What Would I Like to Read in the Next 10 Years of Psychotherapy Research?

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Dear Professor Michael Wirsching (to whom multiple congratulations are due);
Dear distinguished colleagues, Professors Tuschen-Caffier, Kächele, Rudolf, and Strauss;
Esteemed guests; Ladies and Gentlemen:

I.

Anniversaries are occasions when it is natural to congratulate the people involved and celebrate with them, as we do here. But anniversaries also provide an opportunity to pause and consider the broader meaning of one's work. They are a natural time to review past accomplishments and reflect on future goals, to re-examine and renew one's sense of purpose—and, if necessary, to make corrections and improvements in the way we work. Holding a symposium on the future perspectives and development of psychotherapy research is thus a very fine way to celebrate the 50th anniversary of the University of Freiburg's Department of Psychosomatic Medicine and Psychotherapy.

I feel very honored and grateful to participate in this symposium, but I confess that I had to ask myself what qualifies me for this role. Possibly it is the fact that 2007 is also the 40th anniversary of my first published psychotherapy research—a paper called "The Good Therapy Hour" that I wrote with my friend Ken Howard (Orlinsky & Howard, 1967); possibly it is the

because I have collaborated on research with Drs. Hartmann and Zeeck here in Freiburg; but primarily, I suspect, the reason I am here tonight is that two years ago I wrote a rather critical commentary on the state of "mainstream" psychotherapy research (Orlinsky, 2006) which evidently struck a resonant chord with many colleagues, to judge from the number of times it has been reprinted.

The essay was my response to a question addressed to me about "the kind of psychotherapy research that I like to read." This was to be my contribution to a series of essays by past-presidents of the North American Society for Psychotherapy Research for the Society's *Newsletter*. I started by confessing that, in fact, I really don't *like* to read psychotherapy research, in the normal sense of "reading." The stories to be found in research papers are highly repetitive, the writing style is awkward, and there is little wit or humor. Usually I just *scan* the abstracts of articles as issues of journals arrive, more from a sense of duty than *liking*; and, if an article seems relevant to my own research, then I read the *Method* section to learn how the study was done, and scan the tables of data to learn what was found it. I like *doing* research much more than reading about it, and generally follow that preference. Nevertheless, I have sometimes been given opportunities to review psychotherapy research literature for publications that I could hardly refuse (like Bergin and Garfield's *Handbook of Psychotherapy and Behavior Change*), and to accomplish that I *had* to read a very large number of articles and books. So, whether I liked it or not, I have in fact read a lot of psychotherapy research over the past 40 years.

II.

On that basis, I said in my essay that I thought that psychotherapy research in recent years has taken on many of the trappings of what Thomas Kuhn (1970) described as "normal science"—meaning that research by and large has become devoted to incrementally and

systematically working out the details of a "paradigm" or generally accepted model of research. A research model or paradigm contains assumptions about theory and method that are not often questioned by those who follow it, and thus are rarely subjected to critical reflection. Instead, criticism is directed toward studies that do not follow the common research model.

In the case of psychotherapy research, the dominant research paradigm can be described as follows: the therapies to be studied are formulated as *manualized treatment procedures* that are designed to influence *specific types of psychological disorder*, and these procedures are to be studied under *controlled treatment settings* in experiments called *randomly controlled trials* (or RCTs). I recognize that there are psychotherapy researchers who do not follow that follow this 'mainstream' research model (including some of the participants in this symposium), but the studies of researchers who do follow the 'mainstream' model typically gain access most readily to the prestigious 'mainstream' journals—and even those researchers who feel uncomfortable with the dominant model, who prefer to do other types of research, often feel compelled to respect the claims of 'mainstream' research.

In my essay, I deliberately described psychotherapy research which follows this model as having the "trappings of normal science" (rather than simply as "normal science") in order to play on an ambiguity in the English word that create a *double entendre*. The phrase "trappings of normal science" suggests that the 'trappings' or *appearance* of normal science, with its implicit paradigmatic consensus, may also represent 'trapping' or *entrapment* of research in a constricted and unrealistic model. My aim in this symposium is to explicate the limitations and flawed assumptions of the dominant paradigm which I hope represents the *past* of psychotherapy research, and to suggest some approaches to what I hope will be its *future*.

Here are some of the implicit and thus typically unquestioned assumptions of our paradigm. Psychotherapies are assumed to consist basically of discrete and specifiable *procedures* or techniques that can be taught, learned, and applied. It is also assumed that the relative *efficacy* of these procedures in treating distinct and specifiable psychological or behavioral disorders, in controlled laboratory conditions, determines which form of therapy are most *effective* in clinical settings. It is further assumed that the therapists who provide those treatments are well-trained in them and adhere closely to them in practice, and that patients generally are equally willing and able to comply with the treatments that are offered. Therapists are assumed to be *active* agents or providers of treatment and patients are assumed to be *reactive* objects or recipients. Researchers may well believe *in theory* that patients as well as therapists are active subjects, and that what transpires between them in therapy should be viewed as interaction, but *in practice* the research paradigm they follow implicitly defines treatment as a unidirectional process.

Evidence of these implicit conceptions of the patient, therapist, and treatment process is to be found in experimental designs that randomly assign patients to alternative treatment conditions, just as if they were 'objects' (rarely bothering to inquire about the *patient's* preferences) whereas therapists are never assigned to alternative treatment conditions, randomly or systematically (because it seems essential to consider the *therapist's* subjective treatment preferences). The logical consequence of this practice is that comparisons between treatment conditions reflect therapist-by-treatment interaction effects rather than treatment main effects, but this is an embarrassment that all conveniently ignore (as in the fable about the emperor's new clothes).

In addition, the dominant research paradigm constricts our view of the phenomena that psychotherapy researchers presume they are studying by focusing on certain *abstracted* qualities or characteristics of patients and therapists. The target of treatment is not actually the patient as a person but rather a diagnosed *disorder*. Other patient characteristics are presumed to be "controlled" through random assignment—which invokes another embarrassing myth, since the effectiveness of random assignment depends on the law of large numbers, and the number of subjects in a sample or of replicated samples is rarely large enough to sustain this—or else statistically by using the few characteristics of patients that are routinely assessed in studies as covariates. The covariates most typically used for this purpose are demographic variables assessed for the purpose of describing the sample—age, gender, marital status, race/ethnicity, and the like—which are selected *atheoretically* since there are no widely accepted theories to guide the selection of patient variables. (More recently, "alliance" measures have been routinely collected from patients, reflecting the massive accumulation of *empirical* findings on the impact of therapeutic relationship.)

Psychotherapists are likewise viewed in terms of certain *abstracted* qualities or characteristics. The agent of treatment studied is not actually the therapist as an individual but rather a specific set of *manualized treatment skills* in which the therapist is expected to have been trained to an assessed level of *competence*, and to which the therapist is expected to show close *adherence* in practice. The few other therapist characteristics that are routinely assessed—professional background, career level, theoretical orientation, and perhaps gender and race/ethnicity—are used largely to describe the sample or, occasionally, as covariates. Again, this is because there are no widely accepted theories, or extensively replicated empirical findings, to guide the selection of therapist variables.

The constricted and highly abstracted view of patients, therapists, and the therapeutic process in the dominant research paradigm is supported by cognitive biases in modern culture that all of us share. One of these was well-described by the sociologist Peter Berger and his colleagues as *componentiality*. This is a basic assumption that "the components of reality are self-contained units which can be brought into relation with other such units—that is, reality is *not* conceived as an ongoing flux of juncture and disjuncture of unique entities. This apprehension in terms of components is essential to the reproducibility of the [industrial] production process as well as to the correlation of men and machines. … Reality is ordered in terms of such units, which are apprehended and manipulated as atomistic units. Thus, everything is analyzable into constituent components, and everything can be taken apart and put together again in terms of these components" (Berger, Berger & Kellner, 1974, p. 27).

This componentiality is reflected in the highly individual and *decontextualized* way that persons are thought about. Individuals are viewed as essentially separate, independent and basically interchangeable units of 'personality'—units that in turn are constituted by subcomponents which interact in a more or less mechanistic when researchers seek to assess the (hopefully positive but sometimes negative) impact of way—whether the subcomponents are conceptualized as traits that may be assessed quantitatively as 'individual difference' variables, or as clinically theorized components of personality (for example, *ego*, *id*, and *superego*).

Thus when researchers seek to assess the impact of psychotherapy on patients, they routinely focus their observations on component individuals abstracted from their life-contexts, and on the subcomponents of individuals toward which therapeutic treatments are targeted—symptomatic disorders and pathological character traits. They do not generally assess individuals as essentially embedded in sociocultural, economic-political and developmental life-contexts. A

componential view of psychotherapy and of the individuals who engage in it is implicit in the dominant research paradigm, and produces a comforting sense of cognitive control for researchers—but does it do justice to the *realities* we seek to study, or does it distort them?

Another widely shared bias of modern culture that complicates and distorts the work of psychotherapy researchers (and, more broadly, in psychopharmacology and medicine) is the implicit assumption of an essential distinction or dichotomy between *soma* and *psyche* (or brain and mind), notwithstanding the efforts of modern philosophers to undo this Cartesian myth. Because of this, findings that psychological phenomena have neurological or other bodily correlates (by using MRI or CT scans to detect changes in emotional response) are viewed not as interesting findings but as wonders worthy of note in the daily press. The materialist bias of modern culture also fosters a reductionistic view of observed psychophysiological correlation, with the physiological aspect of the correlation assumed to be more basic, and thus the *cause* of the psychological aspect.

Thanks to a conversation at the 2005 SPR conference in Montreal among colleagues from different cultural traditions, I was made aware of how *unnatural* this body-mind dichotomy (with its consequent distinction between 'physical health' and 'mental health') appears from other cultural perspectives, and of how grossly it distorts the basic *psychosomatic continuity* of the living human person. I suddenly understood that when this basic continuity is theoretically split into 'psyche' and 'soma', a powerful but uncomprehended *third* factor is created as a byproduct (much as energy is released when atoms are split). This mysterious factor is labeled in Latin (and viewed dismissively in theory) as the "placebo" effect—and is viewed as a contaminant in experiments that researchers struggle to eliminate, although they typically fail to do so because the placebo effect reflects a fundamental reality of human nature that *cannot* be eliminated.

It seems clear to me that the dominant paradigm followed in 'mainstream' therapy research does not adequately address the human realities of psychotherapy, and for that reason is not truly scientific. Why then does this paradigm dominate the field of psychotherapy research, and why do researchers persist in using it? The answer is *partly cultural*, as the paradigm neatly reflects the componential, psycho/somatically split, materialist cognitive biases of Western culture. It is also *partly psychological*, with supporters of the paradigm becoming more militant as a result of cognitive dissonance generated by the incipient failure of the paradigm's utopian promise of producing rigorously validated scientific knowledge (see, e.g., Festinger, Riecken & Schachter, 1956). The answer is also *partly historical*, because psychotherapeutic *practice* originated in a medical context, and research on psychotherapy evolved in the field of clinical psychology at a time when that field was dominated by a radical positivist agenda. Finally, the answer is *partly economic*, since it is necessary to please biomedical funding agencies (another 'placebo' effect) in order to obtain grants for research.

It may be ironic that the paradigm adheres so closely to the medical model of illness and treatment at a time when the medical psychiatric profession has largely withdrawn from the practice of psychotherapy, at least in the United States (Luhrmann, 2000). The apparent solidity of the paradigm that survives is based (a) on the fact that psychotherapeutic services still are largely funded through health insurance, which had been politically expanded (after much lobbying) to include non-medical practitioners, and (b) on the fact that psychotherapy research still is largely funded through grants from biomedical research agencies. Although there is no for-profit industry promoting psychotherapy and supporting research on it as Big Pharma does with the psychopharmacologic treatments of biological psychiatry, most of the money that can be had in psychotherapeutic practice and psychotherapy research comes from sources that implicitly

support a medical model of mental health. As ever "those who pay the piper call the tune," although perhaps it is more accurate to add that pipers who need and seek financial support (both therapists *and* researchers) try to play their tunes in ways that will be pleasing to potential sponsors. Economic necessity drives us, that is a given; but we also have an uncanny ability to persuade ourselves that advantage and merit coincide. If this is not overtly corrupting, it is nevertheless constricting in ways that seem to me to be highly problematic.

If we are indeed to have evidence-based psychotherapies grounded in systematic, well-replicated research (e.g., Goodheart, Kazdin & Sternberg, 2006), and evidence-based training for psychotherapists (e.g., Orlinsky & Rønnestad, 2005), then it is essential for that research to be based on a paradigm that more adequately matches the actual experience and lived reality it presumes to study.

III.

At this point in my essay, I said that I don't know what that new paradigm for psychotherapy research will turn out to be, and readily assigned the task of constructing to the next generation of researchers. However, since then I have had time to reflect further on what a new paradigm will need. For this symposium, I was asked to play the role of the old man who is asked "What I would like to read in the next 10 years of psychotherapy research," while my younger colleagues were asked "What should we do in the next 10 years of psychotherapy research?" Now I would rather like to step out of that 'old man' role to claim a place among the younger colleagues who I have said will create a new paradigm for psychotherapy research.

I think we 'young ones' must begin, not by abandoning the old paradigm, but by expanding it. This is needed in three directions: first, expanding our view psychotherapy; second, expanding our view of how valid scientific knowledge of psychotherapy and its effects can be

best acquired; and third, expanding our view the human contexts in which psychotherapy occurs. I will mention the first two briefly, and the third at slightly greater length.

The 'official' research conception of therapeutic process needs to include more than just a set of specialized *procedures* that are applied to a specific psychological or behavioral *disorder*. Rather, our research conception of therapy ought to recognize the *persons* who are engaged with one another through their reciprocal roles as patient and therapist, and recognize the circumstances and setting in which they experience their encounters and work together more or less well. In a famous poem, the Irish poet Yeats asked "How can we know the dancers from the dance?" Either it is not possible to do so, or any knowledge so acquired would not be of much value. Studying psychotherapy conceptualized as a set of treatment procedures is like attempting to know the dance without knowing the dancers, and implicitly assumes that the efficacy of therapy inheres exclusively or primarily in those procedures rather than in other aspects of what occurs between the dancers. The research model needs to recognize that psychotherapy is a professionally-guided *'healing' collaboration* between a *person* with some distressing adaptational problems (but also with some problem-solving resources) and a *person* with some clinical skills, therapeutic talent, healing motivation. The research paradigm will become more truly scientific if it can deal more realistically with the complex clinical reality.

The methodology for studying therapeutic process and its effects must also be expanded beyond reliance experimental RCTs as a supposed "gold standard" to include a broader range of quantitative and qualitative methods, each of which should be recognized as having certain advantages *and* limitations. Greater reliance should be placed on the gathering of "treatment-based evidence" through systematic naturalistic research, and particularly through what the late Ken Howard called "patient-focused research" (Howard, Moras, Brill, Martinovich & Lutz,

1996). Our methods of data analysis also need to expand beyond reliance on statistics derived from the linear mode (Krause & Howard, 2002).

However, what I find most lacking in the established research paradigm is an understanding of the human *contexts* in which therapy takes place, and an adequate theoretical account of the *complexity* of those contexts. The key requirement for a better research paradigm is 'context, context, context'. An adequate theory of *context* will allow us to identify the range of variables that need to be included in research studies to make them correspond more closely to the human reality of psychotherapy. In two papers that were published in *Psychotherapeut* (Orlinsky, 2004a, 2004b) I set forth some preliminary thoughts about the human contexts of therapy. For this anniversary symposium, I have prepared a further set of charts that seek to map those conceptual domains in a way that can be useful for therapy research, which I will show in concluding this talk and perhaps discuss more fully in the workshop session to follow.

Present Figure 1

As a baseline, the first chart depicts the current, established paradigm for psychotherapy research. The main elements are (1st) the *patient role*, defined primarily in terms of *problems* that are construed as diagnosable disorders, and secondarily in terms of a few demographic characteristics typically used to describe patient samples; (2nd) the *therapist role*, defined primarily in terms of diagnosis-specific clinical *interventions* that should be applied to the diagnosed problems, and secondarily in terms of a few professional characteristics; and (3rd) the patient's personal adaptation, usually described in terms of the symptomatic condition and life functioning in occupational or familial roles, which the treatment is meant to improve. The *therapeutic process* is viewed primarily in terms of the more or less *competent* application of

treatment interventions to diagnosed problems *suitable* for the treatment (labeled in the diagram as the "Tx-Dx Fit"); and secondarily in terms of a 'working alliance' based on *adherence* to the treatment manual in service delivery and on *compliance* with treatment conditions by the recipients. This schema is largely decontextualized except for the rudimentarily conceptualized aspects of the patients which successful treatment is supposed to benefit.

Present Figure 2

The second chart starts to expand the conceptualization of therapeutic contexts by making two simple distinctions, and suggesting a third. The first distinction is between the *roles* of patient and therapist through which therapy is conducted, and the physical and organization *treatment milieu* where the roles are enacted—giving them, in Shakespeare's words, a "local habitation" as well as a name. The second distinction is between the *roles* of patient and therapist and the *persons* who embody and enact the roles—for, as we all know, the person who occupies the therapist role in one treatment setting is likely at some time to occupy the patient role in another setting.

Adding persons to the research model enables us to expand our view of therapeutic process and outcome. Firstly, it allows us to recognize the obvious fact that these persons are much more than simply occupants of the roles they enact in this situation; that each person has many attributes, which may be divided into those that are directly relevant to the role enacted in therapy and those that are less directly relevant. The directly relevant attributes include their clinical and professional characteristics, as defined in the treatment milieu; their personal demographics; and their personal "presence," which refers to the totality of *expressive behavior* that they manifest in their face-to-face interactions (a domain conceptualized by sociologists like

Georg Simmel and Erving Goffman, and always acutely and beautifully described by great writers like Tolstoy).

The distinction between the *roles* in therapy and the *persons* who enact the roles also permits clarification of a critically important aspect of therapeutic process that is not well recognized in the established research paradigm: the *personal* (i.e., person-to-person) bond, which of course exists in every type of interaction but is here called the 'therapeutic bond'. This bond reflects the personal synergy of the participants—the way that the personal 'presence' of each individual attracts or repels, energizes or inhibits, that of the other person; they way that they affect each other as persons. This is something quite distinct from the roles that they have in treatment, yet a great deal of research shows that the therapeutic bond has a great impact on treatment outcome—so it is obviously useful to include a clear conception of it in our research model of therapy!

It is in the broader realm of personal attributes that are less directly relevant to the roles in therapy—those which are "outside" of therapy—that one should seek to find the impacts of participation in therapy that are termed treatment 'outcome' in relation to persons in the patient role, and that are generally ignored by the research paradigm in regard to persons in the therapist role (although therapists too are affected positively and negatively by their participation).

The broader aspects of any living persons may be distinguished most generally into those that constitute them as individuals and those that comprise their lives. The distinction is simply the familiar one between *being* and *doing*. Every live human being has an on-going life, by definition, and every real life has been lived and belongs to some particular human being. On the one side, we encounter the person as a unified psychosomatic being, which theories too often separate into psyche and soma; on the other side, we encounter the person as a life-in-progress.

Accordingly, the outcome impacts of therapy can be distinguished broadly as person-changes and life-changes. Probably most persons who come to therapy as patients want to change something about their lives, and probably most persons who serve as therapists think they ought to change their patients' personalities—a discrepancy in goals that can undermine their 'working alliance'.

You can see from this chart that a simple dialectical progression (the distinction of a phenomenon into its two main aspects) can quickly become a highly ramified conceptual system—more spread out than can be mapped on a single page. I will just quickly present two more charts to show how a series of simple binary distinctions results in a fairly rich overview of the human contexts of psychotherapy.

Present Figure 3

The third chart continues the unfolding map of contexts by making another round of dialectical distinctions at the next level of specificity: the unified individual being and on-going life of each participant. The person's *on-going life* is differentiated into his or her *current life situation* and the *life-trajectory*. The current life situation is differentiated into the person's *private life* and *communal life*. As commonly understood, *private* life consists mainly of one's family, friends, and intimate relationships, and *communal* life is defined by participation in social, political, religious, ethnic and linguistic communities. Private life and communal life together define what might be called the *existential context* of psychotherapy.

Among the middle classes in stable societies, it is the patient's *private life* that constitutes the main focus of psychotherapy: family relationships with parents, siblings, spouses, children, or in-laws; the vicissitudes of friendship, or the lack of friends; and the never-ending drama of

finding, fostering, or failing intimate relationships. Private life is undoubtedly the primary social context of therapy, and the area in which life-change therapeutic outcomes are most often sought and evaluated—by patients and therapists, if not by therapy researchers. Life-changing impacts of therapy can include increased meaningfulness, satisfaction, productivity, and responsibility.

However, the individual's *communal life* also constitutes a significant context of therapy. This is so partly because the very ability to engage the satisfactions and struggles of private life depends on the adequacy and predictability of support from the economic, political and social structures that define one's communal life. These factors do not intrude on the private lives of patients and therapists in the protected upper and middle strata of stable societies—strata that also include most therapy researchers—so they are not noticed or included in the therapy research paradigm.

But even among those who able to concentrate their attention and efforts on their private lives, the fact that they engage as patient and therapist in a *treatment milieu* presumes that they are members of the same *local community*. Their communal lives therefore overlap, at least to the extent of their speaking the same language (and very possibly to a greater degree), although they may well have no direct contact or connection outside of the treatment situation, particularly in large local communities like big towns or cities.

Just as the treatment milieu is nested within a local community, the local community itself is part of a national community in which large-scale political and economic trends may impact the lives of both patients and therapists. This is more evident in countries that have experienced significant political or economic instability, or for lives in the typically unstable impoverished and oppressed strata of other-wise stable countries. Moreover, national communities in turn occupy different niches in the evolving international world-system, where

they are variously subjected to the influence of economic and cultural globalization. Taken together, treatment milieu, local community, national community, and international community comprise four levels in the *sociocultural context* of psychotherapeutic practice. Interesting studies of psychotherapy exist at all these levels, although in disciplines that most therapy researchers do not know well and in publications that most therapy researchers do not read.

By contrast, most therapy researchers are quite familiar with the *developmental context* of psychotherapy, which however is hardly or not at all represented in the established therapy research paradigm. This developmental context is defined by the respective life-trajectories of the patient and therapist, and in some theoretical orientations the life-trajectory of the patient is subjected to careful scrutiny. Psychodynamically-oriented therapies typically examine the patient's early life history and development, while existential therapies give more emphasis to the patient's future life plans and life prospects—and, of course, the life-course trajectories of patients and therapists exist, they influence the course of therapy, and they are impacted by the events of therapy, whether or not they are focused on in therapy. Needless to say, this area is not part of the therapy research paradigm, so therapy researchers do not think to include it in their studies of process and outcome, even if patients and therapists do focus on it in treatment.

Present Figure 4

Finally, the fourth chart presents a range of contexts more familiar to therapy researchers who are typically trained in the fields of psychology and medicine. These are individual, interpersonal, and collective levels of *psychobiological context*. The distinctions that lead into this range of contexts start from the individual patient and therapist viewed as unified psychosomatic beings, and the first perilous step is distinguishing between the two aspects of the

person labeled ‘psyche’ and ‘soma’. This distinction is perilous because it risks confusion with the Cartesian metaphysical tradition of dichotomizing and essentially separating the individual into *res cogitans* (‘psyche’ or mind) and *res extensa* (‘soma’ or body). To draw the distinction in that way leaves the residual problem of how ‘psyche’ and ‘soma’ influence one another. The modern materialist assumption is that ‘soma’ (in particular, the brain) influences ‘psyche’ but not the reverse—a form reductionism that causes critics of psychotherapy to ask “how merely talking can change anything.” The fact that ‘psyche’ also influences ‘soma’ is recognized informally but formally, in the established therapy (and medical) research model, is given the mysterious label of ‘placebo’ effect—which experimenters always struggle, for the most part unsuccessfully, to eliminate or control.

However, if we make this distinction safely between two aspects of the unified individual, then it leads on the side of ‘psyche’ to a differentiation between *‘objective’ traits* (those directly observable by *other* persons) and the individual’s *subjectivity* (phenomena that persons experience directly). The individual’s objective traits include his or her cognitive, conative, affective, and social reactivity, based on temperament and acquired skills. Beyond earliest infancy, the individual’s subjectivity is structured, in the waking state, into ‘inner’ and ‘outer’ realms of experience populated respectively by interrelated clusters self- and object-schemas. (Dotted lines connect *subjectivity* to the individual’s on-going personal life to indicate the centrality in experience of one’s *perceived* current life situation, *remembered* life history, and *anticipated* future prospects.)

The current therapy research paradigm most clearly (if rudimentarily) recognizes this context area as the main target outcome-impacts. Psychotherapy should in some measurable way

increase the patient's vitality, realism, self-efficacy, and comfort. But this involves 'soma' as well as 'psyche'—in ways that require and merit further investigation.

The last, tentative distinction that I've made in this chart is between *species-typic* and *idio-typic* aspects of somatic functioning. The idio-typic aspect refers to individually variable features of organismic functioning, like the state of one's health and fitness and the profile of one's biological strengths and vulnerabilities. The species-typic aspect refers to the common features that define one's being broadly in anatomic and physiological terms, like one's life-span development and reproductive status. The generality of this collective bio-evolutionary context matches in scope that of the international world-system, as the broadest level of sociocultural context. Both are remote from the level at which psychotherapy process and outcome are usually studied, and exist only to define the outer limits of context that might be included in a new paradigm for psychotherapy research. Yet it is not hard to imagine that our evolutionary adaptation as mammals who depend on care from others for years before we fully mature, and as vocalizing primates with highly developed linguistic and symbolic capacities, has much to do with our potential to devise psychotherapies, nor is it hard to see that the current 'advanced capitalist' state of the international world-system has shaped that species potential for giving and receiving symbolic care into the particular forms of individual, marital, family, and group therapies that we find around us (Illouz, 2007; Orlinsky, 1989)—and that we, as researchers, strive to study.

IV.

In the foregoing comments, I have argued that the established paradigm in psychotherapy research is too constricted, too abstract and decontextualized, to generate realistic (and thus truly scientific) studies. I have argued that the paradigm needs to be expanded, and have tried to show

how this expansion can be made by providing a more adequate conception of the human contexts of psychotherapy. I did this *dialectically* by making a series of binary distinctions—each simple in itself, each intuitively obvious, and each demonstrating its fruitfulness by leading progressively, through further distinctions, to produce an ever-more specific conception of the contexts in which clinical practice occurs. When carried far enough, the process should lead to specifications that suggest how operational measures can be constructed for use in research studies. I think these have the potential for transforming what is now largely a field of applied research—obsessed with questions of "what works" and "what works best for whom"—into a field of basic research that draws on the social sciences and biology as well as psychology to raise interesting questions. I think I will like to read psychotherapy research much more if we can expand the established paradigm in ways that produce studies of this kind, and I suspect that I will not be the only one to do so!

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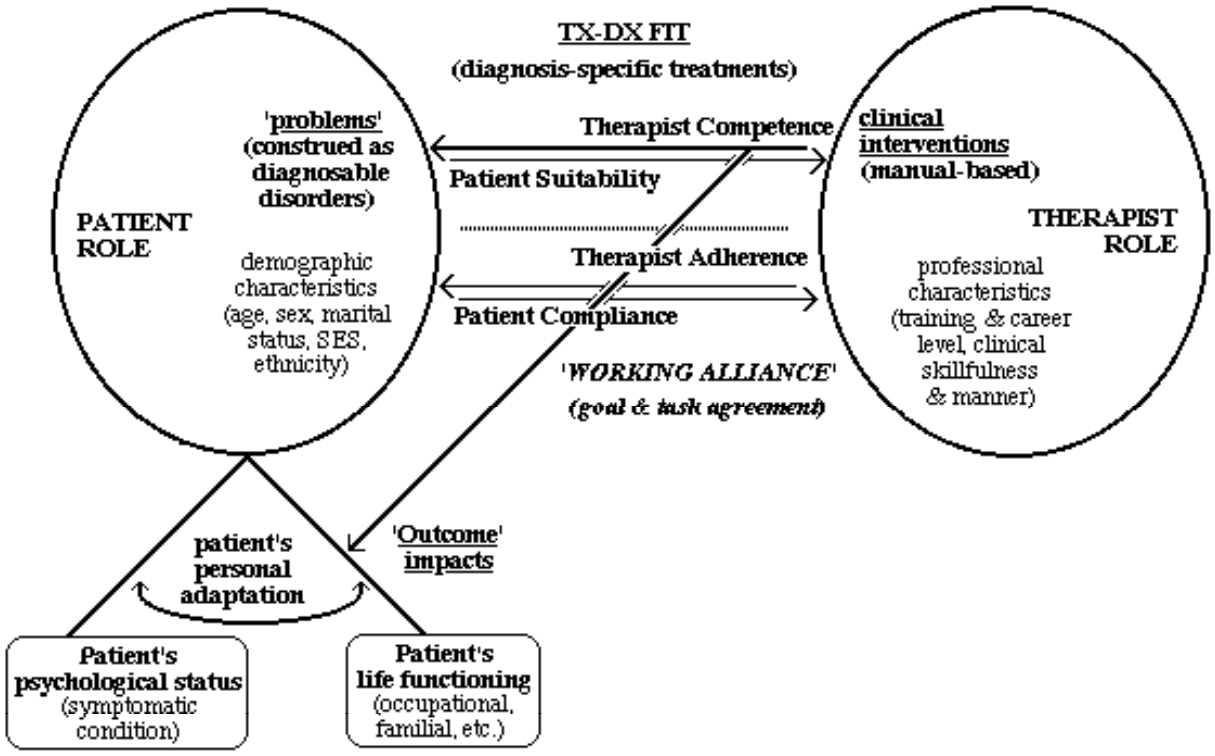

Figure 1. DECONTEXTUALIZED VIEW OF THERAPEUTIC ACTION (PROCESS AND OUTCOME) IN THE DOMINANT THERAPY RESEARCH PARADIGM

D. Orlinsky 8/07

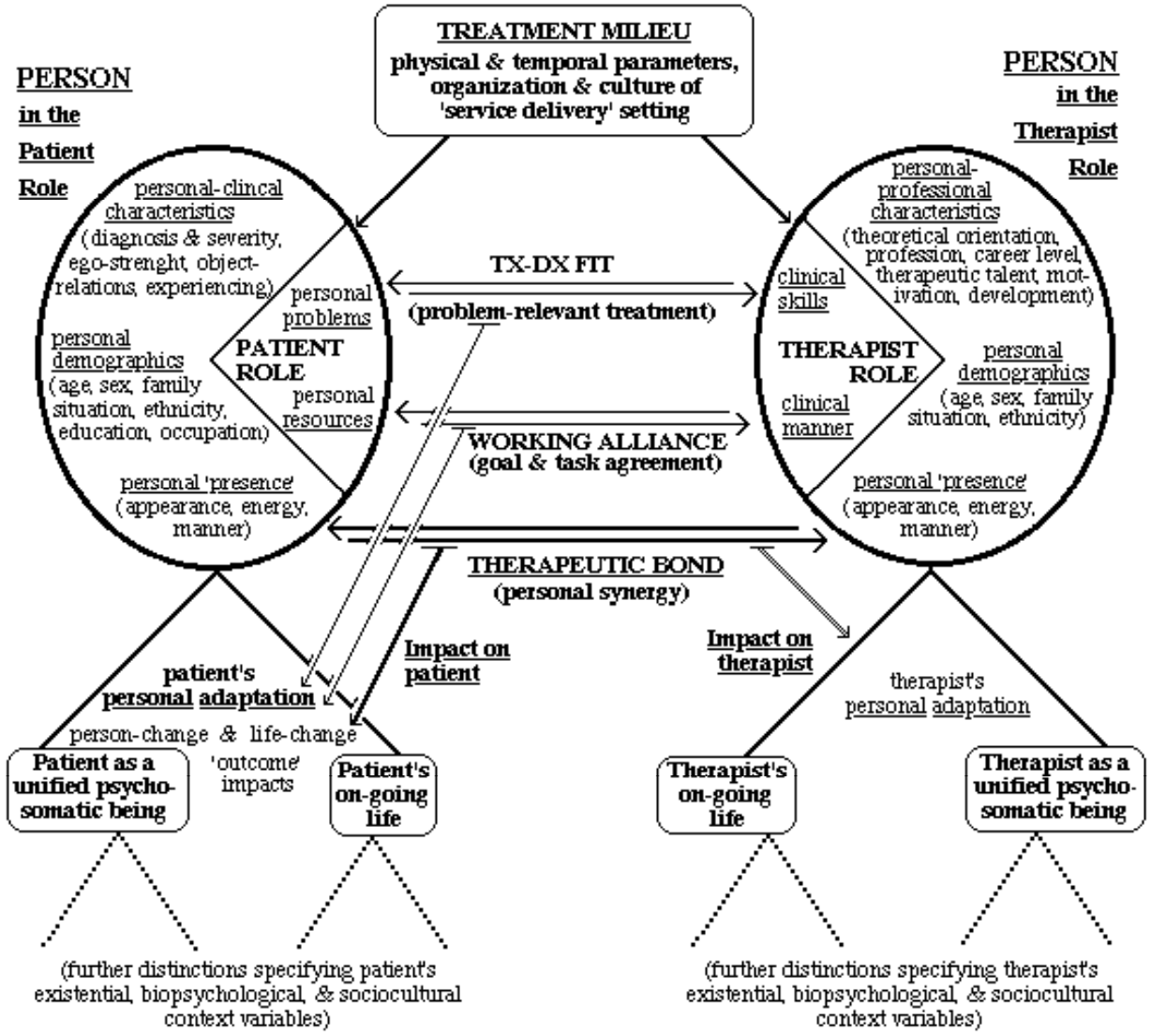

Figure 2. SITUATIONAL AND PERSONAL CONTEXTS OF THERAPEUTIC ACTION (PROCESS AND OUTCOME)

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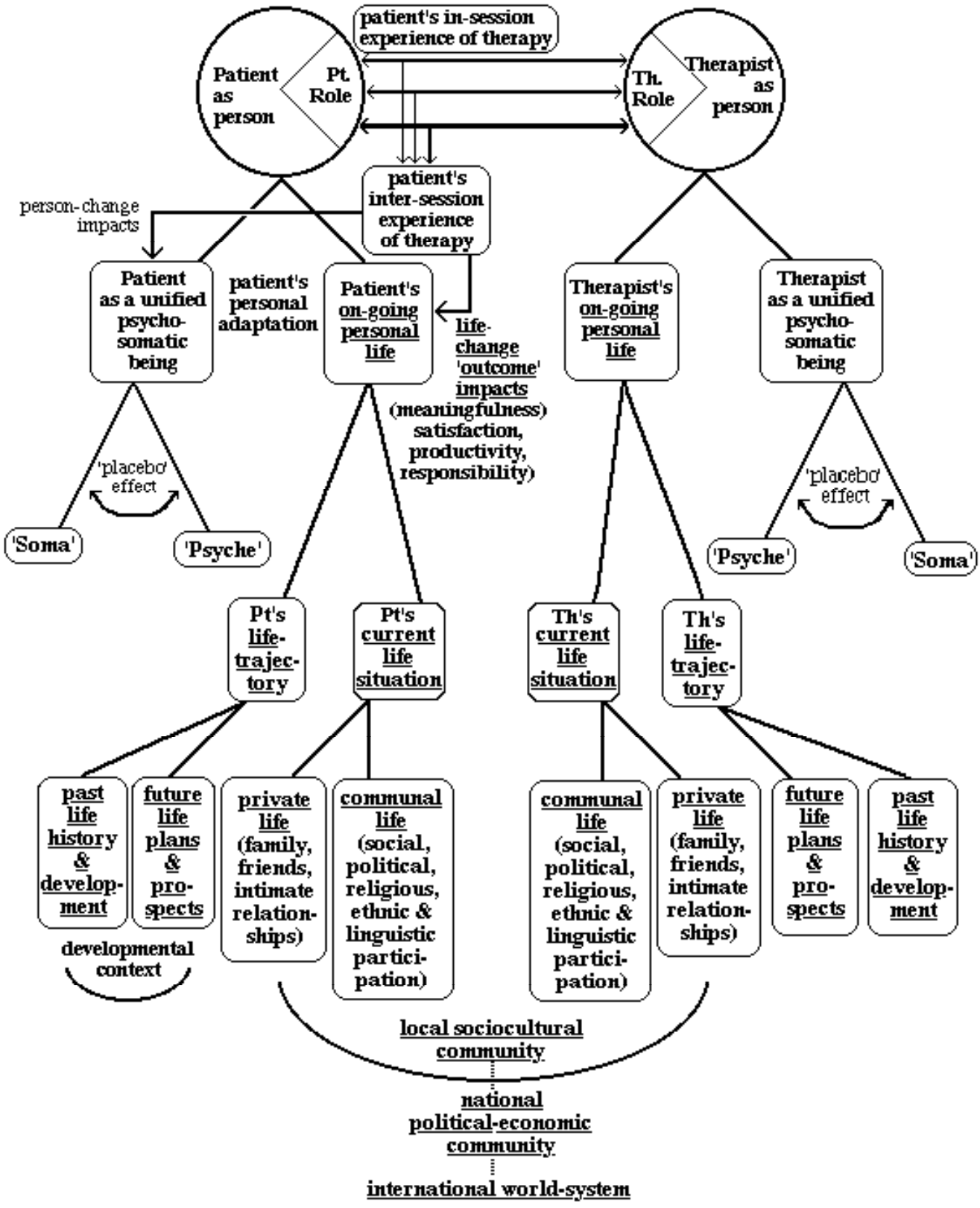

Figure 3. EXISTENTIAL, DEVELOPMENTAL, AND COMMUNITY CONTEXTS OF THERAPEUTIC ACTION (PROCESS AND OUTCOME)

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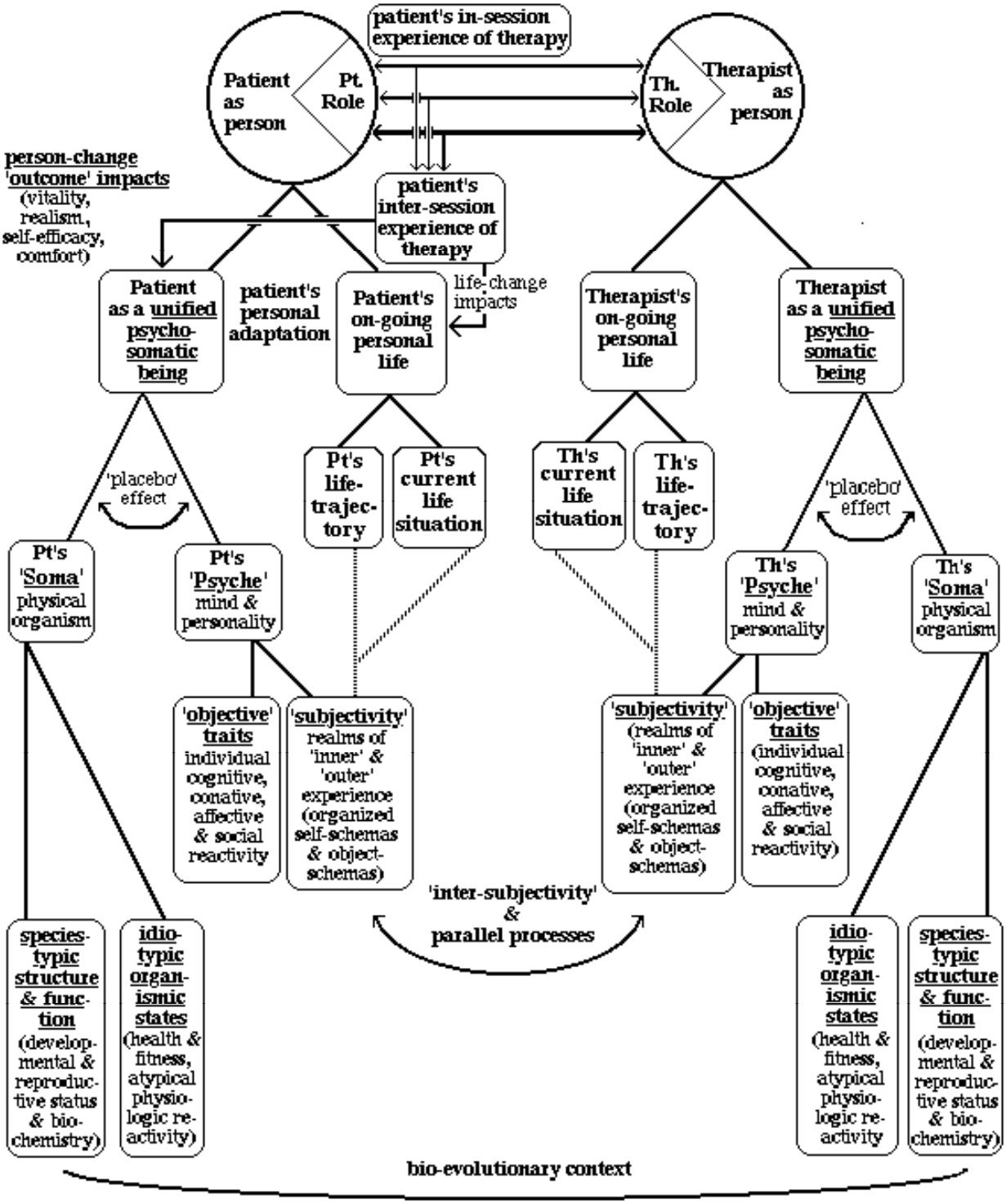

Figure 4. INDIVIDUAL, INTERPERSONAL, AND COLLECTIVE PSYCHOBIOLOGICAL CONTEXTS OF THERAPEUTIC ACTION (PROCESS AND OUTCOME)

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