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# Current State of Psychopharmacology, Psychotherapies and Other Interventions in Mental Health Problems and Disorders

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**ABSTRACT**

**Proposal: The article broadly aims to emphasise the current relevance of physical and psychological treatments for most mental and behavioural disorders. Design: Critical analysis and reasoned opinion of a selected compilation of the best, widely read, high-quality scientific literature. Methodologically, it is a brief meta-synthetic review. Results and interpretation: In general, for almost all mental disorders, combined treatment with psychotropic drugs and psychotherapy seems to be more effective than psychotherapy or pharmacotherapy alone. Particularly in Spain (European Union), the risk for psychotherapies of therapeutic intrusion by non-specialists who are not medical psychiatrists or clinical psychologists is high. A similar situation occurs with the routine prescription of psychotropic drugs by other physicians. The frequent stigma associated with any mental pathology is then addressed, as well as the obligation to obtain informed consent for any therapeutic intervention. Lastly, mention is made of the usefulness of the personal state of full awareness, more commonly called mindfulness, training for which is included in numerous help programmes based on its continued practice, whether or not mental disorders are diagnosed. Conclusions: More randomised clinical trials with low risk of bias and accidental errors are needed to properly assess the effects of psychotherapeutic interventions. From a scientific perspective, based on multiple evidence, the efficacy of properly prescribed psychopharmacotherapy is not in question.**

**Keywords:** Psychopharmacology; Psychotherapy; Mental Health; Mental Disorder; Stigma; Mindfulness

## INTRODUCTION

Mental health is a priority public health issue. As far as treatments are concerned at present, there are no serious, well-documented reservations regarding the use of various psychotherapies and psychopharmacotherapies (in reality, neuro-psychopharmacotherapies), correctly recommended and applied. This is true even though the progressive medicalisation of "normality", the commercialisation of medicine (1,2) – and by extension, psychology – are often criticised. What is certain is that the subject's poor state of mental health will contribute significantly to their overall morbidity.

A sensitive issue, however, is the inevitable commercial interest of pharmaceutical companies in encouraging drug treatments for almost all types of disorders, including mental and behavioural disorders in the current global taxonomic system ICD-10 of the World Health Organisation (WHO), 1992, and DSM-5 of the American Psychiatric Association, 2013, in the US. A separate but similar issue is the supposed efficacy and effectiveness of psychotherapies, which are or may be seen as controversial. This is the case, for example, with couple psychotherapy in clinical depression (3).

In general, in almost all mental disorders, combined treatment with psychotropic drugs and psychotherapy might be better than psychotherapy or pharmacotherapy alone (4), though it is true that many people prefer and prioritise the first option. In any case, little is known about which specific groups of patients may respond better to combination therapy versus monotherapy alone (5).

Meanwhile, by way of example, the situation popularly referred to as the "new normal" following the SARS-CoV-2 (COVID-19) global pandemic declared by the WHO in 2020, the consequent lockdown, teleworking, sedentary lifestyles and so on, has caused worry, anxiety, uncertainty, social withdrawal and other negative consequences in many individuals and collectives. Yet it is clearly up to the health professional involved not unnecessarily to turn difficult, uncomfortable or atypical coping with these and other ordinary life problems into mental or behavioural disorders.

## MATERIAL AND METHODS

The basis for this research has been the compilation selected by the author of the highest-quality, widely read, related scientific literature. Methodologically, this contribution is a brief meta-synthetic review, understood as a way of integrating qualitative research findings on relevant issues related to current psychiatric and clinical-psychological treatments for mental disorders.

The review also aims to be transparent, up-to-date and comprehensive. To this end, an assessment will be made of the nature and scope of the vast amount of linked research. However, the accessible information is of very heterogeneous quality. The main methodological limitation of this study is that it does not include the exact process of assessing the scientific quality of the selected papers included in the bibliography.

## RESULTS AND DISCUSSION

### Psychotherapies: the current situation

With regard to psychotherapies, to give some examples, clinical trials on their efficacy in obsessive-compulsive disorder often compare different interventions in patients who are already on stable doses of antidepressant drugs (6); therefore, the contrast of psychotherapy versus psychopharmacotherapy is inappropriate here. Neither is there any unequivocal high-quality evidence to prioritise one psychotherapy over another in the treatment of panic disorder in adults, with or without agoraphobia.

In any case, it should be noted that placebo response also exists in psychotherapies, as in psychopharmacotherapies, in which the scope and the effects of overestimating their efficacy are as complex as they are little studied (7). Consequently, the time has come for

psychotherapists, both psychiatrists and clinical psychologists, to accept the placebo effect in their daily practice.

We are witnessing an undeniable, seemingly endless proliferation of titles of any kind without official recognition,[1] which in the field of mental health has repercussions and affects in Spain (EU) mainly for specialists in psychiatry (for medical university graduates), and clinical psychologists (for psychology university graduates). The issue is important particularly with regard to the alleged training for the practice of psychotherapies by general practitioners or other specialties and by general psychologists or psychologists who do not have the unique official speciality of clinical psychology.

As examples of fallacious training, see the "continuing education" degrees on "psychotherapeutic intervention" offered by the Universidad Nacional de Educación a Distancia, Madrid (Spain). Such qualifications are supposed to certify the aptitude of the persons concerned to perform the function of psychotherapists, an activity which is eminently specialised in the field of health care. It is argued that Spanish legislation does not endorse any psychotherapeutic qualification, and therefore "scientific associations of psychotherapists are filling this legal gap". In other words, certain parties have decided *motu proprio* that they can fully supplant State's accrediting endorsement in this matter.

It should be remembered that clinical psychology is, in fact, the only speciality for psychology graduates that is officially recognised in Spain. In this regard, the current *Código Deontológico del Psicólogo* (Psychologists' Code of Ethics), approved in 2010, already states in Article 51 that these professionals are not allowed to self-attribute confusing names and qualifications. It should likewise be recalled that Article 149.1.30 of the Spanish Constitution of 1978 attributes to the State the exclusive competence to regulate the conditions for obtaining, issuing and validating professional qualifications.

Meanwhile, psychiatrists continue to integrate diverse psychotherapeutic techniques along with psychopharmacotherapy in their daily clinical practice as a properly inherent part of their activity (8,9). In Spain, Royal Decree (RD) 689/2021 of 3 August 2021 amends RD 1277/2003 of 10 October 2003. According to the current legal text, the psychiatrist is responsible for the study, diagnosis, treatment and rehabilitation of mental and behavioural disorders in adult patients. The aforementioned RD of 2021 also established the new qualification of medical specialist in child and adolescent psychiatry, while updating various aspects of the qualification of medical specialist in psychiatry. The new degree in child psychiatry will be obtained after five years of specific postgraduate medical specialisation.

Particularly in Spain, it is imprudent and potentially dangerous for psychotherapeutic interventions (psychological treatments or psychotherapies) to be carried out by personnel

[1] In Spain, official titles are only those validated by the university conferring them and which, at the same time, are officially recognised by the state. They also need to have the official recognition of the Spanish *Agencia Nacional de Evaluación de la Calidad y Acreditación* (National Agency for the Assessment of Quality and Accreditation). Official titles are then included in the Spanish *Registro de Universidades, Centros y Títulos* (Registry of Universities, Centres and Titles).


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who are not even health professionals or who, if they are health professionals, are not also physicians or clinical psychologists. Likewise, caution and care must be taken with the multitude of pseudo-psychotherapists, particularly amongst physicians and psychologists who are not specialised by the State in psychiatry and clinical psychology, respectively. The same may be true for a variety of other professionals, such as, above all and only on occasion, some nurses and social workers.

For psychologists in Spain, the assessment, diagnosis, treatment and rehabilitation of mental health is the exclusive competence of specialists in clinical psychology (9,10). Currently, those who obtain the four-year university degree in general psychology can opt for two additional qualifications to practice within the country's healthcare system: gain a university master's degree in General Health Psychology (elsewhere in Europe, this practice is known as Healthcare Psychology), or sit the annual national competitive examination of psychologist-in-residence. In the latter case, after four years of tutored, supervised work, one can obtain the official qualification of Specialist Psychologist in Clinical Psychology.

In the EU there is wide variability in the education and specific clinical training of psychologists. However, in Spain clinical psychology has been a separate, official, nationally accredited, postgraduate qualification since 1998. The psychology speciality of clinical psychology comes well after the Medical Speciality of Psychiatry, which dates back to 1978.[2] The speciality of psychiatry also involves four tutored, supervised years of postgraduate study, after the six years required for a degree in general medicine. Throughout the world, the two specialties are radically different, as psychiatrists are medical doctors but psychologists are not, although some clinical psychologists pretentiously aspire to act as if they were and be able to also prescribe psychotropic drugs (11).

Optimal training of psychotherapists is particularly important when they must advise the Spanish Justice Department as an appropriate mental health specialist (12). Although it seems hard to comprehend, there are judicial processes in which opinions or judgements are given as supposed specialists (i.e. as if they had sufficient explicit knowledge) by people who, without being psychiatrists or clinical psychologists, call themselves psychoanalysts, psychotherapists, specialists in psychotherapy, neuropsychologists or clinical neuropsychologists. In addition, those who consider themselves experts in clinical psychopathology (i.e. with skills acquired through experience, but without having the best explicit training of those who are specialist), who are trainers or trained in some specific form of supposedly therapeutic mental intervention, etc., often act as psychotherapists.

Also often included as if they were equivalent or analogous to psychiatric specialists are forensic medical doctors, who are civil servants of the special corps of doctors of the Spanish National Institute of Toxicology and Forensic Sciences (INTCF for the Spanish name) (12). This is a technical body under the Spanish Ministry of Justice, rather than the Ministry of Health, in

[2] In this regard, in Spain, see the eighth final provision of Spanish Law 3/2014 dated 27 March 2014, which amends the revised text of the General Spanish Law for the Defence of Consumers and Users and other complementary laws. In particular, see the amendment to the seventh additional provision of Spanish Law 33/2011 of 4 October 2011 on General Public Health, to which it adds paragraphs 6 and 7.

which forensic medical officers are also psychiatrists on rare occasions. In like manner, the best training is important where the principles of ethics and confidentiality – mandatory for all healthcare workers – must be properly safeguarded (13).

**Psychopharmacological treatments: the current situation**

In the case of implementing a treatment plan for any anxiety disorder from the broad ICD-10 diagnostic code group F40-49, to cite a further example, its expected efficacy, adverse effects, interactions, costs, as well as patient preference, should be considered (14). In particular with regard to the pharmacological treatment of mental disorders in primary health care, the recommendations of the WHO (15), as well as the Oxford University (UK) guidelines for the assessment and clinical management of such disorders (16) may be consulted.

In routine practice, the integrated approach of combining psychotherapy and pharmacotherapy is the standard treatment in the field of mental health (17). In particular, clinical depression is one of the leading causes of disability worldwide. Improving its treatment is a priority. Antidepressant drugs are the first treatment option for adults with moderate to severe major depression. This contrasts with those who claim that medicines should be used as mere facilitators for psychotherapies, or as a last resort (18).

In clinical depression, patients' adherence to antidepressant drug treatment is often inadequate. Non-adherence is generally influenced by the patient's younger age, psychopathological and other medical comorbidities, cognitive impairment and substance use disorders. (19). Some evidence of moderate quality shows that psychotherapies added to usual psychopharmacotherapy with antidepressant drugs are beneficial for symptoms, as well as for response and short-term remission rates in subjects with resistant depression (20).

While there are no "typical" patients with panic disorder, the remission rate achieved in patients with usual pharmacotherapy ranges between 20–50%. The disorder is common in the general population with a lifetime prevalence of 1–4%. To improve outcomes, some atypical antipsychotics and anticonvulsants may have an adjunctive role in the treatment of certain patients with this disorder, although the quality of evidence is also limited (21). According to the UK National Institute for Health and Care Excellence (often named as NICE only considering its abbreviation) and the British Association for Psychopharmacology, antidepressants may be more effective than placebo in panic disorder (22,23). In contrast, current research evidence does not seem to support the widespread practice of prescribing antidepressants for insomnia (24).

Factors including neural circuits, biotypes, biopsychosocial markers, genetics and others have been identified to try to explain individual differences in psychopathology and response to treatment, favouring what is now called "precision psychiatry" (25,26). Using morphometric analyses in adolescent patients with social anxiety disorder (social phobia), the first scientific evidence has been found that there is a delayed and unsynchronised neurodevelopmental pattern of the fronto-limbic system in these patients (27).

The heterogeneity and comorbidity of the most significant mental disorders manifesting in adolescents and young adults has also encouraged so-called "transdiagnostic research". Transdiagnosis is intended as a new alternative paradigm to the traditional categorial


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diagnostic model. This concept is novel as well as utopian, and is promoted mainly by some psychologists who are not specializing in clinical psychology (28). The findings of the Research Domain Criteria (RDoC) of the US National Institute of Mental Health do not allow for the articulation of a concrete model for clinical practice guidelines (29).

Methods have been proposed to provide a means of identifying specific subsets of transdiagnostic symptoms that would represent clinical phenotypes apparently predictive of the transition to the emergence of major mental disorders (30). As can be seen, although there are numerous limitations as well as criticisms, the role to be played in the near future by the aforementioned precision psychiatry is considerable (31).

**Stigmatisation: the current situation**

The tendency to stigmatise mental pathologies occurs in almost every field, which poses significant cultural and communicative challenges. Furthermore, it is always relevant for the health professionals involved, whether or not they are physicians (29). Even so, stigmatisation is a common yet not universal experience. Mental health professionals seem to have more positive attitudes than people in general (32). Particularly in Catalonia (Spain), stigmatising beliefs and behaviours occurring in primary and specialised mental health care services have been studied. (33).

Cross-stigma is a frequent reality that most likely holds back the clinical recovery of numerous patients with mental disorders, but remains poorly understood (34,35). Often moreover, multiple stigmatised identities converge within one person or group. Indeed, experiences of stigmatisation often lead to its internalisation, which can have a negative impact on self-esteem and therapeutic outcomes (36).

Specifically, people with severe mental disorders experience clear, additional psychological harm from stigma (37), so interventions have been tested to address the emotional component of internalised stigma (38). Anti-stigma programmes tend to have little or no long-term effect, which has led some authors to call for action (39). Several anti-stigma group interventions do show promise (40).

**Informed consent: the current situation**

Informed consent (IC), also known as valid or lawfully given consent, is deemed by Spanish jurisprudence a “fundamental human right” in considering freedom a higher value in the legal system. See Spanish Law 41/2002 Regulating Patient Autonomy and Health Documentation and Information-Related Rights and Obligations, valid throughout the country.

In health interventions, exceptions to the obligation to obtain IC are only considered when there is a risk to public health, an immediate emergency situation or when there is a lack of capacity to make decisions (i.e. minors, severe mental disorder or mental retardation). Also when the interested party voluntarily waives such a right, or when medical judgment prevails, as stated in the *Código de Deontología Médica* (Spanish Medical Code of Ethics) in its provisional updated 2018 edition, as well as in the European Convention on Human Rights and Biomedicine (Oviedo Convention, Spain) of 4 May 1997 (41). In this regard, in Spain see the *Estrategia en Salud Mental del Sistema Nacional de Salud* (Mental Health Strategy, National Health System, NHS), approved by the NHS Interterritorial Council in 2006.

We referred above to exceptions to IC insofar as it affects people with severe mental disorder and those requiring inpatient or involuntary outpatient psychiatric treatment (IOT) (9,42). This latter therapeutic option, which invariably requires judicial authorisation in Spain, generally takes three forms: as an alternative, as a complement and as a way of avoiding forced or involuntary psychiatric hospitalisation. Naturally, any form of coercion, whether formal or not, may affect the therapeutic relationship, so it will have to be assessed in each case which will be the lesser harm or the greater good chosen.

IOT is generally known in English as "community treatment orders" or "compulsory treatment in the community" and is also known, mainly in the US, as "involuntary outpatient treatment" or "involuntary outpatient civil commitment". In the US, IOT has also been known as "Kendra's Law" in New York since 1999 and as "Laura's Law" since 2002 in California. In Spain, only Organic Law 5/2000 of 12 January 2000, Regulating the Criminal Responsibility of Minors, explicitly provides in Article 7 for IOT as a measure that may be imposed on minors.[3]

IC always affects psychotherapies insofar as they are treatment options and, therefore, specialised health activities. This includes the need to inform the parties concerned truthfully of the scientific evidence supporting the chosen psychotherapeutic method and possible alternative options. The latter include the use of other evidence-based psychotherapeutic approaches and techniques and, where appropriate, the alternative, priority or concurrent use of psychopharmacotherapy.

Examining mental capacity so as to grant IC is a complex matter that should furthermore solely be undertaken by a specialist mental health expert; that is, a psychiatrist or a clinical psychologist. There is, however, a high risk of professional intrusiveness. See that to which we referred in the first sub-section, valid throughout Spain, on the differentiated health category, but which is not strictly speaking an official speciality, called "general health psychology" (9,12). See also Spanish General Public Health Law 33/2011. While it seems obvious, in order to be able to legally determine IC in Spain, all professionals involved who are not even health personnel must be radically excluded.

**Full awareness or mindfulness: the current situation**

When the term "full awareness" is used, it usually refers to what is typical and characteristic in the term "mindfulness". The latter term appears in English language reference dictionaries, and is not included merely as a neologism; see, for example, "New words" the Cambridge Dictionary or "Buzzwords" Macmillan Dictionary.

The term "mindfulness" was coined by Kabat-Zinn in 1982 (43) and was intended to be the correct English translation of the ancestral concept known as *satipaṭṭhāna* in the Pali language (44). In Spain, the Anglicism "mindfulness", while very popular, is not included as a neologism in the University of Murcia's 2016 *Diccionario NEOMA de Neologismos del Español Actual*

[3] In Spain, a child is considered to be sufficiently mature at the age of 12. At the age of 16 or in emancipated minors, the so-called "healthcare age of majority" is recognised. If the child is under 16, lack of capacity is presumed, unless the physician proves otherwise. Physicians may carry out clinical interventions essential to the patient's health when there is an immediate serious risk to the patient's integrity or to public health.


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(NEOMA Dictionary of Neologisms in Current Spanish). Nor is it included in the latest, recently updated 23rd edition of the RAE dictionary.

Full awareness or mindfulness aims to optimise or improve people's ability to reflect on their thought processes and the way they learn. This is achieved by instructors training practitioners to experience thoughts and feelings, both positive and negative, from a de-centred or disidentified perspective (45) which allows them to distance themselves from the accompanying psychological events.

There are many mindfulness-based help programmes. This is because there is a widespread, pressing need to promote mental health in non-clinical settings, environments in which so-called positive psychiatry and positive or health psychology are sometimes involved. The practice of full awareness or mindfulness has been widely studied in the West to reduce psychological distress, whether pathological or not (46). There are numerous relevant studies that highlight the favourable influences of full awareness or mindfulness on the subject's well-being by reducing mental rumination and emotional dysfunction (47).

## CONCLUSION

We have so far referred to the current state of efficacy of psychotherapies and psychopharmacotherapies in many mental and behavioural disorders. In particular, therapeutic psychopharmacology has sufficiently demonstrated its favourable influence on most mental disorders, even if therapeutic adherence is not always the most adequate. Frequently, combined use of drug treatment and psychotherapy seems to be the most appropriate.

The well-known stigmatising capacity of mental pathologies, the need for so-called informed consent to receive any type of therapeutic intervention and, finally, the role that mindfulness or full awareness plays in mental health have been addressed. The latter affects both the general population and many patients with mental pathologies, as well as those suffering solely or mainly from physical pathologies.

More randomised clinical trials with low risk of bias and random errors are needed to assess the effects of psychotherapeutic interventions. Of course, such interventions must follow the scientific method, or they would be mere pseudo-psychotherapies. Particularly in childhood and adolescent depression, in the absence of sufficient controlled clinical trials with adequate statistical power, neither can the effectiveness of psychotherapeutic interventions in isolation or as exclusive treatments be clearly established.

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