Preface Supplement

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Cognitive Neuroscience and Psychotherapy: Network Principles for a Unified Theory is actually three books in one. I describe them in reverse order. The **third book** consists of Chapters 8 – 12 and concerns **psychotherapy integration**. This is done from a new sixth **Applied Psychological Science** (APS) clinical orientation that supports integrative eclectic evidence-based clinical practice. The APS clinical orientation integrates the science supported elements of what I call the Big Five clinical orientations. They are: (a) behavioral by which I primarily mean Applied Behavior Analysis, (b) cognitive, (c) cognitive-behavioral, (d) psychodynamic by which I primarily mean emotion-focused therapy, and (e) pharmacologic. The APS clinical orientation is authorized/justified by a **Bio↔Psychology Network Theory** (BPNT). It is philosophically rooted in **emergent connectionism**.

Clinical orientations are more general than the theories that authorize them. For example, one need not endorse everything that every psychoanalytic theorist said in order to have a psychodynamic clinical orientation. Nor does one need to endorse everything that every behavioral theorist said in order to have a behavioral clinical orientation. Hence, it is easier to integrate clinical orientations than it is to integrate the theories that authorize/justify them. Similarly, the unified orientation need not include every element of the clinical orientations being unified. This double deletion feature greatly facilitates psychotherapy unification. The resulting clinical orientation was designed to provide all of the Big Five clinical orientations with all of their "must haves". Nothing about the unified clinical orientation contradicts or is inconsistent with anything in every one of the Big Five clinical orientations. However, some elements of each of the Big Five clinical orientations may not be carried forward but that is justified by the same reasoning identified above concerning why one can have a particular clinical orientation without endorsing every aspect of every theory that supports that clinical orientation.

The **second book** consists of Chapters 3 – 7 and concerns **theoretical unification** because clinicians can only be expected to agree upon treatment when they agree upon what is wrong. The common understanding provided by the Bio↔Psychology Network Theory provides the required theoretical unification by focusing on explanatory mechanisms. The Big Five clinical orientations mentioned above are already unified in that they all lack, fail to provide, causal mechanism information. The BPNT provides causal mechanism information that is fully consistent with all of the Big Five clinical orientations and consequently provides a theoretical basis for their unification.

The theoretical unification I propose is a beginning point where psychologists can start to work together constructively rather than at competitive cross purposes. It is not a terminal end point of perfection.

The theoretical unification that is required to support psychotherapy integration requires a **paradigm shift**. Psychology is currently in a preparadigmatic state and must be practiced as a **mature science** in order to achieve the required theoretical unification to support psychotherapy

integration. The **first book** consists of Chapters 1 and 2 and identifies several explanatory problems that keep psychology in its present immature state. The proposed solutions to these explanatory problems calls for a **paradigm shift** that enables psychology to be practiced as a mature science.

I placed the evaluation of the Bio↔Psychology Network Theory in Chapter 7 as a formal conclusion to the presentation of this theory via Chapters 3-6. When teaching, I defer discussion of Chapter 7 until after Chapter 12 where I integrate the clinical implications of this theory in Chapters 9-11. I do this because most of the students in my Cognition & Affect graduate course are doctoral students in clinical psychology and they mainly want to know how helpful the BPNT will be to their clinical practice. Because I expect that most of my readers will also be clinical psychologists, or at least have some interest in clinical psychology, I recommend that they read Chapter 7 last. If I were writing a book concerning the clinical relevance of BPNT it would be entirely evaluated on its clinical contributions.