PSYCHOERGONOMIC METHOD OF CLINICAL PSYCHIATRY

Authorial clinical methodology

10 years of practical application

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1. ABSTRACT

The psychoergonomic method is a clinical methodology in psychiatry aimed at individualizing the diagnostic and therapeutic process by taking into account the specific mental, neurobiological, and life configuration of each patient. The method was developed and introduced into clinical practice in 2016 as a response to the limitations of protocol-based and statistical models of psychiatric treatment, which do not always adequately reflect the high variability of clinical manifestations, individual sensitivity to psychopharmacological interventions, and the real functional goals of patients.

The name of the method reflects its conceptual foundation and derives from the principles of classical ergonomics, which views the correspondence of form, function, and proportion as a prerequisite for stable and effective functioning. Within the psychoergonomic approach, a patient's mental state is understood as a system of individual psychological proportions—between symptoms, capabilities, limitations, and the potential for personal and social realization. Accordingly, identical diagnostic categories may require different therapeutic strategies, dosages, and treatment tempos depending on personality structure, level of functioning, life context, and patient goals.

The psychoergonomic method relies on international diagnostic standards (ICD and DSM) as a necessary clinical foundation while complementing them with an in-depth analysis of symptom structure, state dynamics, subjective patient experience, and individual therapeutic response. The method is based on two key principles: complexity and collegiality. Diagnosis is regarded as a multi-stage process involving an expanded clinical interview, anamnesis collection, analysis of medical and life history, and, when necessary, interdisciplinary interaction with related medical specialists. Clinical decisions are made collegially, with the participation of multiple professionals involved in the diagnostic and therapeutic process.

The core practical principles of the method include prioritizing in-depth diagnostics, striving for minimally sufficient pharmacological intervention, preference for monotherapy, dynamic clinical follow-up, and high responsibility for side effects and long-term treatment consequences. The psychoergonomic method is not positioned as an alternative to evidence-based psychiatry but rather as its clinical evolution, aimed at increasing precision, safety, and sustainability of therapeutic decisions while maximizing patient recovery and adaptation according to individual capabilities and life realization.

2. INTRODUCTION

Modern clinical psychiatry largely relies on protocol-based and classificatory models grounded in international diagnostic systems and principles of evidence-based medicine. These models have played a crucial role in standardizing diagnosis and treatment, establishing a shared clinical language, and significantly improving the safety of psychopharmacological interventions. At the same time, real-world clinical practice increasingly reveals the limitations of an exclusively protocol-driven approach, particularly when working with complex, chronic, and endogenous mental conditions.

Patients with identical diagnostic categories often demonstrate fundamentally different clinical presentations, varying sensitivity to psychopharmacological agents, differing recovery trajectories, and unequal levels of functional, professional, and social adaptation. These differences cannot be fully explained within diagnostic frameworks alone and require deeper clinical analysis that accounts for individual mental organization, personality characteristics, life context, and the real tasks faced by the patient.

It was precisely within this clinical contradiction—between the necessity of standardization and the objective need for individualization—that the psychoergonomic method emerged.

2.1 Origin and Conceptual Rationale of the Psychoergonomic Method

The term “psychoergonomics” was chosen deliberately and reflects the fundamental idea of the method. In its classical understanding, ergonomics studies the correspondence between form, function, and proportion that ensures stable, effective, and safe human functioning within an environment. An ergonomic approach presupposes adapting the system to the person, rather than adapting the person to a rigidly predefined system.

The psychoergonomic method transfers this principle into the field of clinical psychiatry. A patient’s mental state is viewed not as a set of isolated symptoms, but as a holistic system of individual psychological proportions—relationships between symptomatology, cognitive and emotional capacities, personality structure, level of functioning, and potential for life realization.

From this perspective, a diagnosis describes a general category of mental disorder but does not capture the unique configuration of an individual’s mental functioning. Two patients with the same diagnosis may differ substantially in their internal proportions, life goals, levels of responsibility, professional and creative potential, and in what changes in mental state are clinically acceptable and functionally meaningful for them.

Within the psychoergonomic method, therapeutic decisions—including treatment strategy, medication choice, dosage, and treatment pace—are made with consideration not only of symptom reduction but also of preserving or restoring the patient’s ability for personal, professional, and social realization. The goal of treatment is not formal compliance with diagnostic criteria but achieving the highest possible level of stable functioning, adaptation, and quality of life within the patient’s individual mental structure.

The use of the Vitruvian Man as a visual and conceptual representation of the method reflects this understanding of proportionality and balance as the basis of stable functioning. This image is not used decoratively but as a conceptual model emphasizing the proportional alignment of diagnostic conclusions, therapeutic interventions, and the patient’s real capacities.

2.2 Core Methodological Principles: Complexity and Collegiality

The psychoergonomic method is based on two interrelated principles that define its practical implementation: the principle of complexity and the principle of collegiality.

Principle of Complexity

Within the psychoergonomic method, diagnosis is not regarded as a single consultation or formal confirmation of a diagnostic category. The diagnostic process is understood as a multi-stage clinical effort aimed at deep comprehension of the structure of a patient's mental state.

Comprehensive diagnostics include an expanded clinical interview with the patient, detailed anamnesis collection, analysis of medical and life history, and, in most cases, interviews with relatives or significant others. This approach allows for identifying symptom dynamics, developmental features of the disorder, stabilizing and destabilizing factors, as well as real functional limitations and patient resources.

When clinically indicated, the diagnostic process is expanded through the involvement of specialists from related medical fields, including neurology, endocrinology, and other subspecialties. This allows for accounting for somatic and neurobiological factors that may significantly influence the clinical picture and enables development of a maximally substantiated therapeutic strategy.

Complexity within the psychoergonomic method does not imply excessive intervention. On the contrary, it aims to achieve sufficiency of information necessary for clinically and ethically responsible decision-making.

Principle of Collegiality

Collegiality constitutes the second fundamental principle of the psychoergonomic method. Key diagnostic and therapeutic decisions are not made in isolation by a single specialist but are formed through collegial discussion involving multiple professionals familiar with the clinical case.

The collegial approach is applied both at the diagnostic stage and during dynamic observation and therapy. Regular in-person or remote case conferences allow for assessment of treatment effectiveness, correction of therapeutic course, and reduction of subjective clinical errors. Even within psychotherapeutic processes, clinical oversight and unified therapeutic logic are maintained.

2.3 Functional Distribution of Roles and Professional Responsibility

The psychoergonomic method involves specialists from multiple disciplines, with each professional role having clearly defined functions, boundaries of responsibility, and areas of competence. Collegiality in this context does not mean dilution of responsibility; rather, it implies its structured distribution.

The psychiatrist bears primary clinical responsibility for diagnosing mental disorders, making psychopharmacological decisions, defining overall treatment strategy, and assessing clinical risks. The psychiatrist coordinates the clinical core of the process and ensures coherence of therapeutic logic.

Psychotherapy specialists participate in treatment according to their professional training and therapeutic modalities, including cognitive-behavioral therapy, schema therapy, trauma-focused therapies, ACT, DBT, emotion-focused therapy, VR therapy, and other approaches. Selection of the psychotherapeutic modality is determined by clinical objectives, personality structure, and stage of therapy. Responsibility for psychotherapeutic work rests with the respective specialist, while maintaining feedback within the collegial clinical framework.

Related medical specialists—neurologists, endocrinologists, ADHD diagnosticians, and others—are involved when clinically indicated and perform diagnostic and consultative functions within their professional competence.

Holistic and supportive modalities, including art therapy, body-oriented practices, sports therapy, the Feldenkrais method, and other non-pharmacological interventions, are used as supplementary tools aimed at expanding patient functionality, improving adaptation, and sustaining therapeutic outcomes.

These methods do not replace clinical treatment but complement it within the psychoergonomic strategy.

Clinical Coordination and Administrative Infrastructure

A distinct role within the psychoergonomic method is played by clinical coordination and administrative infrastructure, which is considered not an auxiliary service but an integral element of the clinical system. Administrative coordinators undergo specialized training and possess in-depth understanding of psychoergonomic methodology, clinical terminology, diagnostic and therapeutic logic, and collegial decision-making principles.

Clinical coordinators are knowledgeable in psychotherapeutic modalities, differences between them, therapy stages, and clinical reasoning, enabling them to ensure accurate, continuous, and coherent patient support throughout all treatment phases. Administrative personnel do not make clinical decisions or intervene in pharmacological or psychotherapeutic prescriptions, which remain the responsibility of respective specialists.

A key function of clinical coordination is monitoring adherence to diagnostic, therapeutic, and observation protocols, organizing interdisciplinary communication, ensuring timely patient feedback, and collecting clinical data necessary for dynamic state assessment. Thus, administrative infrastructure provides operational support essential for implementing a complex and collegial approach.

An important component of this system is the use of specialized CRM infrastructure developed and adapted for psychoergonomic requirements. The CRM system functions not as an accounting tool but as a clinically oriented environment ensuring proper protocol management, tracking diagnostic and therapeutic stages, monitoring patient dynamics, and maintaining continuity of clinical decisions.

2.4 Clinical and Ethical Responsibility

The psychoergonomic method recognizes the high level of responsibility borne by physicians and the clinical team for long-term consequences of therapeutic decisions. Clinical practice offers numerous potential treatment paths; however, the path aligned with the individual configuration of the patient is typically the only clinically and ethically justified one.

The method emphasizes open and honest dialogue with patients, realistic discussion of therapeutic goals and limitations, and rejection of unjustified expectations. Ethical responsibility is regarded as an integral component of clinical effectiveness and sustainability.

3. DEFINITION OF THE PSYCHOERGONOMIC METHOD

The psychoergonomic method is a clinical methodology in psychiatry and psychotherapy aimed at designing and implementing diagnostic and therapeutic processes in accordance with the individual mental, neurobiological, and life configuration of the patient. The method is based on adapting the treatment system to the person, rather than adapting the person to a universal or averaged therapeutic model.

Within the psychoergonomic method, the patient's mental state is viewed as a holistic, dynamic system of individual psychological proportions, encompassing symptom structure, level of functioning, personality characteristics, cognitive and emotional resources, and capacities for personal, professional, and social realization. These proportions determine clinical significance of symptoms, acceptable intervention boundaries, and treatment effectiveness criteria.

The psychoergonomic method uses international diagnostic standards (ICD and DSM) as a necessary clinical foundation but does not limit itself to formal diagnostic categories. Diagnosis serves as a starting point for clinical analysis rather than a comprehensive description of the patient's condition. Key attention is paid to symptom structure and dynamics, individual treatment response, and functional consequences of therapeutic decisions.

A distinctive feature of the psychoergonomic method is its focus not only on symptom reduction but also on preserving or restoring a stable level of functioning aligned with the patient's individual capacities, life goals, and context. Treatment effectiveness is assessed not solely by symptom disappearance but by the patient's ability to adapt, function, and maintain quality of life.

The psychoergonomic method is implemented as a complex and collegial clinical process. Diagnosis and treatment are conducted in stages, involving specialists from various disciplines, with clearly delineated roles and responsibilities. Key clinical decisions are made collegially, based on sufficient information and considering medical, psychological, and ethical factors.

Pharmacological treatment follows the principle of minimally sufficient intervention, prioritizing monotherapy, individualized dosing, and careful monitoring of efficacy and side effects. Medication is viewed as part of an overall clinical strategy rather than an isolated solution.

Psychotherapeutic and non-pharmacological methods are integrated depending on clinical objectives, personality structure, and treatment stage. Therapeutic approaches are selected deliberately and purposefully, with regard to their functional role within the overall treatment plan.

The psychoergonomic method presupposes structured clinical coordination to ensure adherence to protocols, continuity of observation, and consistency of actions among all participants. This ensures reproducibility, transparency, and safety of treatment.

Overall, the psychoergonomic method represents not an alternative to modern psychiatry but its clinical evolution, aimed at enhancing precision, individualization, and responsibility of therapeutic decisions in conditions of high clinical complexity and variability.

4. PHILOSOPHICAL AND CLINICAL FOUNDATIONS OF THE PSYCHOERGONOMIC METHOD

The psychoergonomic method is based on the view of mental health and mental disorder as dynamic, multi-level, and context-dependent states. Unlike reductionist models focused primarily on the formal description of symptoms and compliance with diagnostic criteria, the psychoergonomic approach proceeds from an understanding of the psyche as an integral system functioning in individually constructed proportions.

Within this approach, a person's mental state is not reduced to the presence or absence of individual symptoms. It is viewed as the result of interaction among biological, psychological, and social factors, manifested in a specific structure of personality functioning. Psychopathology in this context is understood not only as a set of symptoms, but as a disruption of balance between different levels of mental functioning, which may affect quality of life, adaptation, and self-realization in different ways.

4.1 Mental Functioning as a System of Individual Proportions

A key philosophical foundation of the psychoergonomic method is the concept of mental functioning as a system of individual psychological proportions. These proportions reflect the relationship between:

- psychopathological manifestations and compensatory mechanisms
- emotional reactivity and cognitive control
- vulnerability and adaptive resources

- internal capacities of the personality and external demands of the environment
- pathological and preserved functions

From the psychoergonomic perspective, the clinical significance of a symptom is determined not only by its severity or formal diagnostic belonging, but also by its role within the overall structure of the patient's mental functioning. The same symptom may have fundamentally different clinical meaning depending on personality organization, level of functioning, life context, and the patient's subjective attitude toward their state.

This understanding makes it possible to avoid both hyperdiagnosis and excessive intervention, as well as underestimation of the patient's condition. Clinical decisions within the psychoergonomic method are oriented not toward eliminating all symptoms at any cost, but toward restoring or maintaining a stable and functionally adequate balance.

4.2 Functionality as a Key Criterion of Clinical Decision-Making

In the psychoergonomic method, functionality is considered one of the central criteria for assessing mental state and treatment effectiveness. Functionality refers to the patient's ability to maintain adaptive behavior, fulfill personally meaningful roles (personal, professional, and social), and preserve an acceptable quality of life within their mental condition.

Symptom reduction alone does not always lead to improved functionality. In a number of cases, excessive or disproportionate intervention may be accompanied by reduced initiative, emotional expressiveness, cognitive flexibility, and motivation, which results in deterioration of overall adaptation.

The psychoergonomic method proceeds from the necessity of correlating each clinical intervention with its functional consequences. Treatment is considered effective when it enables the patient not only to experience subjective relief of symptoms, but also to live more stably, meaningfully, and productively in accordance with their individual capacities and life goals.

4.3 Individualization as an Alternative to Universalization

A philosophical foundation of the psychoergonomic method is a critical attitude toward universalization of clinical decisions. Despite the importance of diagnostic standards, protocols, and clinical guidelines, the method proceeds from the fact that universal therapeutic models inevitably simplify clinical reality and cannot fully account for individual differences among patients.

Individualization within the psychoergonomic approach does not imply arbitrariness or rejection of scientific foundations. On the contrary, it presupposes more precise and responsible application of clinical knowledge with consideration of the unique configuration of the конкретного patient. Universal models are used as reference points and starting frameworks; however, final clinical decisions are formed at the level of individual analysis and collegial discussion.

4.4 The Dynamic Nature of Mental State and the Therapeutic Process

The psychoergonomic method regards mental state as a dynamic process that changes over time under the influence of internal and external factors. Symptomatology, level of functioning, and response to therapy are not static values and require continuous clinical reassessment.

Accordingly, the therapeutic process within the psychoergonomic method is not constructed as a linear implementation of a pre-set plan. It presupposes flexibility, regular analysis of the state's dynamics, and timely correction of the treatment strategy in accordance with current clinical data.

In this approach, dynamic adjustment is not a sign of uncertainty, but a reflection of the complexity and variability of mental reality and a necessary condition of clinical accuracy.

4.5 Clinical Responsibility and the Limits of Intervention

One of the fundamental clinical foundations of the psychoergonomic method is the recognition of limits of therapeutic intervention. Not every mental condition is subject to full symptom reduction, and not every possible intervention is justified in terms of long-term consequences.

The method proceeds from the principle of proportionality of intervention: therapy must be sufficient to stabilize the state and restore functionality, but not excessive and not destructive to the patient's individual personality structure. Clinical responsibility implies readiness to refrain from aggressive or unjustified interventions, even if they could formally lead to additional symptom reduction, but carry risk of loss of functional, cognitive, or personal resources.

4.6 Psychoergonomics as a Clinical Position

Taken together, the philosophical and clinical foundations of the psychoergonomic method form a distinct clinical position of the physician and the team. This position implies rejection of template thinking, attentive and responsible attitude toward the patient's individual mental reality, and readiness for complex clinical analysis.

In this sense, the psychoergonomic method represents not only a methodology for organizing treatment but also a stable professional position based on balance between scientific groundedness, clinical flexibility, and ethical responsibility.

4.7 The Patient's Subjective Experience and a Partnership Model of Clinical Interaction

One of the key philosophical and clinical foundations of the psychoergonomic method is the recognition of the patient's subjective experience as a clinically meaningful element of the diagnostic and therapeutic process. Unlike approaches in which clinical reality is determined mainly by objectively recorded symptoms and formal criteria, the psychoergonomic method treats the patient as an active participant and partner in treatment.

Within the psychoergonomic approach, the patient is not an object of clinical influence. The patient is regarded as a subject with their own perception of condition, individual values, life goals, and criteria of acceptable functioning. The patient's opinion, subjective assessment of their state, and quality of life are considered an important source of clinical information complementing objective diagnostic data.

The partnership model presupposes open dialogue between specialist and patient, joint discussion of treatment goals, expected effects, and permissible boundaries of intervention. Clinical decisions are formed not only on the basis of diagnostic criteria, but also considering how the patient perceives their state and what changes are desirable or acceptable for them.

The psychoergonomic method recognizes the patient's right to individual characteristics of mental functioning, including manifestations that may formally be considered part of the clinical picture but do not lead to pronounced suffering, maladaptation, or functional impairment. If a person is not dangerous to themselves or others, and certain features of their mental condition are subjectively acceptable and do not pathologically affect their life and the lives of those around them, such states are not regarded as mandatory targets for therapeutic correction.

The goal of psychoergonomic intervention is not to bring the patient to a normative or averaged state, but to support and restore a stable, functionally and subjectively acceptable level of mental functioning. Clinical help in this context is aimed at reducing suffering, improving adaptation, and enhancing quality of life rather than eliminating all deviations from formal diagnostic norms.

The partnership model does not cancel clinical responsibility of specialists and is not applied in situations associated with risk to the patient or others. In cases where there is danger, marked loss of insight, or inability of the patient to participate consciously in decision-making, clinical actions are determined by medical and ethical standards. However, in all other situations, the patient's subjective position is an integral part of psychoergonomic clinical reasoning.

5. DIAGNOSTIC ARCHITECTURE OF THE PSYCHOERGONOMIC METHOD

Diagnostics in the psychoergonomic method is regarded not as a formal procedure of establishing a diagnosis, but as a multi-stage clinical process aimed at reconstructing the individual configuration of the patient's mental functioning. The diagnostic architecture of the method is built in such a way as to ensure sufficiency of information for responsible clinical decision-making, avoid premature conclusions, and minimize the risk of erroneous therapeutic strategies.

Unlike approaches focused on rapid classification of symptoms, the psychoergonomic method proceeds from the fact that diagnostic errors most often arise not due to absence of formal criteria, but due to incomplete understanding of the structure of the condition, its dynamics, and its context.

5.1 Diagnosis as a Process, Not a Single Act

Within the psychoergonomic method, diagnosis is not reduced to a single consultation or one clinical interview. It is understood as a sequential process unfolding over time, including several stages, each of which performs its own clinical function.

The initial meeting is treated as the beginning of the diagnostic pathway rather than the moment of the final conclusion. Final clinical conclusions are formed only after sufficient information has been accumulated and collegially analyzed. This approach helps to avoid premature fixation of a diagnosis and related cognitive distortions, when subsequent data are interpreted solely through the prism of the first impression.

5.2 The Role of the Clinical Curator and Preliminary Information Collection

A key role at the initial stage is played by the clinical curator, a specially trained professional who is part of the clinical coordination infrastructure of the psychoergonomic method. The clinical curator does not make clinical decisions, but ensures completeness, structure, and correctness of diagnostic information.

The clinical curator's tasks include:

- collection of individual anamnesis
- collection of family psychiatric anamnesis
- detailed reconstruction of the history of the mental condition
- analysis of medication therapy history and response to medications
- collection of information about previous diagnoses, treatment formats, and their effectiveness
- documentation of state dynamics and significant life factors

The collected information is systematized, structured, and prepared for subsequent collegial review. This stage allows formation of a preliminary clinical understanding of the case and determination of the optimal format of the further diagnostic process.

5.3 Collegial Preliminary Discussion and Selection of the Diagnostic Route

After completion of the initial information collection, the clinical case is brought to collegial discussion. The aim of this stage is not a formal diagnosis, but the formation of an initial clinical hypothesis and determination of the optimal diagnostic route.

At this stage decisions are made regarding:

- the necessary volume of diagnostic measures
- priority directions of clinical assessment
- feasibility of involving additional specialists
- the sequence of diagnostic stages

This approach simultaneously avoids excessive diagnostics and reduces the risk of missing clinically significant factors.

5.4 Clinical Consultation with a Psychiatrist

In most cases, the central stage is an extended clinical consultation with a psychiatrist. This consultation is conducted after preliminary information collection and collegial discussion and, as a rule, lasts no less than one hour.

During the consultation, the following are clarified:

- clinical criteria of the mental condition
- psychiatric and somatic anamnesis
- medication therapy history, its effectiveness, and tolerability
- characteristics of the course of the condition and response to interventions
- current level of functioning, adaptation, and insight

The consultation is aimed not only at formal compliance with diagnostic criteria, but primarily at understanding the structure of the condition, individual psychological proportions, and the clinical logic of further diagnostic and therapeutic steps.

5.5 Psychologist's Clinical Interview and Pathopsychological Testing

When clinically indicated, the diagnostic process is supplemented by a clinical interview with a clinical psychologist, which may transition into a pathopsychological examination. The main goal is an in-depth study of personality characteristics, cognitive and emotional features, and the psychological structure of the condition.

Validated clinical and projective methods are used (including tests such as Rorschach, TAT, and others), allowing:

- уточнение clinical correspondence to diagnostic criteria
- identification of personality features and defense mechanisms
- assessment of the internal psychological balance
- determination of combinations of symptoms and personality traits

The results are an important component of forming a holistic clinical picture and are considered during subsequent collegial analysis.

5.6 Laboratory and Somatic Investigations

Within the psychoergonomic diagnostic approach, when indicated, basic laboratory diagnostics are performed aimed at excluding or identifying somatic factors influencing mental state.

As a rule, the baseline laboratory block includes:

- complete blood count and biochemistry
- thyroid function parameters (T3, T4)
- vitamin B12 level
- folic acid level
- vitamin D level
- when indicated, inflammatory marker CRP

The scope may be expanded depending on the clinical picture and identified abnormalities.

5.7 Neurological and Specialized Diagnostics

When clinically indicated, the diagnostic process may include consultation with a neurologist and neuroimaging studies (CT or MRI) to exclude organic factors affecting mental state.

If ADHD is suspected, objective diagnostic methods are used (e.g., the MOXO test) to obtain additional data for differential evaluation.

If somatic or endocrine abnormalities are identified, relevant specialists are involved.

5.8 Diagnosis as a Reference Point, Not a Final Goal

In the psychoergonomic method, diagnosis is treated as a necessary but not exhaustive element of the clinical picture. It serves as a reference point for designing the therapeutic strategy, but does not replace understanding of the individual structure of the patient's condition.

Formulation of a diagnosis does not complete diagnostics but opens the next stage: development of a personalized therapeutic strategy. If needed, the diagnosis may be refined or revised during dynamic observation without interpreting this as a clinical error.

5.9 Individuality of the Clinical Case and the Principle of Diagnostic Sufficiency

The psychoergonomic method recognizes that each clinical case is unique and cannot be fully described by a pre-defined set of diagnostic procedures. The diagnostic architecture is adaptive and, if necessary, may be expanded until the clinical picture becomes sufficiently clear and well-grounded to move to the most effective therapeutic pathway.

Additional diagnostic stages are introduced not by formal principle, but by clinical rationale and the diagnostic questions that arise. The aim is not to maximize the volume of examinations, but to achieve sufficiency of information for precise and responsible clinical decisions.

Collegial clinical discussion plays a key role at this stage. The diagnostic process is considered complete not at the moment of formal diagnosis, but when the clinical team reaches a shared understanding of the structure of the patient's condition, its dynamics, risks, and functional prospects. Bringing different professional perspectives to a common clinical denominator makes it possible to minimize errors, reduce the likelihood of incorrect therapeutic decisions, and optimize development of the treatment strategy.

The psychoergonomic method proceeds from the principle that there are many incorrect paths in clinical practice, while the correct path is one. The diagnostic architecture is designed to identify that path with maximum accuracy and responsibility.

6. THERAPEUTIC STRATEGY AND IMPLEMENTATION OF THE PSYCHOERGONOMIC METHOD

Therapeutic strategy within the psychoergonomic method is the result of an integral diagnostic process and is formed on the basis of a collegially verified understanding of the patient's individual clinical configuration. Treatment is not regarded as standard protocol application, but is designed as a personalized system of interventions aimed at achieving an optimal clinical and functional outcome.

The psychoergonomic method proceeds from the principle that clinical practice offers many potential therapeutic paths; however, the path corresponding to the patient's individual structure is, as a rule, the only clinically and ethically justified one. The purpose of therapeutic strategy is to identify and implement precisely this path.

6.1 Designing Therapy on the Basis of Diagnostic Architecture

In the psychoergonomic method, therapy never begins before completion of the key diagnostic stages and formation of a collegial clinical understanding of the case. Diagnostic architecture serves as the foundation for designing therapy and determines:

- target levels of intervention
- priority clinical tasks
- permissible boundaries of therapy
- potential risks and limitations
- criteria of treatment effectiveness

Each therapeutic decision is correlated with diagnostic data and the overall clinical logic of the case. This avoids empirical trial-and-error selection of treatment and reduces the likelihood of therapeutic mistakes.

6.2 The Principle of Minimally Sufficient Intervention

One of the basic principles is minimally sufficient intervention. Therapy is designed so as to achieve clinical goals with the least necessary intensity of impact.

This means:

- preference for minimal effective dosages
- avoidance of excessive pharmacological burden
- refusal of unjustified polypharmacotherapy
- cautious and stepwise intensification when required

Minimally sufficient intervention is considered not as a restriction but as a way to preserve the patient's functional, cognitive, and personal resources.

6.3 Priority of Monotherapy and Rational Expansion of Treatment

Within the psychoergonomic method, priority is given to monotherapy as the most predictable and clinically manageable form of pharmacological treatment. Monotherapy makes it possible to:

- more precisely assess medication effectiveness
- timely identify side effects
- correctly track clinical dynamics
- reduce the risk of drug interactions

Transition to combination therapy is considered only with clear clinical grounds and after sufficient observation time. Treatment expansion is always deliberate and stepwise.

6.4 Dynamic Observation and Treatment Adjustment

The therapeutic process is dynamic. After treatment initiation, regular monitoring is conducted, including:

- evaluation of symptom dynamics
- monitoring of side effects
- analysis of functional level
- the patient's subjective assessment of their state

Adjustment of therapy is made on the basis of objective data, the patient's subjective experience, and collegial discussion. Changes in treatment are treated not as evidence of error but as a natural part of an adaptive clinical process.

6.5 Integration of Psychotherapeutic and Non-Pharmacological Methods

Pharmacological treatment is not an isolated intervention. It is integrated with psychotherapeutic and non-pharmacological methods depending on the structure of the condition and clinical tasks.

Selection of psychotherapeutic approaches is individualized and may include different modalities applied purposefully and in coordination with the overall therapeutic strategy. Non-pharmacological methods are considered an important resource for increasing stability and adaptation.

6.6 Collegiality in Implementing Therapeutic Strategy

Treatment implementation occurs within a collegial model. While responsibility for pharmacological decisions rests with the psychiatrist, the therapeutic process is continuously supported by interdisciplinary interaction.

Collegiality enables:

- timely identification of therapeutic risks
- correction of the treatment strategy
- incorporation of different professional perspectives
- maintenance of clinical accuracy and responsibility

6.7 Criteria of Treatment Effectiveness

Effectiveness is assessed comprehensively and includes:

- clinical symptom dynamics
- change in level of functioning
- the patient's subjective assessment
- stability of achieved changes

Absence of complete symptom reduction is not considered treatment failure if meaningful improvements in quality of life and adaptation are achieved.

6.8 Therapy as a Joint Process

Therapeutic strategy is implemented within a partnership model. The patient is informed about treatment logic, possible effects, and boundaries of intervention in a volume corresponding to the patient's condition and understanding.

Joint participation increases adherence, reduces the risk of premature discontinuation, and supports more stable clinical outcomes.

6.9 The Principle of Clinical Responsibility

The psychoergonomic method implies a high level of clinical responsibility for each therapeutic decision. This includes readiness to:

- revise strategy in the absence of effect
- refuse unjustified interventions
- take into account long-term consequences

In clinical practice there are many potential paths; however, the correct path is the one that corresponds to the patient's individual configuration and minimizes risks with maximum effectiveness.

7. MONITORING, OBSERVATION, AND CLINICAL SUPPORT PROTOCOLS WITHIN THE PSYCHOERGONOMIC METHOD

Within the psychoergonomic method, monitoring, observation, and support are regarded as a system-forming part of the clinical process. Therapy is not limited to the moment of diagnosis or prescription, but is implemented as a continuous, structured, and adaptive system of patient support over time.

The psychoergonomic method has been formed over more than twenty years: approximately ten years were devoted to its development and conceptualization, and more than ten years the method has been functioning as a clinically refined and reproducible system. During this period, a multi-level architecture of clinical monitoring protocols was developed, fundamentally different from the fragmented and episodic support typical of conventional psychiatric practice.

7.1 Clinical Protocols as the Basis of Support

Monitoring is implemented not as a single universal format, but through a system of specialized clinical protocols adapted to:

- the type of mental disorder
- the stage of the condition
- the leading therapeutic instrument (pharmacotherapy, psychotherapy, combined formats)
- the level of clinical stability
- the patient's social and family context

Each protocol is a clearly structured package of clinical observation with a defined frequency of contacts, forms of state assessment, and mechanisms of collegial oversight.

7.2 Intensive Monitoring Protocol for Endogenous Conditions

For endogenous mental disorders, including conditions where pharmacotherapy is the key component, an intensive clinical monitoring protocol is used, typically designed for 3–4 months.

This protocol includes:

- weekly clinical curator contact: a structured interaction aimed at collecting information about the patient's state, symptom dynamics, tolerability, and possible side effects
- preparation of a regular clinical report on the patient's condition, including evaluation of treatment effectiveness, functional changes, and risks
- mandatory documentation of all information in the clinical CRM system
- regular collegial discussions and case conferences with participation of relevant specialists responsible for the patient
- monthly in-person or online consultation with the treating psychiatrist aimed at assessing dynamics and adjusting therapy

Within this protocol, therapy is treated as a process of stepwise selection of optimal medications, dosages, and regimens to achieve maximum effectiveness and clinical stability.

7.3 Psychotherapy Support Protocols and the "4 + 1" Model

When working with personality disorders and conditions where psychotherapy is central (including schema therapy, DBT, and other modalities), specialized psychotherapeutic monitoring protocols are used.

One such protocol is the "4 + 1" model, which includes:

- four weekly psychotherapy sessions with the patient
- one monthly session with the patient's referent (parent, partner, or other significant person)

The aim is to prevent a situation in which psychotherapeutic work is undermined by return to a destructive or toxic system. Work with the referent enables:

- development of correct interaction patterns
- reduction of retraumatization
- strengthening stability of therapeutic changes
- significant increase of overall treatment effectiveness

7.4 Supportive and Long-Term Clinical Observation

For patients in stable remission on maintenance pharmacotherapy, a long-term monitoring protocol is applied.

This format includes:

- a monthly clinical report prepared by the clinical curator
- a quarterly (every three months) consultation with the treating psychiatrist
- continuous monitoring through the CRM system

This protocol maintains clinical stability without unnecessary intensity while preserving a high level of clinical safety.

7.5 Adaptivity and Escalation of Protocols

All psychoergonomic clinical protocols are adaptive. If changes occur—stressful events, interruption of treatment adherence, symptom exacerbation, or other clinically significant factors—the system presupposes:

- increased frequency of contacts
- transition to more intensive protocols
- unscheduled consultations
- collegial review of strategy

This allows flexible response to clinical dynamics and prevention of severe complications.

7.6 Online and Outpatient Support Formats

The psychoergonomic method is implemented both in outpatient and online formats using protected communication technologies and clinical digital protocols. Online formats of observation, consultations, and psychotherapy are treated as full instruments of modern clinical practice when safety, confidentiality, and professional standards are met.

7.7 The Role of the Clinical Curator, Administration, and CRM

The clinical curator is a central figure ensuring contact regularity, collection and documentation of clinical information, and adherence to observation protocols. The administrative team and CRM system provide clinically significant support by ensuring:

- control of timing and formats of contacts
- structuring of data
- organization of case conferences
- continuity of the clinical process

7.8 Collegiality and Stability of Clinical Decisions

All monitoring data are analyzed collegially. Bringing different professional positions to a common clinical denominator minimizes errors, improves decision accuracy, and implements the core principle of the psychoergonomic method: there are many incorrect paths, but the correct path is one.

8. ETHICS, CLINICAL RESPONSIBILITY, AND PROFESSIONAL STANDARDS OF THE PSYCHOERGONOMIC METHOD

The psychoergonomic method is based on the recognition of high clinical and ethical responsibility when working with mental conditions of varying severity. The method does not treat clinical effectiveness separately from ethical principles. On the contrary, it proceeds from the position that sustainable therapeutic outcomes are possible only when professional standards are observed, the patient's personhood is respected, and boundaries of intervention are clearly understood.

The ethical stance of the psychoergonomic method is formed at the intersection of medical, psychological, and humanistic principles and is aimed at protecting the patient, the specialists, and the clinical system from arbitrary, excessive, or unsafe decisions.

8.1 The Principle of Clinical Responsibility

Clinical responsibility means individual and collegial responsibility for each diagnostic and therapeutic decision. Specialists make decisions not only based on formal indications, but also considering short- and long-term consequences for the patient's mental, functional, and personal state.

The method presupposes readiness to:

- revise clinical hypotheses
- adjust therapeutic strategy
- refuse interventions that do not provide expected benefit
- recognize treatment limitations

Clinical responsibility is understood not as a formal requirement, but as the foundation of professional position.

8.2 Ethical Boundaries of Therapeutic Intervention

The method proceeds from recognition that not every mental condition requires maximal symptom correction. The ethical boundary of intervention is defined by the balance between reducing suffering, maintaining functionality, and respecting the patient's individual personality structure.

The method excludes:

- aggressive and disproportionate interventions
- therapy aimed at "normalizing" the personality
- interventions that ignore the patient's subjective position
- use of treatment as a tool of pressure or control

If the patient is not dangerous to self or others, and their state is subjectively acceptable and functionally stable, such a state is not treated as a mandatory target for correction.

8.3 Informed Participation and the Partnership Model

The partnership model is an ethical foundation of the method. The patient is regarded as a subject of the clinical process and has the right to informed participation in decisions in a volume corresponding to their condition and ability to consciously perceive information.

The patient is provided information about:

- the clinical logic of treatment
- expected effects and risks
- alternative therapeutic options
- boundaries and goals of intervention

Informed participation does not eliminate clinical responsibility and is not applied in situations associated with risk or loss of insight. In all other cases it is a mandatory element.

8.4 Work with Risks and Crisis States

The method includes clearly defined ethical and clinical protocols for risk situations, including conditions associated with crisis-level destabilization and pronounced loss of self-regulation.

In such situations priority is given to:

- safety of the patient and others
- clinical and medical standards
- timely decision-making
- activation of intensive observation and intervention formats

The partnership model may be temporarily limited by clinical necessity, but is restored as stabilization occurs.

8.5 Professional Roles and Competence Boundaries

The method presupposes clear differentiation of roles and zones of responsibility. Each specialist acts strictly within their competence and professional training.

In particular:

- pharmacological decisions are made exclusively by a psychiatrist
- psychotherapeutic interventions are carried out by relevant specialists
- the clinical curator and administrative team do not make clinical decisions
- collegiality does not substitute personal responsibility

This distribution is an important component of clinical safety.

8.6 Confidentiality and Information Protection

Work within the method is conducted with confidentiality and personal data protection. Use of digital systems, CRM, and online formats presupposes protected protocols of data storage and transfer.

Access to clinical data is limited to specialists directly involved in the patient's care and is used exclusively for professional purposes.

8.7 Method Limitations and Refusal of Universalization

The method does not claim universality and is not treated as a replacement for all modern psychiatry or psychotherapy. It recognizes its limitations and proceeds from the need for individualized selection of clinical tools.

When a patient's state requires care formats beyond the method's scope, alternative or additional help is recommended.

8.8 Ethics as the Basis of Method Sustainability

Ethical principles, clinical responsibility, and professional standards form the foundation of sustainability. These elements allow the method to maintain clinical accuracy, adaptivity, and patient trust in conditions of high complexity.

8.9 International Multidisciplinary Team and Specialist Certification

The method is implemented by a multidisciplinary team geographically distributed across different countries. The method was originally developed with consideration of international clinical work and remote interaction, ensuring continuity, quality, and clinical accuracy regardless of the physical location of specialist or patient.

All specialists participating have relevant education, confirmed qualification, and clinical experience corresponding to their role. Regardless of country, each specialist acts strictly within professional competence and in accordance with local and international professional standards.

A separate mandatory condition of participation is special training and certification within the method. Specialists undergo training in principles of the psychoergonomic approach, diagnostic architecture, therapeutic logic, ethical framework, and the monitoring system. Only specialists who have completed this preparation and confirmed mastery of methodology are admitted to work within the method.

Certification means not only formal familiarity with protocols, but also the ability to integrate one's professional expertise into the unified clinical system, work collegially, and follow unified standards of documentation, monitoring, and clinical responsibility.

Thus, the method is not a set of disconnected specialists, but a unified international clinical system, united by common methodology, professional standards, and ethical principles ensuring reproducibility, sustainability, and clinical reliability in an international context.

9. TRAINING, EDUCATION, AND CERTIFICATION WITHIN THE PSYCHOERGONOMIC METHOD

The psychoergonomic method is regarded not only as a clinical approach, but as a structured system of professional knowledge, skills, and clinical thinking requiring targeted learning and standardized specialist preparation. Reproducibility is impossible without a formalized system of training, certification, and subsequent professional support.

The method proceeds from the principle that clinical competence within the psychoergonomic approach is not an automatic consequence of basic professional education, but is formed through specialized preparation, practical integration, and work within a collegial clinical system.

9.1 Principles of Training in the Psychoergonomic Method

Training is based on the combination of theoretical, clinical, and practice-oriented preparation. The core objective is formation of systemic clinical thinking corresponding to psychoergonomic methodology.

Training principles include:

- understanding philosophical and methodological foundations
- mastering diagnostic architecture
- integrating therapeutic logic
- understanding collegiality and clinical responsibility
- assimilation of ethical boundaries and professional standards

Training is aimed not at mechanical memorization of protocols, but at formation of ability to apply the method consciously and flexibly in real practice.

Training formats

Training may be conducted online, offline, or in hybrid formats. Format choice does not influence requirements for quality, depth, and volume of preparation. Regardless of format, training presupposes mandatory mastering of methodology, clinical logic, and ethical standards.

10. CLINICAL OUTCOMES, EVIDENCE-BASED LOGIC, AND PROSPECTS FOR DEVELOPMENT OF THE PSYCHOERGONOMIC METHOD

The psychoergonomic method was formed and developed through long-term clinical practice and relies primarily on systematized empirical experience of many years of work with patients with different mental conditions. The method is not positioned as experimental or theoretically isolated. It represents a clinically validated model that has undergone prolonged testing in real psychiatric and psychotherapeutic practice.

Evaluation of effectiveness is based on analysis of clinical dynamics, stability of achieved changes, level of functional adaptation, and quality of long-term support, rather than on declarative statements or isolated symptom indicators.

10.1 Principles of Assessing Clinical Outcomes

Outcomes are assessed comprehensively and multi-level. Effectiveness is not reduced to individual symptoms or scale scores but considered within the patient's overall clinical trajectory.

Key parameters include:

- dynamics of psychopathological symptoms
- changes in psychosocial and professional functioning
- stability of clinical condition over time
- frequency and severity of destabilizations
- patient's subjective assessment of quality of life

This approach accounts for individual differences, complex clinical presentations, and comorbidity without reducing the process to simplified metrics.

10.2 Evidence-Based Logic and Clinical Verification

The method relies on the principle of clinical verification. Evidence-based logic is formed through:

- systematic clinical observation
- long-term dynamic patient follow-up
- collegial analysis of cases
- comparison of therapeutic strategies and outcomes
- reproducibility of clinical decisions in similar cases

The method does not oppose evidence-based medicine, but recognizes limitations of classical randomized models in evaluating individualized, multi-stage, long-term therapeutic processes. In this context, special importance is given to quality of clinical reasoning, structured diagnostics, and longitudinal control of therapeutic decisions.

10.3 Clinical Observations and Sustainable Effects

During long-term use, sustainable clinical effects have been observed in work with different groups, including endogenous disorders, personality disorders, affective and anxiety conditions, and complex comorbid cases.

Among the most reproducible observed effects are:

- increased accuracy of medication selection
- reduced frequency of unjustified polypharmacotherapy
- improved treatment tolerability
- increased adherence
- reduced frequency of acute destabilizations during long-term observation

These results are treated as the consequence of diagnostic architecture, collegial decision-making, and structured monitoring, rather than isolated therapeutic techniques.

10.4 Limitations and a Critical Approach

The method recognizes its limitations and the need for critical evaluation of outcomes. It does not claim universality and does not exclude variability of clinical results determined by biological, psychological, social, and cultural factors.

Absence of expected effect or need to revise strategy is treated as part of clinical reality and a basis for further analysis, not as formal non-compliance of methodology.

10.5 Prospects of Development and Scientific Systematization

Further development is associated with gradual systematization of clinical data and expansion of evidence base without loss of individualized approach.

Prospective directions include:

- formalization of protocols for observational studies
- participation in multicenter clinical projects
- development of international educational and certification environment
- integration of digital monitoring tools
- adaptation to different medical and cultural systems

10.6 The Method as a Clinically Responsible Evolving System

The psychoergonomic method is treated not as a static model, but as an evolving clinical system capable of self-reflection, adaptation, and integration of new data while maintaining methodological integrity.

The combination of clinical caution, evidence-based logic, and ethical responsibility allows the method to be treated as a sustainable and promising approach in modern psychiatric and psychotherapeutic practice.

11. LIMITATIONS OF THE PSYCHOERGONOMIC METHOD, AREAS OF APPLICABILITY, AND CRITERIA FOR REFUSAL OF USE

The psychoergonomic method was developed as a clinically responsible, systemic, and individualized approach to diagnostics, treatment, and long-term follow-up of mental conditions. At the same time, it is not positioned as a universal solution for all clinical situations and recognizes the need to clearly define its boundaries of applicability.

Formulating limitations is treated not as weakness, but as a necessary condition for clinical safety, professional honesty, and sustainability in real practice.

11.1 Areas of Clinical Applicability

The method is applicable across a wide range of mental conditions, including but not limited to:

- endogenous mental disorders in an outpatient format
- affective and anxiety disorders
- personality disorders
- comorbid clinical conditions
- conditions requiring long-term structured observation

The method is particularly effective where complex diagnostics, personalized strategy, collegial decision-making, and longitudinal monitoring are needed.

11.2 Conditions Requiring Special Caution

There are clinical situations where use requires increased caution, additional assessment, or temporary constraints:

- acute psychotic states with pronounced disorganization
- states with high risk
- severe manic episodes

- pronounced cognitive impairment
- states with loss of insight and inability to cooperate

In such cases, the method may be applied only in combination with intensive medical intervention or after stabilization.

11.3 Criteria for Refusal of Use

The method provides clear criteria for refusal or temporary discontinuation in the interests of clinical safety:

- need for emergency hospitalization
- inability to ensure minimal clinical safety conditions
- lack of capacity for regular monitoring
- patient refusal of any interaction in the presence of risk
- situations beyond outpatient or remote practice

In these cases, priority is given to medical and legal standards of emergency care.

11.4 Voluntary Participation and Responsibility Boundaries

Use is based on voluntary patient participation, except where clinical condition requires other forms of intervention in accordance with law and medical standards.

The method clearly separates responsibility areas and does not allow substitution of clinical decisions by administrative, educational, or methodological considerations.

11.5 Refusal of Universalization and Therapeutic Pressure

The method refuses universalization and the presentation of itself as the “optimal” or “only correct” approach. It is not used as an instrument of pressure, imposition of treatment, or personality correction according to external expectations.

If the patient’s goals do not align with the method’s possibilities or logic, this is treated as acceptable and ethically correct.

11.6 Clinical Honesty as an Element of the Method

Awareness and articulation of limitations is part of clinical honesty. The method presupposes readiness to:

- recommend alternative forms of help
- temporarily suspend work
- revise interaction format
- acknowledge inability to achieve goals under current conditions

This approach protects patients, specialists, and the system from unjustified expectations and risks.

11.7 Limitations as a Sustainability Factor

Limitations are treated not as an obstacle, but as a factor of sustainability and professional maturity. Clear understanding of applicability boundaries allows preservation of clinical accuracy, ethical correctness, and patient trust in the long term.

12. CONCLUSION

The psychoergonomic method represents a systemic, clinically validated, and ethically grounded approach to diagnostics, therapy, and long-term support of patients in different mental conditions. The method was formed at the intersection of long-term clinical practice, interdisciplinary interaction, and consistent development of professional clinical thinking.

At its core is recognition of the individuality of each person's mental structure, the impossibility of universal solutions, and the necessity to precisely correlate therapeutic interventions with the patient's clinical, functional, and personal characteristics. The method proceeds from the premise that identical diagnoses do not presuppose identical treatment and that clinical work requires flexibility, responsibility, and time.

A key principle is refusal to treat the patient as an object of treatment or a carrier of symptoms. The patient is regarded as an active participant in the clinical process and a partner in diagnostics, therapy, and observation, provided insight and clinical safety are preserved. The human being, not an abstract "condition," is at the center of clinical attention.

Key elements include comprehensive diagnostics, collegial decision-making, the principle of minimally sufficient intervention, structured monitoring, and respect for the patient's subjective position. These components form a unified clinical system in which diagnostics, therapy, monitoring, and ethics are not separate, but mutually reinforce one another.

The psychoergonomic method does not oppose modern psychiatry or psychotherapy and does not claim universality. On the contrary, it recognizes its limitations, relies on existing clinical standards, and aims to integrate into the professional field as a responsible, reproducible, and evolving approach.

An important feature is the formalized educational and certification system ensuring reproducibility of clinical logic, unified professional standards, and sustainability in an international context. The method is implemented by a multidisciplinary team of certified specialists sharing common methodological and ethical principles.

The method is regarded as a living clinical system open to further development, scientific dialogue, and integration of new data. Its evolution presupposes preservation of foundational principles while adapting to changes in clinical practice, technologies, and professional standards.

Thus, the psychoergonomic method may be treated as an independent clinical model aimed at long-term effectiveness, clinical accuracy, and respect for the mental reality of the person. Its purpose is not reduction of personality to diagnosis or condition, but responsible support of the patient on the path to the maximum possible stabilization, adaptation, and quality of life within their individual capacities.

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