The author discusses the state of the art of psychotherapy at the brink of the new decade. The theme of the 1990s is rapprochement, the bridging of divisive aspects of the field. Four major manifestations of increased detente are explored: convergence of mind and brain, collaboration of research and public policy, coordination of economic constraints and ethical standards, and connection between psychopathology and therapeutic practice. Factors of major importance for the future of psychotherapy are the impact of the neurosciences on psychological phenomena, the role of the computer in human simulation, the socioeconomic influence of government and third-party payers on the direction of treatment, and the utilization of clinical practice in devising new diagnostic dimensions.

The state of the art of psychotherapy has been a major theme of the literature for over a decade; in fact, the field has been undergoing a “continuing revolution” since the inception of psychoanalysis. Today, this revolution is particularly evident in the ever-increasing extension and diffusion of the boundaries of the field. Although many overviews and forecasts tend to look upon the contemporary changes with some combination of nostalgic concern and confusion, others reflect a renewed sense of optimism and promise for the future.

More specifically, there have been enormous strides in the “science” of psychotherapy: in the neurophysiology and biochemistry of psychological phenomena; in the standardization of diagnosis, training, and treatment; and in the development of improved research tools for testing therapeutic efficacy. The growth and development of new, innovative clinical modalities, especially short-term techniques in keeping with the temper of the times, have contributed to cooperative efforts to combine and integrate different therapeutic approaches drawn from the rich armamentarium of treatments available today.
greater attention to the interface between public policies and professional standards, as governmental and third-party influences come to play a greater part in shaping modern-day treatment.  

These issues mark our entry into the latest stage of psychotherapeutic development, rapprochement—a needed and welcome change after years of unbridled expansion and polarization in the field. As an adaptive process, rapprochement will proceed in the 1990s despite a host of economic, political, and bureaucratic impediments. In surveying the state of the art, I will discuss four major manifestations of this increased integration in psychotherapy today: 1) convergence of mind and brain; 2) collaboration of research and public policy; 3) coordination of economic constraints and ethical standards; and 4) connection between psychopathology and therapeutic practice.

Convergence of Mind and Brain

The mind is a correlate of the brain. Perhaps the most complex and intriguing of current developments are those that advance the welding of the post-Cartesian mind-body split that has plagued psychiatry since its inception. Links between the biological and the psychological have been forged in recent studies that connect the neurosciences with the behavioral sciences, investigating the biology and chemistry of psychological phenomena and the cellular effects of environmental events on brain structure and function. The studies by Rosenzweig and associates of brain changes in response to experience; Hofer's psychobiological perspective on the loss of relationships in bereavement; Libet et al.'s investigations of neurophysiological expressions of psychodynamic phenomena such as repression and other defense mechanisms; Winson's neuroscientific evidence for some of Freud's formulations about dreaming, memory traces, and unconscious processes; and Reiser's neurophysiological understanding of free association, transference, and other patient-therapist processes are all recent efforts in exploring the mind-brain connection.

The studies of Hofer on bonding, attachment, and object relations have implications for how a mother's actions toward her infant alter brain structure. Dependency can thus be translated into broadly physiological terms, as the persistence into adulthood of the need for excessive external physiological regulation. In a comparable approach to treatment, Reiser has conceptualized free association of the analytic patient as a way that the analyst attempts to gain access to and alter synaptic connections (wherein memories are equivalent to strongly facilitated synapses). Mohl, on the basis of such findings, provocatively asks whether psychotherapy should actually be considered a biological treatment (and implies an affirmative answer); he goes so far as to advance the alternative thesis that not only medication but also dream interpretation and even empathy, acting through biochemical mechanisms, may be viewed as diverse ways of altering different neurotransmitters.

In such a recent attempt to bridge psychology and neuroscience, Brothers' biological perspective on empathy, attempting to touch its neural substrate, is a challenging case in point. Although the human being is regarded as a thinking animal, the most human quality is considered to be empathy. The human's ability to empathize is ordinarily attributed to the "mind," a psychological phenomenon that transcends the biological brain. But now, new scientific developments show that the differences between humans and other mammals in the field of emotions, including empathy, may not be as qualitatively different as traditionally assumed. In fact, empathy may be a phylogenetically and ontogenetically determined phenomenon in all primates.

The researches of Miller et al., Mirsky et al., and Sackett show that nonhuman primates are well endowed with the capacity...
for effective emotional communication. These studies have specifically demonstrated the presence of an inborn capacity to distinguish facial expression. Single-neuron studies have in fact shown that cells responding to pictures of faces had "preference" for the identity of the face. Neurons reacted selectively for certain parts of the person, the face gestalt receiving the strongest reaction. But the most impressive finding was the cell's specific firings in response to facial expression.

So far, the amygdala is identified as a determinant of the organism's attitude toward its environment, responsible for imparting an emotional tone to analyses of sensory data. Following this line of development, we could well be on the threshold of locating specific cells for specific emotions. The implication is that there may be a basic molecular grammar underlying the various elements of "mind." Referring to empathy as "a biological concept par excellence," Brothers'6 concluded, on the basis of a confluence of data from a variety of disciplines, that "empathy (a subjective experience between people), social-emotional communication (in animals), and social signal processing (by neurons) can be understood as aspects of a single phenomenon" (p. 17). Thus, future collaboration of psychotherapy with molecular genetics and cellular neurobiology may ultimately solidify their interconnections.

The ultimate change agent in psychotherapy may be the alteration of gene expression—a biological justification for long-term treatment in the 1990s. Affective experiencing, cognitive mastery, and behavioral modification, also known by a variety of other names, are considered three overlapping and complementary pathways toward bringing about changes in a patient through psychotherapy, which may be the finest and subtlest form of learning. But the question remains, by which bio/physiological mechanisms does such learning alter symptoms or characterological traits? Kandel and Schwartz36 have proposed that "learning produces enduring changes in the structure and function of synapses. Thus learning is likely to involve self-maintained alterations in gene expression, for which a new protein synthesis is required" (p. 439).

Kandel's15,37 pioneering explorations of the integration of psychiatry and neurobiology are evidenced in his research on sea snails, in which studies of social and sensory deprivation, processes of sensitization and habituation, and the development of anxiety become phylogenetic models for comparable biological mechanisms underlying such experiences in humans. The findings, during conditioning, of both structural and functional changes in synaptic transmission (e.g., alterations in neurotransmitter release, enzyme levels, and calcium channel activity) reveal that genetically determined pathways as they relate to anxiety can be interrupted, as well as restored, by learning. In particular, his translation of the nature of anxiety from metapsychological to molecular biological terms15 poses some major reformulations of ideas about human learning and memory, with direct implications for psychopathology and psychotherapy. By demonstrating how psychological disturbances reflect neuronal and synaptic changes, he proposes that psychotherapy can in fact act on these biochemical events.

Most neurotic disturbances are related to acquired or learned conditions. Biologically speaking, the alteration in synaptic functions produced by externally induced modulation may lead to neurotic conditions. Personality traits, severe and intransigent neurotic disturbances (i.e., obsessive-compulsive disorders), and psychoses, on the other hand, may be primarily inherited conditions. But even here, environmental experiences may teach the genes pathological expressions of what is inherited.

Holding a special prospect for the future, this recognition that alteration in gene expression is the common biophysiological pathway to bring about change in feelings, thoughts, and behavior, in conjunction with
the length of time needed for such an alteration to take place, gives the psychotherapist the first scientific support for justification of long-term psychotherapy. Because regulating gene expression requires induction of a new protein kinase to alter synaptic relations, such induction necessitates sustained treatment: certainly a number of months, if not years.

In spite of all these developments, the convergence between mind and brain will remain mainly academic for psychotherapists, except insofar as it may persuade them to be more scientific in differentiating conditions that are potentially responsive to pharmacology, thus enabling them to make better use of medication.

**The future psychotherapist will be a pharmacopsychotherapist.** Of significant therapeutic impact, with implications for welding the mind-body split, has been the increasing rapprochement between psychological and pharmacologic therapies. Marked changes have occurred in models of combined treatment over the last three decades: in the 1950s, a reciprocal model favoring psychotherapy; in the 1960s to 1970s, a reciprocal model favoring drug treatment; and as a hallmark of the 1980s, an additive model that demonstrates maximal effectiveness by a combination of the two types of treatment. For example, Weissman and colleagues have shown that, in treating patients with depressive disorders, pharmacotherapy and psychotherapy worked synergistically—pharmacotherapy alleviated acute vegetative symptoms like somatic complaints, lack of appetite, and sleep disorders, whereas psychotherapy enhanced attitudinal, interpersonal, and social functioning (i.e., reduced suicidal ideation, increased work performance). A recent systematic analysis of the evidence provides further support for these findings.

The increasing wealth of scientific data on combined treatment augurs well for contemporary attempts at psychobiological detriment, especially for the joint future of pharmacotherapy and psychotherapy in the 1990s. Each has different effects or loci of outcome. Drugs have their major effects on symptom formation and affective distress, whereas psychotherapy more directly influences interpersonal relations and social adjustment. Each is activated and sustained on a different time schedule. Drugs may take effect sooner, be of shorter duration, and be used prophylactically; psychotherapeutic results may not reveal themselves until later, but they last longer.

The ideally noncompeting, noninhibiting, positive synergism of the two modalities, then, may occur through both simultaneous and sequential interactions. The two would work in mutual enhancement through the complementarity of their temporal activities, aims, and sites of action. For example, in clinical practice, pharmacologic agents could be used to address symptom removal or relief, reduction of anxiety and depression, improvement in attention and control, and correction of perceptual disturbances; by thus laying the groundwork for facilitating interpersonal accessibility, drugs can serve as a prerequisite and a continuing condition for the establishment of a therapeutic relationship and, thereafter, as a means to facilitate ongoing psychotherapeutic interventions.
see increasingly close collaboration of researchers and practitioners, not only for mutual academic benefit, but also for financial survival. Unfortunately, the latter motive, arising from the expedient practices of funding agencies, may also force clinicians to find quick pseudosolutions for complicated questions. This in turn may generate misleading results since, under the guise of efficacy and safety, the government is primarily interested in cost-effectiveness if not simply cost-cutting. The flaws in recent large-scale federally funded clinical investigations demonstrate the risk that researchers may prematurely test hastily conceptualized hypotheses, thus unwittingly colluding with the funding agencies.\textsuperscript{42}

As I have suggested, an example of rapprochement that will be useful to clinical practice is research focused on the interaction of psychotherapy and psychopharmacology. Although the combining of medication and psychotherapy is a common practice, empiric research supporting the relative superiority of such a regimen is limited. For example, only a small number of studies have considered the efficacy of combined treatment for depression, and most such studies have methodologic problems. However, general strategies for the study of this issue have recently been suggested.\textsuperscript{40,41} In order for such research to be carried out, accessibility to large medical settings or multicenter collaborations will be required, although such collaborations have their own shortcomings.\textsuperscript{44}

Another example of recent efforts to coordinate research and practice concerns the role of clinical training in contributing to the effectiveness of psychotherapy. Strangely, reviews of the literature have concluded that trained clinicians do not seem to have better therapeutic outcomes than relatively untrained ones.\textsuperscript{45,46} Research on this problem should be concerned with a more precise description of the nature and amount of clinical training that experienced and inexperienced therapists have, the nature of the therapy they provide, and the appropriate

ness of the outcome measures that are used. The nature of the experience in psychotherapy is so much a part of the maturing process of the therapist as well that it cannot be meaningfully measured on a per annum basis. But if the years were to be counted, a minimum of 10 years, wherein the therapist practices psychotherapy 20 hours per week and makes a living from it, would be an optimum criterion for defining the experienced psychotherapist. That is the reason why meta-analytic reviews do not reveal that experience makes much of a difference, even though such a conclusion is at variance with clinical observation.\textsuperscript{47} If these studies had used the criterion of 10 years' experience as defined above for their cutoff point, they would have found a difference.

\textit{Process research means studying nuances of psychotherapeutic practice in its natural context.} Much of previous psychotherapy research has been concerned with examining aspects of therapy as seen at a few discrete moments in time. Thus, for example, considerable effort has been expended in trying to find variables that predict (or correlate with) outcome. Such work is summarized extensively by Luborsky and his associates in their recent book, \textit{Who Will Benefit From Psychotherapy? Predicting Therapeutic Outcomes}.\textsuperscript{48} In a sense, this work signals the end of an era; despite hundreds of studies, our ability to predict outcome is very limited.

Thus, increased attention in the decade of the 1990s is likely to be directed, at least in part, to locating better measures of psychotherapeutic results. By and large, outcome criteria have naturally been concerned with symptom change. Useful as this is, however, it does not reflect a number of transformations that are believed to occur in psychodynamic therapies. These include changes in such important dimensions as ego strength, emotional stability, rational judgment, conflict resolution, and affective range. Although psychodynamically oriented investigators have invested relatively little time in the past
in developing new scales, serious efforts in this behalf may turn out to be quite fruitful. At the same time, clinicians need to help researchers develop valid dimensions of therapeutic effectiveness and allow them to investigate systematically what practitioners do intuitively and write about anecdotally.

A consequence of the limitations of outcome research is an increase in the study of psychotherapy as a process. Such research addresses not simply what happens at the beginning and end of therapy, but also what transpires within the course of sessions and gradually changes over time. Focused on the content and interactions as actually practiced by the psychotherapist, it is research in its natural context, the therapist's office. This concern with the ongoing tactics and strategies of psychotherapeutic interaction will be a growing area of special interest for the next decade. Although clinical textbooks discuss this subject in a general way, relatively little specific research has previously been conducted on it. The increase in such interest is reflected in the fact that many new instruments for assessing process have begun to appear in the literature. Special concerns include the ingredients for a "good" vs. a "bad" hour, and those aspects of the psychotherapist's behavior that are "helpful" or "hindering.

Yet another important development in the focus of psychotherapy research is the greater attention to the therapist as a therapist in the here and now. Whereas in previous years research was preoccupied with the kinds of personality factors that make for effective or ineffective therapists, this question of whether A or B therapists were better or whether warm therapists were superior to cold ones was not fruitful. We all intuitively recognize a good clinician when we "see" (i.e., immediately experience) one.

In light of this interest in process, the new focus on the individual therapist is not so much on his or her background, training, or personality traits as on his or her specific behaviors within therapy sessions per se. For example, there is now direct exploration of what therapists say (or should not say) when faced with various "critical incidents," that is, events that threaten suicide, criticize the therapist, become seductive, or arrive drunk to the session (R. Plutchik, H.R. Conte, T.B. Karasu, paper presented at the meeting of the Society for Psychotherapy Research, 1989). Special emphasis is placed on the issues of how the therapist establishes trust, makes interpretations in a non-threatening way, and decides on precisely what avenues to pursue with a given patient and at a particular point in time. As process research narrows its domain to examine actual practices as mini-outcome studies, it will get closer to a more genuine understanding of the subject and to more natural collaboration between researchers and others involved in clinical care.

Modern psychotherapy will "deconstruct" in the computer age, enhancing its scientific and technical dimensions. The availability of small but powerful microcomputers will make possible major advances in both psychotherapy training and practice in the next decade; in recent years these changes have been represented by three types of technological developments: 1) the use of the computer for verbal content and dyadic interaction models, 2) computers for interviewing, and 3) human simulations of psychotherapeutic communication of both patient and therapist.

Although content analysis schemes are not entirely current (perhaps two decades ago computer programs were already being developed to sort interview material into grammatical and content categories), earlier efforts were relatively inadequate for tapping the complex therapy process. Most recently, however, there have been several improved developments of this kind. Drawing on psychoanalytic theory of unresolved conflict, Luborsky et al. have attempted to locate core conflictual relationship themes in patient therapy content. Although still in the formative stages, such use of computerized transcripts to identify "relationship episodes"
may eventually predict psychotherapy outcome.

Other investigators have constructed more complex models. The work of Benjamin, for example, which is less psychoanalytic in theoretical approach and utilizes such concepts as Leary's interpersonal circle and Schafer's language concepts (e.g., the circumplex), has actually analyzed dyadic interactions via a system called "Structural Analysis of Social Behavior." Using verbal as well as nonverbal cues placed over 100 categories, her analysis combines intrapsychic states and interpersonal behaviors and is able to tap not only current styles of interaction but their historical antecedents as well. Applying this type of structural analysis to DSM-III diagnostic categories, Benjamin has recently extended her investigations to the study of narcissism, relating therapist interactive style to therapeutic effects.

In addition to computer analyses of dyadic verbal interactions, a growing number of studies reflect the increasing use of computers to interview, to maximize the gathering of information from patients, and to assist the clinician in making diagnoses. In these studies, digital computers are programmed to conduct medical or psychotherapeutic interviews. The computer is able to present questions with varied wording, skip irrelevant questions, and branch from topic to topic in a flexible way. An important finding is that such computer interviews often elicit more personal embarrassing information from patients than do interviews by clinicians. Further, several studies have revealed that patients find computer interviews at least as acceptable as clinician interviews.

A related development in psychotherapy research has been the use of computers as simulators of the therapist or the patient. Although earlier efforts, such as the Massachusetts Institute of Technology's simulation of a nondirective therapist devised two decades ago, were expensive, unwieldy programs, comparable systems can now be purchased much more affordably in microcomputer formats. For example, a recent attempt has been made to create a form of short-term computer-assisted psychotherapy. In this setting, patients use the computer to identify problems, beliefs, and self-concepts and then use that information in discussions with a therapist-led group. It is likely that the next decade will also see an increase in experimentation on this role of the computer.

The computer has also been programmed to behave like an "anxious" patient, a "paranoid" patient, and a "schizophrenic" patient. These reproductions pose enormous possibilities of simulating the strategies and postures of all forms of therapeutic encounter; however, such efforts have tremendous educational potential both for the trainee and the clinician. In addition, automated systems have the mechanical advantage of being tireless; they can be used any time of the day or night. Moreover, computerized simulations spare the therapist and the trainee the ethical problems of confidentiality that arise when observing and discussing an actual patient.

In summary, while psychotherapy as an emotional intersubjective experience will remain relatively immune to technological advances, psychotherapy as a cognitive experience will be greatly influenced by computers. Nonetheless, computerized research still will not represent true clinical practices, and applications of computer technology to psychotherapy research may only raise the connection between psychotherapy and the computer to a higher level of uncertainty.

**Coordination of Economics and Ethics**

The 1990s will be increasingly a buyer's market, dominated by a "fourth-party" payment system. In addition to (and interfacing with) these intrinsic issues in psychotherapy is the increasing influence of extrinsic forces on clinical practice. In particular, governmental
bodies and external agencies (e.g., third-party payers) are now playing a larger role in psychiatric planning and decision-making than ever before. Five major arenas in which governmental responsibility is currently involved are 1) the licensing of professionals, 2) the accreditation of facilities, 3) judgments as to safety and efficacy of treatment, 4) approval (or disapproval) of proposed research, and, integrally related to all of these, 5) the use of public monies for reimbursement and funding. Although psychotherapeutic practices no doubt need to be placed in the larger context of overall mental health policies, total population needs, already existing systems of care, and viable treatment alternatives at any particular point in time, Keisler suggests that whether psychotherapy is ultimately considered to be cost-effective depends on whether one takes a "bottom-up" or a "top-down" approach. (The latter is believed to lead to a view of clinical practice as too labor-intensive to provide an overall national solution to psychiatric care.)

In the new decade, both clinical practice and training of psychotherapists will be increasingly affected by economic factors. Until the early 1960s psychotherapy by and large was paid for by patients themselves. It was a private financial arrangement with tax deductibility as the only potential point of contact with another agent (the IRS). Otherwise, psychotherapeutic practice was a relatively closed system, limited to the therapist and his or her patient. The fact that both practitioners (almost exclusively psychiatrists) and patients were few in number made psychotherapy primarily an elite occupation, largely unaffected by the medical reimbursement system. Thus, psychotherapy practice was essentially a seller's market. Only the quality and reputation of the therapist were issues of consumer concern; the patient searched for the best therapist, who quite often did not have time to see him.

As both providers and consumers have increased, and as third-party reimbursement has developed over the last three decades, the nature of the practice of psychotherapy began to change. As psychotherapy has evolved from a humanist to a scientific to a corporate phase of health care delivery, cost efficiency has become the "bottom line" of treatment, at the expense of the system's capacity to be empathic.

The 1990s will see the full impact of these ongoing changes and will witness further evolution. More specifically, the purchasers of psychotherapy are now likely to be not the patients, but employers through their own negotiations with a third party; once a seller's market, psychotherapy will become a buyer's market. The consumers are no longer the patients, but, on their behalf, a fourth party, if not a fifth or sixth party, whose interests are increasingly economic: how to get passable services with the least amount of expense. This means the willingness to opt for the lowest bidder among the increasing number of competing providers, irrespective of the quality of the therapist employed. Worse yet is the countertransferential view of patients as "bad objects" who financially deprive those who serve them.

**While tolerance for minimum competence is permeating professional lines, a model of optimum standards is needed.** The interface between economy and ethics has another important ramification: the training of psychotherapists in the future. In the past, a large portion of the curriculum in psychiatric residency was devoted to mastering psychotherapy. At the end of training, one could have reasonably assumed an optimum competence on the part of the graduate, albeit further development had still to be nurtured. But with the evolution of more diverse curricula, one no longer can assume that. Even though department chairpersons and directors of residency training consider psychotherapy central to the training of future psychiatrists, in actual curriculum the time allocated to psychotherapy training is getting smaller.

The average resident may get minimum exposure to psychotherapy training, and only
especially interested residents may seek and receive additional experience in psychotherapy during their residency or, more likely, postresidency (e.g., psychotherapy fellowships or institutes). Of course, as more professional disciplines come to practice psychotherapy, the subject of competency standards becomes even more diffused. There are over 150,000 psychotherapists practicing in this country, belonging to various professions (psychology, social work, counseling, etc.); naturally, their training and experience in psychotherapy varies widely.

It is quite unlikely that in the 1990s the individual states will provide cross-professional standards for practitioners of psychotherapy. It will still be left to professional organizations to set some standard of experience and training for psychotherapists within their membership.

The Joint Task Force of the American Association of Directors of Psychiatry Residency Training and the Association for Academic Psychiatry have recently proposed a minimum training curriculum:74

[E]ach resident must spend a minimum of 200 hours treating patients with psychodynamic psychotherapy... Preferably, these 200 or more hours of experience will extend over the entire training period of the general psychiatrist. Each resident should see at least four different patients, at least one for more than 50 sessions and at least one, preferably more than one, who is treated until termination; the termination should be planned and dealt with as part of the treatment. A minimum of 100 hours of supervision by well-trained psychodynamic psychiatrists is expected. There must be at least one year of weekly didactic seminars on theory and technique and one year of weekly case conferences. The readings for the didactic seminars should include at least one widely respected text on psychotherapy and one widely respected basic text (or collection of classic papers) on the core concepts of psychodynamic theory. (p. 12)

At the same time, they say very little about other psychotherapeutic approaches such as cognitive therapy and short-term therapies. In any event, these are, as the authors say, just "minimum standards." If the APA sets higher standards for its membership, this could be the movement toward the recognition of the need for setting some optimum standard for all psychotherapists, regardless of their professional background.

A code of ethics in the 1990s will expand to include the therapist's scientific and philosophical assumptions. Out of an "age of ethical crises"75 has come greater attention to accountability, morality, and values in psychotherapy and the establishment of codes of conduct to better protect the rights of patient and therapist.76,77 Lesse78 has pointed out that there is no organizational code of ethics or concept of honor and morality that is comparable to the code that has guided individual physicians throughout the ages. He believes health scientists should dedicate themselves to defining such a code. More specifically, Karasu76 has offered recommendations to help psychotherapists make ethical choices. These recommendations include openness to consultation with others in making the best ethical decisions in treatment, constant examination of one's own attitudes and behaviors within and outside of the therapeutic relationship, development of and allegiance to a code of ethics, and greater exploration of the ethical assumptions on which psychotherapy is predicated.

Others have reflected on the increased soul-searching about basic assumptions on which modern psychiatry and psychotherapy are based.76,79 In ideological discussions, the tasks of science often conflict with those of ethics. Chessick79 points out that scientists examine conclusions, but philosophers examine the conceptual models we employ and the implicit concepts and ordering patterns we use. After exploring the fundamental premises behind various psychotherapy ideologies (existential, behavioral, Freudian, and modern psychoanalytic), he warns that, whether we like it or not, we are forced in
practice to make philosophical assumptions and choices that affect clinical work.

**Connection Between Psychopathology and Therapeutic Practice**

*Psychotherapeutic diagnoses as well as treatment will be based on deficits and conflicts of the patient.* The 1990s may help the psychotherapist to come to terms with the clinical realizations that neither separate schools of psychotherapy nor disease-entity-oriented approaches are suitable for designing specific strategies or particular types of therapeutic alliance for the individual patient. Rather, multiple perspectives (e.g., drive, ego, object relations, self theories) must be brought to bear on both diagnostic and therapeutic tasks if they are to relate realistically to one another.

Scientific advances in clinical psychiatry of the last decade include the development of a standardized diagnostic instrument (the DSM and its updates). This has the advantages of using explicit, operationalized diagnostic criteria and, as a unique innovation, permits multiaxial discriminations that separate personality (Axis II) from more florid clinical disorders (Axis I). These new nosologies are also more reliable than previous attempts of this kind. For better or worse, they have also opened up debate about the value and limitation of such systems as they impact upon actual clinical practice.

In an earlier collaborative paper, the insufficiencies of DSM's psychodynamic dimensions were reflected upon, and the authors recommended the addition of a sixth axis that would encompass factors like the patient's conflicts, object relations, coping mechanisms, and defenses; these dimensions are relevant to therapeutic assessment as well as treatment. Case illustrations of depressed patients who were identically diagnosed, but whose psychodynamics were extremely different, highlighted the failings of disease-oriented entities for clinical use. These findings later connected with ongoing studies of the psychotherapy of depression that confirmed its appearance as a spectrum disorder and as an illness of our time. In turn, this has led to some nondiagnostic clinical conceptualizations of psychopathology, especially as they relate to the future treatment of affective and other contemporary psychological disturbances.

In the above vein, I suggest that what may be most useful in the practice of psychotherapy is to assess not the symptoms of a patient's illness (e.g., anxiety, depressive mood), nor the illness itself (e.g., anxiety disorder, major depression), but different constellations of psychological deficits and conflicts that originate in the formative years and that are invariably experienced, reactivated, or perpetuated in the present. Each psychotherapist may intuitively attempt to remedy these deficits and conflicts primarily by providing a specific type of therapeutic relationship as the vehicle through which various therapeutic techniques are called upon to promote affective experience, cognitive mastery, and behavioral modification as generic routes to change and growth. Such a nondiagnostic clinical conceptualization, which comes out of the therapist's actual experiences and draws upon multiple theoretical perspectives, is represented in a "deficit/conflict" orientation to psychopathology.

Such an orientation attempts to bridge diagnosis and clinical care by suggesting that different constellations of problems are composed of combinations of deficits and conflicts—that disturbances in the mother-child relationship and its mental representations result in dyadic deficits or conflicts, whereas disturbances in the mother-father-child relationship and its mental representations result in triadic deficits or conflicts.

More specifically, dyadic deficiencies, such as defective development of self-esteem, adequate self-worth, a stable internal mental representation of self and others, a basic sense of trust and hopeful expectations, the proper level of satiety for narcissistic supplies,
and healthy attachment, are viewed as manifestations of insecure bonding of the child to the psychologically absent, unloving mother, or, more commonly, the conditionally loving mother, the latter being the most common source of dyadic deficiency, leading to chronic depressive dispositions. As no maturational accomplishment is without some relative failure, the growing child remains in constant potential anxiety and depression in his or her relation with the conditionally loving mother. Insofar as the child internalizes this critical aspect of the maternal figure, successes and achievements become the only source of well-being, and the conditionally loving mother becomes depressogenic in her influence on the insecure child.

Similarly, dyadic conflicts (dependence versus independence, controlling versus being controlled) are not conflicts in the traditional id/superego sense but are manifestations of separation, individuation, and autonomy-related struggles toward the development of a cohesive sense of self. They are varied expressions of “wish versus wish” (as opposed to more traditional “wish/fear”) conflicts and occur as a consequence of miscarried dyadic stages associated with the child’s relation to an intrusive and controlling mother.

By contrast, disturbances in child/mother/father relationships may produce triadic deficits and conflicts. Sex, aggression, and competition/submission-related disturbances in the triadic configuration and their mental representations (e.g., the parent preferring the spouse to the child or the child to the spouse, with the other’s retaliative anger and threats, being seduced by the child or being seductive, dismissing the child’s sexual and other interests, discouraging or excessively promoting assertion and competition, etc.) lead to various unconscious conflicts and their conscious, observable manifestations such as lack of initiative, sexual inadequacies, concerns, or reactive adaptations, excessive aggression or submission, fear of competition, or excessive and harsh competition and its related consequences. The more severe disturbances of the triadic relationship (such as the physical or psychological absence of the father, or a father who is abusive to the child and/or to the mother and who is untrustworthy, undesirable, or unrespectable), generate triadic deficits in the child.

But whereas the conditionally loving mother is depressogenic, the unprincipled, unworthy father is sociopathogenic. Thus the child (patient) may act out sexual and aggressive impulses unchecked and may not believe in authorities, social structure, or values (whether religion, marriage, friendship, law, or the therapist). The patient may structurally lack the formation of goals and values or development of ideals, and may make tangible gains (however defined) the focus of life at the expense of relationships. The patient may even behave as if obeying the rules of society, but only out of immediate fear, not out of internalized guilt. He or she will act as if making friends or as if committed to causes, merely because of the desirability of such traits, but in reality the patient does not genuinely engage with others. As the exploitative, non-self-respecting father does not respect women and devalues his wife, in return the insecure wife cannot present herself to the child as a desirable sex object (for a boy), or an object for identification (for a girl). Thus, neither parent emerges from this scenario as an object of desire or for healthy identification. The child ends up not believing the father (father figures and symbols) and devaluing the mother (women).

These dyadic/triadic deficits and conflicts are not, of course, categorical distinctions. They overlap with various degrees of combination and intensity, culminating in highly individualized patterns outside and within the clinical situation. In the '90s the psychotherapist must continue to recognize such specificity of individual diagnostic variations and to systematically formulate such a theory of practice in order to be credible despite external pressures to do otherwise.
C o n c l u s i o n

The 1990s are bringing with them an accelerated version of the last decade's evolution in psychotherapy. Changes are anticipated on many fronts. The neurosciences will increasingly enhance the biophysiological knowledge base of psychotherapy and will be effective in broadening the field of practice only by making the future psychotherapist a pharmacopsychotherapist. At the same time, the separate universes of researcher and clinician will be brought together as the psychotherapist in the dual roles of scientist and practitioner enters the computer age. In addition, the splits between private services and public policies (influence of government, third- or fourth-party payers) will be welded as both sectors have to deal with the interface between economics and ethics in treatment as well as training. And lastly, psychopathology will be newly conceptualized in a way that is more useful in the practice of psychotherapy, based upon such dimensions as deficits and conflicts instead of symptoms and illnesses.

In sum, psychotherapists will be facing the 1990s with escalating change and its closest companion, unprecedented challenge. Through the allegorical vision of Charles Dickens, one may look into the future of psychotherapy: it is a far, far worse world that we enter than we have ever known; it is a far, far better world that we go to than we have ever had.

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