Asian Journal of Psychiatry 44 (2019) 177–178

Contents lists available at ScienceDirect

Asian Journal of Psychiatry

journal homepage: www.elsevier.com/locate/ajp

Letter to the Editor

Translating psychiatric research into good clinical practice

ARTICLE INFO

Keywords:
Clinical practice
Research
Diagnosis
Classification
Treatment

The diagnostic and classificatory revolution in psychiatry resulted in operational criteria, improved reliability, and universal diagnoses. Yet, research driven approaches do not do justice to the complex reality of clinical practice. The article discusses the crucial issues related to translating research evidence into good psychiatric practice.

Despite objective behavioral criteria for diagnosis and continued sub-categorization of classical syndromes, they remain heterogeneous on etiology, pathology, clinical features, treatment response, course and outcome (APA, 2013). Negative symptoms, cognitive deficits, impaired functioning, socio-occupational deterioration, livelihood issues and a failure to reintegrate into life are seen across diagnostic labels. Consequently, psychiatric diagnoses poorly predict future trajectories of illness and may misrepresent individual illness patterns, even when employed as rough guides. In addition, clinicians regularly see changes in clinical patterns over time, confounding even astute practitioners (Baca-Garcia et al., 2007).

Universal models, with their symptom checklists, de-emphasize the role of context and culture. Nevertheless, heterogeneity within phenomenological categories mandates the need to individualize care. However, social and cultural context, and patient beliefs are never systematically elicited, as they are not essential to diagnosis; the biomedical model is considered universal and transcendental (Ecks, 2016).

Nevertheless, psychiatric diagnosis is syndromic, whereas psychiatric treatments are symptomatic and used across diagnostic heads. However, the inordinate and continued focus on symptoms results in a persistent hope of clinical recovery, even for chronic and persistent mental illness; it results a continual tweaking of medication-based approaches rather than an acceptance of deficits and an emphasis on rehabilitation (Deegan, 1988). There is a need to distinguish clinical recovery (i.e. freedom from symptoms) from personal recovery (i.e. recovering a life worth living) for conditions where cure seems a distant reality.

The clinical process encompasses the translation of the patient's world. Illness (subjective experience of distress), disease (structural and functional abnormalities) and disorder (encompassing disease, illness and distress) are often used interchangeably highlighting the lack of conceptual clarity (Boyd, 2000). Consequently, patients and their psychiatrists are often on the opposite ends of many divides: illness-disease, healing-cure, mind-body, and subjective experience-objective clinical phenomena dichotomies (Jacob, 2015). Checklists now trump the art and science of clinical medicine. The complexity of mental disorders, the tentative and uncertain implications of research findings based on group and population data for individual patients complicate clinical practice.

The complex issues related to mental distress, illness and disease do not allow for the mechanistic application of symptom checklists, algorithms and diagnostic labels as they fail to address the probabilistic nature of clinical diagnosis (Elstein and Schwartz, 2002). On the other hand, they mandate a continual assessment of evolving lifetime pattern, and response to interventions. The switch to a rehabilitation approach for chronic mental disorders, particularly for those with distressing deficits and a failure to integrate back into life, will allow for a shift in focus from symptoms to an emphasis on functioning and coping. Such a change in emphasis will provide an opportunity of personal recovery despite disabling symptoms (Deegan, 1988). People with persistent symptoms not responding to optimal medication need an affirmation of life and an acknowledgement of the complexity of their condition and context. Detailed functional assessments, setting of realistic functional goals, appropriate environmental modifications and implementation of psychosocial and occupational therapy, rather than emphasis on symptom counts, are cardinal.

Nevertheless, the limitations of the biomedical model for chronic diseases, marked by its inability to reverse pathology, its symptomatic treatments and the failure to restore function in many people has led to increasing disillusionment with the approach and resulted in the emergence of more holistic perspectives; biopsychosocial (Engel, 1980) and recovery models (Deegan, 1988) with their focus on person-centred approaches.

Most clinicians live in several different cultures simultaneously (E.g. contextual, disciplinary, clinical, academic); their particular positions and practice make a unique mosaic. Clinical contexts should not only change practice, they should be able to change theoretical and academic perspectives. The pedagogic process must address the clinical context characterized by ambiguity, diversity and uncertainty. This is particularly true of using research standards for the diagnosis and management of mental disorders in clinical psychiatric practice. There is a need to theorize psychiatric practice particularly in contexts where theoretical structures do not have a good fit with clinical reality (Jacob,

https://doi.org/10.1016/j.ajp.2019.07.049
Received 26 July 2019

2017). The biopsychosocial model, which now operates within a paternalistic physician-patient relationship, is often praised but seldom practiced as psychosocial interventions are often outside the therapeutic repertoire of many psychiatrists.

While the psychiatry prizes evidence-based narratives, it rarely pauses to focus on the probabilistic nature of diagnostic inferences. The discipline needs to move from a physician-psychiatrist stance towards a shared approach, within a more equal patient-clinician partnership. It needs to move beyond paying lip service to the biopsychosocial model, while employing the biomedical approach to mental disorders in clinical practice. It needs to acknowledge and address the complex demands of clinical reality and practice.

Author's contribution

The author trained in medicine, psychiatry, epidemiology and anthropology and retired as professor of psychiatry, Christian Medical College, Vellore, India. He is a practicing clinician and an academic. He reviewed psychiatric practice, analyzed literature, and wrote the paper.

Funding

No specific funding received.

Declaration of Competing Interest

None.

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