

Bonus Chapter 1

Synthesizing Integrative Systemic Therapy (IST) and Making It Your Own

It had been a good day, although not one without challenges. Michael began his workday by conducting a session with a young, professional, white, heterosexual couple who erupted into an intense conflict over who did or did not contribute sufficiently to the upkeep of their apartment. Michael reflected on the very high level of tension, how it impacted him in session and how difficult it was to “stop the music.” He was able to interrupt the conflict and make some headway in helping this couple see the need (and have some hope) for managing their struggles. The presenting problem was defined as an escalating level of conflict and a goal for the therapy (reducing and managing conflict) was established. Michael planned to give some thought to solution sequences prior to the next session.

A second session that day had been poignant, as a 57-year-old woman who Michael had seen in individual therapy for over two years had her last session. Client report and STIC data indicated that she had made and sustained significant changes over the course of therapy and a month ago they had agreed that it was time for the therapy to come to an end (see Bonus Chapter 2 for more information about STIC). In this last session, the client gave heartfelt thanks to Michael for support and problem-solving assistance concerning two great life challenges: her adjustment to divorce and her management of breast cancer treatment. It was a deeply emotional session. Michael felt fortunate to have been this woman’s therapist and fortunate to have a free hour after the session. He took a few minutes to reflect on their relationship. Michael knew he would miss her.

During the rest of his open hour Michael completed session notes on his first two sessions and returned emails and phone calls. One call was from a gay man seeking couple

therapy. The man explained that he and his husband had married one year ago and were struggling with whether they were ready to adopt a baby. A background factor that stood out for Michael was that the spouse was 12 years younger than the caller. He wondered briefly whether the different developmental levels of these clients were a constraint to their decision-making process—perhaps a hypothesis to test. Scheduling, payment, and insurance issues were discussed and the first appointment was set. Michael stated that the caller’s husband should feel free to call in advance of the first session, if he had questions.

Michael then met with an African American heterosexual couple in their 70s who had been working to manage and resolve their differing responses to their son’s infidelity and decision to divorce. The decision was made to invite the son to attend a session when he would be in town the following month. Following that session Michael met with Elizabeth, his office mate, for a brown bag lunch and case consultation, where they discussed cases that were currently challenging each of them.

Then it was time to head over to the university to conduct his weekly supervision group. Michael met for three hours with four second year graduate students in clinical training. He checked in with the students on dilemmas and urgencies. Nothing too challenging that day. In “live supervision” he observed and supervised a student’s session from behind a one-way mirror. The session was with an Asian American family of five (father, mother, and three elementary school age boys) who had been dealing with the eight-year-old boy’s posttraumatic reactions to a serious dog bite that had occurred six months previously. Michael conceptualized intervention on two levels of the therapy system: the supervisor–therapist and the therapist–family levels. Prior to and during the session, he guided and supported the student with the learning goal of assuming greater leadership in the process of constructing solution sequences. He suggested that the

therapist propose a solution sequence that would involve the reduction of fear through progressive exposure to dogs—beginning with photos of dogs and progressing to in-person encounters with dogs in a controlled setting. He felt good about the student's work in the session and the family's openness to the plan.

Michael returned to his office and conducted one more session that day. It was with a white, heterosexual couple and their three adult children. In the context of couple therapy six months ago, Michael had helped the husband (and father) come to terms with the effects his drinking was having on his marriage and family life. The session today had focused on the family's adaptation to his sobriety and, in particular, the place of alcohol in the lives of the other family members. Toward the end of the session, the oldest son expressed concern about his own drinking. All agreed to follow up on this in the next session.

At the end of the day Michael reflected on his career. He enjoyed working with different types of presenting problems and working in various contexts of therapy (individual, couple, and family). He loved the process of getting to know clients—learning about their unique circumstances, personalities, and relationships. He enjoyed the detective work of identifying problem sequences, collaborating to develop solution sequences, and identifying strengths and constraints. He reveled in (and sometimes struggled with) the process of conversing with clients, including reading and understanding their responses. Supervising the clinical work of others was also very interesting and meaningful for him. It sometimes fascinated him that the IST concepts he used in therapy (essence, blueprint, web, matrix, and alliance model) were extraordinarily useful in helping therapists-in-training acquire skills and attain competence. Any and all of the activities involved in doing or supervising therapy could be stressful for him and, from time-to-time, bring discouragement or generate self-doubt. However, overall, he felt he had the tools he

needed to do his job, the continuing opportunity to learn new strategies and techniques, the professional support of colleagues, and the sustenance of his own family life. It was a good day—a good life.

As can be seen in Michael's day, as well as in the material presented in the preceding chapters, IST is, indeed, a systemic, integrative, and empirically informed therapy. It builds on common factors that underlie all successful therapy and imports specific concepts, strategies, and interventions derived from the rich base of knowledge and methods within psychotherapy. It is a comprehensive approach which organizes these concepts, strategies, and interventions such that practitioners are able to work with a broad range of presenting client concerns. IST has its own logic, decision-making tool, and guidelines for therapy, but it also contains vast stores of information about the process of therapy. This storehouse of information, organized within the components of the blueprint and sequenced by guidelines, facilitates working in a simple, straightforward manner to solve problems that are accompanied by fewer or less severe constraints; yet it has the depth of theory and diversity of strategies to accommodate client systems that present with severe and/or multiple constraints. To manage a broad variety of presenting problems and client systems and to account for the unique nature of each case, IST is necessarily complex. Thus, it cannot be fully absorbed and internalized by simply reading a book. Rather, study and continuous practical application to cases is required for the development of an IST therapist.

Our main text discusses all of the components of IST, including its pillars, foundational concepts, essence, and a blueprint for therapy which includes the tools for hypothesizing, planning, conversing, and reading feedback. In this chapter we review IST as a whole by illustrating its comprehensive nature, discussing factors that bring cohesiveness to its integrative

complexity, and considering the factors that contribute to the diversity of therapeutic pathways within IST. We begin by reviewing key dimensions of IST that maintain the coherence of the approach while accommodating complexity of theory and diversity of strategies.

IST as Relationship

All of IST therapy takes place in the context of a relationship. Therapist and clients come together to solve problems and the therapist leads a collaborative process toward this end. Clients may begin the process with confusion, fear, skepticism, mistrust, or ambivalence about making changes in their lives, so the establishment of trust and rapport is an essential requirement of therapy. IST encourages therapists to think about their work and approach it purposefully, but therapy also involves the emotional aspects of a genuine encounter in which the therapist brings care and concern for clients' struggles and dilemmas. As we have noted earlier, this begins with listening so clients feel heard. Privileging and understanding the clients' experience is vital as is respecting and adapting to the clients' cultural context, creating a sense of collaboration, and recognizing and promoting their strengths.

IST therapists all have their unique styles of relating and their special ways of conveying that they are there *with* their clients and there *for* them. They tailor their response to client presentation and feedback to help them feel the therapy is safe, yet productive. This involves far more than a therapist being likeable, genuine, and caring. It requires collaborative and effective goal setting and intervention. A fundamental element of IST therapy is the establishment and maintenance of a relationship through a focus on the presenting problem and the building of an alliance around agreed upon goals and tasks in therapy. The alliance that develops becomes the vehicle for both approaching any number of problems or constraints that become identified in the course of therapy and accessing client strengths and resources to address them. The therapeutic

alliance, the common factor most highly correlated with successful outcome (Friedlander, Escudero, Heatherington, & Diamond, 2011; Horvath & Bedi, 2002; Norcross & Lambert, 2011b), is a central and unifying factor of all IST therapy.

Michael reflected on his relationships with the clients he saw that day. He saw clearly that a caring, problem-centered, and solution-seeking approach was at the heart of his work. In the case of the young conflictual couple he saw that morning, he felt there were challenges ahead in establishing and balancing that alliance. He would keep his eyes and ears open to read the feedback in session and monitor the STIC data that would signal problems or ruptures in the alliance. In the case of the woman who had just terminated a long individual psychotherapy, the alliance had been very strong through much of the therapy. Michael did recall one significant tear in that alliance, caused by his failure in one session to be empathic with the client's fears about the possible recurrence of cancer and her anger that she had to continue to worry about it, perhaps for the rest of her life. Michael had acknowledged his insensitivity and had worked successfully to repair the alliance. Michael felt that their relationship was stronger after this tear and repair and the STIC data supported this.

IST as Problem Solving

IST therapy occurs in the context of a relationship which is built to a significant extent on a problem and solution focus. Further, the problem-solving dimensions of our perspective, in and of themselves, provide a central unifying influence on the nature of the work. In every therapy case we are concerned with the problem solving tasks of the IST essence and in any particular session we are focused on one or another of these which include:

1. Defining a presenting problem.
2. Locating the problem in a problem sequence.

3. Identifying a solution sequence.
4. Implementing a solution sequence.
5. Evaluating the outcome of the solution sequence (successful or unsuccessful).
6. If successful, going to Step 9; if unsuccessful, identifying constraints to the solution sequence.
7. Attempting to lift constraints.
8. Implementing the solution sequence.
9. Maintaining the solution sequence.
10. Terminating therapy or repeating the steps with a focus on additional constraints and/or new problems.

This essential process of problem solving, represented in a flowchart (essence diagram, Figure 3.1) in Chapter 3, is utilized to focus the work with a full diversity of presenting concerns and client system compositions. It is characteristic of our approach to conceptualize the work in terms of these steps and IST therapists are encouraged to be clear on which of these problem-solving tasks they are focusing on at any given time.

Michael reflected from time-to-time on his work. Sometimes he felt disappointed in his ability to help particular clients reach their goals. Other times he worried about the welfare of particular clients. He could be soul-searching about how his own reactions and conceptualizations affected the work. Often though, he felt good about his work. He felt good about practicing a problem-centered, strength-based therapy that examined how problems are embedded at various levels of human systems. In particular, he appreciated the utility of the essence diagram as a device that informed the overall direction of the work and continually clarified his purpose with any given case at any given moment. He often asked himself: “What

am I trying to do now?”—define the problem, describe a problem sequence, propose a solution sequence, follow up on the implementation of a solutions sequence, identify constraints?

He marveled at the great range of problem sequences he encountered in his work. Just today he had worked with problem sequences of an escalating couples conflict, the posttraumatic avoidance of an eight-year-old boy and his family, the habitual use of alcohol to manage feelings and needs, an aging couple’s differing ways of coping with disappointment in the choices of their son, and the tendency of a therapist-in-training to hold back from exerting more effective leadership in session. Each of these problem sequences had required a careful tracking of patterns and a detailed description of them before solution sequences could be constructed. In constructing the solution sequences he utilized client input, common sense, knowledge of best practices, empirical findings, and his own experience and intuition. He understood that attempts at enacting a particular solution sequence would not always be successful, but that failure would present an opportunity to identify the constraints that prevented the solution from being performed or from working. He knew that the hypothesizing metaframeworks as represented on the web of human experience could be utilized to understand most any constraint that might be operative and that the matrix provided many strategies to address the constraints. He also used the blueprint and guidelines to make the many challenging clinical decisions involved in his work.

IST as an Approach to Decision Making in Therapy

IST provides a set of therapy guidelines, discussed in various chapters of this book and listed together in the Appendix, that address the question of what to do when (and why), but the specific course of therapy at any point in time is determined also by the recursive decision-making and decision-evaluating process we call the blueprint (shown in diagram format in

Chapter 4). The processes of developing and maintaining a therapeutic alliance and leading a collaborative approach to the tasks specified in the essence diagram require many decisions that are conditional upon what the therapist thinks would be helpful at a given point in time and what the client agrees to discuss and do. This is an ongoing and continually-evolving process that invites client participation and welcomes course correction as therapist and clients address the various tasks of therapy. The blueprint for therapy guides decision making with respect to problem solving and alliance building, allows integration of strategies from various models of therapy, facilitates evaluation of the effects of the work, and provides the basis for the clinical–scientific method of IST’s integrative approach to therapy.

The blueprint components—hypothesizing, including hypotheses about solution sequences, the alliance, strengths and constraints; planning, involving the formulation of interventions; conversing, how we maintain an alliance and implement essence tasks, including the provision of interventions; and feedback, how we register and incorporate information that arises as a result of conversing—describe a process in which hypotheses about the therapeutic relationship and the problem-solving tasks of the IST essence are generated, tested, and progressively refined until the clients solve the presenting problems. The therapist uses the blueprint as a guide in leading the therapy while knowing that there will be many minor course corrections, as well as major shifts as the therapy progresses. In a sense, each therapy is a single case study in which the blueprint is continuously used to intervene and course-correct until the presenting problems are solved. The blueprint serves as an organizing tool for managing the moment-to-moment events in session and planning the therapy between sessions, as well as over the full course of therapy. The therapy is both planful, in that all activities are directed toward alliance building and the problem-solving tasks of the IST essence, and improvisational in that

the actual therapeutic conversation requires the therapist to respond creatively to the feedback of the client system and revise the plan accordingly.

An IST therapist uses the blueprint to accomplish the tasks of the essence within the context of the IST guidelines. As the blueprint is applied to the relational and problem-solving tasks of therapy, the therapist seeks to enhance and constrain the work according to these guidelines. The IST guidelines encourage focusing on a presenting problem, setting solution sequences as the goals for therapy, seeing assessment and intervention as ongoing processes, prioritizing the therapeutic alliance, and the using empirical data to inform therapy. Further, the guidelines encourage the therapist to begin working in an interpersonal context with an initial focus on hypotheses that require here-and-now, action-oriented strategies as well as strategies that address current aspects of emotion and meaning. More complex strategies involving longer term or more intensive therapy, especially those that address the internalized effects of past experience, are reserved for cases that do not improve sufficiently with more basic problem solving approaches.

For example, as Michael began to work with the highly conflictual couple that began his day, IST guidelines led him to privilege a hypothesis that the couple was constrained primarily by their interaction pattern and with guidance could work directly in the realm of action to modify their sequences of conflict and, in turn, the meanings and emotions related to them. He saw strengths to build on despite the intensity of the conflict and knew that his hypothesizing (assessing) and planning would develop and redevelop on the basis of ongoing intervention. He would hypothesize, plan, converse and read the feedback within the guidelines. The failure-driven guideline would encourage him to utilize feedback to modify his hypothesis and plan. If the couple was not able to improve their conflict through initial attempts to “just do it”

differently, he would become increasingly interested in their inner worlds and possibly their physiological reactions, which may constrain the patterns of interaction. Over his years of practice he had learned to utilize the decision-making function of the blueprint to approach the essence tasks within the guidelines IST specifies. This is how he knew what to do when, and why he would be doing so.

He was not rigid about the planning guidelines depicted on the matrix as dotted arrows (see Chapter 6, Figure 6.1). While feeling strongly committed to the general thrust of these guidelines, his flexibility with their administration allowed him to let certain compelling information or strong feedback (e.g., a traumatized client feeling unsafe in therapy, a client's acute need for medication, a client's refusal to involve a spouse or partner) lead him to draw intervention strategies from levels of the matrix likely to address the special circumstances of the client system. Similarly, his light touch or flexibility in the application of the planning guidelines let him balance them with the feedback and data that emerged in the work.

IST as a Storehouse of Information Needed to Conduct Therapy

In addition to being organized by its problem solving essence, its focus on the alliance, its guidelines, and its use of the blueprint as a decision-making tool, IST, by virtue of its "loaded" blueprint, also contains and organizes the knowledge, theories, and skills required for the practice of therapy. In this sense, the blueprint is utilized to carry all of the details and operations of the IST approach and, to a great extent, the information and strategies of the field of psychotherapy. Information needed for the conduct of therapy can be accessed readily in that it is organized according to its relationship to a particular blueprint component. Hypothesizing utilizes a set of frameworks (hypothesizing metaframeworks) that facilitate the description of the complex, multileveled functioning of the client system, especially with regard to strengths and

constraints. Planning organizes strategies for enacting solution sequences and removing constraints into a set of frameworks (planning metaframeworks) that are applied according to the IST guidelines and in concert with evolving hypotheses. Conversing contains a body of knowledge about the linguistic choices and communication skills that are utilized to build alliances, learn about the client system, and execute interventions. Lastly, feedback contains a body of knowledge about types of information (client responses, therapist reactions, and empirical data) that inform the conduct of therapy. The four larger classes of information (hypothesizing, planning, conversing, and feedback) and their organization around the blueprint are illustrated in Figure B1.1 (also presented in Chapter 12, Figure 12.1), the “loaded” blueprint. All of the categories of information listed in the diagram have been discussed in this book. As

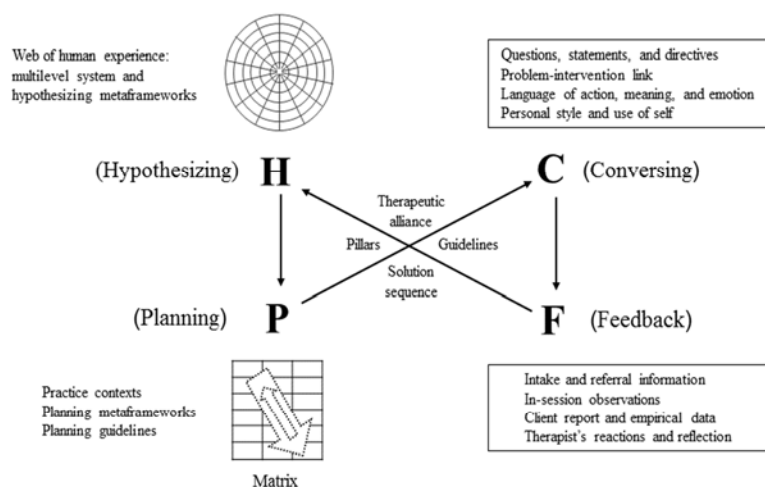


Figure B1.1. The loaded integrative systemic therapy blueprint. From “Integrative Problem-Centered Metaframeworks Therapy II: Planning, Conversing, and Reading Feedback,” by W. M. Pinsof, D. C. Breunlin, W. P. Russell, and J. L. Lebow, 2011, *Family Process*, 50, p. 334. Copyright 2011 by John Wiley & Sons, Inc. Adapted with permission.

the reader has seen, the categories of information corresponding to the four components of the blueprint each contain extensive information and provide an understanding for how additional information and skills can be integrated within a particular component as a therapist and, indeed, the field itself, develops and grows.

In addition to providing an overview of IST and organizing the knowledge, theories, and skills it contains, the “loaded blueprint” serves as a reminder of what to look for when engaging in the activities associated with a particular blueprint component (hypothesizing, planning, conversing, and feedback). As a visual representation of all of IST, it is useful in pointing the therapist in the direction of the information that is needed for various aspects of therapeutic activity. For example, when hypothesizing, it provides the reminder of the web of human experience. Additionally, since IST remains open to a particular therapist’s new learnings and the larger developments in the field, the “loaded blueprint” structure facilitates a practical classification of new information and techniques. With this in mind, it is important to emphasize that the practice of IST is not limited to the information and strategies specifically described in this book. As the field of psychotherapy develops, new findings and techniques will be incorporated. Similarly, as each practitioner develops, they add their new learnings to an understanding of doing therapy within IST.

Elizabeth, Michael’s office mate, recently attended a training on cognitive behavior therapy. Prior to the training she knew enough about this approach to know it contained many useful techniques, some of which she had learned and utilized in her work. In attending the training, she did not have the intent of becoming a cognitive behavior therapist. Rather, she wanted to become more knowledgeable and proficient with the approach in order to integrate

some of its strategies and interventions into her work with clients, particularly anxious or depressed clients, who seemed to be constrained by their process of thinking.

Pathways in IST

In order to be a comprehensive therapy that is applicable to a diversity of presenting problems and most any client system, IST must be adaptable. It must make room for a variety of pathways to problem resolution. The path that a particular IST therapy takes is influenced by a number of variables including the unique client system presenting for therapy, the style and preferences of the therapist, and the context of the work.

The Influence of the Unique Client System

In IST there is no one way to approach a particular type of presenting problem. Each client system is seen as unique with its own strengths and constraints and with their own problem sequences. The problem sequence (and related constraints), not the type of problem, is the key to how to begin problem solving. For example, when Elizabeth received a call from a depressed man, she did not, on the basis of research on the treatment of depression, invite him to an individual session and assume he would need cognitive behavior therapy. Rather, she convened a client system, in this case the man and his partner, and began the process of defining the problem, building an alliance, and tracking the interaction around the presenting concern. She discovered an underadequate/overadequate pattern with this couple in which the man's partner tried to modify the depressed symptomatology with hostile criticism, a pattern which is known to exacerbate depression. This was Elizabeth's starting place with the case and successful intervention with this pattern led to improvement in the man's depression. She also worked with the meanings and emotions of each of the partners with an eventual special focus on an internal

problem sequence of the depressed man's thinking and feeling. For this work she integrated techniques from cognitive behavior therapy which she had learned at a recent workshop. This had been a successful case that took place entirely within the couple context, drawing interventions exclusively from the action and meaning/emotion planning metaframeworks. Had the depressive symptomatology not lifted with this work, she would have considered (on the basis of the failure driven progression of the matrix) biobehavioral strategies, for example, referring the depressed man for an evaluation for psychotropic medication.

The Influence of Therapist Style and Preferences

Elizabeth was quite aware that the way she handled the case might differ somewhat from the approach of other IST colleagues. The judgment, for example, on how soon to consider medication, while typically a failure driven decision, might well be made at a different point in therapy by a different IST therapist. IST is not a manualized therapy, nor is it one that provides a prescribed set of interventions that apply to all cases or certain types of cases. As there is no one correct IST approach to a particular type of problem (e.g., depression, marital conflict, child behavior problem), so there is simply no one correct course for a given client system. Rather, the therapist and client system create a pathway which is designed for particular problem sequences and constraints within a particular client system. The path created is not the only possible path for the client system, but it is *a* path created specifically for the particular client system in order to move it toward enactment of a solution sequence(s).

IST provides a systemic template for problem solving, a decision-making process, a set of therapy guidelines, and a means of drawing strategies and interventions from various approaches to therapy. These tools are utilized by a practitioner who, within the parameters of

the IST approach, has a unique personal style of relating, preferred forms of conversing, and a particular set of skills and preferences. The practitioner's style and preferences intersect with a unique client system and together they produce a once-in-a-lifetime problem solving therapy. Part of the excitement of working with IST is the process of collaborating with clients to discover their mechanics and encounter their mysteries in order to find a unique path to the resolution of their problems. Each therapy, guided by the model, informed by science and practiced as an art, is an adventure. Neither therapist nor family knows in advance how it will progress or where it will end.

Elizabeth and Michael had gone to graduate school together. Elizabeth had seen him work many times and respected his skills as a therapist. He was naturally less expressive than she, especially with new clients. He forged alliances with a calm, earnest approach—slower to use humor or express emotion than Elizabeth. Michael also differed in his preferred points of entry to the client system's web of constraints. Like her, he focused the work on solution sequences and followed the information given in session to hypothesize what kept clients from implementing them. Elizabeth had noticed, though, that his hypotheses more often involved the development and spirituality metaframeworks than hers did. And his choice of strategies within the meaning/emotion planning metaframework more often utilized strategies associated with the narrative approach than did hers. From this planning metaframework she more often drew strategies from emotion focused therapy and, more recently, cognitive behavior therapy. So, due to differences in personality, viewpoint, and preferred interventions, their work often progressed in a somewhat different manner. They enjoyed discussing cases and sharing hypotheses. They often discussed how elements of the hypothesizing metaframeworks influenced each other, and

observed how their initially divergent hypotheses involving particular metaframeworks often dovetailed in a comprehensive description of a web of constraints. They understood that their work would likely take somewhat different paths, but ultimately cover much of the same ground.

Commonalities among IST Pathways

If each IST therapist will find his or her own pathway with a particular client system, what makes IST, IST? Despite the differences in style and preferred strategies, IST therapists share important assumptions, principles, and procedures including the following:

1. Commonly held pillars and core concepts.
2. The focus on presenting concerns.
3. Close attention to defining problem sequences and solution sequences.
4. A shared model of the therapeutic alliance.
5. A collaborative approach emphasizing client strengths.
6. An interpersonal and multisystemic focus with an emphasis on convening couples and families when possible and appropriate.
7. A shared set of hypothesizing metaframeworks to help understand system functioning and constraints.
8. A shared set of planning metaframeworks and therapy guidelines that influence the choice of strategies of intervention.
9. Careful and purposeful attention to the process of conversing and client feedback (including empirical feedback).

IST practitioners' approaches to a particular family would likely be most similar in the early sessions and, ultimately, through the course of therapy, in the overall set of constraints addressed. At the outset of therapy IST practitioners would be trying to engage the same

participants and would likely define the presenting problem and problem sequence in a similar way. Close tracking of the problem sequence would likely lead to the construction of fairly similar initial solution sequences. As the client system struggles to implement a solution sequence, IST therapists would ask the same question: “What keeps you from being able to do it?” Beyond the clients’ initial responses to this question and the work to address the constraint(s) initially identified, the work of different IST therapists would likely begin to diverge. As the work progresses, the order of the constraints that are addressed and the particular interventions chosen to address them would also vary from therapist to therapist. We believe that further commonality would ultimately be found, however, as the overall course of therapy would likely have covered, at one point or another, the key set of constraints that had kept the client system from solving the problem.

Integrating Art and Science in IST

In this chapter we reviewed IST by illustrating its comprehensive nature, discussing factors that bring cohesiveness to its integrative complexity, and considering the factors that contribute to the diversity of therapeutic pathways within it. IST is comprehensive in that it can be utilized with a great variety of problems and client systems. It is systemic in that it sees human problems as embedded in patterns of interaction and values working directly (or indirectly, if necessary) with relational systems. IST is integrative in that it provides a blueprint for integrating many of the concepts and strategies that have been developed within the various models of therapy. It is empirically informed in that it utilizes knowledge established by the scientific method and encourages the use of instruments that track change within client systems over the course of therapy.

IST specifies a problem-solving process (the essence) and makes explicit the implicit decision-making process (hypothesizing, planning, conversing and feedback) that guides all planful psychotherapy. In IST, therapists and clients are “coinvestigators”—developing and testing hypotheses with behavioral, experiential and interactional experiments, evaluating the results (observational and empirical feedback), and revising hypotheses and plans until the presenting problems have been solved. IST therapists engage clients as partners on a journey in which failed solution attempts are welcome opportunities to try something different.

IST is a perspective for transcending the models of individual, couple, and family therapy and constructing intervention based on a systemic understanding of a unique client system. It sees therapy as a planful, but also an idiosyncratic and improvisational, process that integrates art and science to provide clients with interventions that are designed for their problem sequences and constraints. Since IST is so comprehensive in its application, it is necessarily complex. Further, it is designed, within its own procedural logic, to accommodate many different concepts and strategies of therapy. It is an open knowledge system in that each blueprint component is designed to accommodate extensive bodies of existing and emerging knowledge and practice. Thus, there is always more to learn and a therapist can never fully master this perspective. In this sense, IST is not only a perspective for conducting therapy; it is also a framework that invites and supports continued learning and growth for therapists over the course of their careers.

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