Psychotherapies and Psychiatry

In spite of the importance biological psychiatry has attained in the last years and the predominance it has been given, some times markedly, in some residence programs the world over, the psychotherapeutic attitude—when not psychotherapy itself—*in practice* is still the psychiatrist's indispensable tool and hallmark.

Not failing to recognize in any way the importance of the contribution of biology to psychiatry in the treatment of our patients, there exists from the very beginning of our discipline, and even before, and indispensable psychotherapeutic attitude. It accompanies us in our common everyday work and has made the development of different psychotherapeutic techniques possible, which all aims at providing the patients' integral care with the essential human element, i.e. the element based on a conception of the physical, mental and social well-being of the individual, so extolled since so long ago in our definition of health. Since the essential contributions of psychoanalysis, and the first attempt to rigorously systematize the psychotherapeutic technique, there have been many and very different intervention modalities in this field. However, all are based on the importance of the human relationship and the word in the treatment of human pain.

We could say that the relationship we pretend to outline here is silent, as psychotherapy may be in many occasions: Methodology is to science what psychotherapy is to psychiatry.

We will not discuss this relationship here, as we believe it explains itself. We wish, however, to insist on the importance - not to be postponed - of reflecting on how the above-mentioned psychotherapeutic attitude determines our essence, if not our very identity. It is this, in fact, that constitutes what is singular in our exercise and trade. The only thing that makes the psychiatrist genuinely different from the other medical professionals is not the way we prescribe a medication or abstain from doing it. In this sense, it is worthwhile to recall that prescribing by colleagues with specialties different from our's is getting increasingly frequent and often quite appropriately. On the other hand, our identity is based, we believe, on the possibility to exercise the science and art of psychotherapy in the capacity in which we may seek to cure our patients by means of the word.

In spite of being so ancient and, as already mentioned, even older than the psychiatry itself, psychotherapy has more or less radical opponents and - height of paradox – within our own group. The other ones, those who oppose it from outside, sometimes do so based on their own ignorance, not even knowing the most elemental modalities and techniques. Others base their position on unfortunate personal experiences. Finally, others are guided, if not by ideologies strictly speaking, they are so by political and economic motives, a point we would wish to dwell on.

The resolution 5261, dated August 5th., 1994, by which the "Manual for Activities, Interventions and Procedures of the Obligatory Health Care Plan (MAPIPOS) within the General System of Social Health Security" was established, sets forth in its article 18 on "Exclusions and Limitation of the Obligatory Health Care Plan", paragraph j, the following:

From the reference Plan will be excluded:

"Treatment with individual psychotherapy, psychoanalysis, or long-term psychotherapy. Individual support psychotherapy is not excluded during the critical stage of the disease and only during its initial stage; nor are group therapies excluded. Critical or initial stage is understood as that with an evolution lasting up to maximum thirty (30) days".

It is worth while to ask ourselves, to begin with: "What difference does this Plan consider there exists between psychotherapy and support psychotherapy? And then we may ask ourselves if, what here is denominated "support psychotherapy", has shown any usefulness and in which entities, since most of the available evidence strengthens the importance of psychotherapy in its different modalities for the most frequent psychiatric entities. However, we could extend even further our questions and doubts: During these initial 30 days is it allowed to hold 30 sessions or just one? Why one thing and not the other? Moreover, group therapy is included among the permitted therapies. It is not clear, however, if for each patient who attend the group of a different entity (EPS) a determined sum is to be charged, or if this sum is to be divided between the 6 or 12 patients who attend. In such case, how must one proceed on the administrative side?

There are many paradoxes and gaps in the legislation. Likewise, the ignorance about what psychotherapy actually is and what significance it has as a treatment modality is much too large. It is difficult to explain why, when establishing such limitations, it is ignored that in the world-

wide disease burden study, in the top 10 causes for discapacity at least 5 are accounted for by psychiatric entities. Moreover, this is true in both developed and developing countries. What is the Government's answer to this unquestionable reality? Is the importance of psychotherapy actually limited to a support modality and then only for 30 days? Does this really help in anything, is it of any use? What can we psychiatrist do in the face of such a reality? It is our belief that these questions must be assumed as one of the responsibilities of the new Board of our Colombian Psychiatric Society.

We sincerely hope that this supplement, diverse and with first order authors, will serve our readers to increase their knowledge on the developments taking place in the field of psychotherapies, in their different modalities.

Alejandro Rojas-Urrego
Editor Invitado
Director
Instituto Colombiano de Psicoanálisis

Carlos Gómez-Restrepo
Editor Invitado
Director
Revista Colombiana de Psiquiatría