The Mediated Learning Experience Contribution to the Therapeutic Process
Il contributo dell'esperienza di apprendimento mediato al processo terapeutico

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ABSTRACT
This paper proposes the application of mediated learning experience (MLE) as a foundation of the therapeutic process. It brings Feuerstein's theory of structural cognitive modifiability (SCM) and its application MLE into an integrative model of social cognition that links MLE to the developmental and outcome objectives of a therapeutic interaction. The role of cognitive functions is described, and process concepts are linked to the model, including the nature responses (content and process), the quality of responding (implicit vs. explicit), and a parallel process of development. The application of MLE is linked the developmental phases of a therapeutic relationship.

Il contributo propone l'applicazione della teoria dell'esperienza di apprendimento mediato (EAM) come fondamento del processo terapeutico. Per fare questo applica la teoria della modificabilità cognitiva strutturale (MCS) di Feuerstein a un modello integrato di cognizione sociale che connette l'EAM agli obiettivi attesi e di sviluppo dell'interazione terapeutica. Il contributo descrive innanzitutto il ruolo delle funzioni cognitive, poi collega i processi e i concetti al modello, incluse la natura delle risposte (sia in termini di contenuto che di processo), la qualità della risposta (sia implicita che esplicita), e il processo parallelo di sviluppo. Il paper termina mostrando come si può applicare l'EAM alle fasi di sviluppo della relazione terapeutica.

KEYWORDS
Mediated Learning Experience; social cognition; cognitive functions; micro-skills, therapeutic process.
Esperienza di Apprendimento Mediato; cognizione sociale; funzioni cognitive; micro-abilità; processo terapeutico.

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1. Introduction

The concept of *micro-skills* (Ivey 1971; Egan 1986) has been influential in framing the training curricula for counselors and psychotherapists. Several scholars have extended this focus into areas of treatment planning (c.f., Teyber 1996; Kottle, 1993; Kottler & Carlson, 2014). Another more recent focus has been to identify cognitive aspects of the therapeutic process, joining the affective domain, in promoting therapeutic change. The theoretical formulations of Reuven Feuerstein and his colleagues, notably that of structural cognitive modifiability (SCM) mediated learning experience (MLE), initially directed to educational and remedial objectives, are proposed as a meaningful contribution to the therapeutic process (see Feuerstein & Falik, 1990; Falik 2021). Piaget (see Flavel, 1963) considered cognition metaphorically as "two sides of the same coin." Feuerstein considered the coin as "transparent," with the edge of the coin integrating the sides, where the mediation takes place. Thus, behavior change is "neither exclusively cognitive nor an affective phenomenon, but a combination of both" (Falik 2021, p.3). MLE is proposed as the integrative vehicle to make this happen. For both those who are learning to become therapists, and those already functional therapists, the MLE perspective can be a useful addition to the repertoire of skills.

2. The Role of social cognition in therapeutic interactions

The integration of cognitive and affective elements of human experience can be modeled and generalized as producing *social cognition*, that is further proposed as a critical element in the process of behavioral change. The model of Figure 1 suggests a foundational platform for the changes in behavioral and emotional structure and functioning.

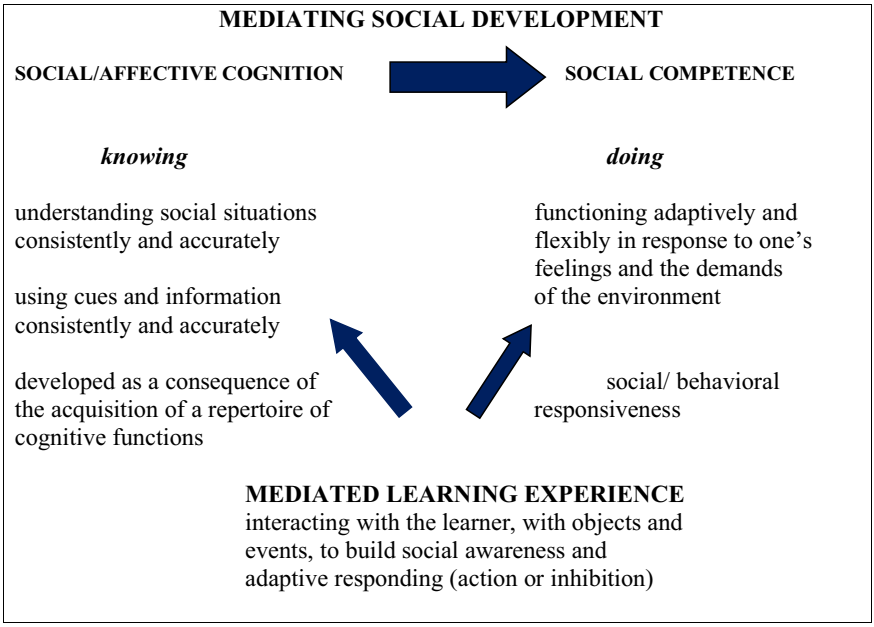

Figure 1: The social cognition model

The outcome of applying MLE to the process of psychotherapy is to create a cognitively

oriented transformation in the social, emotional, and behavioral response potential of the "client," who is the recipient of the therapeutic interaction. An initial objective of a therapeutic interaction is to identify *what* needs to be changed, and *why* it needs to be changed. Effective therapeutic intervention seeks to identify, with the client, in a mutually experienced encounter, the target of change and move toward it to modify meaning, experience, and relevant response skills.

There are developmental phases of the therapeutic relationship. They influence readiness and propensity in the formulating of therapeutic responses consistent with the interactional parameters of MLE. Mediational responding within the phases is directed toward the *knowing* of what is being responded to, and the *doing*—taking relevant actions. Mediated learning experience parameters guide intervention (Feuerstein et al., 2001; Falik, 2021).

Feuerstein and his colleagues (1979, 1980, 2006) proposed that the process of modifiability required a focus on functions—what the client can do and the range and effectiveness of responding. The "cognitive functions" may be *deficient, fragile, or well established*. Deficient or fragile functions interfere with adequate and appropriate behavior. This was recognized early (Falik and Feuerstein, 1990), but not fully elaborated. This paper elaborates this relationship by proposing the *social cognition* as a model for conceptualizing the process and goals of intervention. The cognitive aspect implies that emotional and behavioral changes imply (and require) cognitive modifiability. The focus on cognitive aspects of social responding is consistent with existing and accepted approaches to psychotherapeutic interventions, among them cognitive behavioral therapy, advocated by Beck and others (1990), but not limited to them.

The personality and behavioral propensities that the client brings to the therapy relationship are the result of two developmental learning experiences: (1) the cognitive functions that have been mediated from the outset of his/her human existence (prior to coming into the therapeutic relationship), and (2) the interpersonal interactions that the human individual is exposed to in encounters with the world. Both occur with the active and necessary interaction with mediators, historically and concurrently, and become the "details" or content of therapy.

3. What is social cognition?

Social cognition is the outcome of responding in a functionally appropriate and personally satisfying way to the demands of a situation. Sustained behavioral change requires an understanding and acceptance of the meaning of situations. Diverse social/emotional situations expose the individual to complex and varying demands. Social awareness and understanding determines accurate, satisfying interpersonal outcomes. The proposed model describes the characteristics of behavioral responding addressed. This is an adaptation that goes beyond Feuerstein's initial formulation of deficient cognitive functions, extending into the social/behavioral realm (Feuerstein et al., 2006; Falik 2021). Applied to the social realm it brings into focus the social dimensions of experience of the client and provides options for formulating therapeutic responses. Behavior is accompanied by feelings and thoughts that are played out in a social context. Identifying them and placing them into an interactive perspective advances the therapeutic process. All therapeutic interventions implicitly reflect this phenomenon to some de-

gree. The functional focus on social dimensions becomes a clear lens to view and target the relevant social and interpersonal interactions. This occurs through assessing the encounters that the client is having or has had with his/her world of experience, and the development (or lack thereof) of supportive personality processes and interpersonal relationships. When MLE is integrated into social cognition, the dynamics of the client's behavior are identified, enabling an understanding of the deeper structure of the client's social and emotional responding, leading to the formulation of responses in the therapeutic relationship. Referral statements, data from prior experiences, and observations of levels of social cognition guide responses invoking MLE parameters.

3.1 Evidence for social cognition

Daniel Goleman (1995, 2006, 2017) has assembled powerful evidence on the relationship between aspects of cognitive functioning and their impact on social, affective, and behavioral comfort and competence. He presents research evidence for biological and neurological correlates. He shows how each is affected by the other, how each is amenable to modifiability (described as re-education, restoration, and repair). His conclusions have been greatly expanded by others, extending into the neurophysiological sphere, such as Norman Doidge (2007; 2015), Daniel Siegel (2007), and Jeffrey Schwartz (2002). Jerome Kagan pointed that "some traits are harder to change than others, due to neural chemistry but *that no human quality is beyond change"*. As further justification of the Feuerstein approach to social cognition, Goleman links cognitive, affective, and neurobiological as follows: "All learning implies a change in the brain, a strengthening of synaptic connections… (For show(ing) that emotional habits are malleable throughout life, with some sustained effort, even at the neural level" (1995, 227).

3.2 Applications to psychotherapy

The social cognition model differentiates *social competence* to denote the functional aspect of the psychotherapeutic process the (distinguishing the "knowing" from the "doing"), focusing social interactions reflected in designing and carrying out a therapeutic change process. Social cognition is the *target* and MLE is the *pathway* for interventions.

4. The role of cognitive functions and their phases

The cognitive functions are dimensions of learning that develop naturally through individual's interaction with their worlds, exposed to the natural human interactions (that are *mediational*). Mastering the elements of the cognitive functions enables the individual to process, adapt, and respond to learning experiences and the requirements of the environment. For the purposes of application to psychotherapy, the cognitive functions have been described in the context of social/affective relationships (see Falik 2021). Feuerstein (1980; 2006) originally identified eight *input* functions (data gathering), twelve elaboration functions (processing and using the information gathered), and eight *output* functions (using what has been processed to express "solutions"). These phase differentiations still hold when the focus shifts to the social/behavioral realm.

The input, elaboration, and output phases represent structural elements, in a hierarchal sequence reflecting experiencing and interacting with the world of stimuli. Mastery at earlier phases contribute to subsequent functional accomplishment and amenability to further responding. The dimensions within each phase determine what is processed, retained, internalized, and applied to new experiences. They are at once both cognitive and social. Narrative therapists see a continuity and refer to this as one's *life script (*White & Epston, 1990*)*. The phases of the cognitive functions are significant and related to the phases of the developing therapeutic relationship. Gathering accurate information (*input*) leads to processing (*elaboration*) it in an understanding and forward moving way, connecting to past experiences, considering situations and problems to be solved, and making decisions regarding what and how to respond, actions to be taken or avoided. In the *output* phase one's experience is acted upon, felt internally, and interacted upon externally, extending from self to others. The inter-relationship among the phases alerts us to the influence of impairments or blockage from earlier phases. The ability to respond to experience accurately, maturely, comfortably is a function of what occurs at the input and elaboration phases. Extending the relationship of cognitive functioning to social cognition takes the following form: when social/emotional responses are aligned with self-perception, and levels of both comfort and acceptance are experienced, reactions are felt as appropriate, satisfying, efficient, and the like. This becomes a focus for the treatment planning. Responses to the environment and the interpersonal interactions within it are an inextricable mix of cognitive acquisitions in the structural schemata of the organism and behavioral reactions.

Social learning is at the heart of these options, making available to the individual a full range of interpersonal and adaptive experience. The delineation of the cognitive functions, framed from the perspective of their social/emotional components gives the counselor/therapist a structural road map and orientation to developing "tools" to mediate therapeutic or re-educational interventions. Social cognition can therefore be viewed as the manifestation of responses to situations the client has or is experiencing. Every internalized thought and resulting action have both objective and subjective components, in the *content* of experience and in the *process* of the experiencing. They are complementary and reversible—one's social and emotional state plays a role in the acquisition and performance of cognitive functions and one's cognitive functions are instrumental in fashioning one's social, emotional, and interactional behavior.

5. Applying mediated learning experience

Mediated learning experience includes 12 parameters grouped into three categories. They are hierarchically built upon one another. The parameters in the first group are considered *universal*—they must be established and present in any interaction that is mediational. They are *intentionality and reciprocity, transcendence,* and *the mediation of meaning*. Once the universals are established, the next opportunities for mediation are *situational*, invoked when focused on an event or situation occurring in therapy or in the life of the individual. They include the mediation of *regulation and control of behavior, feelings of competence, sharing behavior, individuation and psychological differentiation, goal seeking/ setting/ achieving/ monitoring*, and the mediation of *novelty/ challenge*.

Following these mediational interventions, mediation is directed toward con-

solidation and reinforcing the changes experienced through earlier mediational interventions, including the *mediation of awareness of the ability to change, searching for optimistic alternatives,* and *feelings of belonging*. These focus on *belief system* transformation. These parameters are well described and elaborated in the literature on the Feuerstein method (see Feuerstein, et al. 2006; Falik, 2021). The parameters present the mediator with directions and options for intervention rather than specific prescriptions for action, rather than a prescribed set of interventions. In this sense, MLE is a *process* rather than a *methodology*, providing a potentially supportive framework for any therapeutic methodology or desired outcome objectives.

6. Integrative concepts derived from the social cognition model

The social cognition model encompasses three operational concepts unique to model and one integrative concept from the existing and accepted framework of counselor/therapist training. First the integrative concept:

- The developmental phases of the relationship: four developmental phases in the therapeutic relationship have been identified (c.f., Ivey, 1994; Hackney & Cormier, 2001): *attending, listening, responding*, and *intervening*. To this delineation we add a final phase: *termination*. Each phase presents both opportunities and limitations in formulating and directing therapeutic responses. An interaction that has "therapeutic" intentionality develops according to these phases, and the author's experience with developing a training curriculum based on these distinctions (see Falik, 2021) revealed that when aspects of the MLE parameters were infused into the developmental phase encounters, outcome effects were significantly enhanced.
- Each phase presents differential opportunities to invoke responses that reflect the MLE parameters: briefly described, the *attending* phase establishes the relationship, *the listening phase* accesses the information and directions for proceeding, the *responding* phase creates intentionality and direction, the *intervening* phase is one of action to reach established goals, and the *termination* phase consolidates the experiences of the preceding phases. Each of these phases encompass specific skills and interventions (including observation, questioning strategies, reframing opportunities, and the like) that are well described in the literature but have been delineated elsewhere (see Falik, 2021).

  The unique concepts deriving from the social cognition model are:

- Partners in the process of transformation: initiating and sustaining change requires changes in three "partners" in the process—the client (mediatee), the therapist (the mediator), and the content of the interaction (the reframed content/stimuli) (see Falik and Feuerstein (1990); Falik, 2021).
- The focus of the interaction: this parameter considers the differential emphasis on *content vs. process*—what the interaction directs attention to, and what is engaged in, related to client readiness (in the relationship) and situational factors. Within phases, this consideration is the active experience that occurs from session to session and phase to phase. This takes the form of what is talked about, what is emphasized, and what is put aside for the moment, to be dealt with later and as appropriate. While not "new" in relation to counseling and therapeutic process considerations, the distinction has meaning with re-

gard to the social cognition model and MLE oriented response formulations. So, in a sense it is not unique, but acquires a new focus, infusing the MLE parameters with cues for formulating responses—*when* and *why* to say or do *what*. Content refers to the "facts" and details of the client's experience. Process refers to the affective experience in the interpersonal interaction, as the client's story is being told or as the encounter is being experienced. In early phases content often needs to be preceded (but not ignored—it is a matter of emphasis) by a focus on the process of the interaction, to create comfort and readiness to confront, and gain access, to enable the client to recall and experience the content of their experience. Later in the phases of the relationship, content and process blend to promote working on the issues of concern that have been accessed and identified as relevant to work on. This leads to a corollary concept, the *parallel process* (Figure 2). It is proposed that therapeutic experience content and process move together in a synchronous and predictable way, each contributing to the other but requiring differential considerations of timing, impact, readiness, etc. Bringing the MLE parameters into play, content and process dimensions are influenced by the specific mediational parameters guiding responses.

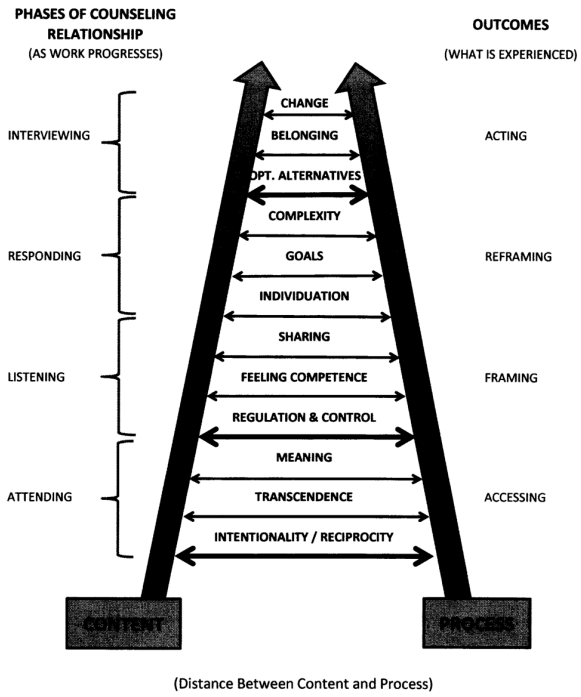

Figure 2: The parallel process in therapy: Content and process foci

At the outset of the relationship (the attending and listening phases), there is more distance between content and process, requiring differential focus, and separation in what is addressed in the relationship, made meaningful by employment of the universal MLE parameters. But as bridging (bringing the content and process dimensions together in experience and meaning) starts to occur and as the relationship is ready to access more of the specific situational factors, the di-

stance is reduced, and content and process contribute in tandem to outcome results. This affects the potential outcome of the therapeutic experience, as potentialities and goals are reframed and experienced. MLE is the linkage as the counselor and client climb the metaphorical ladder. The therapy experience links content to latent (underlying and previously inaccessible) meaning, opens the client to the experience of the process related to the content, and moves to a reframe of the problem.

Effective mediation ensures an acceptance of the need to work on what is accepted, recognized, and needed—connected to the immediate experience and the deeper dynamics of the content. This instills a sense of positive engagement and initiates a focus that will be elaborated and deepened as the therapy proceeds. In the schema presented above, the sides of the ladder get closer to one another as process and content are blended in the response formulation. This is what can be termed *dynamic meaning*. As this occurs, the sides of the ladder begin to come closer, reflecting the content and process merging in the working framework and in the client's functional awareness.

The nature of the response: this dimension is the "how" of the mediator's responses, linked to both the phases of the counseling process and the process/content distinctions addressed above. The distinctions reflective of this dimension refer to when to be *explicit*, meaning being overt, direct, and confrontational (in gentle and respectful ways) and when to be *implicit*, indirect, covert, and implicational. Each posture has its place in the processes of the interaction, related to the phases and is an important part of forming the therapeutic relationship and treatment planning. It determines the way in which responses are framed and conveyed. Implicit responding is inferred and indirectly conveyed through either words or non-verbal means.

There is a relationship of this dimension to the content/process considerations addressed above. Generally, a process focus generates more implicit responding (as a function of client comfort level and readiness to access the content). As the focus moves more toward content, there is more readiness to tolerate and gain from explicit responding. Within the phases of the relationship, the frequency of explicit responding increases at the responding and intervening phases, as issues are being confronted and change strategies are being formulated and acted upon. Strategic considerations require an assessment of the client's level of readiness and responding and the developmental phase of the relationship to know when to be implicit or explicit, and to know when to make an implicit response explicit and an explicit response implicit.

Examples of these distinctions are as follows: when the therapist paraphrases the client's communication, restating what is heard, to help the client understand the meaning, but does not offer an interpretation, the interaction is *content* focused, but *implicit* in the nature of the response. Conversely, when the therapist observes and interprets a change in the client's facial expression when suggesting an intervention, the focus is on *process* and the nature of the interaction is *explicit*.

7. Conclusions: Integrating phases and functions. Targets for mediational intervention.

Social cognition is proposed as a model for a deeper, functional, and potential directional understanding of the structural aspects of a therapeutic relationship, and both identifies and integrates the dimensions of the relationship. The para-

meters of MLE are proposed as guidelines for formulating responses consistent with the content and process elements of the therapeutic relationship—what the client brings to the therapy, what the therapist focuses upon, and how responses are formulated. It is further proposed that these perspectives are embedded in the full range of different methodological orientations, and that an understanding of them enhances the effectiveness of the therapeutic process, whatever the specific "technique" or purpose of the interaction envisioned. In this sense, the value of the model is both consolidative, bringing together the well-established technology of clinical/therapeutic interviewing and a new paradigm or perspective on the underlying processes and how to utilize them in facilitating a more meaningful, effective, and transcendent potential for the interaction. The interrelationships among these variables are presented below so they can be viewed systematically (Figure 3); the reader is encouraged to scan both horizontally, to see the developmental progression as a therapeutic process develops, and vertically to see what happens within each phase.

Figure 3: Integrating phases and functions in counselling and in psychotherapeutic interactions.

MLE enters the therapeutic process at strategic and tactical levels. The strategic level is framed by considering where the therapy is going, what are the issues that must be addressed, and why is it important to go in the identified direction. The MLE parameters that uncover and set the conditions are *intentionality/reciprocity, transcendence,* and *meaning*. The tactical level addresses how to get to the meeting of strategic goals. The MLE parameters that guide the therapy in this direction are mediating *feelings of competence, regulation, and control of behavior, sharing behavior, individuation, goal seeking/ setting/ planning/ achieving, challenge /no-*

velty/ complexity, awareness of capacity to change, awareness of optimistic alternatives, and *feelings of belonging*.

The application of the model, specifically the understanding of the mediational parameters delineated by MLE requires considerable acquisition of familiarity, going well beyond the goals of this paper. There is a comprehensive literature, and training and consultation activities developed and disseminated by the Feuerstein Institute offered on a global scope.

In summary, the integration proposed by the social cognition model and linking MLE parameters to the formulation of therapeutic responses reflects the structural and process dimensions of a therapeutic relationship, integrated with the desired goals and outcome variables of the interaction. The social cognition model provides a foundation or platform for the implementation of a meaningful and directed change experience, the framing of responses and the formulation of techniques (responses) that originate from diverse theoretical and practical orientations and outcome objectives. In this way, the promise of structural cognitive modifiability can be brought into the framework of therapeutic interventions, and the perspective of MLE, as the guideline for focusing on behavioral and social change, offers optimistic alternatives. This has both educational (training) and proficiency of practice implications.

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