

INTEGRATIVE STRATEGIC PSYCHOTHERAPY

VOLUME 1

THEORETICAL FOUNDATIONS

Contents

Preface.....	9
CHAPTER 1. HISTORY OF INTEGRATIVE PSYCHOTHERAPY	11
1.1 What Is Psychotherapy.....	11
1.2. Approaches and Models in Psychotherapy	15
1.3. Why Is Psychotherapy Effective	20
1.4. Common Factors in Psychotherapy	23
1.5. Models of Common Psychotherapeutic Factors	26
1.6. The History of Integrative Psychotherapy	27
1.7. Contemporary Integrative Psychotherapy.....	29
CHAPTER 2. CONTEMPORARY APPROACHES IN INTEGRATIVE PSYCHOTHERAPY	37
2.1. Multimodal Psychotherapy	37
2.2. Systematic Treatment Selection.....	44
2.3. Beitman's Future Predictions Model	50
2.4. Informed Clinical Strategy	52
2.5. The Transtheoretical Model	54
2.6. Cyclical Relational Psychodynamics.....	61
2.7. Assimilative Psychodynamic Psychotherapy.....	64
2.8. Cognitive-Behavioural Assimilative Integration	67
2.9. The Relational Gilbert-Orlans Model	70
2.10. The Contact-in-Relationship Model.....	73
2.11. The Developmental Needs Meeting Strategy – DNMS.....	75
2.12. The Internal Family Systems Model.....	80
2.13. Multi-Theoretical Psychotherapy.....	83

2.14. Multicultural Integrative Psychotherapy.....	86
2.15. Wilkinson's Theory of Meta-Modality of Psychotherapy.....	89
2.16. The Predictive Processing (3PI) Model	92

CHAPTER 3. FUNDAMENTALS OF INTEGRATIVE STRATEGIC PSYCHOTHERAPY	105
3.1. Theoretical Foundations of Integrative Strategic Psychotherapy	105
3.2. Basic Principles of Integrative Strategic Psychotherapy	109
3.3. Case Formulation in Integrative Strategic Psychotherapy	116
3.4. Classification of Common Factors in Integrative Strategic Psychotherapy	127

CHAPTER 4. THE INTEGRATIVE STRATEGIC MODEL OF THE SELF	139
4.1. The Structure of The Self: Domains, Levels, Axes.....	139
4.2. The Proto-Self.....	143
4.3. The Core Self	157
4.4. The Plastic Self	165
4.5. The External Self	172
4.6. The Neurobiological Model of the Self	177
4.7. The Self and The Ego.....	184

CHAPTER 5. THE UNCONSCIOUS IN INTEGRATIVE STRATEGIC PSYCHOTHERAPY	195
5.1. Unconscious Processes and the Proto-Self	195
5.2. Implicit Memory and the Core Self	198
5.3. The Role of Unconscious Conflict Across Axes (Cognitive, Emotional, Psychodynamic)	200
5.4. Developmental Origins of the Unconscious	203
5.5. Attachment, Affective Encoding and Unconscious Templates	205
5.6. Epigenetics and Transgenerational Transmission of the Unconscious	208
5.7. The Body as a Repository of the Unconscious	210
5.8. Neuroscientific Perspectives on the Unconscious.....	213

5.8.1. Implicit Memory Systems and Emotional Brain Circuits	213
5.8.2. Right Hemisphere Processing and the Nonverbal Unconscious	214
5.8.3. Affect Regulation, the Default Mode Network and the “Hidden” Self	216
5.8.4. Neuroplasticity and the Transformation of Unconscious Patterns.....	218
 CHAPTER 6. THE BIOLOGICAL LEVEL OF THE SELF.....	227
6.1. Genetic Inheritance	227
6.1.1. The Genome	227
6.1.2. The Epigenome	230
6.1.3. The Phenotype.....	234
6.1.4. Genetic Vulnerability and Resilience	237
6.2. The Role of Genetics in Psychotherapy Practice	240
6.3. Body Schema	243
6.4. Biological Clocks and Chronotypes.....	247
6.4.1. Biological Clocks	247
6.4.2. The Chronotype.....	250
 CHAPTER 7. THE COGNITIVE AXIS.....	259
7.1. Cognitive Maps.....	259
7.1.1. Proto-Cognitions	259
7.1.2. Core Beliefs.....	262
7.1.3. Intermediate Beliefs	287
7.1.4. Automatic Thoughts	307
7.2. Perfectionism	311
7.3. The Explanatory Style.....	315
7.4. Self-Efficacy.....	318
7.5. Learned Helplessness.....	321
7.6. Mentalization	325
7.7. Archetypes as Universal Proto-Cognitive Maps	328

CHAPTER 8. THE EMOTIONAL AXIS	339
8.1. Affect, Emotions and Feelings	339
8.2. Emotion Regulation	344
8.3. Emotional Expression	347
8.4. Neurotic Guilt and Repression of Emotions	352
 CHAPTER 9. COMPLEX PSYCHODYNAMIC PATTERNS	 359
9.1. Conditions of Worth	359
9.2. Self-Esteem	361
9.2.1. Definitions and Functions of Self-Esteem	361
9.2.2. Factors Contributing to The Development of Self-Esteem	364
9.2.3. Self-Esteem Assessed According to Competence and Worth	367
9.2.4. Additional Dimensions of Self-Esteem	370
9.2.5. States of Self-Esteem	373
9.2.6. High and low self-esteem: Clinical features and functional implications	376
9.3. Motivation	379
9.3.1 Conceptual Foundations of Motivation	379
9.3.2 Intrinsic and Extrinsic Dynamics of Motivation	380
9.3.3 Psychodynamic and Relational Dimensions of Motivation	383
9.3.4 Motivation and The Integrative Strategic Model of the Sself	385
9.3.5 Motivation, Goals, and Agency in Psychotherapy	386
9.3.6 Contemporary Research and Integrative Implications	387
9.4. Body Image	388
9.4.1 Conceptual Foundations of Body Image	388
9.4.2 Developmental and Sociocultural Formation of Body Image	388
9.4.3 Psychodynamic and Relational Dimensions of Body Image	390
9.4.4 Embodiment, the Self, and the Integrative Strategic Model	391
9.5. Mental Schemas About Illness and Health	393
9.5.1 Conceptual Foundations: Health Beliefs and Behaviour	393
9.5.2 The Health Belief Model and Its Components	393
9.5.3 Family, Culture, and the Social Learning of Health Attitudes	395
9.5.4 Anxiety, Control, and Psychodynamic Patterns in Health Beliefs	395

9.5.5 Illness, Denial, and the Dynamics of Meaning	396
9.5.6 Integrating Health Beliefs in the Framework of Integrative Strategic Psychotherapy	397
9.6. Psychosomatic Mechanisms	398
9.6.1. Developmental Foundations of Psychosomatic Regulation.....	398
9.6.2 Neurobiological Integration of Emotion and Immunity.....	399
9.6.3 Attachment, Affect Regulation, and Somatic Vulnerability	400
9.6.4 The Psychobiology of Early Deprivation and Illness Formation.....	400
9.6.5 Psychosomatic Expression and the Dynamics of the Self	401
9.6.6 Integrative Strategic Psychotherapy Perspective on Psychosomatic Disorders	402
9.7. Parts of the Self.....	403
9.7.1 Conceptual Foundations of Parts of the Self.....	403
9.7.2 Neurobiological and Developmental Basis	404
9.7.3 The Function and Organisation of Subpersonalities	405
9.7.4 Introjection, Mirror Neurons, and Embodied Simulation	405
9.7.5. Parent, Adult and Child as Parts of the Self.....	406
9.7.6. The ISP Perspective: The Dynamic System of Selves	410
9.8. Dissociative Processes and Structural Fragmentation of the Self.....	412
9.8.1 Conceptual Foundations of Dissociation	412
9.8.2 Structural Dissociation and the Continuum of Fragmentation.....	412
9.8.3 The Developmental Origins of Fragmentation.....	413
9.8.4. Dissociation Across the Domains of The Self (ISP Framework).....	414
9.8.5 The Body, Memory, and Implicit Dissociation	415
9.8.6 Therapeutic Reconstruction and Integration	415
9.9. The Life Script	416
9.9.1 Origins and Theoretical Context	416
9.9.2 Early Encoding: From Proto-Self to Core Self	417
9.9.3 The Formation of the Script	418
9.9.4. Script Maintenance and Re-Enactment	419
9.9.5 Life Script Types and Existential Patterns	420
9.9.6. Transformation of the Life Script in Psychotherapy	420

9.10. The Perception of Time.....	421
9.10.1. Time Perspectives.....	421
9.10.2. Neurobiology of Time Perception.....	425
9.10.3. Urgency and Time Perspective.....	428
9.10.4. Psychopathology of Time.....	432
9.11. Death Anxiety	436
9.11.1 Conceptual Foundations and The ISP Lens.....	436
9.11.2. Theories on Death Anxiety.....	437
9.11.3. Psychopathology Organised Around Death Anxiety.....	438
9.11.4. Symbolic Immortality.....	440
9.12. The Meaning of Life	443
 CHAPTER 10. THE SELF AND THE RELATIONAL LEVEL.....	459
10.1. Intersubjectivity	459
10.2. Differentiation of the Self Within the Family	462
10.3. Family Roles	466
10.4 Family Myths and Narratives.....	470
10.5. Family Patterns and Structures	473
10.5.1. Boundaries and Family Functioning.....	474
10.5.2. Alliances, Coalitions and Triangles.....	476
10.6. Intergenerational and Transgenerational Patterns.....	477
10.6.1. Intergenerational Transmission and Its Mechanisms	477
10.6.2. Transgenerational Transmission and The Unconscious	478
10.7. The Individual and Spirituality	482
10.8. Multiculturality	485

CHAPTER 1

HISTORY OF INTEGRATIVE PSYCHOTHERAPY

1.1 What Is Psychotherapy

As a young university student, I vividly remember persistently asking my psychiatry professor, “But what do I actually say to a person with schizophrenia?” At the time, I didn’t yet realise that what I was really asking was a much deeper and broader question: *What is psychotherapy?* Although I never received a particularly satisfying answer, something inside me remained convinced that my path lay in working with people through words.

When I shared my career intentions with my father, he reacted with caution, even fear. He warned me of the dangers of entering the psychotherapy profession, describing it as a risky field in which therapists might be psychologically overwhelmed—or even harmed—by their patients. At the time, the media was abuzz with a macabre story of a cannibalistic psychiatric patient who had literally eaten his psychiatrist. While this may seem extreme, it symbolised a deeper concern: that psychotherapy is not merely a job, but a profound and at times perilous encounter with human suffering.

Despite those warnings, I have spent decades working with patients, sitting with their pain, listening to their stories, and continuously returning to that same question: *What is psychotherapy, really?* Even now, after more than thirty years of clinical experience, I still find myself pausing when my aunt casually asks, “What do you actually do in your office?” I sometimes struggle to give a clear answer. What *do* I say to my patients?

I’ve discovered that this question isn’t unique to relatives at family dinners. It often comes from psychotherapy trainees, clients, and curious friends alike. And rightly so—psychotherapy is difficult to define in a few simple words. It is, at once, a science and an art, a discipline and a mystery. It is a learned craft, yet often

feels like something that can only be “stolen” by observing, by being present, by absorbing through intuition rather than manuals.

Over the years, psychotherapy has been described in countless ways. Some see it as a scientifically based professional activity (Senf & Broda, 2005), others as a unique relational encounter between two human beings (Hough, 2010). It has also been defined as an interdisciplinary domain that bridges medicine and psychology (European Association of Psychotherapy, 2011), and as a structured process for resolving emotional or psychological difficulties (Sutton & Stewart, 2008). But perhaps the most meaningful definition I’ve heard came from a student, who once said: *“Psychotherapy is a way of talking where you use logic, empathy, and every skill you’ve developed—after understanding how the human mind works—to help your client see the world differently.”*

Another student, attending his very first psychotherapy workshop, likened it to science fiction. He observed a psychotherapist working with a client and said, *“It was like the psychotherapist had telepathic powers. They just knew what was going on inside the client—how is that even possible?”* Months later, that same student would chuckle and admit, *“Back then, I didn’t understand a thing about psychotherapy.”*

Many beginner psychotherapists yearn for structure—for a set of universal techniques they can apply to specific symptoms. I am often asked questions such as: *“If my client has depression and their partner doesn’t support them, what should I do?”* My honest answer—one that always surprises them—is: *“I have no idea.”* But this is not helplessness; it is truth. I do not know what to do until I understand *everything*—the details, the unspoken meanings, the emotional logic, the relational history. That’s what psychotherapy is: a process of *knowing* through listening.

But listening is harder than it seems. Active listening is not merely nodding along or remembering what the client said. It means listening with all your attention—while silencing your own internal dialogue. It requires holding space without mentally drafting your next intervention. It demands that you follow the client’s logic rather than your own assumptions. For many trainees, this is a difficult skill to master. In their eagerness to “help,” they often focus too much on what to *do* next, and not enough on what to *understand* in the moment.

Psychotherapy is, in many ways, like mathematics. There is a logic to it—an internal coherence in the client’s narrative that reveals itself when you listen

carefully. I often find that when I am truly attuned to what a client says (and doesn't say), I can identify contradictions, distortions, or unexamined beliefs that shape their suffering. From these patterns, questions arise—precise, strategic, and sometimes transformative. But this process depends on having a conceptual framework, a map of the human psyche that can hold the complexity of emotions, cognition, and relational dynamics.

Yet even the most brilliant framework will fail if it is not grounded in a solid therapeutic relationship. No technique or intervention can compensate for a broken alliance. Psychotherapy is not a one-way application of tools—it is a shared journey that only works when the client feels supported, understood, and never abandoned. This alliance is essential regardless of modality—whether one practices psychodynamic therapy, CBT, humanistic therapy, or integrative psychotherapy.

In fact, one of the biggest mistakes beginner psychotherapists make is rushing the change process. Once they grasp the structure of the client's difficulties, they often feel compelled to start "fixing." But in psychotherapy, the pace is not ours to set. The client determines the rhythm of change. And often, problems persist for good reason. If someone is unable to move forward, it's usually not because they are stubborn or lazy—it's because there are unconscious blocks, unresolved pain, or core beliefs that are so deeply rooted they feel like absolute truths.

So—what is psychotherapy?

According to the Romanian Federation of Psychotherapy (2019), psychotherapy is *"a comprehensive, intentional, and systematic approach to addressing behavioural, emotional, cognitive, psychosomatic, and psychosocial issues, or states of psychological distress, using scientific therapeutic methods. This process involves interaction between one or more clients and one or more psychotherapists, with the aim of alleviating disruptive patterns and fostering psychological change, growth, development, and well-being."*

The European Association for Psychotherapy (EAP, 2003) goes further, defining psychotherapy as *"an interdisciplinary field that bridges medicine and psychology. It is a deliberate, structured, and holistic treatment method based on scientific methodologies, supported by a theoretical and clinical foundation, aimed at alleviating symptoms, mental disorders, psychosocial and/or psychosomatic suffering, and maladaptive behaviours."*

The International Association for Integrative Psychotherapy views the psychotherapist as *"a professional providing psychotherapy and mental health*

services, including the application of integrative psychotherapy theories and techniques to prevent and alleviate mental and emotional disorders and psychopathology, while promoting optimal mental health, rehabilitation, and growth."

In simpler terms, a psychotherapist is someone who knows how to listen—not just with their ears, but with their mind and heart. They must understand at least one psychotherapeutic model deeply enough to help clients explore what lies beneath the surface. Because most of the time, the true problem is not immediately visible. It lives in the unconscious. Clients do not understand why they keep sabotaging themselves, why they procrastinate, or why they choose partners who hurt them. If they *could* understand—and change—on their own, they would. No one chooses to suffer.

But suffering often serves a hidden purpose. It may protect against unbearable feelings, reinforce a familiar identity, or preserve a connection to someone long gone. Our job as psychotherapists is to carefully uncover these unconscious mechanisms, bring them into awareness, and help the client find new, healthier ways of being.

Psychotherapy can be individual, couple, family, or group-based. It can be offered to children, adolescents, adults, and the elderly. And while theoretical approaches vary—psychodynamic, cognitive-behavioural, existential, systemic—the common goal remains: to help people live more conscious, coherent, and fulfilling lives. Psychotherapy helps clients understand what they value, harness their inner strengths, explore their feelings, reflect on past experiences, and face life's difficulties with greater clarity and resilience (Sutton & Stewart, 2008).

And sometimes, the most powerful change comes simply from being heard. Words—when chosen with care—can change lives. The human brain is shaped by language. The stories we tell ourselves, the names we give to our emotions, the interpretations we adopt—all these become neural pathways. For example, if as a child I was told repeatedly that I am “too sensitive,” my brain would build that story into its architecture. When faced with criticism, I might cry—not because I’m weak, but because that’s the most deeply ingrained response.

In psychotherapy, we use language to build new neural maps. We help clients see things differently, respond differently, and ultimately *feel* differently. This is not metaphorical—it is biological. Psychotherapy, then, is not only a conversation. It is a relational, cognitive, and emotional experience that rewires the brain.

It is also, still, a mystery. A place where science meets soul, and logic meets empathy. Where we don't always have answers, but we sit with the questions—together.

1.2. Approaches and Models in Psychotherapy

Modern psychotherapy, as we know it today, traces its roots back to Sigmund Freud (1856–1939), the founder of psychoanalysis and the pioneer of the first structured psychotherapeutic movement (Erskine & Moursund, 2011). In collaboration with Joseph Breuer on the treatment of hysteria, Freud developed a novel clinical approach that one of their patients famously termed the “*talking cure*” (Freud, 1910). This simple yet profound phrase captured a revolutionary idea: that healing could be achieved through conversation—through words rather than physical intervention.

Central to Freud's legacy is the concept of the unconscious mind, a notion that remains one of the most influential and enduring in the field of psychotherapy (Hamlyn, 2007). Freud's ideas gave rise to a multitude of theoretical evolutions. Carl Jung, Alfred Adler, Otto Rank, Wilhelm Reich, and Sándor Ferenczi each took psychoanalysis in new directions, developing their own psychodynamic models and laying the foundation for the diverse schools of depth psychology that followed.

Psychodynamic therapy remains focused on uncovering unconscious conflicts and working through them in the therapeutic relationship. Techniques such as free association, dream analysis, exploration of resistance, transference and countertransference, and the processing of painful memories continue to define this orientation. The emphasis is placed not just on what is said, but on how, when, and why it is said—and what remains unspoken.

Though many of Freud's original concepts have been critiqued or evolved significantly, it's important to recognise the revolutionary nature of his ideas at the time. In the 19th and early 20th centuries, the suggestion that psychological distress could be alleviated through speech was nothing short of radical. Today, research in neuroscience and affective science continues to validate Freud's central intuition: that much of mental life occurs outside of conscious awareness, and that emotions play a foundational role in structuring thought and behaviour (Fonagy, 2017). In fact, a 2011 review by the American Psychological Association confirmed that

psychodynamic therapy is an empirically supported treatment, comparable in efficacy to more structured approaches.

By the mid-20th century, however, a number of psychotherapists working within the psychodynamic tradition began to grow dissatisfied with the limitations of classical psychoanalysis. Out of this dissatisfaction, new schools emerged—most notably, behaviourism. Though it remains uncertain whether Hans Eysenck or Arnold Lazarus first coined the term “*behaviour therapy*” (Hamlyn, 2007), what is clear is that behaviourism rose rapidly to prominence in the 1960s. It positioned itself as a more empirically verifiable and efficient alternative to psychoanalysis (Hawkins & Nestoros, 1997), with an emphasis on observable behaviours and measurable outcomes.

Soon, behaviourism gave rise to cognitive-behavioural therapy (CBT), a framework that maintained the empirical rigour of behaviourism while introducing the concept of cognition. Unlike traditional behaviourism, which rejected the study of mental processes as speculative, CBT accepted that beliefs, interpretations, and internal narratives play a crucial role in human experience. Aaron T. Beck, often regarded as the “father” of CBT, showed that many psychological difficulties are rooted not in unconscious forces, but in *automatic thoughts*—beliefs and assumptions that are often just beneath awareness but still accessible (Popescu, 2021; Popescu & Vișcu, 2016).

Over time, CBT evolved to incorporate a rich array of techniques and sub-approaches. Rational-emotive behaviour therapy (REBT), acceptance and commitment therapy (ACT), dialectical behaviour therapy (DBT), EMDR, cognitive processing therapy, multimodal therapy, and reality therapy are just a few examples of how the cognitive-behavioural tradition has expanded and diversified.

The rapid expansion of CBT sparked a parallel reaction from other psychotherapists—one that led to the rise of the third major orientation in psychotherapy: the humanistic-existential approach. Emerging strongly in the 1940s and 1950s, this movement prioritised the whole person over symptoms or diagnoses. Carl Rogers’ person-centred therapy, Fritz Perls’ gestalt therapy, Eric Berne’s transactional analysis, Viktor Frankl’s logotherapy, and J. L. Moreno’s psychodrama all emerged from this fertile intellectual soil.

What these approaches share is a commitment to the autonomy, dignity, and potential of the individual. Humanistic approaches aim to free people from limiting

beliefs and internalised conditions of worth, using primarily conscious processes. Existential approaches, on the other hand, delve into questions of meaning, mortality, freedom, and isolation. They seek to help individuals confront the existential givens of human life and to create meaningful lives despite uncertainty.

Thus, by the latter half of the 20th century, three primary paradigms had come to dominate psychotherapy: 1. Psychodynamic approaches, which explored unconscious conflicts and symbolic meanings; 2. Behavioural and cognitive-behavioural approaches, which focused on learned responses and thought patterns; and 3. Humanistic-existential approaches, which emphasized agency, presence, and meaning-making (Hawkins & Nestoros, 1997).

But as these paradigms matured, something curious happened. None of them proved sufficient on their own to explain the full complexity of the human psyche. Each offered valuable insights, yet each was also partial. As Fall, Holden, and Marquis (2010) aptly noted, no single model has succeeded in capturing the full breadth of human psychological functioning.

I sometimes compare psychotherapy to a scene from a science fiction novel I read as a teenager. In the book, aliens leave behind a collection of highly sophisticated devices on Earth. Humans, unable to understand their true function, repurpose them for mundane uses. Someone picks up a microscope and uses it to hammer in nails. It works—but it's not what the tool was designed for. Sometimes, I wonder if we're doing the same with psychotherapy: using brilliant tools in ways that only vaguely resemble their intended purpose. Are we truly understanding the human mind—or are we wielding microscopes as hammers? (Popescu & Vișcu, 2016).

One of the core challenges in our field is the lack of a unified theory. Years ago, I wrote that in 1991, the United States alone had 25,000 psychiatrists, 50,000 psychologists, and countless social workers engaged in psychotherapeutic work (Frank & Frank, 1991). By 2012, Wikipedia listed 167 different psychotherapeutic approaches. By the end of 2020, that number had risen to 182 (Popescu, 2021; Popescu & Vișcu, 2016).

Some of these approaches are widely known; others are obscure, strange, or even controversial. “Attack therapy,” a derivative of “ventilation therapy,” involves group confrontation and verbal humiliation. “Chess therapy” uses the game of chess as a relational and projective tool. The “counting method,” used in PTSD treatment, involves the therapist counting aloud while the client recalls traumatic

memories. “Immobilisation therapy,” based on attachment theory and used mainly with children, involves physically restraining the client to provoke catharsis—an approach now linked to several malpractice lawsuits and even fatalities (Gravelles, 2003).

This staggering diversity reflects both the richness of our field and the limits of our knowledge. Even now, potential clients frequently ask me whether I am a cognitive-behavioural psychotherapist or a psychoanalyst—believing that one method is inherently more effective. They’ve read articles online, perhaps watched a YouTube video, and developed strong opinions without understanding the techniques themselves. Ironically, most people—psychotherapists included—are unaware that specific techniques contribute less than 7% to the success of psychotherapy. It is the therapeutic relationship, the client’s engagement, and the shared meaning-making process that matter most.

Despite this, many schools of psychotherapy continue to promote the illusion that they hold the “one true method.” Techniques are taught as miracles; rival approaches are dismissed as superficial or pseudoscientific, depending on who’s doing the judging.

Years ago (I’ll let you guess how many...), I decided to train extensively across a variety of therapeutic orientations: integrative psychotherapy, clinical hypnosis, psychoanalysis, CBT, systemic therapy, gestalt therapy, psychodrama—you name it. I gained something valuable from each. But what saddened me was the hostility I witnessed between schools. In training groups, it was not uncommon to hear one method discredited, even ridiculed, by adherents of another. To avoid conflict, I learned not to mention that I had trained “across enemy lines.”

Unfortunately, this tribalism hasn’t disappeared. As recently as 2024, I’ve had workshop participants from other modalities arrive with the intention of correcting or confronting integrative models. Yet, by the end of the workshop, they often realise they already use elements of CBT, psychodynamic thinking, or systemic theory—just under different names. That’s the beauty of integration: it honours complexity and welcomes plurality.

As Fall, Holden, and Marquis (2010) asked in their book *“Theoretical Models of Counselling and Psychotherapy”*: “Why isn’t there one counselling theory that everyone agrees on?” Their answer is elegant: psychotherapy is like a hologram. Each theoretical model reflects a different angle of the same whole. Each is true, and yet incomplete—because each captures only a fragment of the human experience.