



Pharmacotherapy Vs. Psychotherapy: An Educational Challenge in Current Psychiatric Training

Saeed Shoja Shafti*

Professor of Psychiatry, Razi Psychiatric Hospital, Tehran, Iran

*Corresponding author: Saeed Shoja Shafti, Professor of Psychiatry, Razi Psychiatric Hospital, Tehran, Iran

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Abstract

Despite the fact that the swing of the pendulum toward biological psychiatry has led, in general, to a downgrading of psychotherapy within the realm of psychiatry, in current years a fresh debate regarding practice of psychotherapy by psychiatric residents and psychiatrists has gained a new place in the realm of academic training. Such kind of encouragement, for using psychotherapy on behalf of patients who are suffering from psychiatric complications, has instigated essential modification in the contemporary educational programs in different countries, including developing civilizations. In the present paper the exact condition and outlook of such an amendment has been discussed to understand that whether simple addition of a national curriculum can answer back, applicably, to increasing necessities of mental health in developing cultures, and how the honest exercise of psychological managements by psychiatrists can be improved.

Introduction

"Psychotherapy," wrote Freud, in his 1905 paper of that name, "is in no way a modern method of treatment. On the contrary, it is the most ancient form of therapy in medicine." He went on to explain that there is an old saying that certain diseases are cured not by medication, but by the "mental influence" of the "personality of the physician." No one, of course, can really trace the origins of psychotherapy, but they probably extend back to

primitive medicine men, priests, and soothsayers [1]. According to the Oxford English Dictionary, the earliest use of the term "psychotherapeia," meaning "remedial influence of the mind," appeared in the 1850s. By 1897, in a textbook of mental disease, the term "psychotherapy" was defined as "every means and every possible agency which primarily affects the psychical rather than the physical organization of the patient in a curative direction." [1]. What has been confusing is that Freud used the words "psychoanalysis" and "psychotherapy" interchangeably for many years, and it was only considerably later that he and others sought to distinguish psychoanalysis from other psychotherapies. In an early paper, On Psychotherapy, for example, Freud wrote that psychotherapy seems "positively unscientific and unworthy of a serious investigator" but asked his reader to allow him to defend

it: "There are many ways and means of practicing psychotherapy, to the method Breuer called 'cathartic,' but which I prefer to call 'analytic.'" [2]. It is well established that a majority of the effectiveness of psychotherapeutic treatments can be accounted for by the common elements that all psychotherapies share. The features shared by all include a healer-patient relationship, in which the different roles carry different expectations and a differential balance of power; a nonjudgmental, supportive acceptance of the patient; and an alliance of working together on shared goals. These common elements are rooted in the universal need for attachment and connection. Human brains are designed to seek out attachment when they feel isolated or threatened, and to reciprocally be moved by the pain and loneliness of those who reach out to us. Resting on this foundation, psychotherapies of many different stripes are able to provide an experience—sometimes as quickly as the initial session of feeling comforted, finding hope, and experiencing an amelioration of the sense of being alone or marginalized by one's presenting difficulties. But if all therapies share these comforting elements, what accounts for the existence of so many different psychotherapies? The development of a specific psychotherapeutic method begins with the creation of a psychological model.

Each individual model is built upon a unique conceptualization of how psychopathology evolves and what must happen to achieve an effective and satisfying life, either through the resolution of the psychopathology or in spite of the ongoing psychopathology. Thus, psychotherapy is always a learning process, taking advantage of the brain's neuroplasticity and the related human capacity for durable change at the most fundamental levels of being. Yet, as in formal education settings, learning within psychotherapy is a unique process among individuals and requires a diverse range of approaches. One way to understand the wide array of psychotherapeutic methods, therefore, is as an attempt to accommodate the various learning styles [2]. In addition, what the therapist hopes the patient will learn in the course of treatment is remarkably diverse, and often rooted in very different fundamental ideas about the nature of psychopathology and about what defines an effective and satisfying life. As an example, the cognitive therapist believes patients need to learn about implicit maladaptive thoughts, which eventually, results in changes to deeply held belief systems that contribute to recurrent emotional distress and dysfunctional interpersonal engagement.

The psychoanalytic therapist, on the other hand, believes the most effective learning approach involves exploration of unconscious wishes and conflicts, which allows for the release of longstanding, self-imposed obstacles that hold people back from living life in the fullest way possible. In both instances, the aim is to relieve suffering and promote the growth and development that hopefully, will prevent suffering in the future. How this aim is achieved and the specific goals that occur within the treatment itself are quite different. Through the years, new psychotherapeutic approaches have been developed, usually borne out of a desire to fill an identified need in the treatment of mental illness [2]. But the situation is now shifting: we are becoming more cognizant of the boundaries of organic managements, particularly for long-lasting ailments; there is a rising evidence base for the efficiency of certain psychological treatments; and patients have become more wishing of all-inclusive attention. Consequently, there is a new emphasis on psychosomatic characteristics of medicine with evolving motivations to re-integrate psychotherapeutic procedures into general medical practice [3].

Minor and Major Techniques in Psychotherapy

In this regard, simple psychotherapies are formal varieties of the therapeutic element of physician-patient interactions that consist of counseling, psycho-education, problem-solving skills and supportive psychotherapy. The technical, structured or major psychotherapies as well can be divided into two categories: those that have been derived from psychoanalysis (i.e. psychoanalytic or psychodynamic psychotherapy) and those which are founded on cognitive and behavioral theories. Also, there are several mixed or hybrid therapies, like Cognitive Analytic Therapy (CAT), Interpersonal Therapy (IPT), and Dialectical Behavioral Therapy

(DBT). Other widespread well-known methods include Family therapy and Group therapy [2]. Generally, psychotherapy includes any kind of psychological intervention that is planned to enhance adaptive functioning and reduction of distress or maladaptive behavior [3]. The objectives of treatment involve improving functioning and adjustment in both interpersonal and intrapersonal domains and decreasing maladaptive behaviors and different psychological and sometimes somatic complaints. Therapeutic goals are usually achieved by means of interpersonal processes and verbal interactions [3].

Research in Psychotherapy

The question of whether psychotherapy works has been definitely answered. There is a plethora of evidence from efficacy and effectiveness studies indicating that therapy is effective in alleviating emotional distress and behavioral dysfunction. Questions being addressed by researchers include the relative importance of specific (e.g., interventions) versus nonspecific (e.g., the alliance) curative factors, differential effects of treatment techniques (i.e., are some interventions more powerful for some clients or conditions?), and the transfer of research methods and technology to actual practice [4]. Two models of psychotherapy—the medical model and the contextual model—have competed in the last two decades. The medical model suggests that psychotherapies have specific ingredients that address some problem within the patient and account for outcomes. In contrast, the contextual model holds that therapies are effective owing to universal relational and psychological factors, which vary according to the skills and qualifications of therapists. Meta-analysis supports the contextual framework: There are small, if any, differences among treatments; there is little evidence for the specificity or necessity of any particular intervention; the therapeutic relationship is a necessary aspect of treatment, regardless of the type of psychotherapy; and therapists' qualifications and contributions are a critical factor in the outcome of psychotherapy [4].

There is emerging consensus on the importance of patient-focused research, which uses research to inform case-based treatment decisions about the effectiveness of a specific treatment with a specific patient [4]. The principal goals of psychotherapy research are to understand what the effective components of psychotherapy are and how they work, to determine how patient and therapist factors influence outcome, to improve the effectiveness of psychotherapeutic interventions, to guide the development of new therapeutic techniques and evaluate their effectiveness, and to inform public policies that increase the availability of quality mental health care [4]. On the other hand, psychotherapy researchers distinguish between efficacy and effectiveness research. Each has a distinct purpose, methodology, and interpretative context [5]. Efficacy studies evaluate the sufficiency of a specific treatment to reduce distress, symptoms, and impairment with a group of patients having a particular psychiatric disorder. To minimize the

influence of confounding factors, efficacy studies are conducted using randomized clinical trial methodology in a controlled setting. Patients are screened to control for excessive patient variability and are randomly assigned to interventions that are being compared. The treatment under investigation might be compared to no treatment, a waiting list, placebo, minimal intervention (e.g., psychoeducation), or an alternative treatment. Therapists are trained to conduct the competing treatments to maximize the integrity of putative therapeutic ingredients. To achieve this, most efficacy studies use treatment manuals, which direct (to some extent) the therapist with regard to the intervention offered.

Most studies also perform integrity checks, such as reviews of taped sessions, to see whether the therapy under study was actually implemented [5]. Effectiveness studies are concerned with whether psychotherapy delivered in actual clinical settings is effective in reducing the symptoms, distress, and dysfunction associated with mental illness. The experimental controls used in efficacy studies are absent in effectiveness studies, just as they are absent in community settings. (Indeed, most effectiveness studies are conducted in the community.) [5] In addition, hundreds of meta-analyses of psychotherapy have been conducted, and most have reached the same general conclusion: Psychotherapy is an effective intervention for psychiatric illness across diverse populations and settings. Most meta-analyses have focused on specific disorders (e.g., the efficacy of psychological treatment for bulimia nervosa) or on specific therapeutic approaches for various disorders (e.g., comparing CBT to other therapies). In general, meta-analytic studies have shown that psychological treatments are vastly more effective than no treatment (e.g., wait-list controls or minimal interventions), are about as effective as biomedical treatments for most disorders, and are about equally effective when compared to each other [6-8].

Psychotherapy and Pharmacotherapy: Completing or Competing Procedures

Perhaps the most consistent finding in comparative research into the treatment of mental illness is that combining psychological and biological treatments provides the maximum likelihood of benefit. While various meta-analyses have found psychotherapy and pharmacotherapy to be equivalent in efficacy at both post-treatment and follow-up, and combined psychotherapy and pharmacotherapy has been routinely found to be superior to either alone [9], some important variables as well are existent, which may well separate these two from each other (Table 1). On the other hand, like all other clinical managements, psychotherapy can have adverse in addition to beneficial effects. These are more probable with inexperienced and non-supervised psychotherapists and with psychotherapists who are in a situation to purposefully abuse the patients. It must not be overlooked that even well-delivered therapies can be ineffectual or detrimental. An example is asking improperly patients who have undergone a traumatic shock to talk

about it in excessive detail to a therapist (so-called debriefing) [10]. Within the previous ten years, huge modifications have occurred in the field of counseling and psychotherapy.

Table 1: Different variables related to outcome of psychotherapy.

Treatment Variables Related to Outcome	Patient Variables Related to Outcome
Therapeutic Alliance	Patient Demographic Characteristics
Therapist Interventions	Patient Cognitive Characteristics
	Patient-Therapist Matching
	Patient-Treatment Matching
	Patient Clinical Characteristics

Psychotherapeutic Core Curriculum and Training of Psychiatric Residents

For many years, psychiatric training was the same with learning psychotherapy. As one psychiatrist had narrated, "In 1952, becoming a psychiatrist meant becoming a psychotherapist." In contrast, present psychiatric apprentices planning their forthcoming practices face several choices for incorporating psychotherapy and psychopharmacology, involving providing principally drug-focused visits. In reality, over the past ten years lots of psychiatrists in developed countries have shifted to more medication checks and fewer psychotherapy visits [11]. Consequently, some psychiatric instructors have stated worry that reduced attention to psychotherapy teaching in residency has moved the career's central characteristics away from psychotherapy. Such a shift has caused one noticeable professor to answer "yes" to the challenging label of his article, "Are psychiatric educators 'losing the mind?'" Others have proposed psychiatry could play an important role in medicine by incorporating the mind- and patient-centered applications of psychotherapy with neurobiological developments [11].

Many of psychiatric instructors continue to view obtaining the skills, knowledge, and outlooks underlying psychotherapy as necessary elements for a psychiatrist's role, disregard to upcoming practice setting or professional objectives. Furthermore, consistent with the 'Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee (RRC) for Psychiatry 2008 Program Requirements', all psychiatry residents "should show ability in using 'psychodynamic', 'supportive', and 'cognitive-behavioral' psychotherapies to both 'short-term' and 'long-term' individual practice, as well as convincing acquaintance with couples, group, family, and other individual evidence-based psychotherapies." [11] But in contrast, the practice of psychotherapy by psychiatrists has dropped around 20 % from 2002 -2010, maybe due to low repayment planes and the incapability of a lot of patients to pay for psychotherapy sessions out of pocket, based on outcomes from a 2010 study completed by 394 working psychiatrists [12].

Also, through the same period, psychiatrists incorporated pharmacotherapy more firmly, with the usage of drug therapy growing to 89% of responding psychiatrists in 2010, in comparison

to 81% in 2002 and 54% in 1988 [13]. As said by an assessment, psychiatrists had found pharmacotherapy to some extent more operative, with 87% saying that they were pleased with the effectiveness or usefulness of pharmacotherapy, compared with 76% who had the same verdict of psychotherapy [13]. Accordingly, although there was a new remarkable drop in the delivery of psychotherapy by means of psychiatrists in the United States of America, this tendency maybe is due to a decline in the number of psychiatrists specializing in psychotherapy and a parallel escalation in those focusing in pharmacotherapy - alterations that were probably inspired by economic reasons and growth in psycho-pharmacological managements in recent years [13]. No doubt, there are numerous factors that have unfavorably affected the place of, for example, 'psychodynamic standpoints' within psychiatric practice and 'psychoanalytic training' over the last generation. One consequence of these powers has been to produce a lost generation of psychiatrists with slight familiarity or practice with psychoanalytic treatments [14]. In this regard, novel forces and priorities presently strengthened in educational psychiatry contradict the significance of psychodynamic psychotherapy and, by extension, its basic conceptions such as 'unconscious', 'defense and resistance', 'transference and countertransference', and 'the past repeating itself in the present'. Parenthetically, a recent shift in academic world that prioritizes Evidence-Based Medicine (EBM) and a deficiency of psychiatrist investigators in the field of psychotherapy can be important threatening factors [15].

According to a study, While 46% of psychiatric residents show interest in more psychodynamic psychotherapy teaching, only 22% exhibit interest in applied psychoanalysis. In this regard, most of them had mentioned the time and cost involved as reasons they would not pursue further training [16]. Though psychiatric residents usually thought that their training managers had sustained psychotherapy teaching, nearly 30% was not certain that other key academic leaders were similarly supportive [17]. As said by Cohen: "old-style programs are no longer sufficient to get apprentices ready for practice in the epoch of 'managed-care'. Managed-care's stress on the delivery of mental health facilities at limited expenses necessitates particular practice abilities, mainly quick assessment, brief management, and the capability to document treatment consequences" [18]. What are the abilities required to respond to the necessities of a managed care setting? In most preparation programs, an effort contains assisting learners improve interrogating and interaction abilities. Bradley and Fiorini, too, found that, in a review of mental health programs, the most often talked practical capabilities involved the micro-skills (like empathy, listening, reflection of feelings, and genuineness) that have been emphasized by Rogerian philosophy, too [18].

But regrettably, most psychotherapeutic course books and mental health teaching programs do not address the requisite for new abilities inclusively. This leaves apprentices with no

satisfactory background preparation. Texts have usually been lacking in creating a link between the philosophies and the contemporary practical necessities of mental health experts. Most writings present the schemes of psychotherapy and counseling without considerable assistance on the subject of how they can be modified to encounter the problems imposed by 'managed-care' necessities or in work with various people. In the course of training period, particularly in 'managed-care' situations, the models of psychotherapy educated by apprentices are of little aid in meeting clinical evaluation, treatment, and outcome necessities [18]. Short-term methods and procedures that have developed from these models are not presented, nor is there enough emphasis on the incorporation of theory and practice. This has caused a cutting off between what apprentices learn from writings and the abilities they are anticipated to apply under managed-care policy and duty strategies. Moreover, learners are given little supervision in working with different subcultures or minority groups [18].

Discussion

Approximately 25 percent of the US population meets criteria for a psychiatric disorder in any given year, but most do not seek any type of formal care. The likelihood of obtaining treatment increases with emotional distress and functional impairment. Accordingly, those with comorbid mental illnesses or with severely disabling disorders, such as schizophrenia, are the most likely to seek professional help. In contrast, a lack of insurance and concerns about how to pay for services decrease the likelihood of seeking treatment. However, the primary barriers to mental health care are psychological, perhaps primarily the stigma related to having a mental illness. Negative attitudes toward admitting that one has a psychiatric problem and toward seeking care from a specialty mental health provider have actually increased over the last five decades. Research suggests that this is related to the increasing conceptualization of mental health problems as medical, which may translate into the impression that the problem is permanent. Consistent with this, most who seek care increasingly do so in the general medical sector rather than from a mental health specialist [19].

J. West' wrote a paper entitled "The Future of Psychiatric Education." In it he had foreseen that by 1984 most psychotherapy will be done by psychologists and social workers and much of today's office psychiatry by internists and family practitioners. Though he notifies against losing the "expertise in psychodynamics accumulated over the past 90 years," he nonetheless sees future psychiatrists as much more of behavioral scientists, endocrinologists, and neurologists than their forerunners. He believes that upcoming psychiatrists will also be teachers for, and provide liaison to, many medical and mental health disciplines. Some financial factors have increased the credibility of West's forecasts as regards psychotherapy. First, psychiatrists are physicians. Hence, they and their services are usually very expensive. Also, according to Jerome

Frank [20], no type of psychotherapy or psychotherapist has ever been proven better than any other. Therefore, one might ask, since social workers and psychologists usually charge lesser costs than psychiatrists, why not send patients to them? Undoubtedly, the managers of national health insurance might feel this way, as might patients incapable to pay for a psychiatrist's charge.

Briefly, increased economic and governmental pressures, together with an emergent requisite within medicine itself for the scientific and medical expertise, which only a physician-psychiatrist can provide, might well push psychiatry in the path that had been anticipated by West. According to Bertram Brown [21], former Director of the National Institute of Mental Health, the era of the analyst and dynamicist in psychiatry seems to be done and the epoch of the biological psychiatrist is upon us. Brown states that during the past decades most developments in the field of psychiatry have been in biology, pharmacology and the treatment of psychoses-not in psychotherapy. So, the biological psychiatrists, he declared, are the final outcome of today's psychiatry [22]. In this regard, Massachusetts General Hospital's Chairman of Psychiatry, Thomas Hackett [23], goes a step further: "Unless we are at home in medicine, psychiatry is homeless." He feels that, apart from their medical teaching, psychiatrists have little more to offer to patients than social workers, lay therapists and clerics. Psychotherapy is now broken into many schools and divisions, and he notifies that if psychiatry does not get rid of psychotherapy and back into medicine, we are, in his words, "an endangered species." [22] Conversely, Sederer believes that psychotherapy, as like as moral therapy in past era, is very hard to do, and had felt that the medical model is very seductive, especially to medical students, for the reason that it includes a lesser amount of personal anxiety on a therapist's part [24].

Also, because biological management is cheaper than psychotherapy and places a lesser amount of emphasis on patients' accountabilities to play a part in their own treatment, and is likely to treat patients like children, biological psychiatry is likewise more acceptable or easier to do by psychiatrists. Therefore, he argued, with more and more people demanding psychiatric care, with the rising cost of health care, and with the increased need for psychiatric consultation within the medical setting, the aforesaid tendency, should psychiatrists ever stop learning and practicing psychotherapy, will push for continuation of the aforesaid separation. Once separated, he feels, these factors will maintain a perpetual split. According to Sederer: 'science is a form of humanism, but "scientism," the cult of science that worships technology for its own sake, is unidimensional and antihumanistic, and reduces man to a mechanistic, concrete, non-individual entity' [24]. But if the circumstances in industrialized states are so, then what will be as regards developing countries that wish to publicize psychotherapy from the initial point, based on printed textbooks

or accredited literatures in developed countries. Previously in some earlier articles, in addition to accent on the requirement of national-based researches and modifications, the societal and educational difficulties concerning practicing or advancement of major psychotherapeutic methods in developing countries had been discussed [25].

At this point, once more, it deserves to be mentioned that, essentially, if practice of psychotherapy by psychiatrists is supposed to be an indispensable fact, then a renovation in the viewpoints of psychiatrists, too, appears to be indispensable. For instance, psychotherapy can not be expected to be established if it is not going to be supposed as a complete career and in need of enthusiast followers. A modern psychiatrist is more an organic-minded physician who has been entirely and persistently educated about psycho-pharmacotherapy through the entire educative program. Bases of core curriculum of psychiatric residents, like inpatient and outpatient medical practices, lectures, grand rounds, case presentations, journal clubs and other didactic apparatuses and strategies, are commonly based on biological grounds and Evidence Based Medicine (EBM). In the border of such a scholastic perception and context, no one can anticipate abrupt jumping out of enthusiast psychotherapist, except than a psychiatrist with individual preferences for acquiring and performing 'The talking cure'. The present programs commonly create psychiatrists who are just acquainted with different techniques of psychotherapy, and the related indications for referring patients to other expert psychotherapists. A clinician who desires to practice psychotherapy, disregard to the technique, should see and imagine that style of treatment as the best manner that can aid the patient to get rid of his distresses, maybe even a bit fanatically, to be able to practice doubtlessly. He should be familiar with and accept its complications and variability, and do his career without uncertainty and have a passionate energy to prove the profits of his favored mode of psychotherapy methodically and progressively, in the frame of EBM. Presently, all mental health careers (like psychiatry, clinical psychology, social working and counseling) are advocating the outlook that managements must always have an 'evidence-based' attitude and methodical approach.

On the other hand and in keeping with the existing evidences, a psychotherapeutic outlook may not be cultivated easily or genuinely in the ground of organic psychiatry. It demands its specific and psychotherapy-based journal clubs, case presentations, visits, lectures, practices, researches, and so on. Such a course and attitude is not the same for non-medically oriented experts and medically-oriented psychiatrists, and achievement of such a view is, for sure, more difficult for the second one. He should initially conquer his interior doubts as regards the usefulness of psychotherapy in comparison with the absolutely evidence-based pharmacotherapy, and at that point, increase its position in his mind in competition with pharmacotherapy, despite the whole existing dissimilarities. On the other hand, when available meta-analyses have shown that

psychotherapy, and 'Complementary and Alternative Medicine (CAM)' are effective, mainly or completely, because of circumstantial aspects rather than the definite disease-treating issues suggested by the therapy or therapists, and psychotherapists are the most important circumstantial feature and their effectiveness varies from zero to about 80%, and, also, studies have failed to detect what makes a good (i.e. fascinating) psychotherapist, expecting today's psychiatrist to spend enough time on psychotherapy or to trust its scientific value is not an easy task [26,27]. According to a study, therapists who provide Cognitive Behavior Therapy (CBT) - including the most experienced therapists - regularly leave the CBT techniques defined in treatment handbooks. 'Only 50% of the clinicians claiming to use CBT use a method that even approximates to CBT,' [28]; such a practice is not in harmony with the evidence-based expectations of modern psychiatrists.

Currently, psychiatrists are unconsciously or consciously hooked on pharmacotherapy, a significant reason that interferes with their innermost preferences for practice of psychotherapy in the course of their usual appointments. In the present years, quick improvement of symptoms and restoration of function are the most significant issues that are generally wished by clientele and the public. Such set of circumstances inspires and allows psychiatrists to return quickly to medicines or increasing their dosages if met with refractoriness or elongation of symptoms. Therefore, it is imaginable that in such statuses the psychotherapy can not have in their minds the equivalent place or worth in comparison with pharmacotherapy and it will be moved inevitably to the second or less significant place. This context is sufficient for declining practice of psychotherapy by psychiatrists, especially analytic or insight-oriented methods, like psychoanalysis and psychoanalytic psychotherapy, which demands adequate perseverance and time. Although psychiatrist may sometimes properly distinguish that probing of unconscious struggles, intellectual biases, prime suppositions, and personal interactions are necessary for crucial modification of psychological processes, the abovementioned dynamics, stops psychiatrist from expending adequate amount of time and effort intended for psychotherapy. Such a recess or negligence in the first cases can be repetitive in future and will be turned finally into a fixed method of approach. Knowledge is not always equivalent to motivation and the later is not at all times correspondent to practice. Maybe, personal analysis of psychiatric residents or even encouraging them for using eligible psychotherapeutic facilities with regard to their own anxieties, will help them to sense more skillfully the usefulness of psychotherapy. But according to a study, currently a significant minority of psychiatric residents pursues 'personal psychotherapy', mostly psychodynamic approach. While this number appears to be much smaller than in the past, residents identified training demands and financial cost as the top barricades to following psychotherapy [29].

Moreover, if setting permits, coaching psychotherapy for psychiatric residents or graduated psychiatrists by means of

expert psychotherapist psychiatrist, in place of non-psychiatrist psychotherapists, appears to be a better method, for the reason that it may boost learners' enthusiasm by means of identification with mentor, by way of role-modeling. In accordance with the present circumstances in Iran, as a typical developing country in the region, after inauguration of new academic national core curriculum for formal education of psychotherapy to psychiatric residents in the preceding seven years, excluding simple psychotherapies like 'counseling', 'supportive psychotherapy', and 'psycho-education', no considerable escalation in practice of structured, major, or hybrid psychotherapeutic procedures, like 'psychoanalysis', 'psychoanalytic psychotherapy', 'brief dynamic psychotherapy', 'CBT', 'DBT', 'IPT', 'CAT', 'family therapy' or 'group therapy' by recently graduated psychiatrists was evident, in comparison with the periods without such a course.

Nevertheless, if we consider the reducing practice of psychotherapy in the advanced societies, then we can foresee its sluggish advancement and possibly unclear prospect in developing countries. Even though in a new study and opposing to the existing facts, it has been proclaimed that 80.9% of psychiatrists in Canada continue to incorporate pharmacotherapy and psychotherapy in their clinical practice, and the delivery of psychotherapy among psychiatrists that have been graduated in the preceding 10 years has been greater than before, disregard to the rate of drop-out, since it has not discriminated simple approaches from structured, major or hybrid techniques, the conclusions can not be recognized as flawless [30].

Anyway, as has been stated by some lecturers like Macdonald, 'medical training, with its stress on intra-somatic functioning and negligence of a systematic understanding of the organism in total, and its affiliation to its coworkers and its surroundings, has restrictions as teaching for psychotherapists.' 'Clinical psychotherapist would be an applicable name for those physicians who sensed themselves free to use any psychological technique with or without the usage of the significant drugs and somatic treatments now obtainable.' According to him: 'The psychotherapist should be subject to various inspirations other than merely ideas of Pavlov and Freud and their byproducts. For example, any course of teaching would be unfinished without an impact from the social researchers' [31]. Essentially, it must not be ignored that psychotherapeutic abilities are required in every situation in psychiatry since the same phenomena that appear in psychotherapy - like resistance, transference, countertransference, schema and automatic thoughts - appear in other circumstances too. Psychiatric residents should be educated that psychotherapeutic doctrines apply in all locations where psychiatric management is provided [32,33]. Anyway, the marriage between psychotherapy and psychiatry has always been a troubled one [23].

Descriptive psychiatry, came to life by Kraepelin, has habitually been in conflict with dynamic psychiatry, which had come to life by

Freud. Psychotherapy is not at all easy to do, because, as Greenblatt has pointed out, it is very difficult for a person to learn how to deal with the deepest feelings of patients [23]. So, Descriptive psychiatry is much easier to do, as it places less emotive pressure on the therapist. On the contrary, Strain pointed out that the psychiatrist who consults with his medical colleagues is often asked to deal with emotions, doctor-patient issues, and environmental issues [34]. Without an understanding of psychodynamics and interpersonal interactions, the psychiatrist will be of limited value to his consulters. In addition, Dogherty has warned that the 'subject-object' relationship between doctor and patient, inherent in the medical model, is very different from the personalized 'subject-subject' relationship of psychotherapy [35].

According to Eisenberg, medicines alone are generally no cure for psychiatric illness; they merely diminish symptoms. "Brainless psychiatry," he asserted, is as bad as "mindless medicine." [23] Some believe that 'psychotherapy must be considered as a biological treatment that works by changing the brain and is therefore just as important as pharmacotherapy in terms of general treatment planning' [36]. While the current 'Accreditation Council for Graduate Medical Education' necessities for psychiatric residents follow an approach based on particular schools of psychotherapy (highlighting proficiency in psychodynamic therapy, cognitive-behavioral therapy, and supportive treatments), evidence shows that we are failing even in these efforts [37]. The considerations and strategies of such a policy should be decided by chief mental health and scholastic superintendents of each nation, by taking into account the existing high academic organizations, human resources, shortages and assets, community mental health centers or private clinics for providing psychotherapeutic services, and also national strains and problems. Lacking such an outline, advancement of psychotherapy as a useful healing tool is not imaginable.

Conclusion

In general, a balance between 'Evidence-Based Medicine' and the individual clinical experience with patients (Experience-Based Medicine) must be recognized within medical education, rather than supporting one against the other [38]. Past controversies regarding the ability to examine scientifically various psychotherapeutic techniques have largely been settled. Valid and reliable methods for measuring therapeutic events and their effects have been developed. These have included intensive analyses of patient and therapist variables, in-depth assessment of therapeutic processes, and implementation of outcome measures that assess general distress, symptoms related to specific disorders, and functional impairment in emotional, cognitive, and behavioral domains. Controlled clinical trials comparing replicable, distinct psychotherapeutic interventions are normative, as are sophisticated analytic methodologies, including growth curve analysis, time-series panel analysis, and structural equation modeling.

Most significantly, various methods of meta-analysis-techniques that combine results across different studies to evaluate the effectiveness of particular treatments for specific patients and problems— have been applied to psychotherapy research [4]. In spite of all of the existing endorsements, criticisms, advises, foresees, national curriculums, set of courses, and etc., while practice of psychotherapy by today's biological psychiatrists is an approvable, logical and possible expectation, its achievement, due to inherent or contextual inconsistencies between organic structure of medical attitude and practice, and psychological construction of psychotherapeutic philosophies and approaches, does not seem to be easily or efficiently attainable. Psychotherapy needs to be accomplished by enthusiasts, who practice that as a full job and see that as an intact therapeutic tool. Such a perspective can only be encouraged by interested instructors in apt learners, disregard to their present-day job or past education.

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