

Psychiatry and Psychotherapy

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Abstract

This report considers the differences between the medical psychiatric and the psychotherapeutic (in particular, the psychodynamic) approaches to the diagnostics and treatment of mental disorders, and it describes a generalized model of the psychotherapeutic process. It traces the development of the relationship between the medical psychiatric and the psychotherapeutic approaches, which has resulted in different models of the interrelatedness of these paradigms in different countries (a unified model encompassing both the psychiatric and the psychotherapeutic approaches, and a model of two relatively independent approaches). Examples are provided of the difficulties and inconsistencies which have arisen from attempts to employ different variants of the unified model that purports to unify the two different approaches into a single whole. It is proposed that the medical psychiatric and the psychotherapeutic approaches should each be considered to have their own internal logic, independent from and simultaneously complementary to that of the other, in accordance with the principle of complementarity formulated by the physicist Niels Bohr in quantum mechanics for the systematization of irreconcilable data obtained by observers with differing perspectives. The author proposes that each patient with a mental disorder should be examined simultaneously and independently from the point of view of each of these systems of coordinates (the medical psychiatric paradigm and the psychotherapeutic paradigm).

Psychiatry and Psychotherapy: The Principle of Complementarity

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ABSTRACT

This report considers the differences between the medical psychiatric and the psychotherapeutic (in particular, the psychodynamic) approaches to the diagnostics and treatment of mental disorders, and it describes a generalized model of the psychotherapeutic process. It traces the development of the relationship between the medical psychiatric and the psychotherapeutic approaches, which has resulted in different models of the interrelatedness of these paradigms in different countries (a unified model encompassing both the psychiatric and the psychotherapeutic approaches, and a model of two relatively independent approaches). Examples are provided of the difficulties and inconsistencies which have arisen from attempts to employ different variants of the unified model that purports to unify the two different approaches into a single whole. It is proposed that the medical psychiatric and the psychotherapeutic approaches should each be considered to have their own internal logic, independent from and simultaneously complementary to that of the other, in accordance with the principle of complementarity formulated by the physicist Niels Bohr in quantum mechanics for

the systematization of irreconcilable data obtained by observers with differing perspectives. The author proposes that each patient with a mental disorder should be examined simultaneously and independently from the point of view of each of these systems of coordinates (the medical psychiatric paradigm and the psychotherapeutic paradigm).

Key words: psychiatry, psychotherapy, model of the psychotherapeutic process, unified model of mental disorders, principle of complementarity.

The introduction of the principle of complementarity into scientific thinking

Before turning to the debate regarding psychiatry and psychotherapy, it might be useful to recall from the history of science the “principle of complementarity,” introduced by Niels Bohr in quantum physics to resolve controversies arising between various behavioral patterns of science research objects due to different conditions and observers’ criteria. The aforementioned principle implies that the observers will regard their observation objects from different angles depending on the criteria and terms they set, e.g. whether they consider an electron to be a particle or a wave. According to this principle, findings obtained under different observation conditions and terms cannot be simply summed up or combined to form a single whole pattern, as they reflect different (though complementary) features of an entity corresponding to the research object (Bohr, N., 1929/1961; Bohr, N., 1958/1997). While formulating the principle, Niels Bohr (1929/1961) suggested employing two mutually exclusive but complementary theoretical models, each with its own internal logic, to obtain a complete description of the research object entity, which would help to explain data obtained under different conditions and terms. On creating that mode of description for quantum physics, Niels Bohr (1958/1997) then employed it in biology, psychology, and cultural studies. He wrote: “...The integrity of living organisms, and the characteristics of conscious individuals, and most of human cultures, present features of wholeness, the account of which implies a typically complementary mode of description” (Bohr, N., 1958/1997, p. 7).

The psychiatric approach to mental disorders

Both psychiatry and psychotherapy concern themselves and deal with disturbances in human psychic functioning. They regard them, however, from different standpoints, employing different approaches, forming different concept groups, and using different terminology. They also set different objectives for diagnostics and treatment, as well as having a slightly different notion of what is norm and what is pathology, and they rely on different concepts of mind functioning.

Psychiatry, being a field of medicine, relies on biology and natural science. Medical science traditionally applies the nosological approach that regards pathological processes of the human organism, including those of the mind, as diseases with their own etiology, pathogenesis, course, and outcome. Introduced into psychiatry by E. Krepelin, the a nosological approach was typical of the German school of psychiatry, and today it still defines many clinicians’ mentality directly or implicitly. It is interesting that, in spite of replacing the term “disease” with that of “disorder” in the International Classification of Diseases-10 (ICD-10) in the field of psychiatry, “The ICD-10 classification of mental and behavioral disorders” still remains an integral part of ICD as a whole, meaning that it functions within a medical paradigm characterized by nosological and biological approaches. Psychiatry, as well as medical science generally, predominately uses biological treatment, be it drugs or, for instance, electroconvulsive therapy (ECT). In a typical psychiatric diagnostic process, a patient’s integral pattern of behavior and experience is broken into separate elements as it is successively measured against standard classification schemes (based on psychopathology), like holding up pre-cut stencils to a large picture. Everything that does not fit these classification schemes (certain types of behavior, emotions, and experience, which are not defined in those schemes) is discarded as insignificant. In psychiatry, the process of diagnosis aims to single out those components of a patient’s entire behavior and experience pattern that can and should be treated by medicines, by ECT, or by other means of biological therapy. Obviously, this does not provide the psychiatrist with a comprehensive and thorough understanding of the patient’s experience of his existence in the world in the context of his unique life situation. However, considering psychiatric diagnosis objectives, such comprehensive and thorough understanding is not required.

Dealing as it does with assessing mental processes and with describing their state, psychiatry cannot entirely do without psychology in its conceptual bases. Obviously, however, this psychological conceptual framework should be well suited for achieving the aims and goals of psychiatric diagnostics.

Traditionally, psychiatry as a whole and psychopathology as one of its branches are based on functional psychology, the foundations of which were laid at the end of the 19th to the beginning of the 20th centuries. Consciousness, perception, intellect, thought, emotions, and the will are regarded by functional psychology as separate independent functions comprising human mentality, like cinder blocks. Clinical psychology, employing psychological tests to carry out experimental psychological examination for the purpose of psychiatric diagnostics, is to a large extent adapted to the same functional psychology framework. Even projective drawing tests based on the psychodynamic model are in practice frequently interpreted in psychiatric clinics within the narrow framework of the aforementioned functional psychology. This makes clinical psychology highly suitable for its key task in a psychiatric clinic: helping with psychiatric diagnostics. In this regard, the psychiatric model can be viewed in juxtaposition not so much with the psychological model in general (because clinical psychology, as has been mentioned above, is integrated into the psychiatric medical model) as with the psychotherapeutic model in particular, along with its associated psychological concepts. What psychiatry considers “norm” is the absence of delusions, hallucinations, memory and intellect disorders, the absence of psychogenic functional physiological and vegetative disorders, dissociative disorders, pronounced emotional and mood disorders, as well as motivational, will, and thought disorders that could result in obvious non-adaptive behavior, intense suffering, distorted perception of reality, and inability to work and to build even superficial social ties. In a nutshell, what psychiatry regards as “norm” is actually the absence of mental disorders that fall into corresponding classification frameworks. That is, in psychiatry, norm means lack of certain elements (whereas in psychotherapy, norm implies the presence of certain elements).

Psychiatric treatment aims at patients’ achieving, as close as possible, the state of “norm”, as it is defined by psychiatry.

The psychiatric medical model more willingly recognizes the role of psychotrauma, the part played by an individual’s maladaptive responses to stressful life circumstances in causing a mental disorder, affecting its development and its clinical picture, mostly when it identifies such a disorder as non-psychotic. The above mentioned model, however, disregards those factors in cases of psychotic mental disorders, such as schizophrenia or bipolar disorder. To conclude that there has actually been psychotrauma or stressful life circumstances, psychiatrists rely on their patients’ conscious opinions, which they receive in the process of a structured conversation (interview) carried out for diagnostic purposes. It is clear, therefore, that information obtained or not obtained in the course of such a conversation (interview) will depend on a number of factors: Firstly, on the angle from which psychiatrists choose to regard their patients (that of the medical psychiatric model); secondly, on the goal and objective of such conversation (those of psychiatric diagnostics); thirdly, even on the fact that the conversation in question (the interview) is structured (for during unstructured conversation about their “problem,” patients may let such information “slip out” that they would not otherwise say to psychiatrists, along with corresponding questions). In practice, psychiatrists, albeit only to a certain extent, tend to rely on their subjective opinion based on their own life experience in identifying or not identifying their patients’ traumas or stressful life circumstances. It often happens that psychiatrists themselves haven’t fully undergone their personal psychotherapy, which may hinder separating their patients’ problems from their own. In identifying (or not identifying) their patients’ stressful life circumstances, psychiatrists may also depend on opinions of their patients’ relatives, who are likely to be involved in the patients’ neurotic problems, as well as to be in highly complicated pathological, from the psychological point of view, relations with them (which the medical model ignores as well). In recognizing patients’ traumas and stressful life circumstances, the psychiatric medical model likewise disregards the role of psychological defense mechanisms in mental disorders, mechanisms that break mental links between psychological factors triggering these disorders, simultaneously activating intrapersonal conflicts and clinical symptoms. The concept of psychological defense mechanisms explains why during a diagnostic interview psychiatrists cannot identify psychotraumatic circumstances provoking a mental disorder, not only in cases of psychoses, but also in cases of non-psychotic disorders (e.g. very often in cases of panic or generalized

anxiety disorders).

The psychotherapeutic approach to mental disorders

Psychotherapy and the psychological concepts on which it is based use a different language, a different notion of norm, and different methods of intervention and treatment, with goals and objectives that are rather different from those of psychiatry.

Although each of the main branches of psychotherapy — psychodynamic, humanistic, and cognitive-behavioral, — employs its own terminology, intervention methods, and goal-setting, still the main instrument of treatment and achieving changes (results) in psychotherapy is the interaction between the patient and the psychotherapist.

As an overview of psychotherapy in general, the tasks of a psychotherapist of any of the main branches are as follows, in sequential order:

1. To turn the internal dialogue of the patient into an external dialogue with the psychotherapist, either directly (as is done in psychoanalysis, existential psychotherapy, and cognitive behavioral psychotherapy), or indirectly — in the form of the patient's dialogue with images of internal objects (as may be done in gestalt therapy). In the latter case, such dialogue nevertheless reflects split-off aspects of the psychotherapist–patient dialogue, and the images of internal objects in fact form transitional objects in this dialogue.
2. To create safe conditions for involving the patient in that external dialogue and for further developing the patient–psychotherapist relationship, along with mobilizing all the feelings and emotions evolving in the process.
3. At appropriate moments, the psychotherapist intervenes in order to affect the parameters of the relationship developing in the dialogue and those parameters' modifications. The moments for intervention are chosen in the process of monitoring those parameters. The relation parameters the psychotherapist focuses on vary according to the type of psychotherapy employed. For instance, psychoanalysis will regard resistance/psychological defense mechanisms as well as dynamics of transference/countertransference relations (Greenson, R.R., 1967) (which also helps reach a conclusion about the level of personality organization: neurotic, borderline, or psychotic (Kernberg, O., 1967)); humanistic psychotherapy will concentrate on the ways patients avoid authentic, meaningful contact with their psychotherapists in the “here and now” situation (ways of interrupting contact cycle in Gestalt therapy (Perls, F. S., Hefferline, R., Goodman, P., 1951)), along with congruence/incongruence (Bugental, J. F. T., 1987; Rogers, C. R., 1951); cognitive-behavioral psychotherapy will consider cognitive distortions as well as all the stimuli triggering and reinforcing patients' problem behavior (Beck, J. S., 2011). Successful interventions and modifications of the above-mentioned parameters (in the case of successful psychotherapy) would result in developing more constructive relations in the psychiatrist–patient dialogue.
4. Psychotherapists facilitate the patient's eventual departure from the psychotherapist–patient relationship (from the psychoanalytical standpoint, “transference neurosis” is resolved (Greenson, R.R., 1967)). At the same time, relations modified in the process of the psychotherapist–patient dialogue become internalized, which leads to a more productive attitude of patients toward themselves (in terms of psychoanalysis, there are changes in the ego psychic structures, derived from object relations, that is, internal self and object representations, along with super-ego modification (Kernberg, O., 1966); according to E. Erikson, the patient's sense of ego identity changes (Erikson, E. H., 1950); in H. Kohut's opinion, patients develop a strong, cohesive sense of self (Kohut, H., 1971)), and patients' attitudes towards other people and their environments become different, too. This is what strategic psychotherapy refers to as second-order change (Nardone, G., Watzlawick, P., 1993). Psychotherapy is thus completed.

During the first stage of their interactions with patients, it is very important, both for psychiatrists and psychotherapists, to create the kind of environment where patients are willing to reveal their inner experiences

(feelings, emotions, and thoughts), and to get involved in the external dialogue. The next stage, however, demonstrates significant differences in practices. While interacting with their patients, psychiatrists examine their emotional experience only looking for the information that is required for placing them (patients) as observation objects and carriers of certain symptoms into specific diagnostic categories that facilitate choosing the right biological treatment. In the process, psychiatrists disregard everything (certain complaints, emotional experience, beliefs, behavior, and speech peculiarities) which does not meet this goal. In such circumstances, it becomes psychiatrists' priority to guarantee maximal objectivity by retaining pure scientific observer status. Emotional over-involvement in patient–psychiatrist conversation on either part may hinder the fulfillment of the task. Therefore, the conversation is structured to minimize such involvement (just enough for patients to reveal their emotional experience relevant for the task of psychiatric diagnostics). Psychotherapists, on the other hand, aim to create safe conditions for maximizing their patients' emotional involvement (including their innermost emotions, feelings, and thoughts) in the external dialogue. This is the only way psychotherapists can succeed. It is important, therefore, for psychotherapists to be emotionally involved in the dialogue with their patients, while at the same time achieving a balance between empathizing with their clients (that is, staying emotionally involved) and retaining a certain distance appropriate for a scientific observer. Thus, apart from the initial stage of interaction with their patients, psychiatrists and psychotherapists greatly differ in their goals, process structuring, focus of attention, terminology, and even their position in conversation with their clients. To summarize, psychotherapy employs a special process modality differing in quality from that used in psychiatry. In different fields of psychotherapy, the “impartial observer – emotionally involved participant” ratio may vary. Cognitive-behavioral psychotherapy, for instance, may require less emotional involvement on the specialists' part; nevertheless, to achieve therapeutic success, it should be still deeper than in psychiatry. Postulated neutrality of the analysts' attitude during psychoanalysis implies that they will refrain from injudicious and impulsive emotional disclosure and expressing (acting out) of their own emotions and desires in their actions and behavior, including interpretations; it does not, however, mean complete emotional detachment. On the contrary, emotions and feelings psychoanalysts experience during their interaction with analysands serve as indispensable tools for dealing with their patients and understanding what is going on in their minds. All that requires from psychoanalysts relatively deep involvement in psychotherapist–patient interaction while maintaining a balance between such involvement and impartial observation. This setup is also typical of humanistic psychotherapy. Whichever methods psychotherapists might use, the main change agents in psychotherapy, according to a number of authors, are relations established between psychotherapists and their patients (Bugental, J. F. T.; 1987, Kohut, H., 1971; Rogers, C. R., 1951; Stolorow, R. D., Brandchaft, B., Atwood, G. E., 2000; Yalom, I.D., 1995). If this is the case, in order to be effective, psychotherapists cannot act simply as outside experts observing with detachment the independent object-patients whose state and behavior they logically analyze and divide into separate units. The focus on relations is more pronounced in humanistic and psychodynamic therapy; still, cognitive-behavioral psychotherapy concentrates on dysfunctional interpretation patterns (cognitive errors, dysfunctional basic beliefs) manifested in automatic thoughts — patterns which are actual characteristics and properties of patients' relations with their environment and their attitude toward themselves, rather than properties and characteristics of patients as objects in themselves (Beck, J. S., 2011). A number of studies have demonstrated that the most effective and successful interventions employed by cognitive-behavioral psychotherapists (according to psychotherapists' own accounts and demonstrated by objective observation) had pronounced interpersonal focus and placed emphasis on the psychotherapist–patient relationship (Jones, E. E., Pulos, S. M., 1993; Milton, J., 2001; Wiser, S., Goldfried, M., 1996). Therefore, in order to successfully navigate the psychotherapy process, clinics should be provided with a diagnostic system describing characteristics of psychotherapist–patient interactions, not just a set of patients' internal characteristics (traits) regarding a patient as an observation object entirely independent and detached from the observer. That system should correlate the psychotherapist–patient interaction characteristics with those of patients' relationships with other people and with their own selves. Even assessing the level of personality organization, such as integrity of self, in clinical practice, a psychotherapist largely draws on consistency/inconsistency, on cohesion/incohesion in the patient's communication with him, on compliance of the patient's communication patterns with the accepted cultural “normal” ones, and on the extent of his involvement in communication.

That is why the notion of norm and the grades of deviation from it for psychotherapy clinic practice convenience should be linked to the characteristics of patients' relations (with their therapists, other people and themselves), and not to the characteristics of patients as "things in themselves". The goal of psychotherapy should be defined accordingly: as harmonizing the patients relations with others and with themselves; as further deepening and developing these relations until patients are satisfied with them; and maintaining the flexibility of these relations in adapting to changing life circumstances and the patients' demands and needs. All the above emphasize that whichever psychotherapy is employed, it should consider patients in terms of interaction and relationships, and not in terms of object properties and traits. And that requires a special language for psychotherapy, a language unlike that of psychiatry.

Developing different models for the relationship between the medical psychiatric and psychotherapeutic approaches

The psychodynamic model in general and psychoanalysis in particular have the most developed and elaborated theoretical psychotherapeutic model, one capable of describing and explaining (more thoroughly than other psychotherapies) all the nuances of both the clearly pathological and habitual "normal" psychic manifestations. It was the very first psychotherapeutic model, and founders and developers of the psychotherapies that emerged later (with the exception of behavioral therapy) based their models on it. The appearance and development of psychoanalytical theory started the differentiation between psychotherapeutic and psychiatric medical concepts of psyche, and their interaction began to take shape. The issue of the interaction between psychiatry and psychotherapy has been approached in various ways in different countries. In the USA, a certain conjoint, unified model has been developed that combines both the medical and the psychoanalytical (psychotherapeutic) approaches into a single system in which psychoanalytical concepts are pronounced to such an extent that they sometimes cast the biological precursors of the disorders described into the background (Stone, M.H., 1986 b). In European countries, especially in Great Britain (Stone, M.H., 1986 a) and Germany (Stone, M.H., 1986 b), psychoanalysis (as well as psychotherapy in general) and its associated terminology have been developing relatively independently from biological psychiatry, a field of medical science with its own language. In the USSR, as in the USA, a unified model combining psychiatry and psychotherapy into a single system was developed; this remains true to a certain extent for present day Russia. But unlike in the USA, it was built on the platform of the psychiatric medical paradigm, which significantly prevailed over the psychotherapeutic model. In Russian psychotherapeutic practices today, this is apparent in typically endless searches for "residual organic brain lesions," "mild manifestations of endogenous mental disorders," "genetic predisposition," "hiding" behind neurotic manifestations, and in overlooking the psychodynamic mechanisms involved in causing these phenomena. This is likewise reflected in Russian legislation prohibiting psychologists, who in particular lack formal medical education, providing full-fledged psychotherapeutic treatment of patients; they may provide only counseling. This is also shown by the fact that the oversimplified version of the psychodynamic model employed in Russia, namely, Miasishchev pathogenetic therapy, is mostly applied to neurotic cases where therapists can clearly, and patients much less so, observe the connection between neurosis symptoms and patients' controversial attitudes towards people of special significance in their environment, as well as correlation with the patients' parents' attitudes towards them during childhood. Besides, these are cases in which patients can accept their therapists' interpretations clarifying those connections (often in a rather straightforward and oversimplified manner) and use them (interpretations) to facilitate their recovery process. Otherwise, therapists habitually turn to searching for neurosis symptom triggers in "implicit endogenous psychic disease," "organic cerebral disorders," and so on, returning to the well-beaten psychiatric track. The influence of this conjoint model based on psychiatry dominating over psychotherapy is quite obvious in pathogenetic therapy practices. Patient-psychotherapist relations in them are based on the same principle as in psychiatry, that is, patient-doctor, where patients' "wrong" beliefs are exposed to "correct" clarifying and convincing influence of domineering flawless medical specialists guiding errant patients in the right direction. In this context the dynamics of transference-countertransference in patient-psychotherapist relations is mostly overlooked, as well as the fact that the way these relations develop is affected by both participants. Such attitude, caused by the psychiatric paradigm taking precedence over psychotherapy, is also manifested in the fact that in

Russia, psychotherapy students are not required to undergo a certain amount of personal psychotherapy as patients during their education. On considering another conjoint (unified) model, the American one, which was greatly influenced in its establishment and development by psychoanalysis, one can also find certain problems arising from combining psychotherapy (psychoanalysis) and psychiatry paradigms into one single system. For instance, the American classification of mental disorders (and now the international classification based to a large extent on the American model) DSM-5 does not distinguish between psychogenic and endogenous types of depression, which largely results from a number of specialists' opinion that depression should be regarded as a continuum ranging from mild to severe, without taking into account qualitative differences in depression types. According to this point of view, closely linked to psychoanalytical tradition, all types of depression are caused by the same psychological mechanisms, and so there is no need to qualitatively differentiate between them. As a result, authors of a number of recent publications evaluating effectiveness of antidepressants in depression treatment have reached a conclusion about their effect being statistically insignificantly higher than that of placebos, i.e. about their ineffectiveness (Fournier, J.C., DeRubeis, R.J., Hollon, S.D., Dimidjian, S., Amsterdam, J.D., Shelton, R.C., Fawcett, J., 2010; Kirsch, I., 2009). Patients in the studies discussed in these publications were selected according to DSM and ICD-10 criteria without dividing the cases into endogenous and non-endogenous depression types. However, the studies where those depression types were taken into account repeatedly demonstrated that the effectiveness of antidepressants on endogenous depression patients was much higher than that of placebos (Winokur, G., 1986). Those studies also demonstrated that in cases of endogenous depression, ECT produced a much better result than in treating cases of psychogenic depression (Winokur, G., 1986). Another example deals with introducing two new items into DSM-3: "borderline personality disorder" and "schizotypal personality disorder" instead of "latent schizophrenia" in DSM-2 (Stone, M.H., 1986 b). While it is quite productive to place patients with "borderline disorders" (a term, like that of "latent schizophrenia", describing people balancing on the edge of psychosis) whose state dynamics resemble those of personality disorders rather than of schizophrenia into the personality disorders group, and while it is also useful to break that group into one subgroup of patients with prevailing affective instability symptoms and one subgroup with ideational disturbances similar to schizophrenic ones, certain considerations should be kept in mind. R. Spitzer et al., working on diagnostic criteria for the two above-mentioned disorders, justified replacing the old "latent schizophrenia" item with the two new ones in the new classification in the following way. He reasoned that two groups of different researchers used one and the same "borderline disorder" term to describe two different forms of pathology. Spitzer then suggested defining those two pathologies as "borderline personality disorder" and "schizotypal personality disorder" accordingly (Spitzer, R., Endicott, J., Gibbon, M., 1986). Spitzer, however, seems to overlook the fact that one group of researchers he mentions, O. Kernberg in particular (Kernberg, O., 1967), studied their patients from the point of view of psychoanalysis. Meanwhile, the second group of researchers he refers to, namely S. Kety and D. Rosenthal (Kety, S., Rosenthal, D., Wender, P., Schilsinger, F., 1986), regarded their patients from the position of psychiatry clinicians employing a medical approach. R. Spitzer tried to classify borderline patients from the whole sample group into two separate groups, "borderline personality disorder" and "schizotypal personality disorder," with the help of questionnaires he and his collaborators developed. The result was that 54% of the patients met the criteria for both schizotypal and borderline unstable personality disorder (Spitzer, R., Endicott, J., Gibbon, M., 1986). One explanation for this could be that the two research groups discussed by Spitzer were sometimes looking not so much at two different groups of patients as they were describing the same group from two different positions and using different terminology. Thus attempts to mix the psychiatric (medical) approach with the psychotherapeutic (psychoanalytical) one, each of them characterized by their own language and terminology and their own concepts of norm and pathology, into a single logical system often lead to distortion of their internal logic, misunderstanding, and confusion.

Discussion

The principle of complementarity and the relationship between psychiatry and the psychotherapeutic approach

Would not psychiatry become a more internally logical and coherent science if it were to be freed as much as

possible from psychotherapeutic language (largely focused on interrelations) and if it were only to employ the language describing characteristics (symptoms) of patients as objects, the language discarding therapists' (as interaction participants and observers) influence? For it is language that provides the description of patient (as object) properties, characteristics (symptoms, and their correlation with each other, resulting in syndromes) that will remain set, stable, and unchanged. And these properties and characteristics can be examined in terms of the biological mechanisms on which they are based. This may lead to the discovery and development of pharmacological remedies that will treat those unchanging set characteristics and properties, remedies whose effects will not depend on changing circumstances or conditions of patient–therapist interaction. Isn't that what evidence-based medicine has been striving to achieve in psychiatry, trying to do away with "speculative concepts" embedded in some of its diagnostic formulations? And would not psychotherapy, especially psychoanalysis, benefit were it to be released from psychiatric language and psychiatric diagnostic terms, which are often of little use in psychotherapy, and which may be rather confusing at times? The language and formulations that would suit psychotherapy most are those describing typical patterns of relations built by patients with their environments (including their therapists) — those reflecting potentially evolving patient—therapist relation dynamics. Psychiatry language is often too rigid and static for this aim: It doesn't reflect the depth of understanding of patients' experience of their relationship with themselves and with other people that is required for psychotherapy. Should we consider psychotherapy (especially its psychodynamic branch) as its most developed model) and psychiatry as each having its own internal logic, independent, non-overlapping but supplementary theoretical models for describing normal and pathological functioning of the psyche, would that not stimulate a deeper scientific understanding of mental phenomena? Wouldn't it provide an impetus, playing a role similar to the part of the complementarity principle introduced by Niels Bohr for comprehending quantum physics whereby the electron-as-wave concept is regarded as supplementing that of electron-as-particle and vice-versa? And if we were to use psychotherapeutic (psychodynamic) and psychiatric medical models as two independent coordinate axes to evaluate and examine every patient, wouldn't that lead to a better and clearer understanding than that produced by attempts to mix psychiatry and psychotherapy into one single system?

Conclusion

The complementarity principle employed in the early 20th century by Niels Bohr for the purpose of resolving conflict in the emerging picture of quantum physics research may help us clarify our insights into and achieve better coherence and internal logic in our examination of various aspects of mental processes, both normal and pathological. Viewing the psychotherapeutic (especially its psychodynamic variety) model, focused on relations, as independent of and yet complementing that of the psychiatric medical model, concentrating on the patient-object with specific properties (symptoms), may help rid each of these models of their controversies, making them more internally logical and clear (Chistyakov M. S., 2017). At the same time, this can assist in viewing both models as supplementing and not competing with each other, as equipollent, neither one dominating over the other. This author posits that such a standpoint would enhance both their independent development and their mutual favorable influence. It might also be useful in clinician practices to observe each case of mental disorders, employing the complementarity principle, simultaneously from two angles (two independent coordinate axes): in terms of the medical psychiatric model, and in terms of the psychotherapeutic (especially, psychodynamic) model. Furthermore, the author believes that while applying any type of psychotherapy in complex treatment of patients with periodically recurring outbursts of psychotic states, both psychiatrists and psychotherapists (irrespective of the latter having any formal psychiatric training) have to be involved (owing to different modalities of psychotherapists' and psychiatrists' work) and that this is the obligatory condition for such treatment.

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