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Psychiatry's clarification of expectations

PERSPECTIVES

ANDERS MALKOMSEN

anders.malkomsen@gmail.com
Anders Malkomsen, PhD, specialist in psychiatry and medical specialist at the Centre for Clinical Treatment Research, Oslo University Hospital.
The author has completed the ICMJE form and declares no conflicts of interest.

CARL TOLLEF SOLBERG

Carl Tollef Solberg, PhD, doctor, philosopher and professor at the Centre for Medical Ethics, University of Oslo, and adjunct professor at the University of Southern Denmark.
The author has completed the ICMJE form and declares no conflicts of interest.

Psychiatry's crisis of expectations is due to an increasing gap between expectations and resources. To avoid exacerbating the crisis, we must clarify these expectations.

Ragnhild Kaarbø, Komposisjon med hode, ca. 1925

We have asserted earlier that psychiatry is facing a crisis of expectations (1), and that there are at least three complementary strategies to deal with the crisis: increasing the resources allocated to psychiatry, increasing the efficiency of the service and reducing expectations (2). In our opinion, there is considerable potential to increase the efficiency of the service by reducing overtreatment and prioritising resources optimally. Nevertheless, we need to clarify expectations more explicitly before we can actually identify what overtreatment is and what should be prioritised.

Clarifying expectations entails surveying what clinicians, patients, families, politicians and society as a whole expect from psychiatry, weighing these expectations carefully and then reaching conclusions that can be communicated clearly. Such clarification should cover at least four elements: the treatment goal, who should be responsible for what, which methods should be employed, and who needs treatment. In the following, we will share some preliminary reflections on each of these aspects. But the real work will begin at the end of our discourse.

The goal

Those working in the public-sector specialist health service for psychiatry should be able to give a clear and consistent answer as to the goal of the treatment they offer. Nevertheless, our conversations with staff at different psychiatric units reveal that there are many different understandings of the goal of psychiatric treatment. Such variation can help to explain why some patients find that unclear rather than unrealistic expectations are the greatest challenge in psychiatry (3). The lack of a common understanding of goals may also partly explain the considerable variations when it comes to who gets help and how much help they get – a recurrent problem that the National Audit Office of Norway has pointed out several times in its criticism of psychiatry (4).

Therefore, the goal of public-sector psychiatric treatment should be disseminated clearly from the highest level and be reflected throughout the entire service. Regardless of what goal is chosen, we should adhere to the principles of *smart* goals, i.e. be *s*pecific, *m*easurable, *a*chievable, *r*ealistic, and *t*ime-bound. A zero vision for suicide is a good example of the opposite of a smart goal. Even though it is specific, it is unrealistic, and it is thus impossible to set a time limit for achievement. In ethics, 'ought implies can' is a principle stating that moral obligation only applies to what we are actually able to influence. Zero vision is an unachievable moral demand that simply leads to confusion and uncertainty in the service (5).

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Deciding on the best goal for psychiatric treatment is an ethical question as well as a discipline-related question. For example, a study of patients with depression showed that whereas therapists primarily focused on reducing symptoms, the patients wanted the treatment to promote a better quality of life as well as a more meaningful life (6). Both approaches are legitimate, but they have very different implications for treatment methods, division of responsibility and who is assessed as being in need of treatment. If the goal is to reduce symptoms and the symptoms are defined with reference to diagnostic manuals, the appropriate treatment will be specific therapeutic interventions and medication. One advantage of this is that psychiatry's mandate remains relatively delimited as long as the number of diagnoses does not continue to increase. However, if the primary goal is quality of life or a meaningful life, and symptom reduction is only one of many means of attaining this, treatment will likely become more holistic and comprehensive. Broader treatment goals entail a considerable increase in the number of patients and a longer treatment pathway; far more people find their quality of life is poor compared with the number who meet the criteria for a psychiatric diagnosis, and improving

quality of life is a much more complex task than reducing symptoms. Nonetheless, it is perfectly feasible to decide that this is the way forward for psychiatry, but only if resources are increased at the same time.

Responsibility

However, clear goals are not enough. The responsibilities of psychiatry must also be clearly defined because the division of responsibility for the mental health of the population largely decides the choice of solutions. Someone who is depressed because of an unstable financial situation, with disability benefits as their only source of income, can be helped in various ways: the solution will depend on where responsibility is placed. While the solution of the Norwegian Labour and Welfare Administration (Nav) may be to increase disability pension rates, psychiatry may prescribe anti-depressants. Similarly, children's behavioural issues and learning difficulties may be solved by increasing the number of teachers if responsibility is placed on the school. In contrast, psychiatry will frequently attempt to solve the problem using CNS stimulants. When responsibility for social and structural aspects is placed on psychiatry, the solution is often individually tailored rather than systemic. This may result in a medicalisation of social problems and the undermining of society's responsibility for the improvement of mental health.

The relationship between patient and therapist should be informed by the patient's ability to assume responsibility, and attempts should always be made to clarify this at an early stage. Put simply, the division of responsibility between patient and therapist can be illustrated by three metaphors: the repairer, the trainer and the guide. Those with the most serious mental disorders have limited ability to take responsibility for their own improvement. In such cases, the therapist must play an active role, like a *repairer* who diagnoses the problem, ensures that the repair is carried out and takes charge of more practical tasks. As an extreme consequence, although coercive treatment is necessary, it may be severely limited by legislation on the limitation of coercion (7). On the other hand, patients can also be given too little responsibility for their own treatment. For patients who are more able to take responsibility, the *trainer* approach may be better. The therapist provides information on the condition, gives professional guidance and follows up in an advisory capacity. Patients themselves must do the job by following the guidance, making the necessary lifestyle changes and independently practising the skills the therapy is intended to develop. The healthiest patients perhaps need no more than a *guide* – someone who helps them to understand their inner landscape and to calibrate their internal mental compass. There is no standard answer here. What is most important is that the distribution of responsibility is clearly communicated.

Unfortunately, there are many uncertainties about who is responsible for what in psychiatry, as the National Audit Office of Norway recently pointed out (8). In this context, the thematic organisation of the service and a clearer distribution of tasks are important steps in the right direction (9).

Method

Regardless of psychiatry's goals and areas of responsibility, treatment methods should be evidence-based. When new medications are evaluated for use in the Norwegian public health system, they are subject to thorough assessments through the 'New Methods' national system. There are no corresponding assessments and prioritisations for psychotherapy, making it difficult for patients to find out if the treatment they are undergoing is evidence-based. Therefore, a more systematic assessment of the methods used in psychiatry is essential. The lack of updated guidelines creates further uncertainty. For example, the guidelines for the treatment of depression were recently withdrawn without any plans for a new version, while the guidelines for psychosis focus solely on psychopharmaceuticals. The lack of guidelines makes it difficult for patients to know whether the treatment offered is best practice for their condition, and this reduces patients' ability to appeal against improper medical practice.

Patients are entitled to freedom of choice in terms of treatment, but this must be balanced against the criteria set by Stortinget (the Norwegian Parliament) for prioritisation in the public sector health and care services: health benefit, resource use and severity. Consequently, freedom of choice should be restricted to treatment that is cost-effective. Even though many patients want long-term therapy, this is seldom the most cost-effective alternative. The long-term clinical effect compared with shorter courses of therapy is often small, while resource use is significantly greater (10). This means that an increased focus on cost-effectiveness would probably involve more short-term therapy, ideally in combination with medication (11). Cost-effectiveness is not just about saving money but also about respecting the patient's time and needs. Most patients want to recover as quickly as possible.

The idea that good treatment takes time is a persistent myth that faces challenges from various sources, for example, studies of four-day treatment of obsessive-compulsive disorder (12) or six-day trauma-focused treatment (13). Of course, there are exceptions, but psychiatry should be more willing to take research findings on board, for example, studies on complex personality disorders that show that brief, more intensive courses of therapy often give results that are just as good as longer courses of treatment (14, 15). Parkinson's law, which states that work expands to fill the available time, probably also applies to psychiatry. If publicly-funded psychiatry is to be evidence-based and take patients' preferences seriously, it must not feel threatened by demands for more short-term treatments but rather regard getting more for less as a professional challenge.

Clarification of needs

A real need for treatment cannot be assessed in isolation. It depends on the goals of psychiatry, distribution of responsibility, and methods. Without a common understanding of these elements, we risk confusing subjective expectations and actual needs. But what lies behind our expectations? Expectations can have at least three dimensions – predictions, wishes and needs – and a clear understanding of these is of decisive importance in clarifying actual needs for treatment.

> ***«Those who strongly believe in the efficacy of psychiatric treatment see undertreatment everywhere, while those who do not only see overtreatment. Here, the empirical experience must be decisive»***

Predictions are descriptive assumptions about future treatment outcomes, and the clinician's predictions are often more realistic than those of the patient since they build on professional knowledge and clinical experience. Wishes are personal preferences about what we hope will happen but are not necessarily realistic. Consequently, we must be careful not to emphasise the wish for treatment too much. For patients with the capacity to consent, an autonomous wish for treatment is a necessary requirement but not sufficient. However, it is a paradox in psychiatry that the sicker the patient, the less often they want treatment. Patients who are very ill may make unrealistic pessimistic predictions about treatment effects, either because they believe that their case is hopeless or because they do not realise that they are actually ill. Meanwhile, many patients make unrealistic optimistic predictions about the effects of treatment and, therefore, want treatment or assessment. This shows that incorrect predictions can influence the wish for treatment.

A real need for treatment only exists when there is a documented effective treatment that is actually effective. However, in psychiatry, it is difficult to predict who will, in fact, benefit from assessment and treatment because individual and contextual factors affect the outcome in unpredictable ways (16). Although this epistemic uncertainty makes the clarification of treatment needs challenging, it also leads to an important conclusion. More patients should have the opportunity to try the treatment, and more should probably be offered explanatory conversations, as trial treatment in itself may serve to clarify treatment needs. Therefore, brief care pathways with clear evaluation points are preferable to long, unfinished courses of treatment. This approach will give better resource utilisation and a more realistic assessment of patients' needs. Meanwhile, this demands more of the therapist, who often has difficulty ending the treatment and may thus need clear support from leadership in challenging cases (17).

Consequently, undertreatment can only be said to exist if there is an efficacious treatment that is not offered when the patient's goals correspond with psychiatry's overarching goals and when the patient's problems are classified as

part of psychiatry's defined area of responsibility. Therefore, it is impossible to discuss whether a patient is under- or overtreated without first having a clearly defined goal and responsibility. Undoubtedly, there will always be disagreements on these questions. At worst, this can paralyse psychiatry, as evidenced by the fact that psychiatry has not managed to formulate a sensible contribution to the Norwegian Choosing Wisely campaign. Those who strongly believe in the efficacy of psychiatric treatment see undertreatment everywhere, while those who do not only see overtreatment. Here the empirical experience must be decisive.

«Our ambitions for psychiatry should be high, and this requires a more thorough clarification of expectations»

Vision and leadership

It is frightening to think of psychiatry marching in step towards one single goal, using one single method. No one wants this. At the same time, our conversations with staff, families and patients have left a clear impression that the field lacks an overall vision and, not least, clear leadership, making it impossible for staff to prioritise in practice. Many therapists find that the available resources are not in proportion to expectations or that expectations are unclear. This discrepancy is one of the reasons why many people are leaving the profession (18). If public-sector resources are calculated on the basis of a reduction in symptoms, as we assume, while some therapists have broader goals, this will widen the expectations gap because there is no correspondence between goals and resources. A transparent and honest clarification of expectations can promote a better balance between resources and demands while giving employees a clearer understanding of the purpose of the vital work they do.

However, the most important concern is the patients. Mental health disorders are among the most brutal challenges faced by humans, and patients in psychiatry deserve the best help they can get. Therefore, our ambitions for psychiatry should be high, and this requires a more thorough clarification of expectations. The fact that balancing different considerations will lead to conflict is no excuse for avoiding the task. Norway probably has the world's best range of mental health treatment, but it can be further improved if we dare to embrace unclarified expectations.

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REFERENCES

1. Malkomsen A, Solberg CT. Psykiatriens forventningskrise. Tidsskr Nor Legeforen 2022; 142. doi: 10.4045/tidsskr.21.0895. [PubMed][CrossRef]

2. Malkomsen A, Solberg CT. Forventningsgapet i psykiatrien må reduseres. Tidsskr Nor Legeforen 2023; 143. doi: 10.4045/tidsskr.23.0081. [PubMed] [CrossRef]

3. Kastås HM. Har mer enn et tiår bak seg som pasient i psykiatrien: Det er her skoen trykker. Nettavisen 5.3.2022. https://www.nettavisen.no/norsk-debatt/har-mer-enn-et-tiar-bak-seg-som-pasient-i-psykiatrien-det-er-her-skoen-trykker/o/5-95-401693 Accessed 12.3.2025.

4. Riksrevisjonen. Riksrevisjonens undersøkelse av psykiske helsetjenester. https://www.stortinget.no/globalassets/pdf/dokumentserien/2020-2021/dok3-202021-013.pdf Accessed 25.3.2025.

5. Sjöstrand M, Eyal N. The phantasm of zero suicide. Br J Psychiatry 2023; 222: 230–3. [PubMed][CrossRef]

6. Demyttenaere K, Donneau AF, Albert A et al. What is important in being cured from depression? Discordance between physicians and patients (1). J Affect Disord 2015; 174: 390–6. [PubMed][CrossRef]

7. Helse- og omsorgsdepartementet. Tvangsbegrensningsloven. https://www.regjeringen.no/contentassets/78974ebb760a412cb646611ad2e57b9d/no/pdfs/nou20192019001400odddpdfs.pdf Accessed 25.3.2025.

8. Riksrevisjonen. Helse- og velferdstjenester til personer med samtidige rusmiddellidelser og psykiske lidelser. https://www.riksrevisjonen.no/globalassets/rapporter/no-2024-2025/helse--og-velferdstjenester-til-personer-med-samtidige-rusmiddellidelser-og-psykiske-lidelser.pdf Accessed 25.3.2025.

9. Helse- og omsorgsdepartementet. Forenkle og forbedre: Rapport fra ekspertutvalg for tematisk organisering av psykisk helsevern. https://www.regjeringen.no/contentassets/2402e66428ac40ad9ed416ab2b62646d/no/pdfs/forenkle_og_forbedre_-_rapport.pdf Accessed 25.3.2025.

10. Helsinki Psychotherapy Study Group. The cost-effectiveness of short-term and long-term psychotherapy in the treatment of depressive and anxiety disorders during a 5-year follow-up. J Affect Disord 2016; 190: 254–63. [PubMed][CrossRef]

11. Cuijpers P, Noma H, Karyotaki E et al. A network meta-analysis of the effects of psychotherapies, pharmacotherapies and their combination in the treatment of adult depression. World Psychiatry 2020; 19: 92–107. [PubMed] [CrossRef]

12. Skjold SH, Hagen K, Wheaton MG et al. The effectiveness and acceptability of the Bergen 4-day treatment for adolescents with OCD: a

replication and extension. BMC Psychiatry 2024; 24: 148. [PubMed] [CrossRef]

13. Matthijssen SJMA, Menses SDF, Huisman-van Dijk HM. The effects of an intensive outpatient treatment for PTSD. Eur J Psychotraumatol 2024; 15. doi: 10.1080/20008066.2024.2341548. [PubMed][CrossRef]

14. McMain SF, Chapman AL, Kuo JR et al. The Effectiveness of 6 versus 12 Months of Dialectical Behavior Therapy for Borderline Personality Disorder: A Noninferiority Randomized Clinical Trial. Psychother Psychosom 2022; 91: 382–97. [PubMed][CrossRef]

15. Ciharova M, Karyotaki E, Miguel C et al. Amount and frequency of psychotherapy as predictors of treatment outcome for adult depression: A meta-regression analysis. J Affect Disord 2024; 359: 92–9. [PubMed] [CrossRef]

16. McMahon FJ. Prediction of treatment outcomes in psychiatry–where do we stand? Dialogues Clin Neurosci 2014; 16: 455–64. [PubMed][CrossRef]

17. Elvik I. Psykologer mangler vurderingsferdigheter. Psykologitidsskriftet 2025; 1: 44–7.

18. Arner Y, Grepperud S. Spesialistflukt fra de offentlige helsetjenestene. Tidsskr Nor Psykol foren 2024; 61: 758–65. [CrossRef]

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