Psychotherapy and the Dual Research Tradition

Formulated by the Committee on Therapy

Group for the Advancement of Psychiatry

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This is the fourth in a series of publications comprising Volume VII. For a list of other GAP publications on topics related to this subject, please see page 159.
STATEMENT OF PURPOSE

The Group for the Advancement of Psychiatry has a membership of approximately 195 psychiatrists, organized in the form of a number of working committees that direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisages continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health, and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations.

GAP is an independent group and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

Psychotherapy and the Dual Research Tradition was formulated by the Committee on Therapy. The members of this committee as well as all other committees are listed below.

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INTRODUCTION

The psychotherapist, trying to maintain contact with the onrush of modern science, faces a dilemma. His skills, which serve him well in his consulting room, often seem remote from the laboratory, where research increasingly centers. To him the rules of the laboratory appear stern, sometimes foreign, and often limiting. He may feel that more elastic types of investigation, closer to the clinical tradition, should be rewarding to pursue; but he has been unclear about the principles involved in such work, its place in the hierarchy of scientific endeavor, and the boundaries separating what is research from what is clinical art.

This dilemma has been manifest within the Committee on Therapy of the Group for the Advancement of Psychiatry. Composed of experienced psychotherapists, teachers, and investigators, it has attempted to formulate a general description of various aspects of psychotherapy. In its early years a clinical view was dominant; proponents of this view attempted to describe "the process" of psychotherapy in global terms, which were often impressionistic, metaphorical, and elusive. Other members were research investigators, who insisted on greater precision and more exact specification of levels of discourse in stating the relationship between psychotherapy and science.

Advocates of this more rigorous scientific view divided themselves into those who centered their inquiry on variables that could be manipulated so as to get experimental answers and those who upheld the need for naturalistic description, retaining explicit awareness of the complexity of the observational field. Several attitudes thus became apparent:

1. A clinical attitude, stressing the creative, unique aspects of psychotherapy.
2. A research or investigative attitude, pointing to the need to arrive at conclusions from data according to specified rules, but being further subdivided into:
   a. The experimentalist view, emphasizing isolation and manipulation of variables.
   b. The naturalist view, emphasizing study of pattern, configuration, and integration and minimal interference with the field of observation.

Actually, these contrasting attitudinal threads can be discerned running through the history of much human thought, especially in the biosocial area. We had encountered merely a special instance of a general problem. As was true for us, one or another of these viewpoints is often taken as an absolute. However, close examination of what the proponent of such a stance actually does in his work reveals subtler complexity. More often than not, intuitive clinical appraisal, experimental treatment of data, and naturalistic description are intermingled. We came to believe that the different points of view represented largely tactical emphasis on facets of observational procedure that a given worker had learned to value.

Our deliberations, therefore, seem prototypic of larger trends. We address ourselves to students of psychotherapy, particularly those starting their careers; but we also feel that even experienced workers may find it helpful to review some general aspects of the behavioral scene today, which are not always clearly articulated nor even recognized.

We shall start with a clinician's description of psychotherapy. Our pragmatic definition locates it in time and space, and describes some of its cultural roots, as well as certain dimensions that must be considered if it is to be studied systematically. Our
focus is a relationship involving two individuals, communicating by words, intonations, and gestures. Obviously, therapeutic efforts are expanding in additional directions, on the one hand moving to encompass larger groups, such as family or community, on the other hand using a variety of physical and pharmacological tools. We are limiting our inquiry to the traditional two-person interaction because we believe it is the important common denominator in most forms of psychotherapy, which extensively, though not exclusively, influences the current scene.*

Later sections of this report will contain some general remarks about research and research workers. Finally we shall turn to the two research attitudes and their interactions with each other and with the clinical tradition in psychiatry.

* Some recent reports speak of the need for special forms of therapy applicable to patients suffering from severe educational handicaps, who have allied or real communicative difficulties with middle-class physicians coming from markedly different cultural backgrounds. A number of authors, particularly since the study of Hollingshead and Redlich, 11 have pointed out the inequitable distribution of psychiatric services. This problem has been approached in various ways. Some stress the need to train paramedical personnel as "therapists" because they can speak the language of the disadvantaged. From a socioeconomic viewpoint this may well be necessary. Other studies— which have important implications for our understanding of psychotherapy— suggest that even Class V (Hollingshead) patients and certainly those in Class IV can benefit from a program of brief, traditional psychotherapy. 23

1

PSYCHOTHERAPY: A CLINICIAN'S VIEW

Psychotherapy is defined here as a developing transaction between two people, one suffering from some type of distress or exhibiting disordered behavior, the other offering amelioration as part of his professional activity. The transaction is structured and programmed by culture, as well as influenced by the individual histories and personalities of both participants.

This type of psychotherapeutic relationship evolved while psychiatry was emerging as a special branch of Western European medicine. Clearly some aspects of it are as old as the doctor-patient, the teacher-student, or even the parent-child relationship. As Pande recently said:

Psychotherapy, conceived in a broad generic framework, is coterminous with the history of man. And yet, psychotherapy, as we conceive and recognize it today, is a phenomenon of Western Society and the 20th century. More than a phenomenon it is a cultural institution of this society... affecting and transforming the soil and era in which it thrives.

Psychotherapy shares origins with a number of ameliorative disciplines, including not only medical practice but education, religious and legal guidance, social casework, and psychologic counselling. 23 The following table summarizes many of these elements in the psychotherapeutic situation.

The Participants

Patients—we use the generic term to include clients, counselees, analysands—come from varied circumstances and present a
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<td><strong>Elements of the Psychotherapeutic Situation</strong></td>
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<td><strong>(A) Generalized—Through History</strong></td>
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<td><strong>The Participants</strong></td>
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<tr>
<td>Disturbed Person, distressed or deviant</td>
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<tr>
<td>Practitioner, having special experience, prerogatives, and skills</td>
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<tr>
<td><strong>Aims and Assumptions</strong></td>
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<td>Change, “asymmetrical,” i.e., chiefly in the disturbed person, which is desirable and possible</td>
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<tr>
<td><strong>Structure of the Relationship</strong></td>
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<td>Superordinate-subordinate preponderantly</td>
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<td><strong>The Setting and the Compact</strong></td>
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<td>A Generally Structured Situation, having rules, including varying time and fee relationships</td>
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<td><strong>The Therapeutic Modality</strong></td>
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<td>Human Discourse, at times supplemented by physical methods</td>
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Variety of personal differences. The distress or disturbance that impels them is usually accompanied by some expectation of relief. We need to know much more about which individuals in a society seek help and specifically psychotherapeutic help, and which get it. 48 Both the patient's decision to come and his initial reaction to the situation itself are influenced, variably, by his preformed stereotype of physician or mental healer. Behind immediate and conscious needs can be discerned hidden fears as well as hidden hopes, such as those for magical transformation. Several observers have stressed how important such expectations can be in shaping the course of treatment. 54

Varying personality traits also characterize therapists. As a group, psychotherapists are possibly more homogeneous than their patients, but they show many subtle differences that influence their effectiveness, in general or with particular problems. Empathy, warmth, integrity, and commitment are significant attributes, although they are so meshed with one another that it is hard to assess their respective importance. 55 The desire to achieve a therapeutic result should probably be at an intermediate level, since an underzealous therapist is too detached to be truly effective, while one who is overly eager often ends by defeating his own goals. Freud 56 stressed the importance of scientific curiosity in the therapist and the desirability of having therapeutic work promote mutual understanding rather than exclusively attempt to “cure.”

**Aims and Assumptions**

Amelioration presumes change. Psychotherapy has been called “asymmetrical” 209 or “skewed,” 11 since maximum change is anticipated in one of the participants. 6

Bearing on this broad general aim are certain common assump-
tions. The first is a humanist assumption about the desirability of change, namely, that subjective distress and certain forms of deviant behavior not only can be ameliorated but should be.

Second is an assumption that a learning or developmental difficulty has played an etiologic role in the patient's disturbance.

Third is the assumption that this defect is correctable by relearning, which occurs when support, understanding, and insight at various levels enlarge the range of potential satisfactory behaviors available to the patient.

Fourth is an assumption about the relevance of human relationships, both in giving rise to the defect and in remedying it, namely, that the therapeutic relationship will itself be helpful because of variable combinations of reparative warmth and wise tutelage.

Fifth is an assumption that the abilities of the therapist—and to an extent those of the patient—although in part characterological, can be enhanced by training.

Lastly, there is an assumption of lawful, time-linked processes occurring in the therapeutic relationship. Many observers believe that the most important of these represent unconsciously determined patterns. However, it is here that greatest disagreement occurs between various schools, which differ about conceptualization of these processes.

Structure of the Therapist-Patient Relationship

We have suggested that the psychotherapist, in analogy to the surgeon or teacher, is usually cast in a role of superordinate to subordinate vis-à-vis his patient. The extent of this varies. The role may be carried out in manifestly authoritarian ways, as in many active and directive psychotherapies, or in ways that try to give the patient a large measure of responsibility, as does much present-day psychotherapy aimed at promoting self-reflection and insight. In view of the traditional authoritarian status that the therapist may have, the patient's situation of need, and the strength of his fantasies, efforts to achieve this kind of voluntary alliance in fact produce a double-layered structure, which has contradictory aspects and which elicits conflicting responses in the patient. The decision whether or not to try to resolve these paradoxical aspects in the course of the therapy is an important distinguishing feature between “supportive” and “insight” therapies.

Many situations call for gradual therapeutic involvement of a patient who does not see the need nor sometimes even the possibility of treatment by psychological means. A psychiatrist working in a community, an educational or military setting, or a medical word may deal with individuals unprepared for being helped with psychological conflicts, far less for seeking help by self-examination. Therapeutic activity may exert a beneficial but largely unacknowledged influence, or it may, especially at the start, focus on establishing a psychotherapeutic compact.

The Setting and the Compact

Once established, psychotherapy as we define it occurs in a setting that has certain general characteristics. The physical arrangements usually include an office or consulting room arranged to minimize extraneous interruptions and to encourage serious communication. The protection of privacy is maintained not only by such physical arrangements but also by the explicit or implicit promise of confidentiality.

An additional formal aspect of psychotherapy concerns time. Appointments are scheduled, partly for realistic reasons, on the part of therapist, partly because a regular schedule adds important elements of structure to the therapeutic experience. It provides an opportunity to observe patterns in the patient as he consciously or unconsciously manipulates time, coming late for appointments, reacting in one or another way near the end of sessions, or otherwise using time to highlight his character. Typically, sessions are of arbitrary, pre-established length, often roughly one hour.
hospital or other situation where a therapeutic compact is being struck, it is often possible and useful to vary the duration of sessions widely. It will require further study to assess the true effect of such variations.  

The element of time is important to psychotherapy in other ways. The relationship is ultimately destined to end. Thus it differs from many of the analogous relationships we have mentioned. For example, the role of family, doctor, clergyman, or close relative does not involve the assumption, implicit in psychotherapy, of a limited contact from which the patient must separate, presumably to emerge changed.  

Similar considerations apply to money. Fees vary from large to none; the belief is widespread that even relatively poor patients benefit from paying something, in exchange for the therapist's time and effort. Money, like time, is a part of reality. How it is dealt with illuminates facets of personality.  

Additional aspects of the compact vary in explicitness. Although emphasis is often placed on communicating as freely and as fully as possible, the patient soon discovers that intellectualized, factual, and impersonal reporting is discouraged, while emotive, fantasy-laden, and personal revelations are valued. He is thus implicitly urged to express his more primitive and unacceptable erotic or hostile feelings, which the therapist will accept within wide limits without retaliation. At the same time self-observation is enjoined to promote self-understanding. In this sense then, he is both free and not free. He is the subject of investigation and at the same time co-investigator with the therapist.  

A key feature of the therapeutic compact in a deep sense is its ambiguity. The patient is encouraged to enter it in order to obtain relief by unilateral self-exposure, but many rules remain covert or become clear only gradually. What follows is a series of attempts on his part to resolve the disturbing ambiguity and to elicit predictable—and satisfying—responses from the therapist by resorting to former patterns of behavior.  

The Therapeutic Modality  

We have noted that psychotherapies vary from the more authoritarian to the more permissive and openly warm. In a general sense therapists may show more "activity,” using suggestion and efforts to mobilize conscious motivation, or more "passivity,” leaving initiative to the patient and subsequently interpreting his behavior. Probably both elements are present in virtually every sort of therapy. Edward Bibring 16 described hierarchical steps—suggestion, abreaction, manipulation, clarification, confrontation, interpretation—all of which can be discerned at one or another time in all intensive treatments, including classical psychoanalysis.  

Our impression is that there are highly regular sequences in psychotherapeutic transactions. Study of single interviews, for example, has indicated that, whatever the theoretical school of the therapist and whatever his conceptualization, third-party observation often reveals that patterns unfold during sessions in repeatable and predictable ways. 95, 98, 120 Possibly the effectiveness of some gifted therapists comes about from their ability to vary spontaneously this ingrained rhythm.  

Predictable sequences appear over multiple sessions. One can discern the following stages: first a period in which therapist and patient get to know each other, diagnostic information is obtained, and the patient's role is clarified. Second is a period in which the patient recalls and usually re-enacts basic patterns of his behavior, searching for their origins and allowing these to be examined in terms of desirability and adaptiveness. Fantasies and impulses extend to include the therapist. In the intensive psychoanalytic experience these coalesce into a therapeutically induced regressive transference neurosis. This in turn is characterized by repetition of patterns that have been partially exposed but not abandoned, which are then scrutinized in order to increase their flexibility and range. Finally, patient and therapist sever their connection, with the hope that changed behavior patterns of the
patient will make it possible for him to carry on without therapeutic support or guidance.

This is an oversimplified summary of the course of psychotherapy. It derives from the psychoanalytic model, in which a patient commits himself to extensive self-investigation. Many brief forms of psychotherapy can be viewed as trying to modify the extensive procedure, selecting and applying key elements relevant to a particular problem. Sector therapy and other shortened therapies, often limited to a fixed number of hours, attempt to avoid a kind of interminable quasi-psychoanalysis by understanding the current disturbing pathogenic factors in a given patient and focusing as exclusively as possible on them. A different sort of focus may be necessary when social factors or life circumstances make it inappropriate to try to bring about change through self-understanding alone. Even in these abbreviated or active types of intervention the sequential phases we have sketched—the introduction, the engagement, the separation—can be discerned in telescoped form.

Regularity suggests discoverable law. Numerous related processes seem to characterize psychotherapeutic relationships. How these should be classified is not at present clear. We offer a possible scheme for such an ordering. This suggests that a number of reciprocal features or polarities emerge in the therapeutic situation. Ours is an inevitably arbitrary grouping of phenomena, some pertaining more to patient, some more to therapist, some to what goes on between them. The processes overlap, and although it is necessary to describe them sequentially, they occur more or less simultaneously.

Trusting-Mistrusting. In coming to psychotherapy the patient reveals some degree of helplessness or inability to cope with his life situation, and correspondingly a degree of dependence upon another human being. An important consideration is the degree to which he can trust the other individual to whom he turns. By and large, the stronger and more intact he is, at least in part, the better able he is to trust. This leads to the paradoxical statement, partially true of psychological treatment, as it is of most medical measures, that the patient who least “needs” psychotherapy is the one best able to benefit from it. Certainly in the more profoundly disturbed patient a major problem is mistrust. Its presence or extent contributes crucially to the success of therapy. Vicissitudes in this area probably depend upon experiences in the first year of life, which Erikson suggests is crucial for the development of “basic trust.”

Gratifying-Frustrating. The therapist responds to the patient’s varying dependence with a continuum of activities, ranging from therapies (and therapists) favoring gratification of demands to therapies advocating frustration of these, often systematically and explicitly though probably never totally. Some support is always provided by the total relationship, however detached and purely “interpretive” it is intended to be. What seems required of a therapist is both the intelligence and sensitivity to walk a fine line between excessive frustration and excessive gratification of demands. An essential happening in successful therapy may be the transformation of demands for immediate gratification, which cannot be satisfied, into the desire for what the therapist can impart, namely, understanding.

Revealing-Concealing. Psychotherapy can be viewed as a process of communication, which takes place continuously over multiple channels from the very beginning. There are peculiarities to psychotherapeutic communication, and there is need for much investigation into the precise messages and their qualifications or “meta-messages,” the overt and covert communication and counter-communication that occur in psychotherapy.

The patient comes with some desire, strong or weak, to communicate his distress, and is encouraged by a variety of techniques to impart more and more information. He communicates not only to the other participant but also to himself. At the same time he has reluctances and blind spots. Much of his effort pro-
motes concealment. Conscious withholding is less common than
the host of unconscious modes of avoiding, denying, and dis-
torting communication.

The therapist also reveals and conceals. The cues he furnishes
serve constantly to guide the stream of the patient’s com-
munication. He hopes to be more aware of the nature of this com-
unitive activity, although, being human, he is constantly com-
municating unconscious attitudes as well. His parallel conceal-
ment is not only involuntary but also partly a result of deliberate
intent. We have remarked upon the use of ambiguity, to a variable
degree the therapist endeavors to withhold activity, emotional
response, and value-judgment in order to highlight the patient’s
contribution. The psychoanalytic notion of the therapist as a
“blank screen” is obviously an abstraction never totally achieved.
Yet it still may be that this unusually tolerant, detached, but
sympathetic communicative activity of the psychotherapist is his
most powerful tool.

Encouraging fantasy—Testing reality. One of the most striking
features of therapeutic communication is the double instruction
given to patients. They are urged to suspend their critical facul-
ties and allow the emergence of thoughts and feelings normally
held in abeyance. At the same time they are periodically con-
fronted with the irrational natures of their preoccupations and
attitudes. These opposite instructions frequently lead to further
transient distress. Nevertheless, therapists constantly strive to
reinforce both, eliciting the “unreal” and underlining the “real”
aspect of the patient’s preoccupations. In this respect the use
of the couch in psychoanalysis not only accentuates the ambiguity
of the therapist’s communications, but by removing him from
view, it Reduces ordinary cues and fosters the emergence of inner
imagery and fantasy.

Reliving (transference)—New experiencing (alliance). There
is clinical agreement that humans tend to re-experience the past
in the present, to use Freud’s term. A central discovery in psycho-
analysis was the fact that patients reacted to the analyst in an
exaggerated fashion that could be traced to such past experience,
particularly with parents. Explication of transference fantasies,
by bringing the past alive emotionally in the therapeutic situation,
became a central tool of psychoanalysis and, to a variable extent,
of all related therapies.

Even while these fantasies from the past are maximized, a
current “real” relationship is emphasized. The patient forms an
alliance with a specific person in the present. Zetzel, among
others, discusses the question of mutual commitment and involve-
ment in this alliance. The therapist does not merely remain in
the shadows that have allowed him to assume the form of lover
or enemy. As ally, he works collaboratively to free the patient
from bondage to past loves and hates. Simultaneously, the patient
learns that his old behaviors not only fail to elicit expected
responses, but cannot bring him ultimate satisfaction in this
ambiguous new situation. Thus it comes to pass that he must resolve
an additional paradox: the relief for which he sought therapy is
only possible through a different kind of distress—taking risks
that are involved in new behavior.

Regressing—Progressing. Along with specific images from the
past come whole repertoires of past behaviors. This phenomenon
is not confined to the therapeutic situation, although the latter,
particularly in its more “permissive” forms, specifically encour-
ges it by at least two features already mentioned: the altered
balance of sensory cues and the unconscious delegation of certain
controls to another person. Such regression seems to be an ines-
tiable part of any psychotherapy. It may be as essential as its
counterpart, which is reorganization of the personality. As old
wounds are exposed and, it is hoped, old ghosts laid, reciprocal
processes appear, namely, progressive modes of activity, hitherto
largely unavailable to the patient. The model of maturation seems
the most meaningful one for understanding the complex interplay
of processes in psychotherapy. By removing blocks, conflicts,
anxieties, and inhibitions, psychotherapeutic treatment permits the resumption of interrupted growth.

At this point our list stops. To others, additional phenomena might appear equally inescapable—the part played by strong emotions, the importance of systematic attention to defensive processes, the role of understanding through experiencing (or "ostensive insight," as Richfield as calls it).

As we add "inescapables," however, the number of our escape clauses would have to grow. Certainly the level of disagreement would. We turn now to some remarks about how the therapist works—as professional if not as scientist—and how his attitudes contrast with those of the research worker.

Our insistence upon differences between clinician and research worker may seem strange, not only to some therapists who have been steeped in various branches of science, but also to some investigators who have studied aspects of behavior in a variety of formal programs. Clinical and research views in psychiatry obviously overlap. Nevertheless, there are important differences, which are the focus of this section.

Psychotherapy has grown out of the tradition of healing, in turn part of a wider humanitarian tradition. Erikson, among others, describes many fundamental aspects of the clinician’s work.26

Attitude toward his task. Erikson speaks of a "disciplined subjectivity." A more complete term might be "disciplined emotional involvement." This implies a sense of the clinician’s commitment to his therapeutic work, a belief in the value of training to acquire skill and in the importance of continued application to improve it. It implies, too, the use of intuition to aid his understanding and the ability to let his spontaneous emotions serve as a communication not only to his patients but to himself.26

Such an attitude is in ways an article of faith. The clinician often feels a need for certainty, not about every detail of each case but about his total effectiveness. Moreover, he needs a sense of sureness about day-to-day decisions. This comes originally from his teachers, whom he imitates and with whom he identifies.
Speaking more generally, it derives from example, from accumulated clinical knowledge and precedent. His confidence, then, stems from authority and is modified by his own experience, which he may hand on later as new authority.

Goals. Although he may choose to appear “passive,” the therapist is necessarily committed to a specific course of action. His plan, formulated during and after the initial encounter, is aimed at the relief of distress. Through the course of therapy, regardless of changing tactical objectives, this aim remains the same. The delays and periods of apparent stasis, which are inevitable in forms of prolonged treatment, are experienced by the clinician as a frustration.

Thought processes and their explication. The clinician uses multiple models, which, in Erikson’s phrase, he scans and from which he then selects components for his planning and action. These models tend to be implicit. The medical clinician acquired such a pattern in his training. To him the lungs, for example, are an anatomical region, a biochemical locus for gas exchange, a neurophysiologic system under homeostatic central regulation, an expressive organ involved with emotion and language. Given a patient with “chest disease,” the practitioner uses these models in a loosely differentiated but flexible way to make crucial decisions.

The psychiatric clinician, observing a bit of behavior in his patient, may formulate it in many different frames of reference, according to varying exigencies of the situation. For therapeutic purposes, he may speak from different levels. To encourage a sense of responsibility he may emphasize the sense of “willed” decision and action. To relieve guilt he may stress the overdetermined network of forces playing upon his patient.

Somewhat artificially we may contrast this flexible, often intuitive approach with that of the research scientist.

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* See GAP Report No. 49, Reports in Psychotherapy: The Initial Interview.
Table 2

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<th>Differential Features</th>
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<td>Therapist</td>
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<td><strong>Attitude</strong></td>
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<td><strong>Goals</strong></td>
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<td>Specific ameliorative action</td>
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<td><strong>Thought Processes</strong></td>
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<td>Models are multiple, tend to be implicit, ingrained, vague, flexible</td>
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GAP report entitled THE RECRUITMENT AND TRAINING OF THE RESEARCH PSYCHIATRIST has addressed itself. 45

This gulf hampers both therapeutic and research advance. In trying to bridge it we must go beyond the simple stereotype of the research scientist and examine the contrasting elements within his own tradition.

Some controversies in contemporary psychiatry arise not only from differences between research and clinical attitudes, but also from the fact that there are two opposing major research traditions, which lead to polarization of views.

Research ideally starts with a question. Observations then lead to inferences or generalizations, which implicitly predict; predictions are confirmed or falsified by new observations. 11 At the step of prediction and further observation, opportunity arises for two choices. The field may be observed more or less as a whole, emphasis being placed on naturally occurring patterns of organization; or it may be simplified, separated into parts, and manipulated, the attempt being made to gain a greater measure of control, to make more explicit predictions, or to get a clearer view of crucial phenomena. These different approaches may be called naturalistic and experimental. Since terms are not always used in the same sense, let us try to amplify some aspects of this contrast in method.

The “naturalistic” approach (as we arbitrarily call it; the term “natural history” approach is used by some synonymously) has as its prime consideration minimal interference with the phenomena under study. Sometimes called the field observational method, naturalistic research tends to have another characteristic: it usually examines a complex, often extensive area; it is at times designated as molar or holistic. It frequently begins with study
of large integration and may also try to depict still large entities; the approach tends to be synthetic.

The “experimental” approach (as we use the term) attempts primarily to manipulate one part of the field, or one set of variables, while holding the rest as constant as possible. The term isolation of variables has been applied to it. This usually involves selection of smaller and smaller aspects of the field for study; the approach is therefore relatively molecular or atomistic. Frequently concerned with dissecting out what appear to be the meaningful subdivisions or underlying elements within an area, it also tends to the analytic and may be reductionist.

Dichotomies, like beauty, are often in the eye of the beholder. Our division is schematic. It approximates some traditional differences in science but does not do full justice to the scientific enterprise. Advance may come mainly from observation of the elements in a system and their organization; it may emerge from manipulation or from watching the changes that result from natural processes. Man-made experiment and experiment-of-nature meet at a nebulous border, as in modern astronomy. The choice between naturalistic or experimental approach may be a matter of tactics—or of temperament.

To do justice to what we have already described, a more complex classification is needed. Our initial primary distinction was whether the phenomena under observation were manipulated or left intact. Other differentiating features are not necessarily parallel. For instance, both naturalistic and experimental approaches involve varying emphasis on synthesizing into larger or analyzing into smaller units. A fourfold classification might be considered, as in Table 3 (see page 124). This finer classification takes on meaning when one thinks of examples. Under naturalists, for instance, one can contrast Freud and Darwin (as “macroscopic” naturalists) with many extremely precise histologists or comparative linguists; under experimentalists, one can contrast the flexible and varied pioneering approach of Piaget (as “synthetic experimenter”) with many precise recent neurophysiologic or learning studies.6

These divisions, which are based on method, omit the role of theory. Theories are more than logical explanations growing out of research findings. They are also crystallizations of philosophical and sometimes cultural attitudes, which may determine what for a given age is deemed researchable.

It is just this cultural dimension of science that makes us feel that the separation of research endeavor into two broad clusters, however approximate, may be useful. At various times in history, naturalist and experimenter have occupied different roles on the scientific stage and have been valued differently.

In the present century the experimental approach has achieved high prestige, enhanced particularly by spectacular advances in chemistry and physics. It is often the popular image of science; the experimentalist has achieved dominance throughout much of behavioral science. Naturalistic observations tend to be seen as

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6 Still other classifications suggest themselves. Scientific outlooks differ in their underlying nosological and statistical assumptions. Kurt Lewin,6 for instance, speaks of the Aristotelian mode of thought, which seeks a priori categories, as opposed to the statistical frameworks of the Galilean mode, which infers lawful processes from scrupulous study of a single instance, an approach that he derives from the work of one of the great early experimenters.
preliminary explorations, which may suggest hypotheses but which precede the acquisition of "true" knowledge by experiment. There is more than a hint of this view in such recent documents as the GAP reports SOME OBSERVATIONS ON CONTROLS IN PSYCHIATRIC RESEARCH and THE RECRUITMENT AND TRAINING OF THE RESEARCH PSYCHIATRIST.

Some investigators have questioned whether experiment is necessarily the preferred approach, at least at this time, to understanding the behavioral complexities of living creatures. For example, Hinde17 says:

Psychologists who try to model their approach on that of classical physics fail to recognize that it dealt largely with everyday events, falling apples, sticks in water or melting ice. It could, therefore, often afford to pass quickly over the descriptive phase which is so important in the development of other sciences. In biology, by contrast, the work of generations of taxonomists and systematists was necessary before much progress could be made; and in the study of behavior description and classification are essential.

Psychologists whose theoretical systems have been based on limited experimental techniques have ignored this, concentrating their attention on a few responses and neglecting the rest of the behavior of the animal. Indeed the laboratory experimenter, in an attempt to reduce variability, often not only purposely restricts the behavior of the animal in which he is interested, but also limits sharply the aspects which he is willing to record.

Naturalistic approaches have undergone important evolution in recent years. In biology, including animal ethology, in the social sciences, including anthropology and linguistics, in engineering and sociology, the idea of the "whole" has been reformulated as the system. The nature and relations of systems have been the object of a special branch of inquiry—general systems theory.89 As we shall see, this approach is in many ways suited to a study of the intricacies of behavior encountered in psychotherapy.

We should be wary of judgments about these differing approaches. Enthusiasms fluctuate. Kuhn89 emphasizes that science is not simply a cumulative structure, in which advances build one upon another into a uniform edifice. Spiral movements take place; oscillations of orthodoxy and revolution influence the acceptability of scientific strategies.

The origins of revolution are crucial in Kuhn's view. He sees these primarily as conceptual processes, growing out of dissatisfaction with thought "paradigms," which have certain lacunae. Dissatisfaction becomes unrest and leads to breakthrough, reformulation, and a new "paradigm." Then a phase of "normal" science ensues in which the consequences of this new paradigm are fully exploited. In that phase experimental, frequently laboratory methods—particularly in science as we now know it—play the uppermost role. However, sooner or later a new revolution comes, triggered by discrepancies that accrue in the course of accumulating experimental results and by singular bits of naturalistic observation. Both approaches are important for science, and in our view both are necessary for the scientific study of psychotherapy.
Several recent volumes\textsuperscript{92,101,103,107} testify to the diversity of efforts being made to investigate psychotherapy at this time. Most current studies that aspire to more than clinical description are guided by the experimental approach. They attempt to isolate significant variables and emphasize not only precise specification but also the need for measurement. From the field under investigation, components are abstracted and correlated with one another. Attempts are made to manipulate one or more variables while holding constant as many others as possible. Face validity of variables and reliability of their assessment are usually sought by soliciting judges' opinions. Early efforts at devising experiments in an area as complex as psychotherapy used static temporal concepts and ignored the problems of processes changing through time. Further control has depended upon appropriate statistical procedures, as well as upon increasing the number of subjects and the number of observations; in addition, attempts are often made to keep judges independent, or even "blind" to decisive aspects of the data.

Application of these methods to psychotherapy research has not been as spectacular nor as easy as in biological and neurological endeavors. Yet it has led to contributions that can be conveniently divided into the following topics: (1) Analyses of the content of interviews, especially of the verbal interaction of patient and therapist. (2) Contribution of drug studies to psychotherapy research. (3) Quasi-therapeutic analogues of psychotherapy. (4) Qualities of psychotherapists that influence the treatment. (5) Qualities of patients that influence the treatment. (6) The influence of type of treatment on its outcome. (7) Studies of the outcome of psychotherapy.

\textit{Content studies.} The simplest experiments have centered around isolation of clearly measurable variables. In the sphere of verbal behavior, the rate of speech, the frequency and length of pauses, and the distribution of word and phrase patterns have been studied.\textsuperscript{95,\textdegree,61,95,12} Verbal interaction patterns between individuals can be specified with regularity, as in the studies using the interaction chronograph developed by Chapple\textsuperscript{10} and later used by Saslow and Matarazzo.\textsuperscript{94} Various measures of speech content have also been devised, such as the discomfort-relief quotient of Dollard and Miller,\textsuperscript{22} the "anxiety" measures of speech disruption worked out by Mahl,\textsuperscript{67,68} and the indicators Gottschalk et al. devised for anxiety, hostility, and object-relatedness.\textsuperscript{93,95,96} Clerical coding and, more recently, computer technology have facilitated the laborious application of such methods. Correlations have been shown between such variables and other indicators of affect. Similar investigations have used physiologic observations, and some pioneering efforts have shown correlations not only within individuals, but between individuals as well. For example, in one series of observations both the therapist's and the patient's heart rate accelerated when certain types of emotionally laden material were being discussed.\textsuperscript{41} However, it has not always been easy to demonstrate the relationship of these relatively reliable measures to the complexities that uniquely characterize the progressions, changes, and turning points of psychotherapy.

Evaluation of pharmacological agents in mental illness has lent a further impetus to the experimental approach; it has underlined the importance not only of drugs but of "set." The placebo effect, early remarked upon by Beecher,\textsuperscript{9} called attention to the
important influence exerted by the coming together of a doctor and a patient. Subsequent workers have found it possible to manipulate variables outside the field of participant observation, both type and dosage of medication and characteristics of patient and therapist, including their attitudes toward medication. Studies by Uhlenhuth,111 Rieckel,112 Schachter,15 and Fisher et al.,13—to mention only a few of the workers in this area—have contributed to increasing sophistication in experiments designed to keep both patient and therapist “blind” to the nature of the manipulations. We should note that there are probably more limitations on how “blind” the participants actually are than many workers have realized.

Most quasi-therapeutic analogues of psychotherapy are suggested by verbal (operant) conditioning and social reinforcement research. They consider a wide gamut of questions such as: Can we identify the kinds of patients who respond well to reinforcement? What kinds of experimenters seem able to get positive results? These experiments have aroused considerable interest among those doing research, and are beginning to be applied in the practice of psychotherapy. Some representatives of the work in this area are: Martin, Lundy, and Lerwin;17 Kanfer and Marston;30 Waskow.113

Assessing affective qualities and personality traits of therapists has been another approach.197 Rogers199,200 and his students197,199,200 have tried to focus on global “process” qualities that appear important in the functioning of therapists. They have studied these using rating methods, generally variants of the Q-sort technique, at times utilizing patients themselves as control subjects during pre-therapy waiting periods. Work like this underlines the need to examine personality elements in both members of the psychotherapy relationship and to go beyond precisely specifiable, but possibly superficial, aspects of behavior to assessment of more global and perhaps more significant traits. As it does so, the work becomes not only more clinically relevant, but also more difficult.

Patient characteristics. The recent review of approximately 100 studies in which initial characteristics of the patients are compared with their gains in psychotherapy revealed considerable congruence.196 Patients who have initially higher social achievements (including better jobs, education, higher intelligence) and higher effect—especially anxiety—seem to be more capable of profiting from therapeutic interaction. These factors are among the few that are known to influence the fate of the patient in psychotherapy.

Some efforts have been made to compare different types of therapy with each other. The results of recent studies suggest that a conditioning approach as used in behavior therapy is more effective than psychotherapy in the treatment of certain phobic reactions,79 but this work has yet to be properly replicated. Other research has attempted to compare intensive therapy with instances of minimal therapeutic contacts, so that the interventions of a psychiatrist were thus isolated as a variable.81 Efforts of this kind underscore the difficulties that arise from abstracting one element and assuming that other aspects of a situation remain constant.

Studies of outcome represent a final example of the experimental effort. There has been an understandable impatience for assessment of “results” of psychotherapy. Critics have attempted to review outcome studies to show that psychotherapy accomplishes little.24,25 Frank et al.44 bring experimental evidence, based upon simply scored measures of distress, that a preliminary response of the patient to his first contacts with a psychotherapeutic facility, based upon anticipations and suggestive effects, seems to accomplish as much as more prolonged contact. The problem is to determine what the outcome really is. A recent GAP report, PSYCHIATRIC RESEARCH AND THE ASSESSMENT OF CHANGE,41 stresses the complexity of this task.

There is a distressing distance between the fluid and intricate model of psychotherapy presented in Part I of this report and
efforts to observe patients on a “before” and “after” basis. An investigator, after comparing diverse modes of treatment, may observe no significant differences and conclude that psychotherapy is without value; but one is forced to ask many questions about what he is observing. It is a fallacy to think of psychotherapy as a constant. The competence of therapists differs. Each patient’s distress and total adjustment are by no means the same. The interplay between the patient’s reaction to a mode of therapy and the therapist’s own predilections, and the influence of both sets of biases upon assessment procedures, pose formidable difficulties. In psychotherapy one is dealing with complex organisms in interaction with one another, and also with constantly changing influences from the outside world.

Psychotherapy research has been plagued by these problems, as well as by a number of technical ones: (a) Most psychotherapy studies use only one criterion of outcome. Since outcome criteria do not correlate highly with each other, several criteria ought to be included. The only criterion measure that tends to have consistency with other criterion measures is the therapist’s rating of “success” or improvement.\textsuperscript{32} (b) Almost all of the psychotherapy outcome studies are geared to predicting the amount of change, even though a small change in a crucial area may make an important difference to a patient.\textsuperscript{17} A more useful criterion, therefore, might be the type of change the patient needs or desires. The Johns Hopkins group is one of the few trying to predict changes in “target symptoms.”\textsuperscript{2} (c) In making predictions clinically, one never relies on a single predictor; most of the studies of psychotherapy, however, have this limitation. A more desirable approach would be to use configurations of variables in relation to the criterion. A few studies in which multiple criteria are used are those of the Counseling Center of the University of Chicago,\textsuperscript{90} Fiske, Cartwright, and Kirtner,\textsuperscript{23} the Johns Hopkins Phipps Clinic,\textsuperscript{44} Gottschalk et al.,\textsuperscript{39} and the Menninger Foundation Study, which is still in progress.\textsuperscript{118} (d) Almost all the studies in the literature are based upon short-term treatment, usually between 20 and 40 sessions.\textsuperscript{4} This is understandably a way to reduce the time necessary for psychotherapy research studies; it is not known, however, whether the factors that influence change are the same in short-term and long-term treatment.

More recent studies are gaining sophistication in dealing with these problems.\textsuperscript{32,90,110,118} Unless they are dealt with, one must be concerned that conclusions so far reached about effectiveness or ineffectiveness are premature.

The experimental approach is important for the study of large numbers of cases and for examining systematic variations in the style of therapy, level of training, or groupings of patients. It is important to investigate the results of psychotherapy even while searching for better ways to assess them. However, it is legitimate to ask whether research in this area may not have been overly influenced by attitudes derived from the medical and physical sciences. These tend to postulate—though for the most part inaccurately even in their own domain—a “disease” caused by a single agent and “cured” by a single therapeutic activity. What we have called the experimental approach has succeeded brilliantly in certain medical areas using such a model. In the difficult field of psychotherapy its application has yielded uneven results. As the sole ideal for investigation it has clear limitations.

\textsuperscript{*} Some exceptions are the reports of Klein,\textsuperscript{12} Weber,\textsuperscript{111} the Menninger Project,\textsuperscript{116} Knapp et al.,\textsuperscript{30} and Hamburg et al.\textsuperscript{46}
PSYCHOTHERAPY AND RESEARCH: THE NATURALISTIC APPROACH

The alternative research approach is strongly represented in the history of psychiatry, as well as in certain branches of psychology and the behavioral sciences. It has led to advances in biology, ethology, and anthropology, to mention only a few of the relevant disciplines.

It is the method of clinical case study. The growth of psychiatric knowledge at the end of the 19th century and the start of the 20th came about essentially by naturalistic means. The clinical leaders at the turn of the century, such as Kraepelin and Meyer, were first and foremost naturalists. They collected, classified, and organized their data, then proposed hypotheses to unify their observations. The naturalistic observations of Freud, growing out of his clinical experience and biological orientation, brought about a revolution in the understanding of mental illness.

In time scientific difficulties ensued. The stimulating new observations of dynamic psychiatry became commonplace. Attempts to make more refined observation led to differences in interpretation of the same classes of data. Difficulties developed with data collection: the therapist as participant-observer found himself in a dual role that was hard to maintain, and often hard to justify as a position from which unbiased observations could be made. Data reduction also posed obstacles: the complexity of the psychotherapeutic situation became increasingly apparent, and clinical selection of aspects for study post hoc raised dangers of circularity. More serious problems about inference became apparent. The clinical observer was a naturalistic observer, but not necessarily a careful one. One of his major problems was the failure to specify precisely the behaviors upon which his theories were based and the steps that took him from data to conclusion. Thus theory increased in complexity, and disagreement developed concerning its validity and even about precisely what phenomena were being studied.

Various efforts have been made to attack these problems. The most direct has been to introduce increasing thoroughness into longitudinal clinical studies, directed at the over-all understanding of different syndromes. The work of Cohen et al in the study of depression,21 that of Litz and his group investigating family processes involved in schizophrenia,20 that of Bieber and his group in the study of perversion,14 and a number of psychosomatic investigations, such as those of the Chicago group,14 illustrate this type of joint effort.

In the investigation of psychotherapy proper the work of Malan16 illustrates this attempt to cast a careful clinical eye on what a group of therapists actually did and on what resulted. Such an approach generalizes from pooled experience with a large number of cases. A group of workers performed alternate tasks, first serving as clinicians and data gatherers and then as investigators and data analyzers, thereby reducing difficulties of role conflict.

Naturalistic study of process and outcome represents a further step. The work of Weber and his colleagues14 represents an effort by research workers to look systematically at 20 years of accumulated experience at the Columbia Psychoanalytic Clinic, observing both psychoanalyzed and psychotherapeutically treated patients. Similarly, the Menninger Psychotherapy Research Group12 worked with case records of patients treated "naturally" in their milieu. They deliberately kept therapists ignorant of
which cases were being chosen for study. One group of observers examined the record; separate groups appraised the patient at termination and follow-up to evaluate outcome. The raw data, consisting of clinical observations, were reduced to a series of second-order abstractions by a series of judgments and ratings. These then lent themselves to further types of manipulation and to the study of specific questions.

Predictive studies were also included in the Menninger research.\textsuperscript{112} Benjamin,\textsuperscript{6,7} Escalona,\textsuperscript{29} Bellak,\textsuperscript{5} and Knapp\textsuperscript{64} have discussed and applied the technique of clinical prediction matched against clinical outcome, as an effort to avoid problems of post hoc bias. Such an approach permits utilization of the clinical record with all its richness. However, even though predictions may be correct, one still may be left with uncertainty as to whether the result is due to postulated causes or to other unknown possible factors.

As sketched so far, efforts at rigor face difficulties in seeking to reduce a complex field to a set of relevant variables. The very process of selection itself may reflect bias, which the researcher is trying to control. The naturalist often seems unable to free himself from an implicit experimental model and the need for a simple statistically unequivocal result.

An alternative method has been to concentrate on further specification of the data in its complexity, stressing direct observation, minimizing abstraction, and attending to organization of the field as a whole. Such an approach uses extensive records of human behavior, often in multiple situations. As increasing attention focuses on environmental and social behavioral determinants, it becomes necessary also to look at increasingly intricate contexts of an individual's words or acts.

Contextual studies have examined psychotherapeutic transactions as they take place over multiple channels of communication, including the purely lexical, the vocal-linguistic, and the postural-kinesic. An early research studied “direct analysis,” as practiced by Rosen.\textsuperscript{96} A more rigorous study of filmed interview material was that of McQuown, Bateson, Birdwhistell, Brosin, and Hockett.\textsuperscript{74} Subsequent research has continued this type of approach.\textsuperscript{15,14,15,36,67,15,19}

The approach examines standard, culturally determined units of behavior, which tend to occur in lawful sequences. Investigation consists of describing these units and their relations in larger and larger integrations. The stream of behavior is divided into segments; complexity is minimized not by omitting or selecting variables but by finding out how each unit relates to the others and how the units are synthesized upward, level upon level, until clarity is achieved by visualizing multiple integrations as larger single units.

This method attempts to make explicit the structure of the relationship between participants as a system of communication. Forms or codes of communicational behavior appear to be learned quickly, though unconsciously, by both participants in psychotherapy, based on the patterns acquired from parents, siblings, colleagues, and peers of both sexes. This view stresses how each participant performs his part regularly to sustain the relationship. Such regularity was an unexpected finding, which emerged after repeated scrutiny of sound films. Linguistic, para-linguistic, and kinesic units repeat themselves redundantly and predictively during psychotherapy sessions. Examples of similar cultural organization can be seen in such social behaviors as social greetings, church services, and courting patterns.\textsuperscript{81,82,83,99}

Another crucial aspect of this work is the notion that “meaning” is determined by examining a unit of behavior in larger and larger contexts of other visible behaviors. To use one example, the “meaning” of a therapist’s lighting his pipe approximately every 12 minutes during a series of sessions was understood in this framework not by use of such concepts as the therapist’s “oral needs” or the motor “discharge” of anxiety—though these concepts may have applicability within other frames of reference—
but as part of a larger unit in which the pipe-lighting was the first step in each new technical move on the therapist's part.

This naturalistic approach attempts to study sequences with sufficient precision that observation speaks for itself, as it does, for example, in the histology laboratory. It further attempts to build up larger units, which are self-evident in the same way. It is time-consuming, but has made a start toward accurate study of behaviors naturally encountered in the psychotherapeutic situation. Application to the unsolved problems in psychotherapy research remains a task ahead.

Many phenomena of psychotherapy may actually for the foreseeable future lend themselves best to study by naturalistic approaches of this kind and by similar approaches yet to be devised. Psychotherapy deals with metaphor, meaning, and interpretation. While these aspects are difficult to quantify and manipulate in the experimental tradition, they must be studied if we are seriously interested in psychotherapy. The naturalist, by temperament and technique, may be well equipped to investigate this kind of intricate symbolic patterning.

Naturalist and Experimenter: Combinations and Limitations

The contrasting traditions that we have arbitrarily called experimental and naturalistic can never be completely separated. In molecular biology, no sooner had the electron microscope permitted detailed description of the elements within the cell than various microtechniques were advanced for manipulating these elements experimentally. In the behavioral area a similar, if slower, chain of events can be discerned, for example, in ethology, where the original naturalistic approach has been combined with various types of experiment.

Arbitrarily we may single out three types of combination: (1) Studies may be separate with respect to method though related in long-range aims. (2) Studies using one method may add, often at the stage of data analysis, a different approach. (3) In the total planning and conduct of the research, experimental and naturalistic methods may be directly combined.

Methodologically separate but related studies may be part of a broad team attack on a given problem. Such teamwork is common in various types of clinical research. Naturalistic investigation, frequently having marked clinical emphasis, may be associated with various efforts to refine hypotheses and put them to test by experimentation. A familiar example is that of the intensive and extensive investigation. In the psychosomatic field
Reiser and his colleagues have described clinical longitudinal investigations of selected patients with hypertension, along with studies of relatively large groups in which modes of therapy have been manipulated. A similar strategy has been used in studies of asthma, in which longitudinal studies of small groups of patients have been supplemented by experiments with allergic individuals in large groups. Similarly, in work with children intensive naturalistic studies have paralleled experimental investigations of perception in the new-born.

Such team strategy, requiring flexible communication between those of different methodological persuasion, has great potential in the study of psychotherapy. Intensive investigation of the single case yields a measure of understanding that cannot be duplicated by large groups and the systematic varying of relatively gross variables; but, as we have seen, attempts at designing experiments that will yield some kind of clear-cut answer often seem necessary to keep the investigator from becoming mired in inconclusive detail.

Our second category, methodological addition at the stage of data analysis, is more frequent than is generally recognized. Experiments, particularly in those branches of the behavioral sciences that deal with humans, are seldom classical in the sense of consisting of quantitative manipulations of independent variables to elicit regular, quantitative variation of a dependent variable. Instead, most such experiments consist of some sort of manipulation, which attempts to bring the phenomenon under more sharply focused observation, while the outcome is often assessed on a global or clinical basis. Indeed, experimental studies can be ranged along a continuum from those having tightly organized hypothetico-deductive predictions to those of the do-something-and-see-what-happens variety. Many of the experiments of Piaget and his colleagues are at this more open pole. The early work in sensory deprivation and the pioneering work with drugs like LSD can be categorized in the same way.

Similarly, methods of data reduction, plus control over statistical and observer effects, often permit correlational or predictive “experiments,” using data originally gathered within a naturalistic framework. An example of this approach is Luborsky’s study of momentary forgetting, and his elaboration of this into a “symptom context method.” This study examined the context of discrete occurrences within psychotherapeutic interviews and compared them with “control contexts.” Other efforts have used longitudinal psychotherapeutic and psychoanalytic data for purposes of correlation and prediction. As we have noted, the Columbia Psychoanalytic Clinic and the Menninger Psychotherapy Research Group have centered their efforts on such methods of control and contrast.

Finally, methodological fusion in the total conduct of research involves using subjects who in one situation are observed from a naturalistic point of view and at another time are studied in actual experiments. In ethology, this approach is exemplified by Lehman, who combined naturalistic observation of mating patterns in ring-doves with specific manipulation of environmental and endocrine factors. Some of Piaget’s carefully investigated subjects became objects of specific and limited experiments. Engel and his colleagues studied an infant with gastric fistula, using an explicitly “ethological” approach; but they also introduced experimental manipulation to highlight interactions between depression, human relationships, and gastric function. Some recent sleep research has taken advantage of the advancing understanding of the neurophysiology of dreaming to combine longitudinal clinical studies and laboratory investigations on the same subjects. In the psychosomatic field Margolin, working with an adult with gastric fistula, combined psychoanalytic investigations with physiologic experiments. Early studies by Fisher introduced an experimental manipulation directly into the therapeutic situation, namely, the suggestion that the patient would have a dream.
In psychotherapy research Chassen \textsuperscript{20} and others \textsuperscript{40} have studied individual cases and manipulated drug or placebo treatments. Such efforts do not appear to have been widespread in this field, where most workers appear to have an ingrained reluctance to tamper with the complicated and delicate therapeutic situation.

We have remarked on the fact that attempts to "prove" propositions about psychotherapy have yielded at best ambiguous results. Yet it is obvious that those committed to psychotherapeutic methods of approaching emotional disorder feel that psychotherapy has been proved effective, while it is equally true that those opposed feel that the published results prove just the reverse. The difficulty may be that scientific research is difficult to apply to the protracted intimate human relationship that psychotherapy often is.

The psychotherapist in the psychoanalytic tradition proceeds by a continuous process of involvement with the patient that he interprets according to his own learning in a sectarian context. Highly skilled psychotherapists often disagree about the appropriateness of interpretations and upon the timing of even those that they consider to be appropriate. Psychoanalytic concepts have not found the wide scientific acceptance that has been gained, for example, by the main ideas of modern physics. In some parts of the world the kind of psychotherapy with which we are concerned here has met political resistances. For all of these reasons it is perhaps a mistake to evaluate psychotherapy exclusively by traditional scientific methods.

Psychotherapy may be a medical procedure, but it is also a prime example of a variant of human relatedness. As a social movement, psychotherapy resembles religious and political processes; as a human relationship, it resembles other forms of institutionalized collaborative interaction. And as a \textit{metier} or calling to those most involved in working in this area, it is, like Emerson's comment about beauty, "its own excuse for being."

To study psychotherapy we may need, at the very least, a framework that takes into account the wider social context in which it occurs. Even then we may well encounter complexities that cannot be fully grasped. There may be inherent limitations in the study of human behavior, those confronting an intelligence studying a phenomenon as complex as itself. Understanding may still proceed, but it must do so at many levels. Both scientists and artists may contribute to it. Freud's account of the intricacies of human defense was paralleled by that of Proust. Each contribution was informed by a brilliant intelligence. Who can measure precisely the relative contribution of Berger and the electroencephalogram to Rorschach and the ink blot, of a Sherrington as against a William James, of a Pavlov as against a Bertrand Russell—of the more precise as against the more philosophic inquiry?

What is required for the study of behavior is a research approach appropriate to the problems under study. Slavish adherence to rigid laboratory tenets may well miss the essence of the human being. We stress the need for multiple methods, new models, and above all a broad definition of science.

\textbf{Psychotherapist and Scientist:}
\textbf{Conflicts and Confl uences}

Our hope has been that a more comprehensive comparison between some aspects of psychotherapy and behavioral research may throw new light on interactions between both. As we noted earlier, their aims may conflict. This is true throughout many areas of medicine and science. The need to help and the need to find truth are often opposed. Concern over the ethical implications of human research has become a pressing problem in more recent years. Human ingenuity has multiplied the ways in which it is possible to tamper with human bodies and minds. A formidable list of questionable practices can be compiled.\textsuperscript{4} The psychological sciences are far from being the most conspicuous offenders.
Indeed, in the area of psychotherapy, where psychotherapist and investigator both seek understanding from human beings, conflicts may be minimal, though they are still present.

Beneath the conflict over manifest intentions lies conflict over identity. We have already sketched the different elements that characterize the clinician and the scientist. Each may have different economic and status aims. Each prizes the strands that go into his own makeup. Universal ambivalence surrounding activity and passivity, masculinity and femininity, find their expression in the contrasting roles. The clinician values his exuberance, energy, decisiveness, and active involvement in the world, while he may also cling to his latent conception of himself as a nurturing and giving rescuer. The researcher treasures his keenly honed, critical intelligence, while he himself may be nourished by hidden fantasies of vast procreativity. Binger, in his essay "The Two Faces of Medicine," traces some of the ways in which these universal conflicts have been reflected in the history of medicine. They lead to bizarre results. One often hears the question, "What is psychotherapeutic—or psychoanalytic—research?" or "Is there such a thing?" This really seems to mean, when fully paraphrased: "How can I maintain the picture of myself as a powerful, omniscient, and giving person, getting satisfaction from my clinical skills, and still be a member of the skeptical scientific world, which requires public validation and seeks rewards from competitive action in the scientific market-place?"

Nevertheless, a kind of peaceful coexistence often exists between psychotherapist and investigator. The therapist may feel that research is superfluous, since it will only confirm what he knows, or else that it oversimplifies the nature of human behavior; nevertheless, he respects the research worker as a dedicated person, whose efforts may gain bits of new knowledge of ultimate practical value. In turn the investigator regards the therapist as a well-meaning, well-trained person who can even be helpful to research. Clinical work may provide hypotheses and the clinician himself may serve as a sensitive measuring instrument.

To a certain extent this is a reasonable limit of rapprochement. After all, the world needs therapists and research workers, pure clinicians and pure investigators. Our thesis, however, is that there are forces that call for, and that to a certain extent are effecting, a still closer confluence between these two, perhaps more in the psychological sphere than in other branches of science. The therapist needs the research worker. Without him he becomes a cultist. He is not dealing with established and routinized ways of therapy, as is, for instance, the orthopedist or the orthodontist. In crucial ways he lacks new and important knowledge of the tools that are to an extent so powerful, but whose effectiveness is still so unpredictable, namely, the psychologic tools of relationship, communication, and insight. What we have called the naturalistic approach adds a dimension to research that makes further study of these crucial ingredients both possible and necessary. The therapist can no longer say that research has only to do with chemicals or rats and that it bears no relationship to his art. The complex art itself, his own skills, however idiosyncratic and intuitive, can and should be brought into the research arena.

The research worker needs the therapist. Psychotherapy furnishes a unique type of data, not available in any other way. Only the ill person, "trading information for help," is willing, perhaps able, to spend the time and face the pain of revealing his deepest layers of experience.

In a specific sense psychotherapy is an aid to understanding some aspects of research itself. We could cite a number of cases in which gross personal predilections have had a powerful influence on the areas in which an investigator was impelled to move and even on the observations he was able to make. The elegant studies of Robert Rosenthal highlight the importance of observer effects throughout many areas of science. He has brought together evidence of others and his own to suggest that behavioral research, whether conducted on humans or in the more "objective"
atmosphere of the animal laboratory, can be decisively affected by biases of the experimenters. To the extent that psychotherapy can free individuals from personal conflicts of which they are unaware, it can effectively attack sources of some such bias, though we must always recognize the danger of freeing one from old prejudices, only to inculcate new ones.

Other, more subtle and far-reaching research problems may be illuminated by psychotherapy. The studies of Anne Roe\textsuperscript{a} and Kubie\textsuperscript{a} only begin to examine the complex and varied psychology of the research worker himself. The central division between naturalistic and experimental investigators that we have postulated may be itself largely temperamental. The experimental worker may be more a gambler than the naturalist, relying on activity, risking his “all” on outcome, too impatient to sit back and let nature, an uncertain mistress, bring him answers. At the same time he may have a greater need to control, less tolerance for uncertainty, and less real confidence in the regularities of nature that he may discover beyond those that he imposes. Science, like medicine, has more than one face; we must undertake a taxonomy of all their expressions.

A last question is to what extent psychotherapy and research overlap in a more fundamental way. As we have said, psychotherapeutic activity is one kind of search for truth. This is not to imply naive acceptance of the cliché that every intensive psychotherapeutic experience, especially every psychoanalysis, is by itself research. In many senses it is not. Psychotherapy is a pragmatic, remunerative form of clinical practice. Yet it is practice involving a subject of the highest dignity and complexity. Many medical and surgical procedures are to an extent mechanical; in them the patient plays a relatively passive role. Psychotherapy forces the physician to direct his attention to the mind of another human being; the venture is exquisitely cooperative. He is not simply applying salves distilled from the experience of ages, although he may rely on an occasional bromide. Ultimately, the

therapeutic process is a mutual searching out in unknown areas for unique knowledge that may then be generalizable. How to make sure that it is knowledge, and how to generalize from it, are tasks for the scientist. But when dealing with human behavior such scientists are faced with a special need to have personal familiarity with the human mind, gained at the clinical level. Piaget and some of the great figures from the recent past—James, Freud, Schilder—combine aspects of the intuitive artist and the meticulous logical observer. In our sphere of scholarship, as in others, such a fusion has been, if not the rule, the inspiration.
A tripartite division of attitudes is discernible in the evolving discipline of psychiatry, on one hand between a clinical and a research view and on the other hand between experimentalist and naturalistic traditions within research itself. The contrasting attitudes become apparent when one considers psychotherapy and research into psychotherapy.

This report starts by giving a clinician's view of psychotherapy, limited, for purposes of exposition, to the traditional two-person relationship. It describes the participants, the aims and assumptions of each, the structure of the relationship, the setting, and the compact. It proposes a set of reciprocal features, or polarities, that enter into the process of therapy: trusting-mistrusting; gratifying-frustrating; revealing-concealing; encouraging fantasy-testing reality; reliving-new experiencing; regressing-progressing.

Next a hypothetical description is given of psychotherapist and research scientist; this highlights differences between the two as idealized types, which can be placed at contrasting ends of a spectrum.

A brief historical sketch is given of the dual tradition that runs through much of research, including psychiatric investigation. It emphasizes the cyclic nature of "scientific revolutions" (Kuhn) as well as the prestige and popularity of those approaches that are in the ascendance at a given time.

At present the experimental approach has such prestige. The report describes the variety of efforts to study psychotherapy using experimental models, and indicates some of their strengths and weaknesses.

An alternative approach, the naturalistic, less in vogue on the current scene, is described, along with its strengths and weaknesses.

A final section attempts to move toward an integrated view of psychotherapy and research. It points to ways in which naturalistic and experimental approaches are inevitably combined. It hints at limitations of "scientific" study of the complex processes involved in psychotherapy, even when such combinations are used. Finally, it discusses some of the conflicts in aim, and also some of the confluences of purpose, between psychotherapist and scientist.
REFERENCES


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