

DSRP Therapy

Toward a Structural Paradigm in Psychotherapy

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ABSTRACT: *Background:* Most contemporary psychotherapies focus on content—the stories, beliefs, or emotions expressed by clients—while leaving the structure of cognition largely implicit. DSRP Therapy® introduces a structural alternative, defining thinking as the organization of information ($T = I \rightarrow O$) through four universal cognitive patterns: Distinctions, Systems, Relationships, and Perspectives (DSRP). This study explores how licensed therapists understand and apply DSRP after foundational training, as a preliminary step toward defining DSRP Therapy as both a supplemental and standalone paradigm. *Methods:* Five licensed therapists completed the White Belt (1 hr) and Yellow Belt (8 hrs) DSRP trainings, which introduce structural cognition, the Love Reality Loop (LRL), and the Six Moves. Following training, participants engaged in one-hour semi-structured interviews conducted via Zoom (July–September 2025). Transcripts were coded at the sentence/idea level using a two-phase analysis: (1) inductive content analysis to identify themes, followed by (2) deductive mapping of those themes to three exploratory hypotheses—supplemental value (H_1), distinctiveness (H_2), and competency prerequisites (H_3). *Results:* Across 33 coded segments (mean 6.6 themes per participant), therapists consistently described DSRP as both (a) a structural scaffold that clarifies and augments existing modalities, and (b) a distinct, structure-first framework focused on the organization—not the interpretation—of thought. They identified broad clinical applicability (anxiety, depression, trauma, relational issues), emphasized DSRP’s client-centered and nonpathological stance, and highlighted four prerequisites for DSRP Therapy practice: structural relevance recognition, conceptual fluency, mapping skill, and reflexive metacognition. *Conclusions:* Findings provide early existence evidence that structural cognition is perceptible and valued by clinicians. DSRP appears to add conceptual clarity to traditional therapies while constituting a potentially unique therapeutic paradigm. The principal barrier is not theoretical but pedagogical: therapists require concise, visual, and practice-oriented training to operationalize structural thinking in clinical work. These results define the competency and training architecture needed for DSRP Therapy’s professionalization and set the stage for outcome-based validation in applied clinical contexts.

KEYWORDS: DSRP Therapy | Structural cognition | Systems thinking | Cognitive architecture | Psychotherapy training | Object-Oriented Thinking | Metacognition | Love Reality Loop (LRL) | Thinking Quotient (TQ) | Evidence-based innovation

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1. Introduction

Modern mental health exists within accelerating complexity. Daily life unfolds through constant exposure to overlapping streams of information, expectation, and demand. Moments meant for rest now fill with mental noise from messages, news, and notifications. The body may pause, but attention remains tethered to the next signal. Phones, tablets, and screens pull attention in many directions at once, leaving little space for sustained focus or quiet thought. Minds absorb more messages, images, and cues than they can organize. Days stay full of activity but often without direction or purpose. People talk more yet feel less connected. Information grows faster than understanding, leaving thought scattered and out of order. Under these conditions, attention fixates on content while the structure that organizes meaning remains unseen and unattended.

Clinical practice reflects this pressure. Clients rarely arrive with a single problem; they bring interconnected layers of strain that link exhaustion, anxiety, distraction, and loss¹. Work demands mix with grief, self-criticism fuels fatigue, and digital stress amplifies emotion. Each concern connects with others until no clear beginning or end can be found. These configurations cross diagnostic lines and resist linear explanation. Standard diagnoses such as depression, anxiety, or trauma organize records and treatment plans yet describe content rather than revealing how patterns of thought and perception create distress. Each label adds information while obscuring the structure that organizes meaning. The result is a clinical landscape rich in terminology but limited in methods for seeing and working with the organization of thought at the center of therapeutic engagement. Without that visibility, both therapist and client risk treating symptoms without addressing the system that sustains them. The field now stands at a threshold: continue interpreting stories or learn to see the architecture that builds them.

Across the broad landscape of psychotherapeutic traditions, including psychoanalytic, behavioral, cognitive, humanistic, systemic, and integrative—one common thread persists: most approaches operate at the level of *content* rather than *structure*. They treat the stories, beliefs, or emotions that populate the client's world as primary, while the *organization* of those mental contents remains largely invisible. Yet, it is precisely this organization—the architecture of thought—that determines how people perceive, feel, and act². Without addressing the underlying structure of cognition, therapy can correct narratives without transforming the mechanics that generate them.

DSRP Therapy[®] emerges as both a response and a complement to this condition. It is a structured, systems-based, and realist approach to transformation grounded in a universal principle of cognition: *thinking is the organization of information* ($T = I \rightarrow O$). Every mental model ($\mathbb{M}$) that a person holds is the product of the information it contains (I) and the organization (O) it applies to that information, formally expressed as $\mathbb{M} = I \cdot O$. When information or organization changes, cognition itself changes. When both evolve together, understanding expands in depth and accuracy.

The organizational structure of thought—O—is not arbitrary. It follows four universal, recursive patterns that occur in all cognitive and natural systems: Distinctions (D), Systems (S), Relationships (R), and Perspectives (P). Together, these patterns form a universal grammar of cognition, describing how all minds construct reality³. DSRP Therapy brings this structural grammar into the clinical space, helping clients and therapists make thinking visible, test it against reality, and reorganize it toward greater coherence, clarity and function.

This structural orientation fundamentally reframes what therapy is and does. Instead of analyzing content or assigning meaning, DSRP Therapy externalizes cognition itself. The therapist acts as a *structural mirror*, using *Object-Oriented Thinking in Therapy (OOTiT)*—a suite of visual, tactile, and linguistic techniques—to map how a client’s thinking is organized in real time. Through this process, mental models (M) become visible, comparable to reality’s organization (R), and transformable through iterative realignment—a dynamic process known as the *Love–Reality Loop (LRL)*⁴. Within this loop, clients learn to resist two natural cognitive biases: reality bias (the assumption that one’s model *is* reality) and confirmation bias (the tendency to seek evidence that reinforces existing models). As cognition becomes visible, clients can begin to align their thinking with how events and systems connect, interact, and change in real time.

The result is a therapy that is *nonpathological, nonjudgmental, and empirically grounded*. Dysfunction is not defined by diagnostic categories but by structural misalignment, when the organization of cognition produces results that diverge from lived reality. Progress is measured not by insight or symptom reduction but by improved alignment between mental models and real-world outcomes ($M/R \rightarrow 1$). In this way, DSRP Therapy unites systems science, cognitive realism, and clinical practice into a single structural method for transformation.

Despite its theoretical clarity, DSRP Therapy remains a young discipline. While millions of learners worldwide have completed introductory DSRP training, such as the White Belt and Yellow Belt levels that build foundational fluency in structural cognition. However, these programs are designed for general cognitive development rather than for therapeutic certification. They introduce the cognitive mechanics of DSRP but do not yet provide the professional therapeutic scaffolding, clinical supervision, or ethical frameworks necessary for therapy practice. The structural gap between conceptual knowledge of DSRP and clinical competence in DSRP Therapy presents both a challenge and an opportunity: to define what professional standards, competencies, and credentialing structures are required to translate structural cognition into therapeutic mastery.

Over the past three decades, an accumulating body of empirical research has established DSRP Theory and O-Theory as scientifically valid theories of how mind and reality organize information². DSRP Theory describes the four basic patterns that organize all thought: Distinctions, Systems, Relationships, and Perspectives⁵. O-Theory extends this framework into a science of organization that links cognition and reality through shared structural principles^{3,4,6}. Studies confirm the Cognitive Law ($M = I \cdot O$) and its extension to model–world alignment (M/R), demonstrating that understanding depends multiplicatively on both information and organization^{7,8}. Formal analyses of the four DSRP patterns—Distinctions, Systems, Relationships, and Perspectives—show that these structures exist universally in both mind and nature, functioning as the shared architecture of cognition and reality^{9–12}. Experimental work has verified

their ontological existence, interdependence, and dynamic simultaneity, revealing that activating one pattern activates all others¹³.

This foundational program also uncovered a structural 80/20 Pareto distribution of cognitive biases—the Cognitive Pareto Law—showing that roughly 20 % of recurrent structural biases account for about 80 % of observed cognitive error^{14,15}. These findings gave rise to the Six Pareto Moves, empirically derived interventions that surface and correct those biases through simple, teachable micro-operations of thought¹⁴. Subsequent effect studies demonstrate that deliberate practice of DSRP and the Moves yields measurable improvements in systems thinking, metacognition, and emotional intelligence—gains averaging ≈ 550 % over baseline training controls^{13,16}.

The broader research stream has further linked DSRP practice to the development of Systems 3 Thinking, an empirically grounded expansion of Kahneman’s dual-process model^{14,17}. Whereas Systems 1 and 2 describe automatic and deliberate cognition, Systems 3 Thinking captures the metacognitive capacity that arises through sustained practice in the Moves—the ability to observe and reorganize one’s own thinking in real time to achieve fast and “right” alignment with real world situations^{18–21}.

Finally, the program has established the Thinking Quotient (TQ) as a reliable psychometric instrument ($\alpha \approx .87$; $\omega \approx .88$) for measuring structural cognition and systems-thinking skill²². Collectively, this body of work provides the scientific backbone for DSRP Therapy®, grounding its clinical application in an empirically verified model of how minds organize information—and how that organization can be measured, trained, and transformed.

The present exploratory study represents the first empirical step toward that goal. Five licensed therapists representing diverse orientations completed the *White Belt* and *Yellow Belt* DSRP trainings and then participated in one-on-one semi-structured interviews examining how they could conceptualize, interpret, and apply DSRP principles in their existing clinical work. These participants were not trained in DSRP Therapy itself but were well positioned to evaluate its theoretical and practical potential from a therapeutic professional lens through their professional experience as practicing clinicians.

Three exploratory hypotheses guided the inquiry: (1) that DSRP principles provide *supplemental value* to existing therapies by enhancing structural awareness and metacognitive skill; (2) that DSRP Therapy constitutes a *distinct and potentially transformative paradigm*—one that reorganizes the practice of therapy around cognitive structure rather than interpretive content; and (3) that effective engagement in DSRP Therapy will require therapists to develop specific competencies, including recognition of structural cognition as therapeutically relevant, comprehension of DSRP principles, and practical skill in mapping and reorganizing thought.

By investigating how licensed therapists integrate and reflect upon DSRP concepts after foundational training, this pilot study provides preliminary evidence for both the *value-added clinical potential* and the *distinctiveness* of DSRP Therapy. It also begins to define what formal *training, credentialing, and professional standards* must accompany its evolution from theory to clinical discipline. In doing so, it lays the groundwork for a new class of therapies—structural, transparent, and collaborative—that treat thinking not as a story to interpret but as a structure to be seen, tested, and transformed.

Methods

Study Design and Aims

This exploratory qualitative pilot investigated how licensed therapists, after introductory DSRP training, conceptualize and apply structural cognition to their therapeutic reasoning. The study pursued three analytic aims that also served as guiding hypotheses integrated into the analytic framework:

1. **H₁ – Supplemental Value:** DSRP functions as a meta-therapeutic structure that enhances existing modalities by making the organization of thought visible and trainable.
2. **H₂ – Distinct Paradigm:** DSRP Therapy represents a qualitatively different framework—focusing on the reorganization of cognition (model–world alignment) rather than interpretation or conditioning.
3. **H₃ – Competency Prerequisites:** Effective DSRP Therapy requires therapist competencies in structural awareness, conceptual fluency, object-oriented mapping (OOT/OOTiT), and reflexive metacognition.

These aims were examined sequentially through an inductive first-pass discovery analysis followed by a deductive second-pass mapping of evidence to H₁–H₃.

Participants

Five licensed U.S. mental-health professionals (N = 5) participated voluntarily. Participants' post-licensure clinical experiences ranged from 5 years to over 30 years and represented diverse mental health professions including professional counseling, social work, and clinical psychology. Their education ranged from masters to doctoral level training. Participants had certifications to include EMDR, Registered Play Therapist-Supervisor, and/or telemental health. Participants work in outpatient, private practice, or school-based settings doing either individual and/or group counseling. Some participants primarily offer telehealth while others offer in-person and some offer both. Participants work with clients across the lifespan (children to adults) as well as individuals, couples, and/or families. Participants shared that professional orientation approaches often center on cognitive-behavioral, integrative, motivational interviewing, narrative, systemic, and/or solution-focused. . Finally, participants specialized in working with PTSD / trauma, anxiety, stress, depression, adjustment disorders, and/or relationship issues. Participants were recruited through professional DSRP educator networks and all participants provided informed consent.

Training Intervention

Prior to data collection, participants completed two levels of self-paced DSRP training designed for general cognitive skill development rather than clinical certification:

- **White Belt (WB; 1 hr):** Established a baseline psychometric skills assessment with Thinking Quotient (TQ) diagnostic, producing a personalized structural-thinking profile.

- **Yellow Belt** (YB; 8 hrs = 5 instruction + 3 practice): Introduced the Love Reality Loop (LRL), the model–reality alignment equation $M = I \cdot O$, and initial practice with the Six Moves (Is/Is Not List, Zoom In, Zoom Out, Part Party!, RDS Barbell, and Perspective Circle).

No participant received formal DSRP Therapy training. This design choice intentionally isolated the influence of general structural cognition (DSRP) from the therapeutic modality derived from it.

Data Collection

Following yellow belt completion, participants engaged in one-hour semi-structured interviews conducted via Zoom between July and September 2025. Prompts invited reflection on comprehension of DSRP concepts, perceived clinical utility, comparison to existing modalities, and anticipated training needs. All interviews were video-recorded with informed consent, transcribed verbatim, anonymized, and accuracy-checked. Interviewing was lightly scaffolded to encourage elaboration without interpretation or leading feedback.

Analytic Framework

Phase 1 – Inductive First Pass (Discovery)

The first analytic phase used inductive content analysis at the sentence/idea level using the following process: open coding → categories → higher-order themes → cross-case synthesis. The output was ten recurrent themes—*training clarity & format; conceptual stance; positioning vs other therapies; clinical applicability; populations & equity; implementation barriers & facilitators; settings & formats; measurement & evaluation; access & infrastructure; perceived strengths*. These were quantified using counts of coded mentions and participant coverage (e.g., 33 segments total; mean 6.6 themes per participant). This phase established a data-driven baseline for describing how therapists discussed DSRP Therapy in their own language.

Phase 2 – Deductive Second Pass (Hypothesis Mapping)

A follow-up deductive analysis examined how the inductive findings related to H_1 – H_3 . Each theme was reviewed for evidence supporting or refuting the three analytic aims:

- H_1 : Additive structural language and integration with existing modalities.
- H_2 : References to visible cognition (mapping, structure, alignment) and explicit contrasts with interpretive or affective methods.
- H_3 : Statements identifying learning curves, skill gaps, or competency requirements.

A theme-by-hypothesis matrix captured these linkages. Structural markers—distinction-making, part–whole reasoning, relational/causal phrasing, and perspectival framing—were also identified within discourse segments. No inferential statistics were applied; emphasis remained on descriptive convergence between inductive and deductive layers. A full audit trail (codebook, theme tables, exemplar quotes, and the H_1 – H_3 matrix) ensures transparency and traceability. Integration of both phases produced a layered

synthesis: the inductive pass revealed *what* therapists said, while the deductive pass clarified *how* those insights align with the theoretical and developmental aims of DSRP Therapy.

Thus, the data pipeline for the study was as follows: Training → Interviews → Inductive Coding → Theme Development → Deductive Mapping to H₁–H₃ → Integrated Synthesis. This sequence preserves exploratory openness while linking emergent practitioner experience to the theory’s empirical and pedagogical development.

Results

Overview

Five semi-structured interviews with licensed therapists (N = 5) were coded at the sentence/idea level following completion of the White Belt (WB) and Yellow Belt (YB) DSRP trainings. The inductive first-pass analysis produced 33 coded segments, averaging 6.6 themes per participant. Both quantitative frequency data and qualitative verbatim excerpts were examined to illuminate how therapists conceptualized DSRP’s value, distinctiveness, and training needs. *Table 1* summarizes corpus-level characteristics.

Table 1. Quantitative snapshot of the corpus

Metric	Value
Total coded segments	33
Mean themes per participant	6.6
Most common themes	Training clarity & format; Clinical applicability
Least represented theme	Conceptual stance

The corpus was dominated by practical reflections on training clarity, clinical applicability, and implementation feasibility—findings consistent with the study’s exploratory, practitioner-oriented focus.

Theme Frequencies and Coverage

Table 2 summarizes the distribution of themes and their coverage across participants. Training clarity and clinical applicability were the most consistently mentioned domains, followed by settings, equity, and implementation factors.

Table 2. Theme frequencies and participant coverage (N = 5)

Theme	n (mentions)	Participants (out of 5)
Training clarity & format	5	3
Conceptual stance	1	1
Positioning vs other therapies	3	3
Clinical applicability	5	5
Populations & equity	4	3
Implementation barriers & facilitators	3	3
Settings & formats	4	4
Measurement & evaluation	2	2
Access & infrastructure	3	3
Perceived strengths	3	3

All participants discussed DSRP's clinical reach, and most commented on training design, applicability, and practical barriers.

Inductive Coding and Illustrative Language

Table 3 lists individual codes grouped by theme with corresponding mention frequencies from the inductive first pass.

Table 3. Code frequencies by theme

Theme	Code	n (mentions)
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Training clarity & format	training_length_overlong	2
	need_visuals_examples	2
	need_therapist_specific_training	1
Conceptual stance	client_centered_unbiased	1
Positioning vs other therapies	comparison_CBT_DBT	2
	distinct_standalone	1
Clinical applicability	applicability_common_dx	3
	applicability_psychosis_split_views	2
Populations & equity	diversity_adaptability	2
	IDD_neurodivergence_challenges	2
Implementation barriers & facilitators	implementation_buyin_readiness	2
	need_therapist_specific_training	1
Settings & formats	group_vs_individual	3
	inpatient_outpatient_considerations	1
Measurement & evaluation	measurement_TQ_prepost	2
Access & infrastructure	Accessibility_cost_user interface (UI)	3
Perceived strengths	perceived_strengths_simplicity_visual	3

Verbatim excerpts illustrating each theme appear in *Table 4*.

Table 4. Representative coded excerpts (short verbatim)

Theme	Participant	Excerpt
Training clarity & format	P1	“Any given video could have been 50 % shorter... there should at least be bookmarks.”
	P2	“As a visual learner... the podcasts were kind of long... I would have liked to see it used.”
	P3	“Not completely clear what I do as a therapist with it... show its use in clinical sessions.”
Conceptual stance	P2	“It is all on the client... completely client centered... working through their mental model.”
Positioning vs other therapies	P4	“It’s consistent with CBT... trying to train people to think differently.”
	P5	“I feel it is a standalone... very well researched, very specific.”
Clinical applicability	P4	“Anxiety, depression, OCD... where you need to interrupt thoughts.”
	P1	“Even psychosis... potential to get them to look at perception.”
Populations & equity	P2	“Super adaptable and applicable... because it’s client centered.”
	P1	“This takes thinking... cognition and creativity... challenging for intellectual disabilities.”
Implementation barriers & facilitators	P5	“Mandated clients... not in a space to want to do the work... trust and safety first.”

Settings & formats	P1	“Family > couples > individual for impact... group feasible but needs skilled clinician.”
Measurement & evaluation	P1	“TQ... you can take it over and over... see baseline and growth.”
Access & infrastructure	P3	“Cost and accessibility... might limit clinicians.”
Perceived strengths	P1	“Simplicity... the visual aspect... I benefit from that.”

Therapists consistently praised DSRP’s clarity, structure, and client-centered stance while highlighting the need for shorter, more visual, and therapist-modeled training content.

Deductive Mapping: Themes to Hypotheses

The second-pass deductive analysis examined how inductive findings corresponded to the study’s three hypotheses. *Table 5* displays the evidence matrix.

Table 5. Theme → Hypothesis alignment matrix (evidence mapping)

Theme	H ₁ Supplemental value	H ₂ Distinct paradigm	H ₃ Competency prerequisites
Training clarity & format			✓
Conceptual stance		✓	✓
Positioning vs other therapies	✓	✓	
Clinical applicability	✓		
Populations & equity	✓		✓
Implementation barriers & facilitators			✓

Settings & formats	✓		✓
Measurement & evaluation	✓		✓
Access & infrastructure			✓
Perceived strengths	✓		

Interpretation:

- **H₁ (Supplemental value):** Evident in *clinical applicability*, *positioning vs other therapies*, and *perceived strengths*.
- **H₂ (Distinct paradigm):** Evident in *conceptual stance* and *positioning*, where participants explicitly described DSRP as “standalone” and “structure-first.”
- **H₃ (Competency prerequisites):** Evident across eight of ten themes, underscoring needs for structured training, modeling, and credentialing.

Integrated Findings

DSRP as Additive Architecture (H₁). Therapists described DSRP as a cognitive lens that organizes and clarifies existing modalities, applying its logic across anxiety, depression, OCD, trauma, and relational work.

DSRP as Distinct Paradigm (H₂). Three participants labeled DSRP a “standalone” or “its own entity,” describing its focus on mapping, alignment, and reorganization of thought as distinct from interpretation-based models.

Competency and Infrastructure Needs (H₃). The dominant signal was pedagogical: therapists requested concise, visual, modeled, and practice-oriented materials. Their comments outline a prospective DSRP Therapy training continuum—micro-learning, session demonstrations, role-plays, and measurable skill rubrics (*Table 6*).

Table 6. At-a-glance practice implications (derived from coded data)

Domain	Insight (from data)	Concrete implication
Training	Need concise, visual, therapist-modeled design	≤ 8-min micro-lessons; bookmarks; annotated demo sessions
Conceptual	Client-centered, unbiased stance	Emphasize structural mirroring; non-pathologizing frame

Clinical scope	Internalizing + relational strengths	Position for anxiety, depression, OCD, trauma, relationships
Equity	Cognitive-load concerns for IDD/neurodivergence	Adapted protocols (tactiles, concretes, pacing)
Implementation	Readiness and buy-in pivotal	On-ramps, engagement scripts, low-lift moves
Settings	Works across individual/couple/family/group	Provide setting-specific flow templates and cadence notes
Measurement	TQ pre/post is feasible	Include TQ timing, norms, visualization templates
Access	User Interface (UI) friction and cost barriers	Streamlined User Experience (UX) + clinician fast-track pricing

Participants consistently portrayed DSRP Therapy as operating on the *architecture of cognition* rather than its content. The distinctions above are not theoretical conjectures but practitioner-observed differentiators grounded in their direct post-training reflections. They frame DSRP Therapy as simultaneously meta-integrative (applicable across schools) and structurally distinct (introducing operations—mapping, mirroring, alignment—not found in traditional approaches).

While *Table 3* provides raw inductive coding frequencies, *Table 7* integrates all comparative statements made across interviews, capturing contrast between DSRP with other therapeutic approaches more broadly.

Table 7. Empirically derived contrasts between DSRP Therapy and traditional therapeutic approaches

Dimension	Empirical evidence from participants (verbatim excerpts)	Cross-case synthesis: DSRP Therapy (as described by participants)	Cross-case synthesis: Traditional therapies (as referenced by participants)
Primary focus	P2: “It is all on the client... completely client centered.” P3: “Working through their mental model.” P4: “Training people to think differently.” P5: “Standalone... very specific.”	Focuses on the structure and organization of thought (thinking about thinking). Centers therapy on how clients think rather than what they think.	Focuses on the content of thought, emotion, or behavior. Structure of cognition remains implicit.
Mechanism of change	P4: “It’s consistent with CBT... trying to train people to think differently.” P5: “Reorganizing thought.”	Change occurs through structural reorganization of the client’s mental model via mapping, alignment, and mirroring.	Change occurs through interpretation, reframing, or conditioning within theoretical content.
Therapist stance	P2: “It is all on the client... completely client centered.” P5: “Knowledge is power.”	Therapist acts as co-thinker and structural mirror, facilitating client self-organization rather than interpreting meaning.	Therapist functions as expert or interpreter guiding client understanding through established models.
Role of theory	P3: “It resonates with EQ, mindfulness, EMDR, and cognitive therapy.” P5: “It is a standalone... very well researched.”	Operates as a meta-framework—a universal grammar of cognition that can integrate with any existing modality.	Grounded in school-specific theories (e.g., CBT, DBT, EMDR) emphasizing prescribed content or technique.
Use of visuals / mapping	P1: “Any given video could have been 50% shorter... there should at least be bookmarks.” P2: “As a visual learner... I would have liked to see it used.” P3: “Show its use in clinical sessions.”	Uses visual and object-oriented mapping tools (OOT/OOTiT) to make cognition visible in-session. Mapping is seen as central to practice.	Largely verbal and interpretive; cognitive structure remains unseen or metaphorical.
Definition of dysfunction	P2: “It is all on the client... completely client centered.”	Defines dysfunction as structural misalignment between mental model (M) and reality (R). Focuses on how cognition organizes itself relative to reality.	Defines dysfunction in terms of diagnostic categories or symptom patterns (DSM-driven).
Learning emphasis	P1: “Any given video could have been 50% shorter.” P2: “Podcasts were kind of long.” P3: “Not completely clear what I do as a therapist with it.”	Emphasizes metacognitive skill acquisition and hands-on practice through concise, visual, therapist-modeled learning.	Emphasizes conceptual understanding or adherence to manuals and models.
Session process	P1: “The organizing patterns video was awesome... here’s how it looks practically in the world.” P3: “Show its use in clinical sessions.”	Follows a structured cognitive sequence: complaint → map → reflect → reorganize → contract → practice.	Typically content- or insight-driven conversations; process varies by orientation.

Measurement orientation	P1: “TQ... you can take it over and over... see baseline and growth.” P5: “Assessment as baseline... then take again and see progress.”	Uses Thinking Quotient (TQ) and mapping artifacts as observable measures of cognitive change.	Relies on symptom scales or self-report outcome measures.
Ethical / epistemic frame	P2: “Completely client centered... working through their mental model.” P5: “Trust and safety first.”	Non-pathologizing, bias-aware, transparent. Makes cognition explicit and shared between therapist and client.	Often interpretive or diagnostic, with implicit cognitive biases unexamined.

The contrasts summarized in *Table 7* reinforce participants’ perception that DSRP Therapy operates at a fundamentally different level of analysis than traditional psychotherapies. Whereas most schools focus on the *content* of thought—beliefs, memories, or emotions—DSRP Therapy centers on the *form* and *organization* of thinking itself. This distinction was not imposed by theory but articulated spontaneously across interviews: therapists described DSRP as “reorganizing thought,” “client-centered,” and “its own entity.” In practice, this shifts the therapist’s role from interpreter to co-architect of cognition, using mapping and alignment rather than narrative interpretation as the vehicle for change. At the same time, participants saw this difference as complementary, not oppositional: DSRP can integrate within any modality as its structural backbone. The data therefore support DSRP Therapy’s emerging identity as both a meta-framework and a distinct paradigm—structurally unifying but methodologically unique.

Synthesis

Viewed together, the quantitative distributions and qualitative excerpts depict a consistent pattern: therapists perceive DSRP as a structural meta-framework that both complements and transcends their current modalities. They report broad applicability and conceptual coherence while emphasizing a need for translation infrastructure—the pedagogical bridge from structural theory to live clinical practice.

These findings inform the next stage of DSRP Therapy development: defining standards for training design, mapping fidelity, clinical supervision, and credentialing, thus advancing from theoretical existence to operational practice.

Discussion

1. Overview of findings

This pilot study examined how licensed therapists, after completing introductory DSRP training (White Belt + Yellow Belt), understand and apply structural cognition to their therapeutic thinking. Using both structural and thematic analysis, the study generated convergent evidence across all three hypotheses.

Participants described DSRP as structurally clarifying, conceptually distinct, and practically promising, but also as pedagogically incomplete for immediate clinical application. Their reflections reveal a clear pattern: the obstacle to practice adoption is not skepticism or incompatibility, but the translation gap between *knowing the structure of cognition* and *using it fluently in session*.

2. DSRP as a structural supplement (H₁)

The first hypothesis—that DSRP provides additive structural value to existing therapies—was strongly supported. All participants articulated new ways of organizing or clarifying cognition, often referencing the Six Moves (e.g., *Zoom In/Out*, *Is–Is Not*, *RDS Barbell*). They identified improvements in conceptual framing and client understanding, describing DSRP as a “scaffold,” “lens,” or “architecture” that deepens their existing modality without displacing it.

The clinical range cited—anxiety, depression, trauma, OCD, relationships—suggests that DSRP principles are not disorder-specific but structure-specific. This universality is consistent with the theoretical claim that DSRP operates at the level of organization (O) rather than content (I). Therapists’ spontaneous application of DSRP concepts in discourse indicates *existence evidence* for structural cognition: even minimal exposure led to detectable structural talk, including boundary-making, perspective-taking, and recursive reasoning.

The implication is that DSRP can serve as a meta-therapeutic grammar—a universal cognitive syntax that enhances clarity, precision, and integration across modalities.

3. DSRP Therapy as a distinct paradigm (H₂)

The second hypothesis predicted that DSRP Therapy constitutes a distinct therapeutic paradigm. The data partially but meaningfully confirm this distinction.

Participants compared DSRP favorably to CBT, DBT, EMDR, and mindfulness approaches, citing overlap in intent (“helping clients think differently”) but difference in mechanism. Three participants explicitly identified DSRP as a “standalone” or “its own structured modality.” What differentiates it is not its goals—clarity, change, or insight—but its operational focus on cognitive structure: thinking as an object to be mapped, mirrored, and reorganized.

Therapists perceived this focus as qualitatively different from interpretive, narrative, or skills-based methods. The *object-oriented* and *structural mirroring* aspects—mapping mental models, compressing them into structural anchors, and realigning them against reality—were seen as novel and compelling, though still aspirational. This confirms that DSRP Therapy has crossed the conceptual threshold from “adjunct framework” to “emergent paradigm,” with its distinctiveness lying in *method*, not *content area*.

The finding also validates DSRP Therapy’s nonpathological and nonjudgmental stance. Participants recognized its emphasis on the client’s mental model and the neutrality of structure (“It is all on the client... working through their mental model”). This aligns DSRP Therapy with post-diagnostic, realist approaches—scientifically grounded yet value-neutral.

4. Competency requirements and professionalization (H₃)

The third hypothesis—focused on therapist competencies—was the most empirically rich. Participants converged on the same four domains of readiness required for DSRP Therapy practice:

1. **Structural relevance recognition** – seeing cognition’s organization as therapeutically central;
2. **Conceptual fluency** – understanding DSRP patterns and the Love Reality Loop (LRL);
3. **Mapping skill** – the ability to externalize and reorganize thought visually and linguistically;
4. **Reflexive metacognition** – awareness of one’s own mental models during sessions.

They also emphasized the need for pedagogical support: short, modular, visual training; modeled therapist sessions; supervised practice; and assessment through the Thinking Quotient (TQ). These align closely with the proposed DSRP Therapy Standards (S1–S7) developed in parallel from these findings, which specify the format and scaffolding required for professional competence.

The convergence of practitioner feedback around these competencies represents a bottom-up definition of professional standards—one derived from lived practitioner experience rather than top-down theoretical extrapolation.

5. DSRP Therapy and the state of the field

The findings reinforce an emerging consensus in psychotherapy research that meta-frameworks of cognition—not just techniques—will define the next generation of therapeutic science. DSRP Therapy aligns with broader calls for:

- **Transparency and co-construction:** Making cognition visible rather than interpreting it;
- **Nonpathological framing:** Treating thinking as functional structure, not a symptom;
- **Systems-based practice:** Integrating dynamic, recursive, and perspective-aware reasoning into session work.

Unlike many integrative therapies, DSRP Therapy does not blend techniques; it provides a meta-structure into which any technique can fit. This makes it both complementary to, and independent from, existing schools of clinical therapeutic practice.

In this sense, DSRP Therapy parallels the role of systems thinking in organizational science because it provides the grammar of structure beneath diverse forms of content. This study provides the first empirical evidence that licensed therapists can perceive and articulate that grammar after limited exposure. In practical terms, DSRP Therapy centers on two recursive actions: making thinking visible and testing its structure against lived reality. Every therapeutic technique can fit within this cycle, but the cycle itself is the mechanism of change.

6. Limitations and boundaries

Several limitations are inherent to the design. The sample (N=5) was small and homogeneous in professional status (licensed U.S. therapists). Data were reflective and self-reported rather than observational of client work. All participants completed general DSRP training, not DSRP Therapy certification; therefore, findings reflect conceptual rather than performance competence.

No outcome measures were collected, and the structural coding of D, S, R, and P was descriptive rather than quantified by density or simultaneity. The results therefore constitute existence and perception

evidence, not efficacy data. Future studies should pair structural coding with behavioral observation and pre/post client outcomes using the TQ instrument and adjunct validated scales.

7. Implications for next-stage development

The results specify both *what works* and *what's missing* in translating DSRP into clinical practice:

Stage	Practitioner-identified need	Next-step development
Orientation	Clear entry point and roadmap	“Start Here” modules and clinician belt map
Comprehension	Short, visual lessons	≤8-min micro-learning design
Translation	Therapist-modeled examples	Annotated demo sessions (individual, couple, group)
Practice	Repetition and feedback	Structured drills; supervision rubrics
Implementation	Protocols per setting	Flow templates and on-ramp scripts
Measurement	Use of TQ pre/post	Integrated assessment and progress dashboards
Access	UX and affordability	Bookmarking, clinician fast-track pricing

Together, these components define a *pedagogical architecture* for DSRP Therapy credentialing—bridging theoretical cognition to measurable clinical skill. These steps map directly to a certification arc: orientation modules, skill drills with feedback, supervised mapping sessions, and documented competence on TQ and session artifacts.

8. Toward a professional standard

The cumulative evidence across H₁–H₃ suggests that DSRP Therapy is both existentially valid (it describes real cognitive structures observed in therapist reasoning) and functionally emergent (therapists recognize its potential to change clinical work). The next challenge is institutional: to build standards, supervision models, and certification systems that ensure structural fidelity and ethical transparency.

DSRP Therapy's defining feature—thinking as structure rather than story—requires a professional culture that values *visible cognition* over *interpretive expertise*. This transition mirrors paradigm shifts seen previously in behaviorism and cognitive therapy, where language, mapping, and measurement replaced intuition as scientific anchors.

If that trajectory holds, DSRP Therapy represents the next structural phase of psychotherapy's evolution: not merely *about* cognition, but *of* the construction of cognition itself.

Table X. Comparing Frameworks: DSRP Therapy vs. Traditional Approaches Structural contrasts between DSRP Therapy and major psychotherapy paradigms. Table presents conceptual contrasts, not verbatim participant quotes.

Framework	Primary Focus	Therapist Role	Method of Change	View of Client	DSRP Contrast
Cognitive Behavioral Therapy (CBT)	Identifying and challenging irrational beliefs	Instructor / lead	Cognitive restructuring through reframing	Client as rational actor with thoughts needing correction	DSRP examines <i>how</i> beliefs are structured, not whether they're rational; mirrors structure, not content.
Psychodynamic Therapy	Uncovering unconscious drives and conflicts	Interpreter / analyst	Insight through interpretation and analysis	Client as subject of hidden processes	DSRP avoids interpretation; makes thinking explicit and shared. Bring awareness to invisible structures.
Humanistic / Person-Centered Therapy	Empathic support and unconditional positive regard	Supportive listener	Growth through self-awareness and acceptance	Client as inherently good and self-directing	DSRP maintains empathy but adds structure and metacognitive visibility.
Behavioral Therapy	Conditioning and behavior modification	Behaviorist / coach	Changing observable actions	Client as learner	DSRP focuses upstream—on how cognition structures behavior, not just observable outcomes.

Systems / Family Therapy	Patterns of interaction among individuals	Observer of group systems	Reorganizing relational patterns	Client as member of social system	DSRP internalizes systems thinking— every mind is a system of parts and perspectives.
DSRP Therapy	Structure of thought (organization of information)	Structural mirror / collaborator	Making thinking visible and reorganizing it through DSRP patterns	Client as co-thinker, capable of reorganizing cognition	Transparent, nonpathology-based, results-oriented; focuses on alignment between mental models and reality (M/R).

Conclusion

This exploratory pilot study provides the first empirical insight into how licensed therapists conceptualize and integrate the principles underlying DSRP Therapy, a structural, systems-based, and realist method that aims to make cognition visible and reorganizable in real time. After completing introductory DSRP training (White and Yellow Belt), participants uniformly recognized DSRP's potential to clarify and unify therapeutic thinking. Participants described DSRP as both a supplemental cognitive architecture that enhances existing modalities and a distinct emerging paradigm that reframes therapy around the organization of thought itself.

Crucially, therapists did not question DSRP's theoretical validity or clinical relevance. Instead, they identified a pedagogical and practical gap—the bridge between conceptual knowledge and clinical application. They called for concise, visual, and therapist-modeled training; structured opportunities for guided practice; explicit session protocols; and pre/post measurement using a standardized assessment through the Thinking Quotient (TQ). These practitioner-derived insights delineate the competencies required for DSRP Therapy practice and define the foundations for formal training, supervision, and credentialing standards.

Within the limits of a small, qualitative sample, the findings offer compelling *existence evidence* that structural cognition can be perceived, articulated, and valued by practicing clinicians after limited exposure. The data also provide a *requirements specification* for DSRP Therapy's professionalization: standards that are transparent, measurable, and empirically grounded.

Future research should move from perception to performance—testing DSRP Therapy in live sessions with outcome measures, fidelity tracking, and longitudinal skill assessments. If subsequent studies confirm that aligning the organization of thought ($M = I \cdot O$) with the organization of reality ($R = I \cdot O$) produces measurable therapeutic change, DSRP Therapy will represent not only a new model of psychotherapy, but a new science of thinking in practice.

References

1. Cabrera D, Cabrera L. From one cause to webs of causality. *Systems*. 2025;13(7):1-20. doi:10.3390/systems13070510
2. Cabrera D, Cabrera L. The structure of thought and reality: empirical evidence for the three universal laws linking mind, matter, and meaning. *Journal of Systems Thinking*. 2025;5(1):1-20. doi:10.54120/jost.v25i1.dc6smio6
3. Cabrera D, Cabrera L. The grammar of reality: The organizing principles of structure and emergence. *Journal of Systems Thinking*. 2025;5(1):1-18. doi:10.54120/jost.2025-000003
4. Cabrera D, Cabrera L. From DSRP theory to o-theory. *Journal of Systems Thinking*. 2025;5(1):1-8. doi:10.54120/jost.v25i1.dc6dtot6
5. Cabrera D, Cabrera L, Cabrera E. A literature review of the universal and atomic elements of complex cognition. *Journal of Systems Thinking*. 2023;3(1):1-85. doi:10.54120/jost.0000032
6. Cabrera D, Cabrera L. Any person, any study: a different kind of theory of everything (ToE). *Journal of Systems Thinking*. 2023;3(1):1-14. doi:10.54120/jost.0000030
7. Cabrera D. The Unified Calculus of organization, structure, emergence, and meaning: the patterns that connect mind and nature. *Journal of Systems Thinking*. 2025;5(1):1-41. doi:10.54120/jost.2025-000002
8. Cabrera D. A mathematical theory of organization: DSRP as universal code of mind and nature for organizing, evolving, and understanding information. *Journal of Systems Thinking*. 2024;4(1):1-23. doi:10.54120/jost.00000100
9. Cabrera D, Cabrera L, Cabrera E. Distinctions organize information in mind and nature: empirical findings of identity–other distinctions (D) in cognitive and material complexity. *Systems*. 2022;10(2):1-35. doi:10.3390/systems10020041
10. Cabrera D, Cabrera L, Cabrera E. Systems organize information in mind and nature: empirical findings of part-whole systems (S) in cognitive and material complexity. *Systems*. 2022;10(2):1-36. doi:10.3390/systems10020044
11. Cabrera D, Cabrera L, Cabrera E. Relationships organize information in mind and nature: empirical findings of action–reaction relationships (R) in cognitive and material complexity. *Systems*. 2022;10(3):1-43. doi:10.3390/systems10030071
12. Cabrera D, Cabrera L, Cabrera E. Perspectives organize information in mind and nature: empirical findings of point-view perspective (P) in cognitive and material complexity. *Systems*. 2022;10(3):1-40. doi:10.3390/systems10030052
13. Cabrera D, Cabrera L, Cabrera E. The “fish tank” experiments: metacognitive awareness of distinctions, systems, relationships, and perspectives (DSRP) significantly increases cognitive complexity. *Systems*. 2022;10(2):1-34. doi:10.3390/systems10020029
14. Cabrera D, Cabrera L. The pareto structure of thought - empirical discovery of the six foundational mental moves. *Journal of Systems Thinking*. 2025;5(1):1-40. doi:10.5120/jost.v25i1.dc6par6

15. Di Marco G, Cabrera D. Common biases in systems thinking. *Journal of Systems Thinking*. 2024;4(1):1-43. doi:10.54120/jost.2025-000005DC
16. Aljrarri W'ad, Bustamante J, Ingwell A, et al. New hope for policy schools: examining systems thinking solutions to improve policy education. *Journal of Systems Thinking*. 2024;4(1):1-61. doi:10.54120/jost.00000101
17. Cabrera D. Critical thinking: Broken by design: Diagnosing the flaws in our most trusted cognitive tool. *Journal of Systems Thinking*. 2025;5(1):1-18. doi:10.54120/jost.2025-000004
18. Cabrera D, Silberman D, Cabrera L. Popularity without proof. *Journal of Systems Thinking*. 2025;5(1):1-29. doi:10.54120/jost.2025-000001
19. Cabrera D. *Systems Thinking*. Cornell University; 2006.
20. Cabrera D. Method of teaching thinking skills and knowledge acquisition. *US Patent*. Published online 2008.
21. Cabrera D. Systems and methods of mapping, transforming, and sharing data and ideas. *US Patent*. Published online December 14, 2021.
22. Cabrera L, Sokolow J, Cabrera D. Developing and validating a measurement of Systems Thinking: The Systems Thinking and Metacognitive Inventory (STMI). *Journal of Systems Thinking*. 2023;3(1):1-43. doi:10.54120/jost.0000042