G E N E R A L R E V I E W

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Psychotherapy in psychiatry: subspecialization or integration?

Psihoterapija u psihijatriji: subspecijalizacija ili integracija?

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Introduction

A clearer understanding of the relationship between psychiatry and psychotherapy, both in everyday practice and education, is still needed today. The origin and development of psychoanalysis at the beginning of the twentieth century and its expansion following the Second World War, on the one hand, and immensely accelerated progress in the neurosciences and biological psychiatry started by the pharmaceutical industries, on the other, led to the separation of psychopharmacological treatment and psychotherapy. Economic pressure from insurance groups, with their requests for rapid improvement and prompt treatment for mental health problems, thus minimizing hospital stays, additionally led to favoring pharmacotherapy. All this brought up many questions regarding the relationship between psychiatry and psychotherapy. Many of these questions are yet to be answered. Today, we find ourselves wondering about the role and place of psychotherapy as a therapeutic method in psychiatry, and how both future and current psychiatrists should be educated during their training [1].

The paradox is present because, at the time of great research opportunities and the potential of science to understand the complexity of the mind-brain relationship and thus rise above the artificially created Cartesian dualism, psychiatry is becoming increasingly reductionist [2]. In favor of this, Gabbard [3] notes that psychotherapy considers the treatment of "psychologically caused" disorders, while medications used for treating these disorders affect the brain. In this way, a simplified dualism neglects that psychotherapy creates its impact by changing the brain and that the mind is the result of brain activity [3–5]. Recent papers discuss this issue in more depth. Nobel laureate Kandel [6] noted earlier that psychotherapy could be seen as a biological treatment, creating a parallel between psychotherapy and his research on marine molluscs *Aplysia californica*, which shows that synaptic connections can change indefinitely and increase the expression of genes when learning takes hold, which also happens in a successfully conducted psychotherapy. Some studies have confirmed that psychotherapy as a method of treatment in psychiatry needs a wider context and a more in-depth understanding. The role of psychotherapy in psychiatry should be assessed critically in many different aspects since the separation of these two might lessen not only the possibility of quality treatment for our patients but also the possibility for future psychiatrists to obtain complete training and education.

The aim of this paper was to systematically describe psychotherapy as an inseparable part of basic psychiatry training and keep the subspecialty possibility open.

This paper represents a review of the interaction, firstly through the history of psychiatric education, then through current integrative models, but also accentuates the importance of accepting the possibility of having psychotherapy as a psychiatric subspecialty (fellowship).

We shall begin with a historical review of the relationship as the base for understanding the origin of the artificial dichotomy of the mind-brain [3, 4] and the antagonism of biologically oriented psychiatrists towards psychotherapy.

Historical retrospective

The place and role of psychotherapy in psychiatry discussion starts during the first half of the twentieth century with the beginning of psychoanalysis and revolutionary

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breakthroughs in understanding mental functioning. This new therapeutic method based on free association and careful listening to the patients in a different way, which allows it to be interpreted as an integral part of psychoanalytic work, showed positive results and uncovered a new method of treatment [7]. Psychoanalysis provided many new ideas: knowledge about unconscious mental processes, psychic determinism, infantile sexuality, and possibly most important of all, uncovering the irrationality of human motivations [7]. In this way, psychoanalysis inspired the progress of the contemporary psychiatry of the time. Sigmund Freud's stay in America at the beginning of the twentieth century, along with the years after the Second World War when many European psychoanalysts emigrated to the more open United States (US) society, created the conditions for the development of psychoanalysis in America [8].

Kandel [7] suggested that medicine in that period transformed from a practical trade to molecular biology. Yet, at the same time, psychiatry transformed from a medical discipline to a therapeutic art. It is a surprising fact that during the 50s and 60s, academic centers in the US of America (USA) saw a shift from the biologically-based view of psychiatry to the more socially and psychoanalytically based context, lessening the focus on the brain as the organ of mental activity [6, 7]. The development of psychoanalytic psychiatry does not stop here, according to Kandel [7]. Instead, the development is spreading to different medical disorders that, prior to this type of treatment, did not respond to the pharmacological treatments mostly used in the 40s; thus, the basis of psychosomatic medicine was created. The reach of psychoanalytic therapy spread gradually yet considerably to almost all mental disorders, including general psychoses, schizophrenia, and clinical depression [6, 9].

In this way, the focus of the work, but also psychiatric training, shifted to psychoanalytic psychiatry. Moving from descriptive psychiatry of the pre-Second World War period to psychoanalysis undoubtedly proved beneficial to clinical insights through stronger explanations for observed phenomena; however, it did veer psychiatry away from the breakthroughs of biology and experimental medicine [6]. This situation does not present a good basis for the future position of psychotherapy in psychiatry as a *de facto* medical discipline. That is the beginning of the "seesaw" between biological psychiatry and psychotherapy, a continual shift that is more or less present today as well.

This deviation from biology is the result of the lack of concrete, in-depth knowledge about the brain at that time and also the result of the dominant belief that various mental functions could not be localized in specific regions of the brain and that many more mental functions are diffusely exhibited in the cortex [6]. In this way, the role of psychoanalysis as a psychotherapy method was the result of a number of conditions contributing to this dominance. Both psychiatry and psychology benefited from this separation, developing systematic definitions of behavior from then-unknown correlations with neuron mechanisms. Furthermore, the presence of psychoanalysis in psychiatry contributed to the greater focus on the human side of the interactions with the patient, reducing the stigma associated with the previous period. By 1960, psychoanalytically oriented psychiatry became the main model for understanding all mental and also some physical disorders [9].

Psychoanalysts failed to overcome the shortcomings of psychoanalysis through experimental research, given the role they had in psychiatry as a whole. In this way, psychoanalysis experienced a downfall of sorts, which influenced the entire psychiatry, discouraging new ways of thinking and affecting the quality of psychiatric training. The function of the specialization programs was not to develop good psychiatrists but rather good therapists who could empathize with their patients and their life issues [9].

Biological revolution in psychiatry

From 1950 to 1960, the years were marked by the development of psychopharmaceutic drugs, firstly chlorpromazine, then antidepressants (isoniazid, iproniazid, imipramine), then chlordiazepoxide, all of which contributed to a second revolution in the field of psychiatry [10]. However, the political dominance of psychoanalysis in psychotherapeutic training had several decades of influence at that time, and balancing that with these breakthroughs proved to be difficult. Several influential and critically oriented researchers of the succeeding era of psychiatry spoke of their personal experience during their psychiatry training, how their mentors would often say that the medication serves to lessen the anxiety of the doctor, not the patient. However, the middle of the 1970s showed a great need for understanding the mechanisms of psychopharmaceutic treatments instead of purely clinical observation and patient behavior, and so a new cycle began [9].

The development of psychopharmacology has, apart from the undoubtedly positive changes seen in the treatment of psychiatric patients due to it, pushed aside the important characteristics of psychotherapy. Most of all, in lowering the attention given to psychodynamic and developmental factors influencing psychopathology, mental disorders became a disease of the brain or a "chemical imbalance" in the eyes of the public and many psychiatrists. Changes in the relationship between health insurance toward psychotherapy have also had an impact on the programs of psychiatric specialization, as psychiatric disorders are becoming more identified with a biological or medical model and less with a biopsychosocial one. Because of this, it is presumed that, should this trend continue, psychiatry will lose its essence – humanism [11].

Due to the lack of time and changes in training and education, specialists in psychiatry have less opportunity to learn about the "time-dependent" elements of psychiatry: the capability of empathetic listening, development of a therapeutic alliance, working with resistance to therapy, understanding of psychodynamics, recognizing transfer phenomena, and where and how to provide interpretations [11].

To answer our questions and dilemmas related to the model of psychotherapeutic education and training in psychiatry and the dilemma of integration in the context of

the specialization of psychiatry as a model of subspecialization, as it was for years in Serbia, as it has been in recent years in the United Kingdom (UK), and as it currently is considered in the USA, we will focus on two models: European and American.

European model of psychiatric integration of psychotherapy

In international circles, after the rise of biological psychiatry, the reintegration of psychotherapy in psychiatry went in the following way. In 1958, the Union of European Medical Specialties (UEMS) was established, and after more than thirty years, in 1991, the Section for Psychiatry was formed. The European Forum for all Psychiatric Trainees in Utrecht was established after that with the idea of aligning knowledge through the mutual exchange of ideas and training throughout Europe, in order to aid organizations in individual nations [12–14]. They formed guidelines important for psychotherapeutic training in psychiatry. It was emphasized that basic training must include supervision of clinical practice, which would be supervised by qualified psychotherapists. Next, it was emphasized that in theoretical training, different areas of psychotherapy must be included, while skills are gained mostly in individual areas of psychotherapy. After this education, psychiatrists must be knowledgeable in other forms of psychotherapy as it would allow them to refer their patients to a specialized psychotherapist. Finally, a personal psychotherapeutic experience would be an important component in training, so programs of training for future psychiatrists should have it integrated into their residency training [1, 14].

Section for Psychiatry UEMS recommends to the national bodies that psychotherapy be seen as an integral part of training in psychiatry and that they are to be responsible for establishing a system to finance psychotherapeutic training, as it already is the case with other forms of training in psychiatry. The reason behind that is the fact that psychotherapeutic training would improve the clinical practice of psychiatrists [1, 13].

The theory of psychotherapy is a part of the graduate program and includes at least psychodynamic and cognitive-behavioral theory. Other theories can be included once they are scientifically confirmed. There is a predefined number of hrs of theoretical training, research methodologies, and individual psychotherapeutic cases supervised with a predefined number of hrs. Psychotherapy training (theory and supervision) could be individual or group. Lecturers are obliged to have the training in psychotherapy completed, and the training must be recognized by the national body. Since the training is evidently for psychotherapy in psychiatry, the head of the program has to be a psychiatrist [13].

One of the main missions of the Section for Psychiatry is the implementation of comprehensive knowledge of individual programs in the countries of the European Union in order to align psychiatric training. For obtaining more specific information on the training programs, it was decided that different areas of psychiatry must be looked at in the same way as the three-dimensional approach to psychiatry (psychology, sociology, and biology), which was present in member countries [12, 13].

The Section for Psychiatry UEMS, in Edinburgh, on April 2, 2004, defined psychiatry as a biopsychosocial discipline and acknowledged psychotherapy within this framework. It was defined as a psychological intervention that is structured, focused, and grounded on "evidence-based" medicine. They set it in the center of psychiatric disorders treatment, based on analysis of training [14–16]. According to them, the three theories of psychotherapy used in psychiatry are psychodynamic, behavioral, and systemic [17, 18].

Section for Psychiatry recognizes the following psychotherapeutic components of psychiatric training in Europe – a defined number of psychotherapy cases for clinical experience, a minimum of 120 hrs of theoretical training, and a minimum of 100 hrs of case supervision. That being said, the supervisors ought to be qualified, personal therapy is highly recommended, and training should be publicly funded [13, 17, 19].

USA model of psychiatric integration of psychotherapy

Across the Atlantic, in the USA, the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) in 1999 recognized a group of six principles required for measuring the competency in medical education: patient care; medical knowledge; interpersonal and communication skills; practice-based learning and improvement; professionalism; systems-based practice [20, 21].

In July 2002, the Psychiatry Residency Review Committee (RRC) concluded that every residency program in psychiatry throughout the USA should implement these principles in their clinical and didactic curriculum. As a part of the process of psychiatry adapting to these principles, the Psychiatry RRC recognizes and includes competency in five different forms of psychotherapy [22–24]: psychodynamic psychotherapy; supportive psychotherapy; cognitive-behavioral psychotherapy; short psychotherapy; psychotherapy combined with psychopharmacotherapy. Implementing knowledge in these five areas creates a basis for good psychiatric education for all residents, which speaks of integration based on the current knowledge, research, and practice [10]. It is important to emphasize that tried and tested aspects of training are not discarded [25]. Training for a therapist is an evolving process that requires time, where the dialectic between personal growth and acquisition of psychotherapy skills dances with one another [17].

Collective evaluation, toward which medical residencies are aiming, is inherently unreachable for psychotherapy, and the best we can hope for is a series of formative evaluations consistent with ideas that the existence of the psychotherapist is a process rather than a final accomplishment [25]. Likewise, knowing which instruments are used to measure competency in psychotherapy is

essential [26]. It is also important to make a distinction between whether the decision of the psychiatrist is safe for practice and how competent the psychiatrist is. A recent study that examined burnout in doctors showed that there should be a change in the focus of education from the individual learning styles of doctors to the distribution of knowledge acquired through their experience in teams [27, 28]. Even if there are practical problems in measuring competency in psychotherapy, some studies showed the importance of using tests in psychodynamic psychotherapy, as well as standard candidate screening [29, 30].

Psychotherapy as a subspecialty

The question of psychotherapy as a subspecialty in psychiatry is still a discussed topic, even with the set models of education mentioned before [1, 12, 21, 16]. We believe the complex interaction, which is grounded on an important task that the psychiatrist has – to help patients in everyday practice, far outreaches the situations in the areas of psychological and social dysfunctionality. Other professionals practice psychotherapy and psychotherapeutic counseling. Several aspects should be kept in mind in order to understand the requirement for knowledge and psychotherapeutic skills in psychiatry.

First, in psychiatric practice, there are many types of therapeutic interventions, with the understanding that humans are biopsychosocial beings. Psychopharmacotherapy is included as the basis, taking into account that psychiatry itself is a medical discipline and that medicines are an expected, if not required, method of treatment. Second, psychotherapy arises from specificities of doctor-patient relationships in psychiatry, verbal and nonverbal communication, as well as emotional reactions in the diagnosis and treatment of the patient, and research which shows the possibility of aimed psychotherapy treatment due to plasticity and positive response for psychotherapeutic interventions to certain aspects of personality [3, 31–33]. Finally, as the third component, there are sociotherapy treatments, based on the understanding that recovery of an individual and group becomes whole only after there is an integration of social environments with the biological and psychological treatment, helping in better, more comprehensive understanding of development and functions of the human being [34].

Furthermore, psychiatry offers services in different organizational forms, hospital treatment, day hospitals, outpatient units, and private practice. On all levels, psychotherapy has its role, which differs from psychotherapeutic modalities to types of intervention, as the evidence shows [35, 36]. For a long time, there have been results that show that combined pharmacotherapy and psychotherapy treatments give better results than just using pharmacotherapy in various clinical entities and age groups [33, 37]. Such is the case of treating schizophrenia, as behavioral therapy is used for resocialization and better integration [38], and psychodynamic psychotherapy helps the patient put his personal experience in words, helping them, this way, to reduce symptoms and allowing them to continue work, education, and life [39]. There is no doubt that psychotherapy is vital in comorbid states of personality disorders and recurrent depressions [40], bearing in mind the complexity of this relationship and their combined influence, as Gajić and Pejović [41] previously wrote in 2001. Finally, there is an evident need for psychotherapy in treating personality disorders, where this type of treatment is more impactful than pharmacotherapy. In this field, there is a need for further research and also training for psychiatrists [42].

In our opinion, the psychiatrist who practices psychotherapy must also be a pharmacotherapist since they deal with compatible methods of treatment with synergistic effects [3, 31]. Studies in genetics, molecular biology, and neuroimaging formed a basis for a better insight into dynamic psychotherapy through understanding that early emotional experience, trauma, and intensive interactions between patient and therapist have an influence on gene expression, synaptic neuroplasticity, and metabolism of the brain in certain regions [3]. Furthermore, we have to bear in mind that administering medication, besides its main role, has a phantasmal, irrational, and symbolic role. Based on that, a trained therapist can understand situations in which some side-effects are not from pharmacological causes [3, 31]. This position, and the integration of psychiatrist and psychotherapist, describes the clinician of the future – someone whose treatment represents recognizing the patient as an active participant in the planning and implementation of treatment. This position has yet to become a trend as we aim to improve the quality of mental health care [43].

All this opens the question of whether, even with the described and well-established models of integration of psychotherapy in psychiatric training, a subspecialty should be even discussed [44, 45]. Josef Gregory and David Mintz from the USA and Jessica Yakeley from Tavistock Clinic in London asked the question of subspecialty in psychotherapy, relying on the current state of psychotherapy in psychiatry and the existence of Medical Psychotherapy in the UK [46]. Psychotherapy is, according to these authors, undoubtedly effective in psychiatric practice [45], its role is crucial in treating many diseases combined with pharmacotherapy, and according to meta-analysis studies, the combination is more successful than pharmacotherapy alone [47]. However, the proportion of time given to the psychiatrist for psychotherapy is decreasing [47], and the identity of psychotherapy in psychiatry is diminishing [45]. As medical insurance does not consider psychotherapy as a service of the psychiatrist, the public opinion of psychotherapy itself has changed [45].

Besides that, the ever-more present dichotomous approach decreases the importance of interpersonal aspects of psychiatric care. Giving primacy to pharmacotherapy due to the pressure from the pharmaceutical industry marketing, as well as the fact that the National Institute for Mental Health finances biological mechanisms-based research and psychopharmacology for “brain diseases”, shows us the direction of movement [48]. Meanwhile, psychiatrists are encouraged to perform a highly specialized job, while the

psychotherapeutic job, which they call “counseling”, is done by less specialized and less accountable team members [45]. From this, we can see how psychotherapy is moved to the sidelines.

All this leads to the conclusion that, at this moment, there are many contradictions, from the role of psychotherapy in psychiatry and results from research on the one side to the fact related to the implementation of that work in practice and financing on the other side. All this requires a solution. Gregory et al. [45] believe that with the development of the subspecialized discipline of psychotherapy in psychiatry, an educational structure and adequate training of the psychiatrist could be established, thus improving the status of psychotherapy, allowing for the advocacy and maintenance of psychotherapy as one of the basic skills of the psychiatrist.

The subspecialty of psychotherapy was established at the Faculty of Medicine of Belgrade University in 1978; it was a pioneering undertaking of an academically oriented and organized education. According to the documents and archive materials from one of the founders of this subspecialty, Professor Dr. Miroslav Antonijević, continuing his activity in the domain of psychotherapy, created a background for the development of an institutional approach to psychotherapy education [1]. A very important aspect of organizing that education was that it was a result of interdisciplinary cooperation between several colleges – the Faculty of Medicine, the Faculty of Philosophy, and the Faculty for Special Education and Rehabilitation. Alongside them, several health institutions participated, such as the Institute for Mental Health, Clinic for Psychiatry University Clinical Center of Serbia, and Clinic “Dr. Dragiša Mišović” [1]. The Rectorate of Belgrade University played the final role. The subspecialty of psychotherapy should be something to be proud of since it is one of a kind globally in several aspects. First of all, it was academic cooperation because the work of neuropsychiatrists and psychologists went hand-in-hand. Secondly, Faculty of Medicine of Belgrade University, way before others, established psychotherapy as a highly specialized subspecialty, including it in the program of training.

The professionalism and the need for psychotherapists at that time led to the meeting of the Association of Psychotherapists of Yugoslavia in Zagreb on September 15 and 16, 1984, where the main topic was the request of the Board of the Association of Physicians Societies of Yugoslavia to create a plan and program for specialization and subspecialization in psychotherapy. The commission of educators stated that due to the need for prevention, diagnosis, and treatment of mental disorders, and psychosomatic diseases, there was a need for additional theoretical knowledge and practical training. In this way, psychotherapy as a subspecialized (directed) discipline became a part of the field of clinical psychiatry. One prominent function of psychotherapy was also highlighted – its role in preventing mental health problems and disorders and in the social context. The commission of educators believed that psychotherapists with knowledge and practical experience could aid in the creation of healthier interpersonal relationships [1].

From the organizational view, a very important body should be highlighted – the Collegium of Supervisors. They had their own rules of procedure, accredited by the Faculty of Medicine of the University of Belgrade as the main carrier and sponsor of the subspecialization [49]. On the initiative of the Collegium of Supervisors, the Society of Psychoanalytic Psychotherapists of Serbia was created to strengthen the identity of psychoanalytic psychotherapists in Serbia. It was developed on June 22, 1991, in Belgrade, with the headquarters at the Institute for Mental Health [50]. It was developed as the first of its kind in this part of the world. It was not developed as a place of education but rather as a place where the practitioners of psychotherapy would further strengthen the identity of their field of study. The development of the subspecialty through this program of theoretical and practical training gradually becomes wholly psychoanalytical. After some colleagues and Professor Vojin Matić became accredited by the International Psychoanalytic Association, Professor Dr. Ljubomir Erić included this group of people as a part of the supervisors and training analysts for the 1998 generation. That moment closed the circle of the whole process and set it following international standards.

After more than thirty years, many psychiatrists, neuropsychiatrists, and clinical psychologists were trained. According to our records, the total number of those attending the program is 160, and the number of those who completed a subspecialty is 30 in this period of thirty years. What is keeping that number from increasing? There is a lot to analyze from this, and it would be a topic for another paper. Some of these have been answered in our previous studies [1]. The most mentioned reason is rigorous training, following international standards for the area of psychoanalytic and psychodynamic psychotherapy. The training program and type of schooling required by the Faculty of Medicine at the University of Belgrade are also mentioned. It requires the following from the most recent generations: 300 hrs of individual psychotherapy, 150 hrs of individual supervision, and 100 hrs of group supervision. The academic program of the Faculty of Medicine includes passing general exams (research methodology, statistics), colloquiums in theory and practice of psychotherapy, and the final exam in front of a commission of university professors, including research, writing, and defence of the subspecialty thesis paper. Different aspects of training, experience in this training, and the demands it places in front of candidates have already been discussed in our previous paper [51].

Psychiatrists, as well as other colleagues in healthcare systems, psychologists, and specialists in medical psychology, work with patients, not clients, or in the words of founders of psychotherapy as a profession from the University Sigmund Freud in Vienna, affected persons. It is of great importance to know that at the University of Sigmund Freud in Vienna, treatment of affected persons is conducted at the Psychotherapy Outpatients Clinic, a teaching institution of this university [52]. Why is this the case? Of course, they believe that psychotherapeutic training, even

independent of psychiatry and psychology, is academic; a treatment that their students administer in the process of education and training must be administered through institutions where that education and training take place.

Conclusion

The role of psychotherapy in clinical psychiatry still exists as a very contemporary topic. The history of psychoanalysis shows its strong influence on twentieth-century clinical psychiatry. Aside from the revolution of biological psychiatry, with new medications which brought progress in the treatment of psychiatric patients, the end of this trend brought the realization that future psychiatrists in serious educational systems must have a base of knowledge in psychotherapy. With our experience in the UK, where medical psychotherapy developed into a fellowship, we believe it speaks enough about the importance of this topic.

Psychiatrists – medically trained professionals – have to face challenges every day in their practice, which requires basic psychotherapeutic knowledge, and also subspecialist knowledge. The complexity of conditions in mental health is extremely significant, such that it should not be left without the control of several different professionals trained through informal systems, who are often incapable of recognizing the dangers of working with high-risk groups of patients. It is also important to consider that psychiatrists themselves in the frame of psychotherapeutic training have to learn from specialists in psychiatry and medical psychology on the academic level through nationally accredited programs. On the whole, in this paper, we gave an example of the integration of psychotherapy in psychotherapeutic training and subspecialty training in Serbia and the models for this integration, such as those in the UK and those being considered in the USA.

As it comes to psychiatrists, the model that should continue in Serbia must be both integration and subspecialization. Subspecialization should be modernized with modalities in a similar or even the same fashion as the European and American models. This topic is extremely serious and so important to be left without regulation.

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