Canadian Journal of Biomedical Research and Technology

Can J Biomed Res & Tech
May 2019 Vol:1, Issue:1

Educating Psychological Managements in Present-Day Psychiatry: Is it a Fruitful Struggle?

Open Access **Review Article**

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Submission: April 05, 2019
Published: May 02, 2019

Abstract

Despite the fact that the swing of the pendulum towards biology, 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 management by psychiatrists can be improved.

Introduction

Psychiatry, the branch of medicine concerned with disorders of the mind, has for many years utilized psychotherapy as a principal treatment tool. This has been especially true in the United States, where Freudian teaching has been popular and the psychodynamic principles derived there from widely used. Various types of psychotherapy exist *(Friedmann [1])*. They share in common interpersonal interaction between a healer and a patient, they pay particular attention to social, environmental and intra psychic issues, and they utilize techniques such as suggestion, hypnosis and psychoanalysis aimed at the patient's mind. The psychotherapies are distinct from the somato therapies such as drugs and electroconvulsive treatment-in which attempts are made to alleviate mental symptoms using the biological and chemical soma. Psychotherapy has become so much a part of American psychiatry that, for many, the two terms have become almost synonymous *(Friedmann [1])*. But, on the other hand, no general consensus, as well, is currently achievable. For example, while Yager believes that human behavior is too complex to be treated from one point of view alone, and a psychiatrist, in order to effect the best possible solution to a clinical situation, must know behavioral science, biology, and many types of therapy *(Yager J [2])*. Bertram Brown, former Director of the National Institute of Mental Health, has written that, in his opinion, the era of the analyst and dynamicist in psychiatry appears to be over and the era of the biological psychiatrist is upon us.

Brown asserts that during the past 20 years most advances in the field of psychiatry have been in pharmacology, biology and the treatment of psychoses-not in psychotherapy. The biological psychiatrists, he stated, are the change agents of today's psychiatry *(Brown BS [3])*. Also, Thomas Hackett, Massachusetts General Hospital's Chairman of Psychiatry, has went a step further: "Unless we are at home in medicine, psychiatry is homeless." He feels that, apart from their medical training, psychiatrists have little more to offer to patients than clergymen, social workers and lay therapists. Psychotherapy is currently fragmented into many factions and schools, and he warns that if psychiatry does not get out of psychotherapy and back into medicine, we are, in his words, "an endangered species *(Hackett TP [4])*. Nonetheless, the question of whether or not psychiatrists should continue to learn and carry out psychotherapy is currently a much discussed issue in psychiatric circles. Many in psychiatry are pushing h ard for a divorce. Should such a change come about, the results would affect the entire realm of medical practice *(Friedmann [1])*. In this regard, Lesse warned against the worship of "rating scales": over-objectification at the expense of teaching psychotherapy. He feels psychiatry must move to a new level, by interrelating the psycho biological, psycho dynamic and psychosocial into a total psychiatry. If this can be done, and if we do not cast off psychotherapy in our zest for neurobiology, the marriage can survive. Psychiatry must expand, not contract. And we in psychiatry must take pains to explain to our medical colleagues that psychotherapy, in tandem with the more "medical" aspects of psychiatry, has much that is unique and important to offer. An eclectic psychiatry, properly applied, can be similarly beneficial to psychiatric and non-psychiatric patients *(Lesse S [5])*. 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 *(Friedmann [1])*. 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.

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 *(Gelo O, et al. [6])*. 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 *(Gelo O, et al. [6])*. On the other hand, psychotherapy researchers distinguish between efficacy and effectiveness research. Each has a distinct purpose, methodology, and interpretative context *(Gelo O, et al. [6])*. 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 *(Gelo O, et al. [6])*. 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 *(Gelo O, et al. [6])* 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 definite illnesses. 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 *(Hanrahan F, Cabral RR, et al, [7,8])*.

Pharmacotherapy & Psychotherapy: Incorporating or rival processes

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 *(Wampold BE, et al. [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) *(Vocks S, et al. [10])*.Within the previous ten years, huge modifications have occurred in the field of counseling and psychotherapy.

Psychotherapeutic Set of Courses and Preparation 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 *(Lanouette MN, et al. [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 *(Lanouette MN, et al. [11])*. But in contrast, the practice of psychotherapy by psychiatrists has dropped around 20 % from 2002 to 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 *(Zoler ML [12])*. 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 *(Mojtabai R, et al. [13])*.

No doubt, there are numerous factors that have unfavourably 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 *(Plakun EM [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 counter transference', 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 *(Mellman LA [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 *(Katz DA, et al. [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 *(Calabrese C, et al. [17])*. As said by Cohen: "old-style programs are no longer sufficient to get apprentices ready for practice in the epoch of 'managed-care' *(Sue D, et al. [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 *(Sue D, et al. [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 *(Sue D, et al. [18])*.

Discussion

Eisenberg has pointed out that psychiatry is in many ways similar to healing in primitive cultures. The shaman shares many characteristics with the psychiatrist. He stated that medicines alone are generally no cure for psychiatric illness; they merely diminish symptoms. "Brainless psychiatry," he asserted, is as bad as "mindless medicine." Rather than splitting psychiatry's functions by divorcing the biologic from the psyche, he spoke for a fusion in mind-body relationships. Psychiatry can provide a bridge between soma and psyche, but only if it encompasses both (Evidence-Based Practices for a Diverse Society [19]). Some scholars have 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. Put another way, psychotherapy humanizes the patient and accentuates his unique individuality. A schizophrenic, for example, who fears losing his identity, may have his fears realized if in his relationship with his therapist he is treated like an object with a disease that needs pills. In other words, a totally organic approach to the patient will be anti-therapeutic and lead to further ego disintegration. To adequately heal even the sickest of psychiatry's patients-the schizophrenics-one needs trust and humanism, in addition to medications. And schizophrenics are one group of patients virtually all prognosticators see as viable clients in psychiatry's future *(Friedmann CTH [1])*. In this regard, West has written 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 *(Eisenberg L, et al. [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 *(Frank JD [21])*, former Director of the National Institute of Mental Health, the era of the analyst and dynamism 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 *(Brown BS [22])*. In this regard, Massachusetts General Hospital's Chairman of Psychiatry, Thomas Hackett *(Friedman MA [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." *(Brown BS [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 *(Hackett TP [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 uni dimensional and anti humanistic, and reduces man to a mechanistic, concrete, non-individual entity' *(Hackett TP [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 *(Sederer L [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 *(Shoja Shafti S, Hyland ME [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,' *(Bahíllo SÁ [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 clienteles 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 cannot 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 distinguishes that probing of unconscious struggles,

intellectual biases, prime suppositions, and personal interactions are necessary for crucial modification of psychological processes, the above mentioned 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 (Waller G [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 cannot be recognized as flawless *(Haak JL, et al. [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' *(Hadijpavlou G [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, counter transference, 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 *(Macdonald IJ, Gabbard GO [32,33])*. Anyway, the marriage between psychotherapy and psychiatry has always been a troubled one (Friedman MA [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 *(Friedman MA [23])*. So, Descriptive psychiatry is much easier to do, as it places less emotive pressure on the therapist *(Friedman MA [23])* 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 *(Friedman MA [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 *(Strain JJ [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." *(Friedman MA [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' *(Dogherty EG [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 *(Gabbard GO [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

(Feinstein R [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 *(Hackett TP [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. As Dogherty clearly presented, combining a medical-objective and psychotherapeutic-subjective view of patients is a very difficult task. The pressures for separation are immense. But the benefits to mankind, if the marriage can be saved, are great. If psychiatry broadens, by keeping what it now has and expanding into newer areas, we will all be the better for it. But it will take a lot of work to keep the marriage together *(Resch F [39])*.

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

Table 1: Different variables related to outcome of psychotherapy.

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