoretical explanations and clinical understanding; personalized medicine and personalized psychotherapy[8] (Figure 4).

Figure 4

Dodo's long journey through the winding paths of psychotherapy research, which began in 1936, when Rosenzweig used the allegory of the Dodo bird verdict (Rosenzweig, 1936), has brought him to the point where the possibilities for achieving integration of different polarities are opening up.

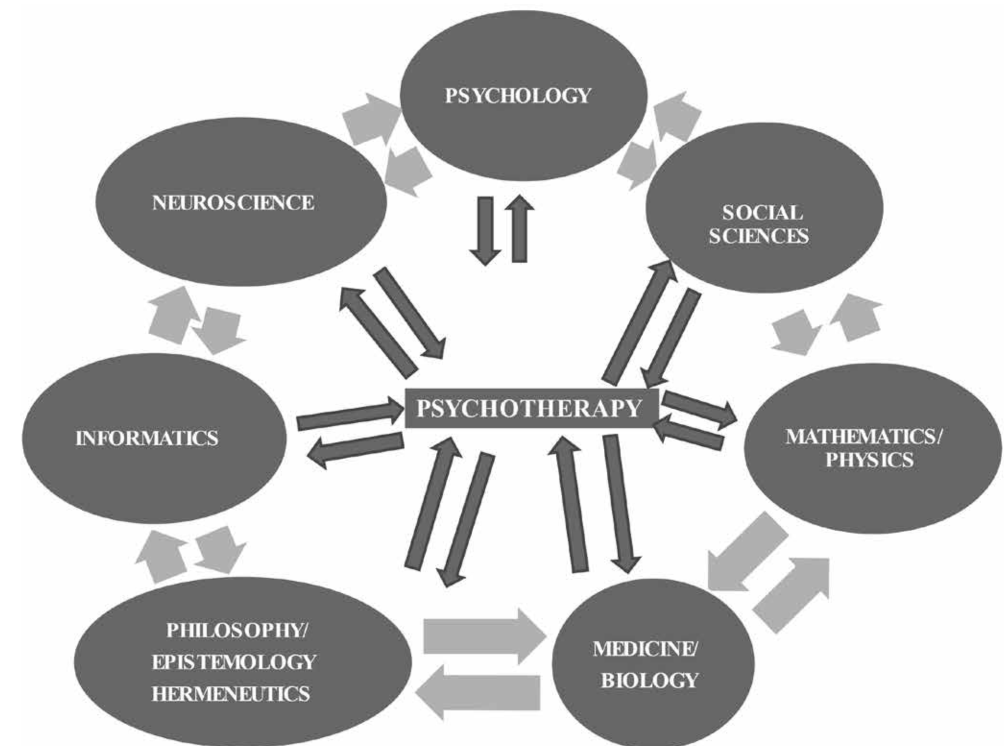


8 The concept of 'personalized medicine', when not understood narrowly as 'genetic personalization' (that is, strictly as measures that take into account the individual's genetic record), but also as developing a relationship and therapeutic treatment with the patient as a complete and unique personality embedded in the social context (who responds differently to treatment, despite having the same diagnosis as other patients) (Somrak, 2015), could represent a bridge to 'personalized psychotherapy' (Fisher, 2015; Fisher & Boswell, 2016). This is based on the individualisation of diagnostic assessments and treatments, as well as process-sensitive therapeutic procedures.

Psychotherapy is no longer just applied psychology but an independent profession; a profession and scientific discipline at the intersection of several different disciplines (see Figure 5), such as psychology, philosophy (epistemology, hermeneutics), medicine (psychiatry), biology, neuroscience (Schiepek, 2011), social sciences, as well as methods of linear and non-linear analysis of time series derived from physics and mathematics and informatics (e.g. using computer-supported feedback systems). Complexity science (which includes, *inter alia*, the theory of complex systems dynamic and systems theory) is useful in establishing the interconnections and transtheoretical framework, including transdisciplinary terminology. Education and training from the scientist-practitioner model is based on the concept of systemic competence (that is, the competences of understanding, modelling, analysing and dealing with complex systems) (Haken & Schiepek, 2006, p. 670).

Figure 5

Psychotherapy as an independent profession and scientific discipline at the intersection of various disciplines (after Schiepek et al., 2015, p. 75).



Even at the current stage of its development, the new integrative systemic approach in psychotherapy provides a way to interpret problem patterns and pathological structures systemically as dysfunctional processes of self-organization or as structural 'precipitates' of such processes, and therapeutic changes can be systematically encouraged on the basis of feedback, which facilitates the creation of conditions for therapeutic (healing) self-organization. But of course, it will take a lot more work to develop, on the one hand, holistic (idiographic) and process diagnostics that will replace the current categorial diagnostics of mental disorders, and, on the other hand, to improve navigational support for effective and successful management of the therapeutic process and outcome (Schiepek, 2008).

7. Integrative systemic approach in psychotherapy based on complexity science

The good news is that, at its present state of development, complexity science is already offering the transtheoretical frame as well as the technologies to realize the integrative systemic approach in psychotherapy, because it is able to provide: a meta-theoretical and generic understanding of change processes (from neuronal to social system levels); comprehensive and formalized modelling of change processes and personality development; an integrative method of case formulation; the ability to understand a variety of techniques in terms of basic change principles; criteria to guide microdecisions in the navigation of the therapeutic process; the application of data-driven feedback and real-time monitoring of change dynamics; standardized assessment of outcomes in naturalistic settings; guidelines for training; and strategies that are well-suited to science–practice integration (Schiepek & Pincus, 2023).

Such an integration based on complexity science, which fulfils the nine criteria proposed by Schiepek in Pincus, acknowledges the four paths of psychotherapy integration outlined by Norcross and Goldfried (2005) but also offers the possibility to go beyond these established four routes. Namely, it represents meta-integration, i.e. the integration of existing integrative concepts for the following reasons:

- In accordance with integration based on common factors, it not only acknowledges them but offers the possibility to present and analyse nonlinear interactions of all common and specific factors or variables which create the self-organized dynamics of any real therapy.
- In accordance with integration based on technical eclecticism, it not only acknowledges eclectic demand to select the best treatment for the client and the problem, but offers the possibility to select treatments according to the client, the problem, and specific moments on the concrete trajectory of a change process, e.g. periods of stability or instability or different degrees of synchronization. If offers feedback technology like the SNS and a theoretical frame to understand what's going on and to justify the adaptive selection of techniques.
- In accordance with the criteria for theoretical integration it acknowledges the aim of such integration but offers a transtheoretical frame and a concrete theoretical explanation of the dynamics and outcome. Beside the theory it also offers the possibility of personalized psychotherapy, including the techniques of case formulation and process feedback, and with decision rules guiding the process.
- In accordance with the criteria for assimilative integration, it acknowledges the need for a flexible theoretical attitude towards different psychotherapy schools. However, it offers a different starting point, which does not belong to any psychotherapeutic school or orientation but to a transtheoretical and transdisciplinary paradigm which can be concretized and applied to any psychotherapy approach. Beside the paradigmatic frame it also offers the possibility to integrate methods and findings from other fields such as brain research or more specifically, from systems neuroscience in relation to cognitive, affective, and social processes.

Based on such transintegration, Schiepek et al. (2015) also propose a more integrative definition of systemic therapies, not in the sense of a systemic psychotherapy school but one that transcends any psychotherapy school or approach: "Systemic therapy enables change processes of states of a system or network of systems (regarding structures and/on functions) that are considered dysfunctional or in deficit. In order to accomplish these changes, methods are used that can be placed in the theory spectrum of complex, dynamic, and nonlinear systems. As essential and integral part of therapy and change is the process measurement of the systems and their dynamics; that is consequent process feedback. The therapy and change process itself is conceived and realized as a dynamic self-organizing system" (Schiepek et al., 2015, p. 79).

According to this definition of psychotherapy as a feedback-driven dynamic systems approach has the following characteristics:

- focus of treatment has systemic qualities (e. g. neuronal, mental, interpersonal systems) and can be modelled by system-theoretical methods;
- there is no a priori constriction to a specific level of functioning (e.g. biological, mental or interpersonal-communicative) is made. Although it is clearly rarely possible to measure biopsychosocial processes simultaneously and

intervene at all these levels, it is important that they are considered and that it is justified in each case why the focus is placed on a specific system level;
- systemic therapies are not limited to psychotherapy – neurobiological, biomedical, psychological, social treatments can be systemic as well;
- no a priori constriction to particular interventions or therapy school is made in the field of psychotherapy (ibid.).

With such a definition of the four characteristics, the conceptualization of psychotherapy jumps to another level of abstraction and becomes a member of the bigger family of systemic therapies in general, which is very different from the prevailing understanding. The implication of becoming a member of the bigger family of systemic therapies is that nothing less than an epistemological shift is needed, but it is definitely worth the effort, as it opens possibilities for bridging established dualisms (Figure 4) and rigid boundaries between different fields of knowledge.

Unfortunately, we are not yet at the point where Schiepek's concepts of integrative systemic approach in psychotherapy and systemic therapies would be accepted as sufficiently abstract unifying concepts or theories for the whole psychotherapy field. On the contrary, at the current developmental stage of psychotherapy science, the great potential of complexity science for psychotherapy research and practice is used to a relatively very small extent. Viewed from the perspective of the epistemological shift proposed by complexity science, the entire field of psychotherapy is at best in a phase of epistemological confusion and transition. Furthermore, from a broad paradigmatic perspective in Kuhn's sense, the psychotherapy community has not yet achieved the paradigmatic shift (Kuhn, 1998). So, the great psychotherapy debate goes on and will go on for some time, and we can only guess how long before the epistemological or paradigmatic shift is completed.

Based on this insight, a key question arises: what can help us to move forward in the direction of a new, unifying paradigm? Will it be the new topics and discoveries of psychotherapy science, and perhaps most importantly, *how* will we engage in a dialogue regarding the theoretical and practical pluralism that currently characterizes us?

8. Epilogue: The current psychotherapy debate in Slovenia on the psychotherapy law

The context of the great psychotherapeutic debate can also help us to understand the current public confrontations on the psychotherapy law in Slovenia. On 19 April 2023, the Ministry of Health sponsored the establishment of a new Working Group for the Psychotherapy Act, which has since been divided by a polarisation between psychiatrists and clinical psychologists working in health institutions, and professional psychotherapists working outside health care. The same thing happened in the previous working group in 2018, which failed to formulate a draft law as the work came to a halt. This polarization can be better understood if seen from the perspective of the great psychotherapy debate, as psychiatrists and clinical psychologists refer to the medical model and psychotherapists to the contextual model.

Psychiatrists and clinical psychologists claim that psychotherapy is a method of work (not a profession) that can only be practised by them and by a narrow selection of certain health professionals who are employed in the health care system (e.g. occupational therapists, nurses) (Jelen Sobočan 2023; Dobnik Čoderl & Škodlar, 2023). One of their main arguments in support of this point is the very specificity that is a key characteristic of the medical model. They point out that only they know how to diagnose mental disorders and that, on that basis, only they can treat them in an appropriately specific way. They deny the competence of professional psychotherapists, who are not doctors or psychologists by training, and those whose primary profession is psychotherapy, to identify and treat mental disorders, citing various cases of nonmedical psychotherapists who overlooked a physical pathology that influenced mental symptomatology. They stress that medical training is essential for the practice of psychotherapy. They are even pushing for the title 'psychotherapist' to be reserved for them, while recommending that professional psychotherapists not employed in the health sector should be called 'psychosocial counsellors'.

Another feature of the polarisation is that psychiatrists and clinical psychologists emphasize the superiority of certain psychotherapeutic approaches, especially psychoanalytic and CBT. This, again, can be better understood from the perspective of the great psychotherapeutic debate, where, historically, psychoanalytic psychotherapists were the first to have tried to demonstrate their superiority, and, with the introduction of the EST methodology, cognitive-behavioural therapists have tried to demonstrate their superiority. Slovenian psychiatrists and clinical psychologists who are trained in psychoanalytic approaches justify their primacy with the actual historical fact that psychotherapy in Slovenia began with the introduction of psychoanalytic training within the framework of psychiatry and clinical psychology (Možina, 2011).

And the argumentation of clinical psychologists, who emphasize the superiority of CBT, is connected to the worldwide CBT endeavours to be the best of all approaches on the basis of EST methodology. According to them, not only CBT, but psychotherapy in general, can only be competently practiced by them and psychiatrists, because CBT:

- is based on empirically validated psychological facts and scientifically accepted psychological theories and uses empirically validated terminology;
- uses specific psychological and psychodiagnostic methods for client examination and assessment;
- formulates specific findings in the context of empirically validated psychological theories and facts;
- provides specific and varied treatments tailored to specific problems or disorders, because a wide array of diagnostic methods are used in clinical psychological practice and different treatment methods are used depending on the nature of the client problem.

However, what is crucial to building the elite status of CBT are not all these 'scientific' arguments, but the simple fact that in Slovenia only doctors and psychologists are allowed to be trained in CBT. Psychiatrists trained in psychoanalysis and CBT and clinical psychologists made only one minor exception by admitting to their elite club psychiatrists and clinical psychologists who are trained in systemic psychotherapy. But again, only those are accepted who are employed in the health care sector and organised in such a way as to ensure that the elite group does not mix with systemic psychotherapists who do not work in the health care system and especially not with those who are not psychiatrists or clinical psychologists.

Psychiatrists and clinical psychologists are also trying to ensure their 'specificity' and 'superiority' in the future by giving their associations and institutes (for psychoanalytic approaches and CBT) the exclusive right to train psychotherapists, while degrading other psychotherapeutic training options in Slovenia, even academic facilities, as inadequate.

On the other side of the Slovenian psychotherapy debate are professional psychotherapists, who see the need for a law to regulate psychotherapy as an independent profession and an autonomous scientific discipline. With this objective in mind, we refer to the common factors theory, the Dodo bird verdict and the contextual model, and point out the negative consequences of applying the biomedical model in the field of mental health care. We highlight that the shortcomings of the categorical diagnostic system of mental disorders, and that psychotherapy cannot be meaningfully planned and implemented if it is based on such classification. We also emphasize that medical training is not necessary (except for selected topics from medicine, psychiatry and neuroscience), as no previous profession is considered to have an impact on psychotherapy outcomes.

The broader context of the described Slovenian variation of the great psychotherapeutic debate is the dominance of the biomedical model that pervades the whole mental health care system in Slovenia. In the increasingly

medicalized environment of the mental health care system, in which most of the public funding flows to psychiatric hospitals and highly specialized care rather than to prevention and the primary level of health and social care (Možina & Okorn, 2022), the dialogue between professional psychotherapists working outside the health care system and psychiatrists and clinical psychologists working in specialised health care institutions is similar to the dialogue between David and Goliath. In the Slovenian psychotherapeutic debate, Goliath behaves in complete contradiction to the criteria of Gelo and Pritz (2020) for argumentative dialogue and dialogical pluralism. There is no safe socialising that allows interactivity, no reciprocity, openness, trust, respect and care. Even according to the criteria of Piaget (1995) for cooperation, a complete contrast is revealed, as psychiatrists and clinical psychologists act in an egocentric, authoritarian way and expect submission to their rules, impose their beliefs and reject all arguments, and want their way to be carved in stone once and for all.

There is a possibility that a positive change could be initiated by the users/clients/patients, i.e. people who seek psychotherapeutic help for their mental distress and do not get it, because in the current state of the health system, they have to wait a year or two to receive such services, and in other sectors (for example social care) there is no option to get psychotherapy supported with public funding. If the Ministry of Health were to come under increased pressure to pass the psychotherapy law from various patient and user associations, it might be moved to act and firmly oppose obstacles from the medical lobby. Unfortunately, for the time being, even these associations, especially those in the field of mental health, are relatively weak and poorly cooperating with each other.

9. I have a dream

Despite the nightmare of the medical model I have a dream which keeps me from despairing at the worsening mental health situation in Slovenia and worldwide. In this dream I see psychotherapy as an independent profession and autonomous scientific discipline, which refers to the common factors, the Dodo bird verdict, the biopsychosocial/contextual model, complexity science, synergetic process management, idiographic diagnostics. I am dreaming about transdiagnostic, transtheoretical, integrative systemic, personalized approach in psychotherapy (Bartuska et al., 2008; Fisher, 2015; Jennissen et al., 2018; Olthof et al., 2020; Schiepek, 2003; Schiepek et al., 2015, 2016; Schöller et al., 2018). I see how psychotherapists use process-based methods of assessment and individualised idiographic diagnosis (in the framework of so-called personalised

psychotherapy), on the basis of which the psychotherapeutic process can be effectively guided and tailored to the client's needs.

It looks like we still have a long way to go and that the great psychotherapy debate will continue for quite some time. A lot of open-mindedness, open-heartedness and courage will be needed to face the discomfort of uncertainty, which inevitably comes with cooperation, as Piaget (1995) pointed out. We can never know where cooperation will lead to, because it includes equality among different personalities, autonomy, free discussion, rationality, reciprocity, contradiction, policentrism, mutual confirmation, the need for proof, inventing the path while walking, heterostasis, distinguishing between facts and ideals, and accepting not knowing where cooperation will lead to.

When, on the path of cooperation, we will suddenly realize that we are still looking for an answer to the question of what is the paradigm of scientificity that is suited to the psychotherapeutic profession, and even what science is and how we know what we know, humility will also be necessary to admit to the vast extent of our ignorance. Without free-thinking, frankness, courage and modesty, we will also not be capable of sufficiently openness to new forms of connecting and cooperation between psychotherapy schools and beyond, and between psychotherapy as an independent profession and other professions involved in the protection of mental health. As psychotherapists we should set an example to all related professions of how it is possible to collaborate with the users of our services and their associations, as well as with all those who, due to increasing social inequalities and injustice, are facing hardships and lack of support from public services.

The pluralist development of various disciplines in the field of mental health cannot be based on the biomedical model. Psychotherapists can contribute significantly to the development of a new, transdiagnostic and transtheoretical approach. This does not imply the eradication of objectivism, but its metatheoretical reframing to constructivist/hermeneutic/contextual paradigm. Our common goal here remains clear: to develop a more diversified, flexible, accountable, highly cost-effective, client- and context-tailored treatments. Integration through dialogical pluralism can help us reach this goal and bring us closer. Psychotherapists alone can go faster, but together with clients and other mental health professionals we can go much further!

I have a dream …

Viri

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