EDITORIAL

Technical and non-technical aspects of psychiatric care: the need for a balanced view

Mario Maj

Department of Psychiatry, University of Naples SUN, Naples, Italy

The role of empathic communication and therapeutic alliance in psychiatric practice has been underappreciated in the past few decades. A de-contextualized and objectifying approach has been promoted in some quarters, ignoring that without a communicative interaction no person will allow any professional to genuinely access his/her personal world (thus rendering spurious and clinically insignificant any superficial degree of diagnostic reliability which may be achieved), that the person's narratives of psychopathological experiences and their origins should be actively encouraged and worked on, and that relationship and context variables have a major impact on the outcome of all mental health interventions.

In part as a consequence of the above attitude, several persons with mental disorders have been complaining of not being listened to, or taken seriously, by mental health professionals, or of being treated in ways which hampered, rather than fostering, their journey to recovery (e.g., 1).

It is also to be acknowledged that the boundary between genuine psychopathology and ordinary mental distress is difficult to draw, and that the added value of clustering psychopathological phenomena into diagnostic categories is at present a matter of debate.

It is finally true that a reductionistic view of mental disorders, regarding them merely as brain diseases, has been endorsed in several (although certainly not the majority of) academic settings, just at a time when neuroscience was acknowledging the complex interrelationships between brain processes and social context, and the rest of medicine was recognizing the impact of relationship variables on the determination, manifestation, course and response to treatment of a variety of physical diseases.

Several papers in this issue of the journal (2-4) highlight the above points, and we should fully assimilate these messages, become aware of the empirical evidence supporting them, and acknowledge their implications for our practice and training.

Does all this imply that the "dominant psychopathological framework" or "technical idiom", and "the way it defines users' problems through an expert vocabulary and logic" (5) should be rejected as useless, obsolete and even harmful? That "interpretation and search for meanings" of users' "mental distress" should replace the above "technology" (e.g., 4,5)? That our current pharmacotherapies and psychotherapies work only, or primarily, through their "non-technical" components (e.g., 5)? That the efficacy of their "technical" (or "specific") elements is just an illusion (fueled, in the case of pharmacotherapies, by the financial conflicts of interests of researchers and clinicians) (e.g., 6)? And that a non-technical approach should be given predominance in ordinary psychiatric practice (e.g., 4)? In all these respects, I would be much more cautious.

True, each individual is unique, and an attention to what renders him/her unique, in terms of meanings, relationships and values, is crucial for an in-depth understanding of his/her problems. However, it is a fact that persons with genuine psychopathology have several features in common with other persons with genuine psychopathology, and that a typification and an assessment of these features is also essential for a thorough understanding of the individual case and, if appropriate, for the planning of management. Such a typification and assessment does require a technical expertise. If the above typification were not possible, we would not have much to learn from our professional education and personal clinical experience, and clinical trials would be useless. We would have to start from zero with each new service user. Fortunately, this is not the case.

At the same time, we should acknowledge that: a) we cannot impose our predefined psychopathological patterns on the individual cases – we should draw hypotheses on the basis of the actual evidence, we should then test these hypotheses by collecting further evidence, and modify them if needed; and we should be open to the possibility that our conclusions be challenged by new evidence; b) our psychopathological patterns may not apply to several people we encounter in our practice, especially in community settings – in these cases, we should accept this reality and its implications for management; we should also be open, however, to the possibility that further evidence, again, will challenge our conclusion; c) our current psychopathological patterns are far from perfect, and we must keep on refining them on the basis of research evidence – nonetheless, the limitations of our current patterns is not a good reason to conclude that any psychopathological typification is useless or harmful.

The search for meanings in the individual case is, as we acknowledged, essential. However, also this search should be guided by a scientific attitude. We should not forget that an uncontrolled, acritical search for meanings has led in the past to conceptualizations such as that of the "schizophrenogenic mother" which have proven incorrect and harmful. Bracken's example of Picasso's *Guernica* (4) is well taken, but, while the variety of discrepant meanings ascribed to that painting along the years has produced no harm to anybody, it is well documented (e.g., 7) that a wrong attribution of

meanings to psychopathological phenomena by parents, friends and not rarely professionals (e.g., interpreting them as "a normal experience of adolescence" or the expression of "an introverted personality") may be, in a young person with a first psychotic episode, a powerful factor leading to treatment delay and sometimes tragic consequences.

True, relationship and context variables have a significant impact on the outcome of pharmacotherapies, as well as psychotherapies. However, the argument that pharmacotherapies work primarily (or even exclusively) through non-technical elements leaves me suspicious, and several papers putting forward that argument give me the impression of a bias related to the authors' ideological conflicts of interests. Actually, a recent review of meta-analyses (8) documented that antipsychotics, antidepressants and mood stabilizers are at least as efficacious (on their target conditions) as many drugs used by the other branches of medicine, when the reference measure is the standardized mean difference from placebo. On the basis of that measure, antipsychotics turn out to be as efficacious in the acute treatment of schizophrenia as antihypertensives in the treatment of hypertension and corticosteroids in the treatment of asthma. Furthermore, the efficacy of long-term antipsychotic treatment in preventing relapses in schizophrenia is almost six times higher than the efficacy of angiotensing-converting enzyme (ACE) inhibitors in preventing major cardiovascular events in people with hypertension. True, the benefits of second-generation antipsychotics with respect to first-generation drugs have been oversold (e.g., 9), but it is a fact that both groups of drugs are very efficacious. True, the difference between antidepressants and placebo has been declining in recent decades (e.g., 10), but a major explanation of this is likely to be the overextension of the concept of depression.

Certainly, our current pharmacotherapies and psychotherapies have limitations, and it is appropriate to highlight them. However, it impresses me that the detailed account of these limitations is never followed by an equally careful delineation of the alternatives. Again, we should learn from the past. I have witnessed in some contexts in my country what the consequences of an indiscriminate denigration of our therapeutic techniques can be. I have seen the gradual deprofessionalization of care. I have seen the therapeutic vacuum filled with a myriad of "experimental" interventions, actually "experimented" without any protocol, any approval by an ethics committee and any informed consent by the users involved, and automatically labelled as "good practices", often with the support of politicians sharing the ideological orientation of the professionals involved, without any kind of formal outcome assessment. I have seen the initial enthusiasm of professionals turning into demotivation, leading to the early retirement of several generations of clinicians. I have seen the initial hope of parents turning into rebellion. I have seen some tragic suicides of young persons with bipolar disorder who had had their mood stabilizers discontinued and "replaced" by involvement in a social cooperative, because the "analysis of needs" dictated so. I have seen the irrational use of antipsychotics at high doses and in cases in which they were not indicated, by professionals who did not feel the obligation to learn to utilize them appropriately, because they regarded them as just a marginal element of care. I have seen the consequent development of serious side effects being exploited to reinforce the ideological prejudice against those medications.

I would not like to see all this at the international level. I would like to see a psychiatric practice in which *both* technical and non-technical elements of care are valued, in which the limitations of our current knowledge concerning both these elements are acknowledged, and in which further empirical evidence on the impact of both elements is collected, driven by a genuine scientific motivation and without being biased by conflicts of interests of any kind.

References

1. Rogers A, Pilgrim D, Lacey R. Experiencing psychiatry: users' views of services. Basingstoke: MacMillan/MIND, 1993.
2. Decety J, Smith KE, Norman GJ et al. A social neuroscience perspective on clinical empathy. World Psychiatry 2014;13:233-7.
3. Arnow BA, Steidtmann D. Harnessing the potential of the therapeutic alliance. World Psychiatry 2014;13:238-40.
4. Bracken P. Towards a hermeneutic shift in psychiatry. World Psychiatry 2014;13:241-3.
5. Bracken P, Thomas P, Timimi S et al. Psychiatry beyond the current paradigm. Br J Psychiatry 2012;201:430-4.
6. Angell M. The illusions of psychiatry. www.nybooks.com.
7. Bay N, Bjornestad J, Johannessen JO et al. Obstacles to care in first-episode psychosis patients with a long duration of untreated psychosis. Early Interv Psychiatry (in press).
8. Leucht S, Hierl S, Kissling W et al. Putting the efficacy of psychiatric and general medicine medication into perspective: review of meta-analyses. Br J Psychiatry 2012;200:97-106.
9. Tyrer P, Kendall T. The spurious advance of antipsychotic drug therapy. Lancet 2009;373:4-5.
10. Kirsch I, Sapirstein G. Listening to Prozac but hearing placebo: a meta-analysis of antidepressant medication 1998. Prev Treat 1998; 1:0002a.

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