ON THE FUNCTIONS OF THEORY IN PSYCHOTHERAPY [1][1]

I. THE STRUCTURE AND FUNCTIONS OF TREATMENT-THEORIES

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I.

Today and in the presentations that will follow I want to engage in a conversation about the diverse functions of theory in psychotherapy and psychotherapy research. I have been led to this topic in several ways. Chief among them is the fact that about five years ago, in the course of preparing a review of process-outcome research, I found myself beginning to have a theory of psychotherapy. The theory, such as it was, evolved through many discussions with my long-time collaborator and friend Ken Howard, and we called it (for reasons that I shall eventually explain) the 'generic model' of psychotherapy. The problem that I found myself having with this theory is that it seems to be different in nature from other theories of therapy that I know. It differs from other theories primarily in not proposing how therapy ought to be done, but in concentrating rather on understanding how therapy is done when it is done effectively. The 'generic model' also differs from other theories in that it is based primarily on research findings rather than directly on personal clinical experience, and it aims primarily to explain some of the apparent paradoxical effects in those research findings -- such as the 'outcome equivalence paradox' described in 1975 by Luborsky, Singer & Luborsky (1975) and in 1986 by Stiles, Shapiro & Elliott (1986). I have thought more and more about this difference in the several years since the 'generic model' was first presented (Orlinsky & Howard, 1985). I have also thought in a more differentiated way about the model itself,

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stimulated by the comments and questions of colleagues and students. At the same time, I have also been wondering how the 'generic model' fit with a number of other theoretical interests, like my persistent worry about what I call the problem of 'time-frames' in observations of therapeutic process and outcome (e.g., Orlinsky, 1988). At the present time I find myself searching for a clearer awareness of how these themes and theories fit together. You may understand, then, how welcome an opportunity it was when Professor Kächele offered me a chance to spend some time with you in Ulm. To make the most of this opportunity, I conceived a series of presentations in which to discuss these newer thoughts and developments systematically with a distinguished group of active researchers, who at the same time have a distinctive (and to me, congenial) approach to clinical practice. My general theme throughout shall be the functions of theory in relation to psychotherapy. In this first presentation, I shall draw a distinction -- a functional, not an absolute distinction -- between two kinds of theory, which I call treatment-theory and research- theory. [By the term 'treatment-theory' I mean something more inclusive and macroscopic than the highly specific 'working models' of Greenson (1960) or the clinician's 'minimodels' studied by Meyer (1988), to which I shall refer at a later time.] I will go on in this first presentation to describe the general structure and functions of treatment-theories, and in the second presentation I will discuss the general structure and functions of research-theories. In the third presentation, I will focus specifically on the 'generic model' of psychotherapy as one concrete example of a research- theory. Finally, as time permits, the fourth presentation will explore another aspect of research-theory that, if correctly understood and applied, should help psychotherapy research do greater justice to the subtlety and complexity of the clinical process.

II.

The relation of theory to therapeutic practice, of course, is particularly apt as a topic for discussion with colleagues in Ulm, since it is a topic to which the good masters of Ulm, Professors Thomä and Kächele, have already in 1975 and again in 1987 given much deep thought (Thomä & Kächele, 1975, 1987). My discussion of this subject has

benefited considerably from reading their work. However, the relation of theory to practice is a vast topic, and I propose here to discuss only one specific point: to distinguish, as I said, between the two kinds of theory to which therapeutic practice may be related. Basically, a theory is a way of talking about some thing, a form of discourse. As such, theory is framed and focused in terms of the realm of discourse for which it is intended. By the phrase 'realm of discourse' I refer to what semiotic theory (Morris, 1938) denotes as the 'pragmatic' aspect of meaning, in contrast to the semantic and syntactic aspects. A 'realm of discourse' is defined by the social identity of the discussants and audience, by their business or purposes, and by the situation in which it is discussed. Accordingly, a theory may have rather different characteristics when used in two different realms of discourse, even though (from a semantic viewpoint) they ultimately have a common referent. Regarding the theory of psychotherapy, the distinction I propose is one between treatment-theory and research-theory. Both are kinds of discourse about psychotherapy and, if we enjoyed inventing new words, we might refer to them together as 'psychotherapology' -- the logos of psychotherapy. The specific realm of discourse in which treatment-theory of therapy functions most appropriately is that of clinical practice. The realm of discourse in which research-theory of therapy functions most appropriately is that of scientific investigation -- which, as Thomas Kuhn (1962) made clear, is also a form of practice. The subject matter of both is the same, so the treatment-theories and research-theories of psychotherapy ultimately must be related as discourses about psychotherapy (or 'psychotherapzology'). However, their functions are so different that there is nothing to be gained, and much to be lost, by confusing them with one another. Treatment-theory, as I said, is theory about psychotherapy in a clinical context. One must have a treatment-theory in order to deal with patients. Treatment-theory guides the psychotherapist's professional activities. To become a therapist, one must acquire a workable treatment-theory. To train practitioners in the art of therapy, one must offer a treatment-theory that others can understand, assimilate and apply. Research-theory, on the other hand, is theory in the context of investigation. One needs a research-theory of psychotherapy in order to engage in scientific studies of therapeutic phenomena. Research-theory guides the researcher's scientific activities. To be an effective researcher, one must have a research-theory that is grounded in the findings of

previous studies, and that suggests specific research questions which are both interesting and soluble. Both treatment-theory and research-theory are action-oriented, but are directed towards different kinds of activity and address different 'problematics.' The problematic to which treatment- theory addresses itself is 'what to do' and 'how to do it' with patients. People come to therapy as patients because they are persuaded that there is something 'wrong' with them, something that they do not understand and cannot fix. They consult therapists to find a kind of help that goes beyond what common sense and the bonds of friendship can provide. The professional therapist's treatment-theory holds the key to that extra measure of help, in ways that emanate from, and relate meaningfully to, the work of a community of professional healers. The problematic to which a research-theory of psychotherapy addresses itself is action of a different sort. The action in question is not the conduct of treatment but the conduct of inquiry. The actor in question is not a therapist but a researcher (who, of course, may be and often is a therapist at other times, in other situations). The function of research-theory is, first of all, to help the investigator raise interesting questions for study. Without this, researchers would not have sufficient intrinsic motivation to sustain them through the time-consuming and often tedious labor involved in scientific research. Furthermore, scientists are motivated not only by individual curiosity but typically also by a strong desire to communicate with colleagues. To practice science is tantamount to being an accepted member of a scientific community. Every study starts with a review of relevant work previously done by other members of the research community, and interprets its new findings in relation to the work of others. In addition to formulating questions, then, a second major function of research-theory is to connect the findings of many studies into an established body of knowledge. The main point I want to make is that research on psychotherapy is just as much a form of praxis as is psychotherapeutic treatment. They are different, even though intimately related endeavors. Practitioners of treatment and practitioners of research operate in different contexts and communicate in different realms of discourse. There is much value in pursuing them both, but little to be gained by confusing the two. If I could have my way, I would make every psychotherapist a psychotherapy researcher, and every psychotherapy researcher a practicing clinician. However, to grasp the nature and extent and consequences of the difference between treatment-theory and research-theory, one need only think about the different kinds of

training that it would take to make both an effective clinician and an effective researcher. In the presentations that come after this, I propose to focus mainly upon research-theory and its relation to the investigation of psychotherapy. To begin, however, I want to describe as clearly as I can what I conceive to be the general structure and function of both research-theories and treatment-theories of psychotherapy. If I can do this, we should be then understand what each type of theory is best suited for. We should no longer confuse the distinct but complementary realms of discourse in which they operate, and should be able to use each more effectively in its proper context. Finally, by recognizing that clinicians and researchers in effect talk different languages that only sound the same, we should ultimately enable them to discuss therapy with each other more meaningfully.

III.

The possession of a treatment-theory, and the ability to use it, is perhaps the distinctive feature of a 'professional' therapist -- along with recognized standing in a community of professional healers. Without some kind of treatment-theory, one is simply an amateur. One may be a very talented amateur, very helpful to troubled friends and neighbors, but without a treatment-theory one is ill-equipped to talk about what one does or to reflect about it consciously to any extent. Even concepts of 'spirit possession' and their associated rituals of exorcism may legitimately be regarded as parts of a therapeutic treatment-theory, as the ethnographic literature suggests. It is in this sense that some scholars have described the infamous text of medieval inquisitors, the Malleus Maleficarum of Kramer and Sprenger (1486/1948), as a treatise on the theory of 'sacramental medicine' (Clebsch & Jaekle, 1964). A definition this broad has the advantage of allowing us to give serious consideration to continuities between the ethnographic research literature on psychological healing and the quantitative psychological research literature on psychotherapy (a possibility I hope explore at a later time). A definition this broad also invites us to clarify the essential difference between the therapeutic treatment-theories of modern psychotherapy and those found in shamanism, religious healing and traditional folk medicine (Kakar, 1983). The fact

that sets modern psychotherapy apart from other forms of psychological healing is that modern treatment-theories seek scientific warrant. Unlike their predecessors, these treatment- theories base their claims to validity on their scientific credibility, rather than on magical power or divine dispensation. Moreover, the legitimacy of modern psychotherapeutic practitioners is almost uniformly associated with some degree of scientific training. Just which science is most relevant for this purpose is, of course, a matter of dispute. Naturally enough, psychiatrists who practice psychotherapy and analysis have been inclined to find training in biomedical science an excellent preparation, while clinical psychologists have argued that training in behavioral and cognitive research is more relevant, and clinical social workers proceed with their work on the assumption that the social sciences provide the most appropriate framework for practice. In the early '70s, some visionaries -- such as Henry, Sims & Spray (1971) and Holt et al. (1971) -- wrote hopefully of the prospects for fusion of these sciences into a unified psychotherapeutic profession. The point I wish to make here is simply that no modern treatment-theory would be credible, either to practitioners or to the public, without a science of some sort on which to basis its claim to validity. Lest I seem to be erasing the distinction that is my basic thesis, I hasten to emphasize that I have set quotation marks around the term 'scientific.' I do not believe that modern psychotherapies are very well grounded in systematic scientific research on treatment process and outcome. What I am saying is only that modern therapeutic treatment-theories must claim to be scientifically founded, in some sense or other; that, in support of these claims, modern treatment-theories typically use imagery drawn by metaphor or by analogy from various fields of physical or biological science; and, finally, that they seek to legitimate themselves socially by reference to the symbolic authority and cultural prestige of [S] Science. Again, to avoid confusion let me immediately add that I certainly don't regard the modern psychotherapies as necessarily 'unscientific,' or on the same plane as shamanistic or mystical practice. A commitment to careful, systematic observation is common to all the sciences, and so the modern psychotherapies have given rise to a richly detailed descriptive literature. Shamans and mystical healers may excel in their use of intuition, but they do not write case histories. Modern treatment-theories also appear to be 'scientific' by limiting their explanatory constructs to 'naturalistic' causes, avoiding all reference to traditional concepts of 'spiritual' or

'supernatural' forces and beings. Indeed, from psychoanalysis to behaviorism, many theories have espoused 'physicalist' and 'materialist' conceptions of psychical functioning in order to counteract the idealism associated with 19th century philosophy and religion. Finally, it is not out of place at this point to note that the field of psychotherapy research undoubtedly owes its origin to the fact that modern treatment-theories aspire to meet the standards of scientific discourse. As the demands of science became in this regard became clearer, some clinicians also started to understand that the empirical grounding of practice required more than case studies, and pioneered the use of new observational methods such as audio recording and the application of psychometric survey techniques. What I mean to say about the current scientific standing of therapeutic treatment-theories generally is no more and no less than what Thomä and Kächele (1987) said about psychoanalytic practice: 'A fully formulated technology of psychoanalysis -- as yet there is none -- would have to demonstrate a sufficient degree of applicability, usefulness and reliability for therapeutic practice' (p. 364-5). The important phrase here is: 'as yet there is none.' How, then, do modern treatment-theories of psychotherapy operate? What is it that treatment-theories contribute to therapeutic practice, and how do their claims to being scientific help in this? Further, if they are really scientifically valid, how can there be so many of them making such conflicting recommendations about how treatment should be conducted? Finally, given their number and competing claims, what is a proper approach to evaluating treatment-theories? To answer these questions we must examine the functions and organization of psychotherapy treatment-theories more closely. These treatment-theories guide practitioners, on the one hand, by giving them a general orientation to the matters with which they must deal (formulated scientifically in terms of 'psychopathology' and 'personality'). On the other hand, they provide psychotherapists with specific strategies for operating in particular clinical situations. Because of this dual functional, we may regard the structure of treatment-theories of psychotherapy as consisting of two parts. I would call the first, most general part a 'philosophical anthropology.' By this I refer to a set of more or less coherent assumptions concerning the nature of the psyche and the vicissitudes of personal life. Although they are usually made to sound scientific, these are not to be understood as scientific propositions in the operationally definable sense required by research-theory. They are actually collective

images of human nature and human potential which organize personal experience, linking individual identities to group identity and endowing them thereby with a socially supported sense of meaningfulness and worth. Every treatment-theory has such a philosophical anthropology, although various schools of clinical practice have given theirs a more or less sophisticated formulation. The second part of every treatment-theory is a psychotherapeutic technology; that is, a compendium of specific of what Goldfried (1980) has called 'change principles,' whose function is to help the therapist identify opportunities for clinical intervention and chose
be formulated as 'rules' of therapeutic procedure; for example, the complementary rules of free-association and evenly-hovering attention in psychoanalytic therapy. My impression is that the two principal components of treatment- theories I have distinguished correspond fairly closely to the two kinds of technological theories, substantive and operational, proposed by Bunge (1967). As described in 1987 by Thomä & Kächele (p. 363): "Substantive technological theories are usually the fruit of the theories of pure science and adopt from them structural elements which, while regularly subject to conceptual coarsening and impoverishment, thereby gain in practical utility. Operational technological theories, on the other hand, refer to the practical act itself. They lend themselves to the development of strategies for the formulation of recommendations for effective action." That is, the 'philosophical anthropology' component of therapeutic treatment-theories corresponds to what Bunge called the 'substantive' type of technological theory, while the 'change principles' component of treatment-theories corresponds to what Bunge termed 'operational' technological theory. A more detailed structural analysis of treatment-theory is presented in Figure 1 [2].

Figure 1: Structure and Functions of Psychotherapy Treatment-Theory

The philosophical anthropology of modern treatment-theories logically consists of interrelated representations of personality and psychopathology. For the therapist, these define basic human nature and the basic problems to which human nature is vulnerable,

giving therapists a set of orientating categories which function to assimilate what patients tell them. These representations also provide a critical orientation for patients as well, through the interpretations and attributions offered to them by their therapists. Their cognitive and emotional function is to domesticate the anomalous, anomic and egregious experiences of the patient -- functioning much like theodicies for the religious, as Max Weber (1922/1964) and Clifford Geertz (1973) have shown. As Bunge pointed out, these schemes draw their elements from more scientific research-theories of personality and psycho- pathology, although initially they may be relatively undifferentiated from the latter, and may even contribute vital conceptions to the latter, as was the case in psychoanalysis. One characteristic difference between research-oriented and treatment-oriented conceptions of personality and psychopathology is that research-oriented conceptions are anchored in the precise operational definitions provided by measurement instruments, while treatment-oriented conceptions are usually rich in metaphor. They are rich in metaphor because they address themselves to affectively significant aspects of personal life, and because their therapeutic efficacy depends to a large extent on their communicability and evocativeness.[3] Treatment-oriented conceptions of personality and psychopathology provide a broad 'symbolic canopy' (Berger, 1967), furnishing the therapist with latitudes and longitudes of global meaning to be spread out through discourse with the patient in the treatment setting and, through that, to enfold the patient's world of personal experience (Kleinman, 1988). These latitudes and longitudes of global meaning give the coordinates by which therapists and patients take their bearing in the confused and painful terrain of the patient's suffering. The next level of differentiation in Figure 1 provides a closer look at the content of these working conceptions of personality and psychopathology. A theory's 'psychopathology' consists of a scheme of problem-types and causal attributions regarding those problem- types; that is, of nosological and etiological constructs (in the familiar medical sense). The working conception of personality consists of assumptions about both the actual functioning and the ideal or optimal functioning of individuals. In some instances the category of 'actual functioning' may be further refined into a differential psychology of personality types, a dynamic psychology of motivation, and a psychological conception of human development. When these are made sufficiently specific, they may correspond more or less closely to parallel

research-theories in those domains. On the other hand, the working conception of ideal or optimal personality has no counterpart in research-theory. It projects cognitive norms, which may specify criteria for cure (e.g., non- hallucinatory, non-delusional ideation, or a preference for experiencing 'visions' and a belief in a God-given personal destiny); ethical norms, which specify moral criteria for handling oneself and others (e.g., a valuation of worldly success, or a commitment to treating other people as subjects in their own right rather than as mere objects); and esthetic norms, which specify standards of attractiveness in behavior (e.g., a celebration of emotional expressiveness, or a preference for disciplined self-restraint).[4] Figure 1 also illustrates how these operational strategies may be divided logically into two parts: (1) strategies for the formation and management of the treatment relationship, and (2) strategies for the implementation of treatment interventions. The treatment relationship, again, has both a formal, contractual aspect which is encoded in the reciprocal roles of therapist and patient, and an informal, personal aspect. The latter refers to such matters as are indicated by the 'controversial family of concepts' described by Thomä and Kächele (1987), that includes 'working alliance,' 'personal bond,' 'transference' and 'countertransference.' Patients present their complaints and narratives to their therapists in the context provided by the formal and informal aspects of the treatment relationship. The technical schemas in the therapist's change knowledge provide both (1) diagnostic procedures with which to identify opportunities for effective interventions, and (2) tactical procedures for implementing those interventions. For example, by instructing the patient to engage in free-association, the analyst is able to detect signs of resistance (through hesitations or parapraxes) and then to give a resistance interpretation. Similarly, Greenberg (1984) shows how gestalt therapy recognizes opportunities for intervention by signs of 'splitting' in the patient's self-experience, and utilizes the 'two chair' technique to resolve intrapersonal conflict through active self-confrontation. Functionally, the two main components of treatment-theory are linked in dialectical fashion by a benign causal circle. The constructs, attributions and values suggested by the therapist's philosophical anthropology help to organize the content of the patient's clinical communications and form them into a coherent discourse. At the same time, these general constructs must be adapted to many individual variations as they are applied in particular cases, and these elaborations and refinements lead to the gradual

evolution of the general constructs. Because of this, major shifts in the types of patients treated have often led to expansions or reformulations of existing treatment-theories. Examples of this include Adler, who opened clinics in order treat working-class patients; Jung, whose practice included more middle-aged patients; and Sullivan, Fromm-Reichmann and Searles, who worked with schizophrenics. Now that we have a more detailed conception of treatment-theory, let us return to the questions that were previously raised. I have already suggested some answers to the first question, which was 'how do treatment-theories of psychotherapy operate?' The remaining questions are: Why do modern treatment-theories advance claims to scientific status? How can there be so many different psychotherapy treatment-theories? How ought these diverse treatment-theories to be evaluated? The answers to these questions would require a lengthy digression about group psychology and its relation to cultural symbolism, about the function of healing in traditional societies, about the peculiar characteristics of modern Western culture and the special role of Science in this culture. At the moment, I can only present a few ideas, taken out of their proper context, as a promissory note for a fuller discussion in the future -- hoping nevertheless that they will be intelligible. Here, then, are my proposed answers to the three remaining questions. First, psychotherapy treatment-theories must claim the authorization of science because they depend on the cultural authority of Science [capital-S] to evoke belief, or at least the 'suspension of disbelief' -- and an essential part of their effectiveness derives from their ability to command belief (Frank, 1974). Treatment-theories must claim the authority of Science not matters of common sense. As Geertz (1983) has noted, the cultural categories of common sense apply to the 'surface' of everyday life, but the concerns that people who come as patients bring to therapy elude and confound common sense. Whatever agrees with common sense is readily believable without further proof or question. However, attributions that go beyond common sense categories require special explanation in order to command belief. Providing such explanations in terms that are persuasive to patients and, a fortiori, to therapists, is a major task confronting every treatment-theory. Now, psychotherapy is a rigorously secular form of psychological healing. Viewed demographically, the main appeal of psychotherapy is to the educated, largely urbanized, secular (or liberally religious) sectors of contemporary societies (Orlinsky, 1989a). These culturally 'modern' segments of the population accept a naturalistic view

of the cosmos as a matter of course. For them, ultimate reality (by which I mean the reality that transcends the common sense categories of everyday life) is defined by the physical and biological sciences, i.e., by what is taught in school and by popular presentations of those sciences. For this public, in effect, scientists have displaced priests as those possessing special access to the reality that lies beyond what is disclosed by common sense alone. If treatment-theories are to be persuasive for this public, they must be couched in terms derived from or at least compatible with the authorized worldview of Science. As to the second question: the reason why there are so many different treatment-theories, all claiming to be 'scientific,' is located in another prominent feature of 'modern' culture. Modern culture is highly differentiated, like the societies which it shapes and reflects. This is true both at the macrosocial level, in terms of the differentiation between subcultures, and at the microsocial level, in terms of the emphasis placed on individuation and the differentiation of individual identity. Subcultures in modern society are differentiated by social class, occupational group, cultural level and ideological orientation, superimposed upon and progressively effacing the traditional distinctions of age, gender, kinship, region and religion. Types of personal identity are similarly differentiated. Because of this, various versions of the basic belief and value orientations have evolved in modern culture, each adapted to a distinctive combination of subculture and identity-type. The element of therapeutic treatment-theory which is most subject to this differential subcultural evolution is the 'philosophical anthropology,' that is, the theories' basic imagery of human nature and human vulnerability. To effectively serve the interrelated functions of communication, cohesion and control, the 'philosophical anthropology' of a treatment-theory must be resonant with the social 'lifeworld' and preconscious self- experience of both the patient and the therapist. Viewing treatment-theories instrumentally, I see no reason to worry, as many commentators have, about their proliferation and diversity. To some extent, that is a result of different therapists attempting to treat different types of patient and modifying or developing new change strategies and techniques. In so far as that is the case, of course, it ultimately enriches the whole therapeutic profession. To some extent, this diversification and proliferation of treatment-theories is a matter of their working-assumptions regarding personality and psychopathology. That diversity is more apparent than real, essentially an effect of phenotypic variation. As I have recently

argued elsewhere, the diversity of treatment- theories can be reduced to the permutation and combination of four basic genotypic images: therapy as a biomedical technique; therapy as an educational program; therapy as a correctional reform; and therapy as a mode of redemptive justification (Orlinsky, 1989b). Each treatment-theory contains all of these elements, but in varying blends and emphases. But to go a step further, if the distinction between the two functional types of theory is accepted, the conceptions of personality and psychopathology found in treatment-theories would no longer be required to meet the same criteria and serve the same functions that corresponding conceptions would in research- theories. The assumptions of treatment-theories about personality and psychopathology need only be reasonably congruent with the research findings that are generally accredited by psychological and psychiatric science. Instead, we may take the following idea as a hypothesis for our own research. Kurzweil (1989) suggests that 'every country creates the psychoanalysis it needs....' And just as every country invents the psychotherapy it requires, so each subculture and identity-type within it with a strong need for psychotherapeutic services will tend to evolve an array of treatment-theories that are suited to it. This now leads to an answer to the third question: How ought these diverse treatment-theories to be evaluated? Basically, the answer is that the various components of treatment-theories ought to be viewed formally as variables for research in relation to therapeutic process and outcome. As a set of prior beliefs, the therapist's treatment-theory is one of the factors that may have a role in shaping the therapeutic process. And, when functioning as categories in the dialogue between patient and therapist, the elements of treatment-theory should be regarded as process variables that may have a role in shaping the patient's clinical outcome. Both as a determinant of therapeutic process and as an element of process, I would conjecture that treatment-theories will be found to have interaction effects rather than to main effects. What I mean by this is that I think treatment-theories will be found to have little impact in their own right, but may well be a source of considerable efficacy in combination with other factors. To be effective, I think that a treatment-theory must, first of all, give symbolic structure and expression to the therapist's personal motivations for engaging in psychological healing; that its imagery of human nature, human vulnerability and human potential must tap into and focus the therapist's unconscious and preconscious urges to act in healing ways; that its diagnostic schema must allay the

therapist's anxieties about doing so; that its change principles must provide a medium and a guide for the therapist's conscious decisions about how to intervene responsibly in a patient's life. Secondly, given all this, I think that a treatment-theory must also give a correspondingly fitting symbolic structure to the patient's personal motivations for seeking psychological healing; that, in the way Levi-Strauss (1963) described shamanistic curing in the Cuna Indians of Panama, the imagery of the therapist's treatment-theory makes manageable poetry of the patient's inarticulate suffering. Now the treatment-theory that does this for one therapist and one patient may not do the same for another therapist, or another patient. So we may expect, I think, that the effectiveness of treatment-theories will be a complex function of the personal, emotional and cognitive styles of the therapist and the patient. However that may be, the proper criterion for evaluating the various elements of treatment-theories is a pragmatic one. As Thomä & Kächele (1987, p. 365) forcefully stated: 'The
success of the therapeutic practice employing the technology.' To paraphrase this for the broader case in question: the effectiveness of a treatment-theory ought to be judged by the success of the therapeutic practice employing it -- granted that the therapeutic success has been specifically related to what is distinctive about the treatment-theory. In other words, the validity of treatment- theories lies in the contribution they make to clinical practice, a contribution that needs to be formally evaluated by psychotherapy research. Having said this, I must of course turn to the complementary question of research-theory. How do research-theories differ in their structure and functions from treatment-theories, and what are their special functions in relation to psychotherapy? These are the questions that I shall discuss in my next presentation.

Notes:

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[2] Figure 1 is constructed as a hierarchical set of conceptual levels developed through a progressive series of binary distinctions, moving top to bottom from generality to specificity. At each level the simplest and most obvious distinction is sought. This has the advantage of allowing one to trace the chain of reasoning, and also to trace parallels and connections between each of the points in the hierarchy. Figure 2 is similarly constructed.

[3] In terms drawn from Habermas' analysis of speech-action, discourse in terms of treatment-theories simply presupposes objective validity (truth) and strives to enhance interpersonal and expressive validity (rightness and truthfulness), whereas discourse in terms of research-theories presupposes expressive and interpersonal validity and strives to maximize objective validity (Pusey, 1987).

[4] The philosophical anthropology of a treatment-theory contributes three of the parameters that I described long ago as the 'Therapeutic Belief-Value Complex' (Howard & Orlinsky, 1972, p. 619), viz.: 'a. human nature, or personality; b. human fulfillment, or ideal person; c. human vulnerability, or psychopathology.' A fourth parameter, 'therapeutics,' is addressed in the 'change principles' or operational component of treatment-theories. This operational component provides the procedural strategies and tactics that guide the therapist's actions in relation to particular patients. The ensuing interactions concretize the general symbolic orientations of the therapist's philosophical anthropology on a case by case, session by session basis.

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ON THE FUNCTIONS OF THEORY IN PSYCHOTHERAPY

II. THE STRUCTURE AND FUNCTIONS OF RESEARCH-THEORIES

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I.

I drew a distinction in my first presentation between two types of theory about psychotherapy, which I called treatment-theories and research-theories respectively. I argued that these two types of theories are different because they have different uses and operate in different contexts. Treatment-theories operate in the clinical context, and their function is to help therapists understand and intervene responsibly, and one hopes also helpfully, in the lives, thoughts and emotions of their patients. Research-theories of psychotherapy, on the other hand, operate in the context of scientific inquiry, and their function is to help researchers design interesting studies and understand the meaning of cumulative research findings. Having drawn that distinction, I then went on to examine the general structure and functions of psychotherapeutic treatment- theory in some detail. I pointed out that treatment-theories consist mainly of two parts. The first is a 'philosophical anthropology' that sets forth, if only by implication, a set of basic images and working assumptions about human nature, human vulnerability and human potential. These are not really scientific propositions susceptible to empirical disconfirmation, but rather a symbolic framework on the basis of which therapist and patient may develop a sense of therapeutic community, and through which they may learn to manage and transform the patient's suffering. The second part of treatment-theories consists of a set of 'change principles.' The 'change principles' guide the therapist's management of the therapeutic relationship and its situational frame, shape his interpretive construction of the patient's communications, and provide a repertory of intervention tactics. I ended with the idea, already stated in principle by Thomä &

Kächele (1987), that it would be best to evaluate various treatment-theories in terms of their contribution to the therapist's clinical effectiveness. To paraphrase those authors, 'the effectiveness of a psychotherapeutic technology is judged by the success of the therapeutic practice employing the technology.' This is really a different test than the sort to which scientific research-theories are usually subjected. A single strong empirical disconfirmation, reliably repeated, is enough to put a research- theory in crisis. A therapeutic treatment-theory, on the other hand, would have to be found invalid only if it did not help even a significant minority therapists to do effective treatment with some group of patients. In other words, from the point of view of evaluation, treatment-theories should be regarded as factors with a tet-to-be tested potential for determining therapeutic process and outcome. For this purpose at least, treatment-theories may be subsumed as a part research-theories, essentially as other aspects of treatment are formulated as variables to be studied. This is purely a practical matter, and takes nothing away from the dignity or independence of treatment-theories. Research-theories and treatment-theories do not exist in radically dichotomized knowledge domains that can have no connection, such as the Naturwissentschaften and Geisteswissenschaften. They are only functionally differentiated modes of discourse about psychotherapy, and ultimately belong to the larger but still incompletely realized realm of discourse in which researchers and clinicians will talk meaningfully to each other. As it is my purpose to contribute to the construction of that larger realm (which so far only has the awful name 'psychotherapology), I now present the counterpart to my analysis of treatment-theories, and will concentrate today on the general structure and functions of research-theories.

II.

Scientific research is a form of praxis carried on in and by communities of qualified practitioners. It is the collective activity of individual researchers and research teams in planning, observing, analyzing, interpreting, criticizing, improving. Research-theory is theory operating in this context of scientific investigation. It is the means by which scientists communicate about their studies in research publications, scientific conferences and informal conversations, the medium in which they reflect individually

through the internal monologue of thought. The distinction between research-theory and treatment-theory, therefore, is not identical with the traditional distinction between 'pure' and 'applied' theory. The distinction drawn by Aristotle between theoretical, practical and productive knowledge does not fit here. Research-theory is as practical, in its own sphere, as treatment-theory. Moreover, despite the influential historical role of philosophers such as Descartes (Toulmin, 1990) in establishing the intellectual dominance of modern Science, scientific research is no more like the contemplative search for clear and certain ideas than it is like the mystic's quest for ecstatic revelation. In my opinion (for what it is worth) philosophers who write about science have tended to overemphasize this contemplative aspect, and also its potential for arriving at certain knowledge -- possibly because the theological tradition from which Western philosophy derived historically had made 'correct belief' the key to personal salvation. The primary aim of research-theory is not so much, or so directly, the accumulation of 'true' knowledge as it is the devising of better research -- research that is more interesting, more precise and more controlled. For researchers, the 'truth' about things (in this case, about psychotherapy) should always be tentatively held, and should be regarded as a highly mutable by-product of research. Because research occupies so much of their time, active researchers tend almost to be more interested in the process of research than in its product. The ways in which research-theory contributes to the furtherance of research practice are indicated in Figure 1. There are two principal functions served by research-theories: generating research questions and hypotheses, on the one hand, and synthesizing research findings, on the other. The first may be called the interrogative function, and the second the interpretive function, of research-theory.

Figure 1: Structure and Functions of Psychotherapy Research-Theory

The 'interrogative function' can be divided logically into two aspects, concerning research questions and research methods, respectively. Research questions differ from questions in general language by the extent to which they are methodologically grounded; i.e., formulated in operational terms that specify how the answer is to be

found. To be 'researchable' in the empirical scientific sense, a problem must be formulated with explicit reference to observational procedures and standards of inference. A well formulated question implies the conditions for finding a determinate answer. Research problems generally are distinguished according to the specificity of the question being asked. Questions that admit of a 'yes-or-no' answer can be converted into the form of statement called a 'hypothesis' or 'prediction.' So called hypothesis-testing research involves studies designed to test whether 'under such- and-such conditions, so-and-so is the case about this-or-that.' The 'prediction' may be derived empirically from prior experience, or logically from a conceptual model. Observations consistent with predictions based on prior experience help to reinforce belief in the reliability and generality of the finding. Observations consistent with predictions logically derived from a conceptual model help to reinforce belief in the model's validity. Despite the prestige of hypothesis-testing research, not all researchable questions admit of a simple 'yes-or-no' answer. Particularly in the earlier stages of investigation into a phenomenon, research problems are more likely to be formulated in more open-ended terms, such as: 'What will these people do if we observe them in a certain situation?'; or, 'What will these people say if we ask them these particular questions?'; or -- more generally -- 'What will we find if we search by such-and-such means in that direction?' In contrast to hypothesis-testing research, studies guided by questions of this sort are referred to deprecatingly as mere as 'exploratory research.' Nevertheless, the findings of exploratory research can be scientifically quite valuable if their observational procedures are carried out systematically, and if the means and conditions of observation are adequately specified. The cumulative results of such studies prepare the ground for hypothesis-testing research -- in the short term by offering a basis for empirically- derived predictions, and in the long term by stimulating the development of data-based conceptual models. The present stage of development in the field of psychotherapy research effectively makes most of the studies that are carried out exploratory in nature, or at the best tests of empirically- derived hypotheses. Even when hypotheses apparently are adduced from therapeutic treatment-theories, they tend in essence to be predictions based on informally codified clinical impressions rather than predictions logically derived from a rigorously defined conceptual model. Figure 1 indicates that research-theory helps

investigators to generate researchable questions by focusing on methods as well as on substantive problems. It also suggests that research methods can be divided logically into observational and inferential procedures. 'Inferential methods' refer to issues of research design and statistical evaluation, and have been generally much explored by other writers. Over the past 40 years, discussions of research design applicable to psychotherapy research have been offered by such authorities as Edwards & Cronbach (1952), Rubenstein & Parloff (1962), Gottschalk & Auerbach (1966), Kiesler (1971), Gottman & Markman (1978), Karasu et al. (1982) and Kazdin (1986). For guidance in statistical evaluation, of course, most psychotherapy researchers use standard textbooks and statistical software packages, although writers such as Gottman & Markman (1978) and Grünzig (1988) have recommended specific models like time-series analysis as specially suited for therapy research. In the related area of 'observational methods,' psychotherapy researchers have devoted considerably more attention to the development of specific observational techniques than they have to questions of observational strategy. Concentration on the invention of quantitative and qualitative measurement procedures is probably natural in a relatively new (in Kuhn_s term, 'pre- paradigmatic') field of scientific study. That is because empirical inquiry cannot advance beyond impressionism without precise and reliable observational procedures. However, after a certain time the inevitable result is a vast proliferation of different measures, many purporting to measure the same or similar concepts (e.g., 'therapeutic alliance") but each used in only a few studies. The time has come to devote some thought to observational strategies as a means to reestablishing an intelligible order. There are two aspects of observational strategy that I think are particularly important in psychotherapy research. One is 'observational perspective,' which is essentially an extension of the familiar distinction between nonparticipant and participant- observation. The other is the 'temporal frame' of observation, by which I refer to the periodicity of phenomena of differing durations. In the context of psychotherapy research, the relevant 'observational perspectives' are those of the patient, the therapist, the diagnostician, the clinical supervisor, etc., as well as that of the external judge or rater who scores recorded or documentary material. As the field has developed, researchers have become more acutely aware of the fact that observations of therapeutic process and outcome might be reliable within a perspective,

yet quite divergent across observational perspectives. This need not seem strange. For example, from the viewpoint of social interaction theory -- whether it be role-theory or exchange- theory or symbolic interactionism -- there is no reason to suppose that all observing participants, let alone non-participant observers, will have equivalent access to the event in which they are joined. Because they have distinct roles and functions they will have distinctive interests and viewpoints. Some will notice one and some another aspect of the event. (In fact, the so-called 'event" cannot be defined from any one perspective alone, but only --in principle -- from all the perspectives of all the participants.) Moreover, each will have a unique perspective on those aspects of the event that are internal, like their physical sensations and unspoken thoughts. In addition, they will also have special cognitive disabilities corresponding, on the one hand, to their individual repressions; and, on the other hand, to that perennial human difficulty in 'seeing ourselves as others see us," which is due to the inherent 'egocentricity' of our perceptual apparatus. It is a mistake to regard this so-called 'method variance' as a form of error, or as an artifact that impeaches the quality of measurement. Rather, it is essential to recognize the inherent relativity of perception to the interactional vantage point and 'interest' of the observer, and to recognize the systematic effects of observational perspective in evaluating research results (Krause & Howard, 1976; Strupp, Hadley & Gomes-Schwartz, 1977). An application of this principle is to be found in the review that Ken Howard and I did for third edition of the Handbook of Psychotherapy and Behavior Change (Orlinsky & Howard, 1986), where we tabulated the findings of studies according to the observational

I hope in my last presentation to dwell at greater length on the important question of temporal frames of observation. For the moment I will only compare this to the effect of magnification on the field of vision in the use of optical instruments such as microscopes, telescopes and cameras. Low magnification gives a wide field of vision that permits the viewing of broad structural features which, at higher magnifications, are effectively invisible. By the same token, high magnification gives a narrow field of vision that permits the viewing of detailed structures that are invisible at lower magnifications. The range of intermediate levels of magnification between highest and lowest gives rise to a hierarchic concept of the scale of phenomena. Since it is the temporal dimension that is in question here, a closer analogy could be drawn from the comparison of high-

speed and time-lapse photography. With high-speed photography, events that are perceptually or attentionally subliminal can be recorded and studied. With time-lapse photography, events that are perceptually or attentionally supraliminal can be recorded and studied. In other words, there are phenomena that are too fast or too slow to be noticed, which can be brought within the range of observation by the use of appropriate procedures. This gives rise to a hierarchic concept of the duration of phenomena. Hierarchies of scale and duration are of critical concern in the formulation of observational strategies. In psychotherapy research, we need especially to become more aware of the level of the temporal hierarchy at which our observations are made, and we need to be aware of the dangers of comparing phenomena observed at widely separate levels of the temporal hierarchy. For example, we need to reflect that the use of tape-recorded sessions and transcripts inevitably draws our attention to the most microscopic aspects of therapeutic process. We also need to reflect that the determination of therapeutic outcome by the comparison of pre-treatment and post-treatment measures focuses on a much more macroscopic level. Such an awareness would lead us to question whether it is fair or realistic to compare temporally microscopic measures of process with temporally macroscopic measures of outcome. We must also ask ourselves whether there are not temporally macroscopic ways to measure process (for example, whole phases of treatment) and temporally microscopic ways to measure outcome (for example, by changes in day-to-day mood and behavior). Finally, we must begin to realize what a vast and vastly intriguing project it will be to systematically map the relations between the different temporal levels of observation regarding both process and outcome. These considerations illustrate some of the ways that I think a proper research-theory assists investigators in raising important and researchable questions. I turn now to the second major function of research-theory, which I referred to as 'interpretive.' The interpretive function is accomplished by synthetic construction both before and after the conduct of investigation. Before, it defines what may be observed; afterward, it explains what has been found. (This distinction applies to both single studies and to the whole set of studies constituting a particular field of research.) Logically at least, a prior condition of research is the selection of variables for study, some to be controlled experimentally or statistically and one or more to be left to vary freely. Practically speaking, however, only a relatively

small number of concurrent variables can be observed in any particular study. These must be selected from among the very large number of conceivable variables that are constitutive of, or possibly relevant to, the phenomenon in question. Making such a selection requires either explicit or intuitive reference to a taxonomy of the domains of variables from which the dependent and independent variables of a study can be selected. It also requires some criterion of relevance to guide the researcher's choice. After all, one can't do a study without some idea of the things that exist to be studied, and without some sense of what among these things it is necessary to include.

A taxonomy of variable domains provides researchers with a preliminary sketch-map of the territory it is their task to chart more systematically. Even a territory as well traveled as clinical practice has been by several generations of passing therapists requires the painstaking assessment of surveyors before its dimensions can be mapped with precision. (The idea of an interpretive map of variable domains resembles the concept of 'pre-understanding' in hermeneutic theory -- an initial prehension, based to a great extent on the observer's expectations, which provides an orientation to the field within which critical scrutiny can then be exercised.) One example of a taxonomy of variable domains is contained in the review Ken Howard and I contributed to the 2nd edition of the Handbook of Psychotherapy and Behavior Change (Orlinsky & Howard, 1978). The taxonomy presented is based on a general social scientific analysis of human interaction, and is broad enough to apply to any type of interactional events in any type of social situation. In relation to this scheme, psychotherapy is treated as one specific type of interactional event occurring in a particular sort of social situation. The generative distinctions in this taxonomy were based on two principles. The first differentiated between focal event-processes and their environing context, on analogy to the distinction between 'figure' and 'ground' made familiar by the Gestalt psychologists. The second differentiated between the physical, experiential, associational and symbolic facets of human interaction, based loosely on the four-fold model of social action advanced by Parsons & Shils (1954). The first distinction led to a formal differentiation of psychotherapy research variables into categories of 'input,' 'process' and 'output.' Process variables include everything that is directly involved in the events of therapy, as commonly understood among psychotherapy researchers. Both input and output refer to the functional relations between focal event-processes and their

environing context. Input refers to the prior state of the environing-context, i.e., to the determinants of process. Output refers to the subsequent state of the environing-context, i.e., to the consequences of process. What is the advantage to the researcher in all this abstract categorizing of variables? Specifically, the advantage lies in raising the researcher's awareness beyond what has already been studied to what might be studied. For example, 'outcome' is the concept that is customarily paired by psychotherapy researchers with process. Clinical outcome is generally understood to refer to the impact of therapeutic events on the personality and life- situation of the patient. Everyone studies either process or outcome, or the relation of process to outcome -- because in the beginning someone began this way, and ever since others have dutifully followed. In contrast to this, the taxonomy of variables complements 'process' with the pair of categories called 'input' and 'output.' Applied to therapy research, recognition of the category of 'input' variables raises the general question of what determines the particular events of therapy and their course over time. For example, the therapist_s treatment-theory may be regarded as one such 'input" variable. Similarly, recognition of the category of 'output' variables raises the general question of what the consequences of therapeutic events might be for all the varied aspects of the environing- context. In this light, clinical outcome -- the impact of therapy on the patient -- is only one of the possible consequences of psychotherapy. One may think about the consequences for the therapist as well, for the treatment setting, for the therapeutic profession, and for culture and society at large. The net effect is to liberate the thinking of researchers from the unconscious constraint of precedent. Another example of this liberating effect emerges from the second distinction in the taxonomy of variables, which led to an important refinement in conceptualizing event-processes and their environing-contexts. As shown in Figure 2, an event-process may be construed in terms of four facets: physically, as the behavior emitted and actions performed in the event; experientially, as the participants' consciousness of the event, including their consciousness of self as part of the event; associationally, as the forms of interpersonal relatedness that evolve through their behavior and awareness; and symbolically, as the communication, nonverbal as well as verbal, through which those forms of relatedness are constituted and expressed. The environing-context can also be interpreted in terms of the same four facets: physically, as the concrete persons who are participants in the

event (i.e., the particular patient and therapist); experientially, as their ongoing lives, their individual 'lifeworlds,' outside the focal event; associationally and symbolically, as the social institutions and cultural patterns of the community in which they live.

Figure 2: General Facets of Process and Context in Social Action

Facet	Physical	Experiential	Associational	Symbolic
PROCESS	Behavior	Consciousness	Relation	Communication
CONTEXT	Concrete	Individual	Social	Cultural
	Persons	Lifeworlds	Institutions	Patterns

The first row in Figure 2 suggests the extent to which psychotherapy process research to date has focused almost exclusively on individual behavioral variables, and directs attention to the other, relatively neglected facets of process, e.g.: the experiences that patients and therapists have of one another and of themselves vis-a-vis the other; the formal interactional patterns that unfold between them over time; and the beliefs and evaluations that are proposed and transformed in their shared discourse. The second row of Figure 2 heightens awareness of how much researchers are in the habit of treating the persons who are patients and therapists simply as the occupants of their social roles in the clinical situation, rather than as complex individualities. Too often patients are conceived simply as more or less disabled bearers of various types of psychopathology, and therapists as more or less skillful transmitters of a specific treatment. Researchers too often also ignore the organizational, political-economic and sociocultural environments in which therapy occurs -- rendering an unrealistically

decontextualized portrait of psychotherapy that merely simulates a universality it has hardly achieved in fact. Recognition of these diverse facets of psychotherapy introduces a multidisciplinary perspective and suggests the need for interdisciplinary collaboration in research, but the main advantage offered to researchers by such a formal taxonomy of variables is the disclosure of hitherto unrecognized aspects of a phenomenon that should be, but have not yet been studied. In turning to consider the last component of a research-theory, I come finally to what most people think of a 'scientific knowledge.' Here the 'interpretive function' of research-theory focuses on the results of investigation, both at the level of individual studies and of the field as a whole. The two main elements of this canonical corpus or body of knowledge commonly are called 'facts' and 'theories,' but it will avoid confusion if we refer to them here at least simply as 'research findings' and 'conceptual models.' Research findings consist of the accredited results of controlled, systematic, methodologically self-conscious observational activity. (By 'methodologically self-conscious' I mean only that observers state what they did and how they did it explicitly, in sufficient detail so that others who wish to may repeat their procedures.) At the level of individual studies, the results of observation are accredited as 'factual' through the establishment, by statistical evaluation, that they were relatively unlikely to occur by chance. This sort of accreditation is a matter of the conventions followed in the research community; for example, that observations would occur by chance less than 5% of the time, or less than 1% of the time, and can by this standard be certified as 'real.' Findings which meet this arbitrary criterion of accreditation are understood to require interpretation. These 'rules of the game" also require researchers to refrain from interpreting observations that fail to meet the criterion, however narrow the margin and however tempting the apparent. (The researcher_s only recourse is to increase the sample size and, if the finding proves stable, to benefit from the increased statistical power of the test to reject the null hypothesis.) Somewhat different standards apply in reviewing the cumulative findings in a field of research as a whole. In this context, the main criterion for accrediting observations as established research findings is consistency or replication. Scientists rarely give credence to the findings of any single study, no matter how well the study appears to have been conducted, because every experienced researcher knows how vulnerable empirical investigations are to errors and artifacts of various kinds. Findings are generally accepted only when they have been

replicated on several occasions at different research sites. The simplest quantitative index of replication is the binary tabulation or 'box score,' in which the number of studies reporting a statistically significant finding is evaluated in relation to the total number of studies that have been done on the relevant variables. This is not as simple as it may sound, since reviewers must first decide which studies to include, on the grounds of relevance and methodological adequacy. Second, reviewers have to decide how to interpret equivocal results. What sense, for example, does one make of an observed relationship has been noted at statistically significant levels in ten out of twenty studies? There are too many instances of significant findings to be ignored, but not a high enough ratio of significant findings to be accepted. A more sophisticated method for estimating the replication of findings is the statistical procedure known as meta-analysis (Glass, McGaw & Smith, 1981; Smith, Glass & Miller, 1980). Here the binary judgment based on meeting or failing to meet conventional standards for rejecting the null-hypothesis is replaced with a continuous quantitative estimate of 'effect-size.' As this is not my area of expertise, I defer to the thoughtful discussions of this procedure that have been provided by others (e.g., Kazdin, 1986). My only contribution is a rejoinder to critics who reject the results of meta-analyses because methodologically flawed studies have been included. The deprecating slogan that one hears is 'Garbage in, garbage out." For myself, I think that critics who complain about garbage must all be well-fed middle-class citizens who always have plenty on their tables, rather than hungry street-people to whom adversity has taught the arts of bare survival. Alley cats, stray dogs and homeless people know how much nourishment is discarded by the rich. In terms of funding, psychotherapy research is a back alley in a poor ghetto, and we who live there may be excused our searching for valuable information among the kind of studies that richer, more established fields of research might readily discard. At the risk of extending this violent metaphor one bite too far, I would add that just as undigested food is not nourishment, so unexplained 'facts' are not yet knowledge. Facts need to be digested theoretically before they become meaningful. Research findings are digested by being assimilated into substantive models of phenomena. These models are conceptual schemes that describe and explain relationships among established findings. By doing so, they synthesize otherwise isolated 'facts' into a tissue of meaning that really deserves to be called 'scientific knowledge.' The grounding of these findings in

measurement operations may guarantee their semantic or referential meaning, but it is inclusion in a conceptual model that establishes the synthetic, i.e., syntactic aspect of their meaning. In principle, of course, there are always alternative possibilities for synthesizing research findings. Even when no satisfactory scheme exists, it is only because no one has yet been clever enough to construct one. So we are left, finally, with the same question with which we concluded our discussion of treatment-theories. That is, when there are two or more competing schemes, how are they evaluated? The evaluation of competing substantive models is based in part on the number of established findings that it successfully includes in its explanatory scheme, and in part on the parsimony and elegance of the concepts used to synthesize them. However, substantive

questions for investigation to which they give rise. A well developed substantive model of a phenomenon should not only integrate and explain the accumulated research findings, it should also generate interesting questions for further investigation. Such research questions constitute the 'logically-derived predictions' discussed earlier. The practical value of research-theories to researchers is measured by how many good research questions they raise.

III.

At this point I have presented as fully and clearly as I can my idea of the distinction between the two kinds of theory and their relationship to psychotherapy. If I have seemed to dwell mainly on their differences, it is because I believe that drawing this distinction will free each type of theory to perform its proper functions most effectively. For example, I think the demand that treatment-theories should offer empirically testable hypotheses about personality and psychopathology places an unfair burden on them. How can one test the proposition that human nature is basically good and needs to be freed of oppressive social constraints, or that is it essentially bestial and requires continuous control for its proper functioning, or that self-actualization is the master motive in human life? These and others like them are statements of faith, whose effect may be uplifting or cautionary according to their content and the context in which they

are used. These are beliefs, that may be necessary for living the 'good life," like the 'golden lies" justified by Socrates in The Republic. Their value for those who play the game of statecraft may be enormous, but their value for those who play the game of science is nonexistent. This parallels the reciprocal demand that the results of scientific research should be directly translatable into improvements in clinical practice. Clinicians too often hold research to an excessively utilitarian standard, failing to appreciate the intrinsically compelling quality of puzzle-seeking and puzzle- solving that constitutes the game of normal science (Kuhn, 1962). By these inappropriate standards, clinical theorizing and empirical research have each been wrongly dismissed as inconsequential by advocates of the other. Treatment-theories will be most useful when allowed to develop freely as an expression of the therapist's intuitive reach towards the patient's experience, and imaginative response to the patient's condition. Like bridges, the main function of treatment-theories is to connect the therapist with the patient, and to bind them both to those aspects of their collective 'lifeworld' in which the ever-renewed accumulation of myriad minute acts of loving concern and mutual regulation generate the healing energy that is brought into disciplined focus by psychotherapy. In addition, by giving concrete symbolic form to previously unarticulated experiences, treatment-theories not only relieve the suffering of bewildered patients (Levi-Strauss, 1963) but also give metaphoric expression to those experiences (Lakoff & Johnson, 1980). Those metaphors, in turn, make the experiences of suffering and healing available for reflection, privately and publicly, poetically by fine writers and in discourse among professional psychotherapists, as treatment-theories. That is the point at which treatment-theories begin to stimulate the growth of research-theories. They are like smoke that attracts attention to a fire. By the same token, research-theory will be most useful when allowed to develop in response to the perplexities of researchers struggling to reach a shared understanding about how best to observe what is most important to know about psychotherapy, and about how best to explain what they observe. There may be little practical effect to be gained by grappling with seemingly intractable problems like the 'outcome equivalence paradox' of Luborsky, Singer & Luborsky (1975) and Stiles, Shapiro & Elliott)1986), or by endlessly reviewing the methodological adequacy and meaningfulness of studies (e.g., Kazdin & Bass, 1989; Orlinsky & Howard, 1986) -- but that is how research-theory advances. Eventually we may have a

data-based conceptual model that also has implications for clinical practice, even though its primary function is to account for research-findings. One rudimentary step in that direction that I happen to like, or at least to know about, is the 'generic model" of psychotherapy of Orlinsky & Howard (1987). I will discuss this 'generic model" in my next presentation: first, as a specific example of an emerging research-theory of psychotherapy; and second, as a way of exploring how research- theory and treatment-theory might finally be related.

References

ON THE FUNCTIONS OF THEORY IN PSYCHOTHERAPY

III. THE 'GENERIC MODEL OF PSYCHOTHERAPY':
NEW DEVELOPMENTS IN A RESEARCH-BASED THEORY

PART ONE: THE ELEMENTS OF THERAPEUTIC PROCESS

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I.

In my first presentation I drew a distinction between two types of theory of psychotherapy based on their differential functions. One type of theory functions as an aid to therapists in the context of clinical practice, and was called treatment-theory. The other functions as an aid to resesearchers in the investigative context, and was called research-theory. I devoted the balance of the first presentation to a discussion of the nature of treatment-theories, and followed in the second presentation with a parallel discussion of the general structure and functions of research-theory. This week I want to present an example of a research-theory of psychotherapy; specifically, the 'generic model of psychotherapy' that I developed with Ken Howard in 1985. Speaking more precisely, the 'generic model' is not so much an example of a complete research-theory as of the particular component of research-theory which involves the conceptual synthesis of accredited research- findings. First I will give a rather brief account of the model and the findings on which it was based. Due to constraints of time, I will concentrate primarily on the elements of therapeutic process as described in the "generic model," including some new material. These are ideas that have occurred to me in response to various comments and criticisms, some friendly and some not so friendly, that have been made by colleagues. In the next presentation, I will enlarge the

focus to include the very important relations that research findings suggest exist between the various process elements, and between the functional units or ensemble of process elements and the context in which they operate. Those relations constitute the real heart of the generic model, so I hope that it will be possible to defer final consideration of the model until both presentations have been heard. The 'generic model' was developed during the preparation of an extensive review of quantitative empirical studies that related measures of actual therapeutic process to clinical outcome. A condensed version of the "generic model" was first presented as part of that review in the 3rd edition of the Handbook of Psychotherapy and Behavior Change (Orlinsky & Howard, 1986). A somewhat fuller statement of the model was also published separately the next year in the Journal of Integrative and Eclectic Psychotherapy (Orlinsky & Howard, 1987). We called our conceptual scheme a 'generic' in order to call attention to the fact that it was meant to apply to all of the varied species of the genus 'psychotherapy.' We also liked the connotation that the word 'generic' had acquired in the pharmaceutical context; that is, a treatment consisting all the 'active ingredients' without the false differentiations created by brand-name advertising. In fact, we were seeking a model that would allow us to integrate the 'active ingredients' in all of the various therapies that had been studied, and that might be identified as operating in some degree or combination in each of them. After a lengthy review of about 1100 research findings reported in the English-language research literature, we composed a list of 34 statements summarizing what seemed to have been learned about psychotherapy in the course of 35 years of empirical investigation. Since it would take more time than we have to present and discuss that list today, I will further condense my list of what I think has been reasonably well established to date by extensive replication in the process-outcome research literature.

II.

First of all, it seems reasonably well established that, on average, psychotherapies of various sorts tend to have a beneficial effect on patients, when compared with patients exposed to no-treatment control conditions (e.g.: Smith, Glass and Miller, 1980; Shapiro

and Shapiro, l982). Nevertheless, a small percentage of patients also deteriorate, although it is not clear how much their deterioration may be due to therapy and how much may be due to other factors (Lambert, Shapiro and Bergin, 1986). The overall conclusion for effectiveness is reinforced by evidence indicating that the amount of benefit received from therapy is related to the amount of therapy received by patients. That is, the more therapy, the more benefit. However, the point at which patients start to improve appears to vary with their presenting condition, and therapeutic benefit also appears to be a negatively accelerated function of the number of therapy sessions (Howard, Kopta, Krause and Orlinsky, 1986). In other words, while patients who remain in therapy typically continue to improve, it appears that proportionately more benefit is derived from earlier sessions than from subsequent ones. Second: there seem to be no consistent significant differences in overall effectiveness among the various types of therapy that have been studied. Since this is found despite the demonstration of clear-cut differences in therapeutic process and procedure, this state of affairs has been called the "outcome equivalence paradox." To the discomfort of some "true believers," but otherwise not surprisingly, it appears that no one type of therapy is generally superior. However, most of the comparisons so far have been between total 'treatment packages' of differing theoretical orientations, rather than of specific types of intervention, so this does not necessarily mean that the effectiveness of therapy is due exclusively to 'common factors.' Third: focusing on specific types of therapeutic intervention or techniques, we find an inconsistent association with outcome. While many studies have yielded nonsignificant findings, too many others (e.g.: exploration; interpretation) have demonstrated a significant relationship between techniques and outcome to completely discount their efficacy. I understand from David Shapiro that he and his students in Sheffield have undertaken a methodological critique of these studies and have drawn less positive conclusions about them, but I have not yet seen their work. Others who have been concerned with statistical power analysis (e.g., Kazdin & Bass, 1989) have warned that studies often do not have samples large enough to permit the detection of significant differences between groups where they might really exist. For the time being, it seems to me that the most plausible interpretation is that while there may be significant interaction effects to be found, there are no robust main effects. In other words, no therapeutic interventions or techniques are effective under all

conditions, but some may well be effective when certain other conditions also have been met. The 'generic model' offers some hypotheses concerning what those conditions might be. The next item on my list of accredited research findings presents a welcome contrast. It is that measures of the therapeutic relationship, especially when made from the patient's perspective, have been very consistently related to clinical outcome. It appears in quite a large number of studies that positive outcomes have been associated with the patient's experience of an actively collaborative relationship to a therapist whom the patient perceives as empathic, caring and credible. What may be called the 'human' aspect of the relationship have a great impact on outcome, and this appears to much more consistent than for the technical aspect of therapy. Fifth: none of the professional, demographic or personal characteristics of therapists studied have been consistently associated with therapeutic outcome. This includes therapist experience, as measured by duration of practice. Although a few studies suggest that some therapists are generally more effective than others (e.g.: Luborsky, McClellan, Woody, O'Brien and Auerbach, 1985; Ricks, 1974), the critical characteristics in this regard are not yet known. Other research indicates that the therapist's activity is a factor in positive outcome; while other studies again suggest that therapist skillfulness is also a factor. Within obvious limits, one might say that how much and how skillfully therapists do what they do seems to be more important than what kind of therapists they are, or which of many possible techniques they use. Sixth: only a few patient characteristics have been consistently found to be related to differential therapeutic outcome. One is the patient's initial level of functioning (e.g.: "ego strength;" degree of disturbance). Another, probably related characteristic is the patient's "openness" or lack of defensiveness in therapy. The patients' social characteristics may be indirectly related to outcome. For example, Garfield (1978) has found that in the United States at least, patients' level of education and their socioeconomic status have been related to duration of therapy. Since in many cases those who have fewer sessions receive relatively less benefit, poorer patients with less education who have briefer treatment presumably also have poorer outcomes. It is worth noting, however, that patients from disadvantaged backgrounds who stay in treatment do as well as others. Moreover, pre-treatment "role induction" procedures for such patients appear to have a consistently beneficial effect. The net impression is that patients who initially are psychologically

stronger, less disturbed, and better prepared for therapy derive more benefit from it. A seventh and final point concerns the demographic and psychiatric status of those who seek therapy in the first place. Epidemiological surveys in the United States, at least, indicate that outpatient psychotherapy is disproportionately utilized by the better educated, by the white population, by the upper-middle class, and by women. Moreover, a significant number of those who enter outpatient therapy apparently do not even meet current standard criteria for psychiatrically diagnosable conditions, and many more have rather mild conditions. On the other hand, the psychiatrically most disturbed segment of the population tends neither to seek nor to receive psychotherapeutic treatment. If for the moment we assume the approximate validity of this short list of research-findings, then we may take them as 'given' (i.e., as 'data') for which any substantive conceptual model of therapy should give an account. I will try to show how we formulated these findings in terms of the 'generic model of psychotherapy.'

III.

I shall start with a very brief account of the conceptual distinctions used in constructing the generic model. These distinctions concern types of research variables. The first differentiates between input, process and output variables. Process variables include the various aspects of activity, experience, association and communication between patient and therapist -- that is: the various therapeutic tasks and social acts that they perform; their perceptions, feelings and fantasies while with one another, and about each other in the times between sessions; the degree and patterning of their relating to one another over time; and the symbolic discourse and drama they create together. The terms "input" and "output" refer to various aspects of the functional context or environment in which the therapy occurs, including the actual persons involved, their individual 'lifeworlds,' the organizational and institutional network surrounding therapy, and the cultural patterns which determine the meaning and value of the therapeutic enterprise. Specifically, input refers to the influence of prior state of those contextual variables on therapeutic process, and output refers to the influence of therapeutic process on the subsequent states of those contextual variables. This includes, of

course, the subsequent states of the patient's personality and lifeworld, which come under the familiar heading of 'clinical outcome' -- but in principle it also includes much more of great theoretical, if not directly clinical interest. Given these definitions of interactional process and context in general, the specific substantive field of psychotherapy was analyzed as follows. The 'generic model' originally divided therapeutic process into five broad categories of variables, called the therapeutic contract, therapeutic interventions, the therapeutic bond, the participants' self-relatedness, and therapeutic realizations. These categories were first employed as a means of grouping process variables and summarizing research findings concerning the relation of process to outcome (Orlinsky & Howard, 1986). In the course of carrying out that task, the empirical content of the process categories became clearer and the relations among the categories became more salient. By the conclusion of the review, the categories of process and a related set of categories for the functional context of therapy had been transformed into a substantive conceptual model (Orlinsky & Howard, 1987). With that conceptual transformation, it became possible to develop the model further through theoretical reflection, with the ultimate aim of generating questions to be explored and hypotheses to be tested in new studies. For example, due to a number of comments that have been made about the scheme which I think are valid, I have introduced 'unconscious transference resistances' as a sixth process category. This refers specifically to 'transference' in the narrow sense originally intended by Freud (1912/1958a); that is, a defensive intrusion into therapy of exaggerated or inappropriate perceptions, expectations and attitudes, based on unconscious neurotic conflicts active in the participants. Although such defensive intrusions typically come from the patient, they of course may on occasion also come from the therapist. (To avoid further confusion of terminology, however, I shall not use the word 'countertransference' in referring to transference-resitances originating with the therapist.)

IV.

With this addition, three of the six categories may be taken together as describing the relationship between patient and therapist: (1) therapeutic contract, referring to the

normative and structurally institutionalized aspect of the relationship; (2) therapeutic bond, referring to the real but extra-normative 'human' qualities of the relationship (who the patient and therapist as individual human beings beyond their roles in the clinical situation, i.e., persons of certain ages and genders with varied officially "irrelevant" but otherwise noticeable physical, personal and sociocultural characteristics); and (3) transference-resistances, referring to manifestations of unconscious conflictual factors in the relationship. The therapeutic contract is the implicit agreement between the participants that specifies the purpose, format, terms and limits of their undertaking. The contract defines the roles and rules of psychotherapy. This includes, most importantly, its participants (who is to be involved in it); its goals (what and whom it is for); and its social norms (what must, what may, and what may not be done). Without such an understanding, the participants would not know what to expect and therefore could not know how to act with one another. The therapeutic contract, on the one hand, is a business negotiation that specifies the frame for therapeutic practice: its venue and schedule (where and when it is to take place); its term (how long it is to last); and its financing (how much it is to cost, and how payment for service is to be made). On the other hand, the therapeutic contract also defines the ideal ethical norms of the relationship, anchored in general cultural norms for caring and helping relationships. This is what Durkheim, in arguing against Herber Spencer, referred to as the essential "non-contractual element in contract." Thus the therapeutic work is rooted in the two aspects of collectivity known referred to by Tönnies (1887/1957) as 'Gemeinschaft' and 'Gesellschaft.'

Insert Figure 1 about here

Further theoretical reflection has led me to distinguish four potentially observable states of the therapeutic contract, as shown in the left-most column of Figure 1. First, the contract may be in an unsettled state; that is, not yet worked out to the understanding and satisfaction of the parties. (As a rule of thumb, any person or agency whose consent is required for therapy to begin, or who has the power to terminate treatment, must be considered a party to the therapeutic contract.) Second, there may be a stable contract in effect, in which case the parties are not so much concerned with the contract

itself as with its implementation. In this case, the contract fades into the background as the assumed and unproblematic foundation of the therapeutic enterprise. Third, one or another of the parties may be testing the limits of the contract by making minor violations of its terms, to see if the relationship cannot be manipulated subtly in their favor, to add gratifications or minimize costs. Usually the patient tests the limits, taxing the ability of the therapist to maintain adherence to the essentials while conceivably renegotiating the frame in an adaptive fashion. Finally, the fourth possible state is one of contractual breakdown, usually caused by the 'acting-out' of an unconscious conflictual fantasy or some other major ethical violation. If the breakdown is relatively circumscribed and can be repaired, the result ultimately may be enhancing (as Kohut has argued). If the breakdown cannot be repaired, the psychotherapeutic enterprise is effectively terminated whether the two people part company or continue on in some different type of involvement. The personal or informal side of the relationship is defined both by therapeutic bond, on the overt and conscious level, and by transference-resistances on a covert and unconscious level. The therapeutic bond roughly is the sense of personal rapport between patient and therapist, in so far as that is determined by their respective social, cultural and psychological characteristics as individuals. These characteristics indicate to each what kind of person the other is, and to what extent he or she may be liked, trusted and understood. In his essay on "The Dynamics of Transference," Freud referred to this as the conscious or preconscious (and usually positive) component of transference. According to sociologists of elementary social interaction such as Homans (1961), a bond of this sort, positive or negative, develops in all relationships. Further theoretical reflection about the therapeutic bond has led me to distinguish four potentially observable states of the therapeutic contract, as shown in the second column in Figure 1. The first is a negative state of noncompliance, in which there is a lack of personal rapport and cooperation between the participants. Noncompliance may be expected of "involuntary" patients who have been coerced or pressured into attending therapy, such as children or legal offenders who have made no real contract with the therapist. Noncompliance may also occur in otherwise legitimate contracts, as a consequence either of transference-resistances or of realistic circumstances. The second state is a 'good enough' working alliance, which implies cooperative motivation and an open-minded investment of the participants in their

respective roles. Without such a minimum of personal investment, therapeutic interactions have the hollow, as- if quality of a performance in which the participants are merely 'going through the motions.' (To avoid confusion, please note that this is a much more circumscribed meaning of the phrase "working alliance" than is usual. I intend it to have the sense of a cooperative but relatively "cool" personal bond.) As stronger state of therapeutic bonding may be called personal warmth. This state reflects the mutual creation of what Winnicott (1965) called a 'holding environment, which is recognizable by the reciprocal empathy and caring evident in the behavior of the participants. This state of affairs resembles what Carl Rogers referred to as "therapist-offered conditions," and thought were the necessary and sufficient conditions of therapeutic change. My concept of personal warmth differs, first, in emphasizing the bilateral quality of the involvement, and second, by making no claim concerning the sufficiency of the state as a cause of therapeutic change. Finally, a most intimate state of shared fantasy can occur when the level of reciprocal trust and empathy permits deep communication in terms of normally private primary-process ideation. I believe that this was recognized by Freud (1912/1958b) under the heading of "unconscious to unconscious communication." It has been referred to by writers such as Harold Searles (1965) and Carl Whitaker (Whitaker & Malone, 1953) in paradoxically positive terms, as a "therapeutic psychosis." Because of the non- intellectual, non-rational and often non-discursive modes of communication involved, some would no doubt stigmatize this state as a mutual acting-out of transference that would almost certainly be destructive. I think it is more accurate to regard this as a mutual "regression in the service of the ego" which, when effectively contained within the bounds of the therapeutic contract, may have a significantly creative effect. Transference-resistances were not originally included in the generic model because the model was based on a review of research findings, and at that time there had been few quantitative empirical studies of transference processes. No doubt that is because transference-resistances are inherently difficult to measure and have only recently been brought under scrutiny by psychoanalytic process researchers, mainly by the authors to be found in the volume edited by Dahl, Kächele & Thomä (1988). Theoretical reflection has resulted in the tentative definition of eight possible states in this category shown in third column of Figure 1, including a state of effective collaboration marked by appropriate personal

involvement with no evident manifestations of transference-resistance. Briefly, the states of active transference-resistance include ingratiating compliance, hyper-dependence, conflictual erotization, competition for control, hostile rebellion, fearful defensiveness and emotional self- absorption. These correspond roughly to extreme developments of the eight octanes in the Leary circumflex as elaborated by Kiesler (Kiesler, 1982; Leary, 1957), and operating in combination to various classical character-types. This agrees with the notion that transference-resistances are interactional projections of the core conflictual wishes whose defensive containment is the prime purpose of character structure. Looking across the first three columns of Figure 1, I think, leads to the hypothesis that any active transference-resistance should lead to a state of noncompliance in the therapeutic bond, and either to limit-testing or overt contractual breakdown on the formal side of the relationship. Another hypothesis is that the state of stable contract on the formal side is a prerequisite for the development and maintenance of the states of working-alliance, personal warmth or shared fantasy, which are varyingly intimate modes of effective collaboration.

V.

The first three process elements of the generic model concern various aspects of what is usually more simply called "the therapeutic relationship." The last three elements, by contrast, refer to the specific or content aspect of therapeutic process. One may imagine the relationship as the vehicle of therapy, and the content elements as the vital cargo carried by it. Thus, the fourth process category of the generic model involves therapeutic interventions, which comprise the technical business of seeking and giving help. This occurs in four logically sequential but empirically overlapping phases. The cycle begins with the patient presenting complaints and associated narratives to the therapist, or demonstrating nonverbally some manifestations of abnormal behavior. The second phase involves the therapist's listening, observing, questioning and assessing. The therapist's treatment-theory ideally enters here by providing a basis for construing the patient's 'real' or 'actual' problem from these complaints, narratives and behaviors presented by the patient, although Meyer's (1988) exploratory study indicates that this is

mediated by various "minimodels" of patients or patient-types rather than by therapist's 'philosophical anthropology' as a whole. That treatment-theory should also supply a repertory of intervention tactics or techniques which the therapist can use in the third phase to remediable or ameliorate what have been defined as the patient's problems. In the fourth phase, these techniques require a varying degree of participation by the patient, ranging from passive compliance with the therapist's actions, at one extreme, to the patient's independently carrying out all the essential steps in the procedure, at the other extreme. Treatment-theories differ considerably in the diagnostic schemes and intervention techniques with which they equip the therapist, making it very difficult to adequately summarize the contents of this process category. A highly provisional listing is given in the fourth column of Table 1, if only for the sake of further discussion. The types or 'states' of therapeutic intervention presented there include the following. The first is diagnostic exploration, in which the therapist's main endeavor is to reach a theoretically satisfactory understanding of the patient's presentation. The second is relationship facilitation, in which the therapist's effort is directed mainly towards enhancing or repairing some aspect of the therapeutic contract or the therapeutic bond. The importance of this has already been emphasized. The third type of intervention includes a broad range of tactics that may be called problem-solving, in the sense of being aimed directly either at solving a problem for the patient or at helping the patient learn to solve the problem. This may be done by a wide variety of means, including interpretive, cognitive and behavioral methods. A fourth type of intervention is focused less on detecting and solving problems than on evoking what are theoretically conceived of as optimal or strengthening modes of experience in the patient. Such experiential evocation presumably provides the patient with indirect resources for resolving or resisting the adverse effects of problematic conditions. Finally, although therapists' interventions are usually dictated by their treatment theory, occasionally they respond with an intervention that is either drawn from the repertory of a different treatment-theory or improvised to cope with an atypical situation. Following Robert Elliott's usage, such instances can be called "out- of-mode" interventions. The fifth major process category is the participants' self- relatedness. This refers to the manner in which individuals experience, define and manage themselves while relating to each other and transacting the therapeutic interventions they have undertaken. Self-

relatedness is a function of the interior dialogue between the 'I' and the 'Me,' as described by G. H. Mead (1956), but is also observable interpersonally in that aspect of the individual's "presentation of self" that Goffman (1967) termed "demeanor." In an interactive situation such as the psychotherapeutic interview, each participant reacts to himself or herself while simultaneously responding to the other person. Because of this, self-relatedness moderates the impact of the other person's behavior, acting like a filtering element that can accentuate, dampen or otherwise transform the significance of the other's behavior for the individual. Clinically, positive self-relatedness is often described as a state of 'openness' or 'centeredness,' and is experienced as a sense of aliveness, self-attunement, self-control and self-acceptance. Negative self-relatedness is exhibited as defensiveness, preoccupation and self-alienation, reflecting a deadening of inner responsiveness, a lack of self-awareness and self-control, and a generally self-rejecting attitude. Theoretical reflection suggests that this process category might be simplified into four states, reflecting the patient's ideational and affective responsiveness. At the two extremes, when persons are emotionally responsive and ideationally active they are in an experientially open state, while individuals who are relatively unresponsive emotionally and relatively constricted ideationally may be called experientially inert. Two intermediate forms involve states in which individuals are ideationally active but emotionally unresponsive (i.e. intellectualized) and emotionally responsive but ideationally inactive (i.e., repressed). In the psychotherapeutic situation, one may expect that most patients will tend to exhibit comparatively negative states of self- relatedness, at least initially; and one may hope to find the therapist is an 'experientially open' state, at least most of the time. If we consider the relations between states of self- relatedness and the other process categories, we may hypothesize: (1) that experiential openness in the patient is the optimal state for effective therapeutic interventions; (2) that patients whose dominant mode of self-relatedness is intellectualized will feel most comfortable with cognitive interventions (i.e., problem-solving) but show the greatest change with affective interventions (i.e., experiential evocation), whereas the reverse will be true for patients whose dominant mode of self-relatedness is repressive; and (3) that states of experiential openness will most readily be evoked and maintained when the therapeutic bond has attained states of personal warmth and/or shared fantasy. The sixth process category in the generic model is called

"therapeutic realizations" for want of a better term. These are the benefits or hurts that participants' experience during sessions, as a result of things that are said and done (also things that are not said and done) between patient and therapist. In principle such "in- session impacts" affect both participants, although impacts on the patient are naturally of greater clinical interest. The latter are still considered to be part of the therapeutic process rather than outcome, because outcome does (or should) concern what the patient "takes home," i.e., the consequences of therapeutic process for the patient's personality and life outside of treatment. Theoretical reflection on the possible states of therapeutic realization leads to the following tentative and simple classification, which admittedly still focuses primarily on the patient. First is the possibility of a negative therapeutic reaction, without any immediate benefit or evident progress. Second is the possibility of therapeutic impasse, involving a sense of obstruction and frustration due to the failure of therapeutic interventions to produce apparent benefit or progress. Third is the possibility of beneficial in-session impacts, which may be of three types: supportive comfort, in which patients draw assuagement and encouragement from therapeutic interaction; cathartic relief, wherein patients unburden themselves of strong dysphoric affect; and cognitive mastery, in which the patients' decision-making and sense of control is enhanced through insightful reorganization of their personal perspectives.

VI.

The components of the therapeutic action system function as an ensemble of interdependent parts. The system as a whole constitutes the operating context for each of the distinct process components. Further contextual connections for the process components are provided by elements of the social, cultural and psychological environment in which therapy takes place. As there is not sufficient time now to do justice to the relationships involved, I will simply show some diagrams with a minimum of comment, as a way of inviting you back for my next presentation.

Insert Tables 2 through 5 about here

ON THE FUNCTIONS OF THEORY IN PSYCHOTHERAPY

IV. THE 'GENERIC MODEL OF PSYCHOTHERAPY':
NEW DEVELOPMENTS IN A RESEARCH-BASED THEORY

PART TWO: THERAPEUTIC PROCESS IN CONTEXT

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I.

My aim in this fourth and final presentation is to restore a sense of wholeness to the discourse I have offered on the functions of theory in psychotherapy. Much of the discourse has been concerned with the drawing of distinctions of various kinds: between treatment-theories and research-theories; between input, process and output variables; between research findings and conceptual models; and most recently, between the elements of therapeutic process distinguished in the "generic model" of psychotherapy, and between several states within each of the process categories. A proper sense of wholeness, of course, is not to be gained by ignoring distinctions. The phenomenon we work with is complex, and the alternative to properly drawn distinctions is not wholeness but either confusion or oversimplification. We have suffered more than we need to from confusion in the realm of treatment-theories, in part because their functions have been confounded with those of research-theories. For much the same reason, because research- theories of psychotherapy have not been developed in their own right, we have suffered from oversimplification in the realm of psychotherapy

research. Having made a start at drawing what I hope are sensible and useful distinctions, I feel that it is equally important to leave you with a clear sense of their interrelations. The Western habit of mind is to dichotomize, to define antitheses rather than complementarities. As a corrective measure, my emphasis today will be on context. I will start by showing how the six process elements of the "generic model" function together, so that each element operates first of all in the context of all of them taken together as a unified system of psychotherapeutic action. Therapeutic contract, personal bond, transference-resistances, interventions, self-relatedness and in-session impacts or realizations are all of a piece. Then I will argue that the system of psychotherapeutic action itself can only be properly understood when it is viewed in its functional contexts. I count among these contexts the participants as specific persons in all their biopsychosocial complexity, above and beyond their participation in the social roles of patient and therapist. I also count their separate individual lifeworlds as functional contexts of the psychotherapeutic action system, including here both the synchronic structure of interlocking social networks, behavioral projects, and time-budgets, and also the diachronic structure of their evolving life-histories. In addition to these essentially individual contexts are the collective contexts constituted by the larger society and the culture in which patients and therapists live as individuals, and of which their separate lifeworlds are ultimately interdependent and co-inherent dimensions. Finally, I shall argue that while the distinction between research- theories and treatment-theories of psychotherapy is vital for certain very practical purposes, such as doing therapy and doing research, it is after all a relative distinction of a functional and pragmatic character. I am not discussing all aspects of theoretical meaning, which would include the semantic concern with anchoring theory in observation and the syntactic concern with mathematical formalization -- just the pragmatic aspect, which concerns how theory is used as a means of discourse. I have put forward this distinction in the spirit of "scientific realism" which Cheshire & Thomä (1990) write about so well in their recent paper on "Metaphor, Neologism and Open Texture" -- from which, with a few minor deletions, I quote the following passage: The brief of "scientific realism" is to represent the methods, discourse and explanations of empirical sciences as they actual occur in vivo, rather than as they have tended to appear in philosophy text-books. .... Characteristic of real science is variety. Variety in methods of observation, investigation

and data collection; variety in the types and uses of evidence ...; variety in the logical patterns of explanation that are constructed ...; and variety in the methods and logic of validation .... (p. 25).

There are varied forms of discourse about psychotherapy, each corresponding to a particular realm of praxis. In addition to the forms of theory about therapy that are shaped by discourse between therapists about treatment, and by discourse among researchers about their studies, I have been led by remarks of various colleagues from Ulm and Stuttgart to think of two other uses of therapeutic theory. One of these is the sociopolitical form taken by theory in debates among competing schools of psychotherapists, which could very properly be called therapeutic ideology. The other practical realm in which there is at least intermittent discourse about psychotherapy occurs between patient and therapist as part of the clinical situation, as when the therapist gives directions or explanations in response to the patient_s questions, or they deliberate together about what is to be done. In this respect therapeutic theory enters directly into the therapeutic process, and serves an essentially rhetorical function as the means by which the therapist persuades the patient towards or against certain forms of action. These and all other forms of discourse about therapy that may yet be recognized constitute a large and shadowy domain that, like a subterranean maze, is constituted by the intersection of varied practical realms of discourse -- a vague domain to which I have given the unlovely name "psychotherapology," the logos of the psychotherapeutic. "Psychotherapology" is the context in which the relationships between research-theories and treatment-theories are ultimately to be found. My final effort, then, will be a sort of speleological exploration of those wonderful caverns in search of intersections. In the time left today, I will do that on a very modest scale by asking what the "generic model" I proposed as a researcher might have to offer by way of advice and encouragement to my therapist- self.

II.

Interrelations Among Process Components

In my last presentation I explored the six categorical elements of therapeutic process posited in the "generic model" in a somewhat piecemeal fashion, focusing on the potentially observable states within each that might lead the researcher to a more precisely organized set of measures. I ended, however, by reflecting that the several components of the therapeutic action system actually function as an ensemble of interdependent parts, and that these together are further embedded in concrete social, cultural and psychological contexts. I shall suggest how these functional relationships may be envisaged with a series of diagrams that are at least consistent with the research findings accumulated thus far in the process-outcome literature. Functional interrelations among the therapeutic contract, therapeutic interventions, the therapeutic bond, personal self- relatedness and therapeutic realizations can be visualized in the form of a flow chart (Figure 1), in which the therapeutic contract and therapeutic realizations are the initial and terminal points.

Insert Figure 1 about here

The norms of the patient and therapist roles which define the therapeutic contract contain the blueprint that patient and therapist follow in the social construction of their therapy. With regard to therapeutic interventions, the contract specifies the appropriate mode of patient problem expression (which the patient learns as part of the patient role) and, based on the type of therapy being practiced, an appropriate range of technical interventions for the therapist. To guide the formation of a therapeutic bond, the contract also stipulates a proper demeanor and manner of relating for the therapist, and projects a parallel expectation for the patient, based on an implicit cultural understanding of how a "helping relationship" is constituted. The major effect of therapeutic interventions, of course, should be attainment of the intended therapeutic realization. This is shown in Figure 1 by the broken arrow leading through the patient's self- relatedness, and the solid arrow beyond to therapeutic realization. This two-step connection indicates the significance of patient self-relatedness (i.e., openness or defensiveness) as a filter or

"gating" variable. If the patient is open to the impact of the intervention, the intent of the intervention may be realized. On the other hand, if the patient is too defensive the attempted intervention should be rendered ineffectual. This, at any rate, offers a testable hypothesis to explain the rather inconsistent findings concerning the influence of therapeutic interventions on outcome demonstrated in the research literature. Some reciprocal influences are also to be noted between therapeutic interventions and the therapeutic bond. The strength and quality of the therapeutic bond ought to be an important influence on the self-disclosures that the patient is willing or able to make to the therapist. The bond should also be a significant factor in determining the therapist's choice of when and how to intervene with regard to the patient's presentation. A good bond should also enhance the patient's willingness to engage in the interventions proposed by the therapist. By the same token, the therapeutic bond may be somewhat strengthened by the sheer activity of attempting helpful interventions, at least early in treatment, if those efforts are viewed as indicating the therapist's commitment to the patient's cause. The multiplicity of functional connections linking the therapeutic bond to other components of the model in Figure 1 indicates the central importance of the relationship in psychotherapy. The major effects of the therapeutic bond are (1) upon post-session outcome directly, (2) on therapeutic realization indirectly through the mediation of patient self-relatedness, and (3) on patient self- relatedness itself. First, a good therapeutic bond should contribute directly to the production of positive outcomes by strengthening the patient's "morale" (Frank, 1974). Heightened morale should affect the patient's manner of self-presentation to others, making it generally more rewarding to them and tending in turn to elicit more favorable and rewarding responses from them. It should also provide the patient with additional motivation to apply insight and other therapeutic realizations to situations outside of therapy. Beyond this, a good therapeutic bond should also contribute indirectly to patient outcome through the mediation of therapeutic realization and patient self-relatedness. In our chapter on "The Psychological Interior of Psychotherapy" in the volume on process methods edited by Greenberg & Pinsof (1986), Ken Howard and I presented data suggesting that the therapeutic bond conveys implicit affective messages to the patient containing information highly relevant to the patient's self-evaluation. A therapeutic bond characterized by reciprocated personal investment, empathic resonance and mutual

affirmation should powerfully imply, at the very least, that the patient's concerns and feelings are worthy of serious interest. Such a message is all the more believable when it is tacitly demonstrated by another's manner of relating. If the patient is not too self-preoccupied for this message to be received, nor so self-deprecating as to find it unbelievable, then the therapeutic bond will have influenced outcome by a second route. Finally, the arrow connecting the therapeutic bond to patient self- relatedness indicates that a strong bond should enhance the patient's "openness" to therapeutic interventions by providing the basic qualities of a "holding environment" (Winnicott, 1965), i.e., a safe, supportive and stimulating milieu. Defensiveness generally is evoked by a sense of inner weakness in confronting what feels like a threatening or hostile interpersonal milieu. All patients have had past experiences in which these conditions were met to some degree, and respond to therapy with greater or lesser defensiveness as events reminiscent of those past experiences are evoked. A good therapeutic bond should gradually counteract this, as the patient tests the therapist (especially through transference-resistances) and discovers that the conditions of the therapeutic relationship are significantly different from what was feared and expected on the basis of past experience. In this way, a good therapeutic bond not only has an impact on therapeutic realization, but also gradually makes the patient more open to explicit and implicit interventions. Patient self-relatedness also exerts a reciprocal influence on the patient's manner of relating vis-a-vis the therapist, which is the patient's contribution to the therapeutic bond. For example, private preoccupations during sessions should detract from the patient_s ability to be emotionally to be invested in the patient role or to be emphatically attuned in communicating with the therapist. On the other hand, when patients are "centered" and "open," their current ability to participate in a good therapeutic bond should be enhanced. The therapists' self-relatedness, too, is a potent influence on their ability to enter the therapeutic bond. It has been our experience that therapists who approach their sessions in a self-attuned state are better able to be fully involved and emphatically resonant with their patients. A complementary influence may also occur, in which involvement in a good therapeutic bond leaves the therapist in a better state of self-relatedness. Figure 1 suggests that therapeutic realizations influence the state of the therapeutic bond, in addition to their more obvious impact on post-session outcome. As noted earlier, the mere attempt to engage in helpful therapeutic

interventions may have a positive effect on the therapeutic bond. However, the surest path to strengthening the therapeutic bond is indicated by arrows connecting therapeutic interventions, made effective through patient self-relatedness, to therapeutic realization, and from there back to the therapeutic bond. A parallel loop connects the implicit impact of the therapeutic bond to therapeutic realization through the mediation of patient self-relatedness, and then back to the therapeutic bond. These recursive lines of influence correspond to the familiar principle that "nothing succeeds like success." When therapeutic interventions are actually seen and felt to be helpful by the patient, the therapist's credibility, and the patient's investment in and affirmation of the therapeutic bond should be enhanced. As the therapist gains credibility in the patient's eyes, the patient should therapeutic interventions are experienced as threatening or harmful, the therapeutic bond should be correspondingly impaired. The bottom line in Figure 1 represents immediate post-session outcomes, such as a new cognitive perspective, improved interpersonal skill, enhanced energy or heightened morale. Two paths lead to the achievement of post-session outcomes. One originates directly in the reassuring and motivating influence of the therapeutic bond. The other path leads indirectly from the therapeutic bond and from therapeutic interventions through the achievement of therapeutic realizations, such as insight, emotional catharsis or problem-solving, and hopefully through these to long- term as well as immediate outcomes

III.

The Functional Contexts of Therapeutic Process

Input An important feature of the generic model of psychotherapy is its explicit recognition of the contexts in which therapeutic processes occur. The influence of these contexts on therapeutic process, as usual in system language, are referred to as "inputs." Figure 2 traces the interrelations among these input variables and components of therapeutic process.

Insert Figure 2 about here

The institutional structure and functions of society, and the cultural beliefs and values that legitimate them, determine the social ecology of the settings in which treatment occurs (e.g.: hospitals, outpatient clinics, university counseling centers, private office practice). These societal factors and the treatment setting together determine whether other parties than the patient and therapist will be involved in the therapeutic contract, and who they will be. The cultural beliefs and values of the society, together with the theoretical orientation favored in the treatment setting, inform and determine many aspects of the therapeutic contract, especially its character as a form of helping relationship. Finally, the institutional structure and the cultural ideals of society in the long run determine the characteristics and vulnerabilities of persons who become patients, as well as the characteristics and qualifications of persons who become therapists. The professional characteristics of the patient refer to such things as diagnosis and prior treatment history. The professional characteristics of the therapist include factors such as training, theoretical orientation and experience. These filter through the normative expectations of the patient and therapist roles to influence the form and content of therapeutic interventions. The personal characteristics of the patient and of the therapist include both their personalities and their personal lives outside their involvement in the specific treatment relationship. The personalities they bring to this relationship, and the ways their personal qualities mesh or fail to mesh, determine the potentials and the limits of the therapeutic bond that they can generate. As Leary, Carson, Kiesler and others have shown, styles of interpersonal behavior that are characteristic of different individuals mesh in ways that may facilitate the establishment of a stable bond or engender either conflict or incomprehension. Depending on idiosyncratic particularities of appearance, manner and life-style, each participant also may evoke significant memories or associations with people in the life of the other. The personal lifeworlds of the participants, as distinct from their personalities, are also likely to influence the therapeutic bond and other aspects of process in varied ways. For example, a different type of relationship would probably form between a single male therapist and a single female patient than would form between a married female therapist and a married male patient, a between a therapist and a patient who each are parents of adolescents. Finally, the patient's and the therapist's self-relatedness

represent traits of personality that become manifest in therapy. Recurring states of self-absorption, defensiveness and disorganization reflect strain or failure in the structure of the ego and its self- schemata. On the other hand, states of openness, centeredness and self-acceptance, especially in the face of stress, indicate resilient integration and equilibrium in the structure of personal identity.

Output The very same social, cultural and individual contexts that influence the form and content of therapeutic process are also, in varying degrees, influenced by it. The consequences of psychotherapy will naturally be greatest for the individuals who are actively participating in it. Generally the term "outcome" is used to refer to the impact of therapy on the patient, which of course is the raison d'etre of treatment, but it is clear that the total "output" of therapy must involve more than that. It may involve more than just idle curiosity to inquire into the nature of the impact that doing therapy has on the life and personality of the therapist (Farber, 1983a; Henry, Sims and Spray, 1973), since it is reasonable to suppose that such impact may in turn have both positive and negative influences on the therapist's subsequent therapeutic behavior. Concern with professional "burn- out" is one example of the latter (Farber, 1983b). The social networks of the patient and therapist are also indirectly affected by the therapeutic process through their connections with the direct participants. Similarly, the treatment setting may be affected by the events of therapy, although the impact is likely to be palpable only in the aggregate rather than in individual cases. In the same vein, aggregate trends in the clientele and practices of psychotherapy over a sufficient period of time are likely to have some eventual impact on the institutional structures and cultural values of society-at-large (Bellah et al., 1985).

Insert Figure 3 (available from the author) about here

The complex web of influences emanating from the psychotherapeutic process are sketched in Figure 3. The upper level of this diagram represents the components of process that have a direct influence on output variables. The three levels below represent consequences on phenomena that are manifested over rather different spans of time. Certain phenomena change so slowly that they seem to be unchanging

structures over fairly short spans of time, while other phenomena are of such short duration that they are hardly noticeable over longer spans of time. This rule of temporal scale applies as much to the realm of psychological and social phenomena as it does in the realm of physical (e.g., geographic/geological) phenomena. Simply as a convenience, we shall distinguish three orders of temporal span of phenomena susceptible to influence by psychotherapeutic process. The first order is constituted by events external to therapy whose duration is measurable in hours and days, e.g., a mood. Therapeutic impact on such events will be called micro-outputs. A second order is constituted by events measurable over a span of several weeks, e.g., an episode of depression. Impact on this order of events will be called meso-outputs. Finally, the third order is constitute by phenomena that may take months or years to unfold, e.g., a long-standing habit or a change in personality structure. Impact on this order will be called macro- outputs. For research purposes, a more detailed scheme such as that shown in Figure 4 may be used.

Insert Figure 4 about here

Recognition of the temporal scale of output variables is essential to a clear delineation of the effects of psychotherapy. For example, "crisis symptoms" related to high levels of stress (e.g., anxiety attacks) tend to emerge and recede over relatively short periods of time; "problem symptoms" (e.g., marital discord) tend to be of longer duration, and "character symptoms" (e.g., paranoid thinking) of even longer duration. Beginning with relations between the two upper levels, the "generic model" first recognizes the obvious fact that the therapeutic contract establishes a balanced system of exchange between patient and therapist. To compensate for the therapist's efforts and the patient's benefits in therapy, the contract imposes monetary and other costs on the patient, and provides monetary and other rewards for the therapist. The cumulative cost of treatment to the patient (e.g., Newman and Howard, 1986) affects many practical decisions, especially the patient's continuation or termination of treatment. Other micro-outputs include the patient's and the therapist's immediate post-session output. For example, Figure 3 indicates a direct impact of the therapeutic bond on both the patient and the therapist. If

the quality of the bond is high, or is improving, the result for both participants should be a sense of genuine connection and affirmation. On the other hand, if the quality of the therapeutic bond is poor, or is deteriorating, the result for both participants should be a disquieting sense of alienation. Therapeutic realizations similarly contribute to the patient's immediate post-session output. The latter refers to what patients carry with them from their therapy sessions as they return to the pursuits and involvements of their daily lives. For example, insight achieved as a therapeutic realization may lead to a shift in cognitive perspective that permits the patient to see a particular problem in a new light. Enlarged perspective, improved skill, enhanced energy and heightened morale are all positive changes of fairly brief duration. Without practice, cultivation and reinforcement they may dissipate in a matter of hours or days. For patients, increases in the understanding, skill, energy and confidence that are available for application in their daily living constitute valuable "micro-outcomes." Other micro-outputs might be anticipated. For example, witnessing the patient's attainment of therapeutic realizations is also likely to enhance the therapist's sense of self-efficacy (White, 1959; Bandura, 1977). By their very nature, the micro-outputs of therapy soon fade or are superseded by the impact of other events. Under favorable conditions, however, these micro-outputs may accumulate over time, and influence the participants' on-going life involvements and their concurrent psychological functioning. Something like a "chain reaction" based on the accumulation of a critical mass of favorable changes, or a "benign cycle" based on positive feedback, must occur to transform micro-outputs into meso-outputs. Naturally, a great interest attaches to what the aforementioned favorable conditions might be. Figure 3 shows that the participants' on-going life involvements are open to influence from both interpersonal and intrapersonal sources. Externally, these influences come from the treatment setting, from the individual participant's social network and from the general economic, social and political conditions affecting the life-chances of the individual and of significant others in the individual's social network. Internally, such influences derive from the individual's on-going mode of psychological functioning, and from the fundamental organization of the individual's personal life and character. To take but one example, the patient's social network creates opportunities, challenges and constraints that must coped be with. If there are sufficient opportunities, appropriate levels of challenge and tolerable constraints, the positive micro-outputs of

therapy should find scope for successful application. Thus, favorable opportunities and challenges presented by situations in everyday life may facilitate the consolidation of enlarged perspective and improved social skills into more effective coping strategies. Similarly, enhanced energy and heightened morale may develop into a more consistently positive "personal attitude" and a more consistently sustained sense of well-being. On the other hand, where opportunities are lacking, challenges are overwhelming and constraints are stringent, any positive micro-outputs gotten by the patient are likely to fall on barren soil. This latter situation is often found when an improved psychiatric inpatient is discharged into a chaotic family situation, or into an anomic social environment. The accumulation and consolidation of meso-outputs into enduring changes in the individual's life and personality poses a similar problem. These are traced at the bottom level of Figure 3. The generic model proposes that the transformation of meso-outputs (i.e., on-going life involvements and modes of psychological functioning) into "structural" changes in the patient's life history and personality must occur within the framework, and be responsive to the influences, generated by the social institutions and cultural patterns of society-at-large. In other words, the production of macro-outputs is mediated by the major economic and social determinants of by what Max Weber (1946) referred to as individual "life-chances" and life-style. Life-chance and life-style determinants include such sociodemographic factors as economic success or failure, marriage or the loss of a spouse, parenthood or childlessness, accidental injury or the trauma of combat service. These formative experiences give ultimate shape to the individual's biography. The individual's attitudes in response to them set the lines of his character. Therapy may challenge these characteristic attitudes directly, sometimes with dramatic results, but it is probably the case that change of such scope is brought about by the accumulation and consolidation of smaller shifts in adaptation under favorable life circumstances. To date, most of the research done to evaluate patients' therapeutic outcome has been focused at the level of meso- or macro-outputs. We do not yet have very much detailed information about the transformation of therapeutic realizations into micro-outputs, or of micro-outputs into meso- and macro-outputs. However, it seems plausible to suppose that the greater the number of positive micro- outputs patients experience, the more likely they are to achieve measurably beneficial macro-outputs.

Implications An overview of the complex flow from input to process, and from process to output, can be gained when the generic model of psychotherapy is represented in its entirety (see Figure 5). The institutional arrangements and the cultural patterns of society are clearly shown to be crucial determinants of the whole psychotherapeutic system.

Insert Figure 5 about here

Sociocultural factors determine the roles and symbols defining the treatment setting, and determine whether other parties than the socially identified "patient" and the culturally recognized "therapist" will be involved in the therapeutic contract. The characteristics of those persons who come to occupy the roles and wield the symbols of "patient" and "therapist" are also to a great extent socially determined (this, of course, does not exclude concurrent determination by other, e.g., psychobiological factors). Even the nature of the therapeutic contract is shaped by its implicit conformance to the more general societal conception of a "helping relationship" (e.g.: Parsons, 1964; Doi, 1973). Another interesting feature of the generic model, viewed in its entirety, is the existence of feedback loops at several points. There is the large loop among process variables that goes Therapeutic Bond --> Patient Self-Relatedness --> Therapeutic Realization --> Therapeutic Bond, which suggests that therapy can become a self-sustaining chain-reaction by creating greater and greater openness to therapeutic interventions. Within this larger scheme there is a very important loop that runs Patient Self-Relatedness --> Therapeutic Bond --> Patient Self- Relatedness. The model points here to the therapeutic bond as the main alternative to the patient's personality in determining the crucial gating variable of patient self-relatedness (openness/defensiveness). Although severely constricted self- relatedness might be given as a reasonable excuse for the limited success of therapy with patients who are borderline or psychotic individuals, this aspect of the generic model suggests that even in very difficult cases there is some hope for success if a "good enough" therapeutic

bond can be cultivated over a sufficient period of time. It is surely the therapist's responsibility in any case to cultivate as sustaining a therapeutic bond as the dyad can generate. Given the influence of therapist self-relatedness on the therapeutic bond, and thus indirectly on patient self-relatedness, the generic model further suggests that one way in which therapists can contribute to the enhancement of patient self-relatedness is by taking care to optimize their own personal self-relatedness. The loop that runs Therapist Self-Relatedness --> Therapeutic Bond --> Therapist Self-Relatedness should provide a natural incentive toward this end, since participation in a good or improving therapeutic bond is likely to have a tonic emotional effect on the therapist. Perhaps the most critical feedback loop is the one linking Patient's Post-Session Outcomes --> Patient's On-going Involvements and Functioning --> Patient's Social Network (Other Contracting Parties) --> Patient's On-going Involvements and Functioning. This loop specifies how constructive changes made in therapy can work increasingly to improve the quality of the patient's everyday life -- enabling patients to take an active role in shaping their life circumstances, and enabling them to realize as much meaningfulness and satisfaction in life as their circumstances permit. The "generic model" indicates that with a resourceful patient in a benign life situation -- e.g., the "YAVIS" type of Schofield (1964) -- psychotherapy will proceed "naturally" with gathering momentum. Even a moderately equipped therapist can help such patients make real gains. However, the generic model also explains why therapy under less optimal circumstances often can be so very difficult. Concerning input variables, for example, parties other than the principal participants (family members, legal authorities, clinic administrators, etc.) can act in ways that effectively undermine the patient's or the therapist's ability to adhere to the therapeutic contract. Similarly, if social class and cultural differences between patient and therapist make it difficult for the patient to understand the terms of the therapeutic contract, or for the therapist to comprehend the needs and expressive style of the patient, then problems are bound to arise in attempting to implement the contract. In these latter cases, preliminary orientation of patients and/or therapists is often an effective remedy (Orlinsky and Howard, 1986b). Further problems at the level of input variables can arise if the life situation of the patient (e.g., inadequate finances), or of the therapist (e.g., rotation to another training facility), or an aspect of the treatment setting (e.g., a policy of offering only short-term treatment) keeps some patients from having

enough sessions to obtain an adequate "therapeutic dosage" (Howard et al., 1986). Clearly some patients need a great deal more than others. This is particularly true of those whose personalities and symptoms make them extremely difficult to work with, even under the best of circumstances. Because they are deficient in the interpersonal skills needed to engage in a good therapeutic bond, and because their personal self-relatedness is greatly constricted, their psychological availability to therapeutic influence is minimal. In these cases, the main process dynamics of psychotherapy cannot even begin to operate until the patient's condition has been improved by other means, such as medication, supportive hospitalization, explicit training in social skills, etc. Important problems arise even in ordinary outpatient settings when patient and therapist are in some ways ill-suited to forming a good therapeutic bond. Their personal characteristics and apparent life styles may elicit negative reactions which deter one or both of them from making a significant role-investment.Their individual psychological characteristics may be too divergent to permit a satisfactory level of empathic resonance. A final example of the difficulties made explicit by the "generic model" of psychotherapy occurs in relation to the domain of output variables. The process by which immediate post-session outputs (micro-outcomes) are applied to make real short-term gains, and by which the latter are transformed into long-term macro-outcomes, depends to a great extent on the benign or disruptive quality of the patient's environment (see, e.g., Voth and Orth, 1973). With psychotherapy no less than with surgery it can sometimes be said that "the operation was a success, but the patient died of complications." The therapist's ability to influence the patient's daily life events, in outpatient treatment at least, is very slight, and the ability to influence major life-chance determinants is nil. Here at last we are brought back by the generic model to consider the pervasive influence of social and cultural factors on the outcome, as well as on the process, of so individual and personal an undertaking as psychotherapy.

IV.

Clinical Implications of the Generic Model

In closing I want to consider whether this research-theory of therapy has any implications that can be carried over from the context of inquiry to the context of treatment. The distinction that I have tried to draw between research-theories and treatment- theories is, after all, a relative rather than an absolute one. Both are aspects of discourse about psychotherapy (i.e., branches of 'psychotherapology'). If theory, viewed pragmatically, is a way of talking about things, then we may ask what therapy researchers should say to practicing therapists when they meet to talk; or, in the context of internal dialogue, since many researchers are also therapists, what advice may one's researcher-self give to one's therapist-self? Perhaps the most pressing piece of practical advice to psychotherapists contained in the generic model concerns the therapeutic relationship: Pay continual attention to the quality of the relationship, especially the patient's experience of 'the relationship.' If the quality of the relationship is good, it is likely that the patient will also experience benefit either immediately or eventually. One might almost say: "Take care of the relationship, and the relationship will take care of the patient." Taking care of the relationship involves, first of all, maintaining a clear therapeutic contract. The integrity of the contract needs to be protected with regard to the procedural frame but most especially with regard to its ethical core: to treat the patient as an end rather than a means, even though as a professional therapist the patient is the means of one's livelihood; and, what is pretty much the same thing, to treat the patient as a subject rather than an object, even while inevitably forming a personal object-attachment of some sort to the patient. The latter implies both that one should not burden the patient with one's own "patient-vectors" (Whitaker & Malone, 1953), nor should one impose the terms and categories of one's own conceptions. To do this one must maintain a non-egocentric (or as Piaget said, a "de-centered") cognitive perspective in understanding the patient's communications. What one wants to attain is a truly intersubjective cognitive perspective. To paraphrase Kierkegaard, it is as natural for therapists as it is for anyone else to understand themselves subjectively and their patients objectively; the difficult but vital thing is to

understand the patient subjectively and oneself objectively. With regard to the therapeutic bond, this piece of advice means more than the necessary minimum of maintaining a working alliance; it also means, especially with needier and more sensitive patients, not to be afraid of the degree of personal warmth required to create a genuine "holding environment," nor the degree of intimacy required to engage in a state of shared fantasy -- if one can do so without unmanageable transference-resistances in either the patient or oneself; that is, if one can do so without jeopardizing the integrity of the therapeutic contract. Since lack of time prevents me from going further at this point, I shall end by expressing my deepest thanks once again to Professor Kächele for creating the opportunity for these presentations, and to all of you for attending patiently and contributing thoughtfully to what, for me, have been most stimulating discussions.

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