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Digital Tools in Clinical Practice of Psychiatry: The Flip Side

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Introduction

I recently participated in the 5th Annual Conference of the Association of Clinical Psychiatry (IPS-UP-State Branch). The theme symposium of the Conference was entitled "Indian digital revolution *vis-à-vis* practice of mental health". I was one of the speakers, and I spoke on the subject as reflected in the title of this communication.

Digital tools in psychiatry are technology-based resources and applications that include software, mobile apps, telemedicine platforms, various devices for therapy or monitoring and AI-assisted systems. Digital tools support assessment, diagnosis, treatment, follow-up monitoring and delivery of mental health care.

Numerous digital tools are currently available, but the ones that are of interest in the context of this write-up are tools that help in assessment and diagnosis, electronic health records (EHR) and clinical decision support systems tools and the whole system of telepsychiatry.

These tools are reportedly easy to administer and some of these do not require a medical qualification or formal training for use. These tools purportedly ease the process of diagnosis and treatment planning and are claimed to be immensely helpful in monitoring patients and record keeping. These tools are time-saving, affordable and have a wider reach. These are considered to be reliable, but their validity is suspect. Being amenable to research is an added virtue.

Great! So, what is the flip side? The ascendency of digital systems and tools has led to the decline and almost total annihilation of the analogue model, which was typified by the continuous nature of variables and a humane (manual - face to face) approach to interaction with patients, thus, putting the art and science of clinical practice in psychiatry into oblivion.

My mentors, the late Profs. Narendra N Wig and Sir David P Goldberg introduced me to the monumental works of Karl Jaspers and Frank Fish, embodying descriptive phenomenology and manifest clinical psychopathology. This was the prevalent model then for understanding the patient's problems in phenomenological and psychopathological perspectives.

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Phenomenological and psychopathological perspectives rest on two pillars- evaluation of psychic phenomenon with which the patient presents and nosology, i.e., formulation of diagnosis. Conceiving and implementing a management plan is a sequential and logical process that follows. In science, an external event that presents itself for observation and evaluation is called a phenomenon, and in a Jasperian sense, psychic phenomena are understood in terms of internal subjective experiences with which the patient presents and narrates.

The task of a phenomenologist (i.e., psychiatrist, clinical psychologist, psychotherapist, therapist) is to establish a conversation dialogue with the patient, providing the patient an opportunity to narrate his experience. Empathic listening is an integral part of the dialogue with the patient. Consensual validation is the process by which the phenomenologist describes their understanding of the narrative of the patient so that both agree that what has been narrated by the patient and what has been understood by the phenomenologist are the same. Evaluation involves ascertaining whether what has been disclosed is normal or abnormal and if abnormal, whether or not it is pathological. Assigning nosological status to the pathology so elicited is the purview of descriptive psychopathology. Categorisation of this leads to diagnostic propositioning.

Empathic listening revolves around empathy, which is the ability to understand and share the feelings of another person, which involves seeing the world from his/her perspective by putting oneself in that person's situation and experiencing how that person feels. It is a key communication and social skill that helps build strong relationships, foster understanding and encourage helping behaviour.

Why is empathy important? Empathy is crucial for building strong personal and professional relationships with the patient. It enhances communication by helping in responding to others' needs and feelings more effectively. Empathy encourages positive behaviour, is linked to helping behaviour, and can reduce prejudice and conflict. It enhances well-being, which can lead to greater self-awareness and contributes to overall mental and physical well-being.

After consensually validating the psychic phenomenon, the next task is to determine whether the psychic experience of the patient is normal or abnormal. If abnormal, then is it pathological and if it is pathological, what is its psychopathological significance and categorization? There is no assumption, presumption, or blind acquiescence or agreement with the patient; the evaluation is rooted in empathic listening and consensual validation! Differentiating normal from abnormal requires knowledge of the subject's personal belief system, familiarity with the patient's culture, ethnicity and traditions, knowledge of religion/mythology/folklore, understanding of philosophy, history, arts, literature, politics, general knowledge, etc.

Traditional – analogue model is epitomized by Guru-Chela or teacher -taught relationship entailing hours of labor, relentless practice and learning under enlightenment leading to mastery in the art of history taking, techniques of interviewing and dialogue, establishing psychopathology through thorough mental state examination.

So, what led to the transition and change from the "analogue" model to the criteria-based digital model and the resultant paradigm shift in psychiatric diagnosis and practice of clinical psychiatry? The watershed was the publication of the monumental research work "*Psychiatric diagnosis in New York and London,"* also known as the US-UK Diagnostic Project**,** primarily funded by the National Institute of Mental Health (NIMH) of the United States of America. The project was a significant cross-national study conducted in the late 1960s and early 1970s that compared the diagnostic practices of psychiatrists in these two cities.

The US-UK Diagnostic Project showed that significant differences in mental illness diagnoses, particularly for schizophrenia and manic-depressive illness, existed between American and British psychiatrists. Its key finding was that these discrepancies were largely due to differences in diagnostic criteria, rather than actual differences in patient populations. The study demonstrated that the American concept of schizophrenia was broader and that differing diagnostic standards were the primary cause for the variance.

The project heralded the need for standardized diagnostic criteria, which played a significant role

in the development of the third edition/version of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. The US-UK Diagnostic Project is a crucial event in the history of psychiatric diagnosis, highlighting the impact of cultural and professional differences on diagnostic practices and it influenced international efforts to harmonize diagnostic practices.

The quest for reliable tools (digital) led to a race for diagnostic criteria and standardized diagnosis. These research endeavors were led by the St. Luis, Missouri group, culminating in the publication of Feighner's Criteria in 1972. Spitzer's Research Diagnostic Criteria-RDC (1975), DSM – III of APA (1980), DSM-5 and ICD of WHO Versions 9-11 followed suit. Interview schedules such as the PSE and SCAN (Wing *et al,* and later WHO, 1974 and 1990), CASH (Andreasen *et al,* 1992) and SADS (Endicott and Spitzer, 1978) made their entry in psychiatric research and practice. Various diagnostic algorithms and glossaries of terms, definitions, and descriptions of symptoms (psychopathology and psychiatric phenomena) also emerged.

Spanning over several years, the approach to teaching and training in psychiatric diagnosis changed. History taking from patients involving conversation, dialogue and empathic listening lost primacy and became perfunctory, leading to less emphasis on ascertaining details of the phenomenon and psychopathology. The latter was replaced by looking at glossaries and applying those descriptions to arrive at the identification of symptoms. Making these as a foundation, appropriate criteria were approved or selected. Based on the criteria, the diagnosis was approximated. Mental state examination surreptitiously disappeared, and the case discussion mostly revolved around which criteria the patient "fitted" in rather than what the patient was all about! With the passage of time, these glossaries, interview schedules, diagnostic criteria and diagnoses became available in questionnaire form and were soon digitized, obviating the necessity of paperwork and detailed documentation. The irony is that rather than expanding learning from digital tools, surrender to tools for learning became the norm, thus heralding the death of phenomenology and descriptive psychopathology.

In a thought-provoking article, Andreasen (2007) lamented these developments and opined that the publication of DSM-III in 1980 and the subsequent demise of phenomenology in the USA, later all over the world, is an example of the unintended consequences of DSM. Entry of DSM-III led to a swing in psychiatry, leading to a waning in the teaching and training of careful clinical evaluation and phenomenology, which focus on understanding individual patients' problems and social contexts.

It was envisaged that the DSM-III would improve communication, provide reliable diagnoses for research, and enhance teaching and training. One of the most striking innovations of DSM-III was the introduction of diagnostic criteria and a multiaxial approach to diagnosis. However, DSM's focus on reliability over validity and its use as the ultimate authority on diagnosis steered interest away from research and teaching of descriptive psychopathology, with concerns about its long-term impact on the field. It seems that these concerns have materialised and now history-taking is reduced to DSM checklists, which discourages clinicians from understanding patients as individuals.

Andreasen (2007) exhorted that *"We need to make a serious investment in training a new generation of real experts in the science and art of psychopathology. Otherwise, we high-tech scientists may wake up in 10 years and discover that we face a silent spring. Applying technology without the companionship of wise clinicians with specific expertise in psychopathology will be a lonely, sterile, and perhaps fruitless enterprise"*.

Sadly, this prophetic prodding went unheeded. There is a great rush to embrace digital tools and transform the clinical practice of psychiatry into a digital practice. Another helping hand in the shape of AI is waiting around the corner. The amalgam of these two will be perhaps the final nail in the coffin of the art and science of practice of clinical psychiatry! RIP phenomenology and *"hallelujah"*!!

Disclaimer

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