Precision without participation: why precision psychiatry needs Collaborative/Therapeutic Assessment

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Summary Contemporary psychiatry often assumes that more precise diagnosis will yield more effective care. Biomarkers, digital phenotyping, artificial intelligence and related tools promise better diagnosis, treatment selection and outcomes. Yet this expectation is clinically incomplete: objectively valid information may not improve treatment when patients experience it as impersonal, imposed or disconnected from their concerns. Collaborative/Therapeutic Assessment (C/TA) complements precision psychiatry by engaging patients as partners in meaning-making rather than passive recipients of expert conclusions. It can transform technically precise findings into personally useful knowledge, making diagnosis more likely to foster engagement and meaningful change instead of merely producing refined classification.

Keywords Precision medicine; mental health services; diagnosis and classification; collaborative assessment; Therapeutic Assessment.

Precision psychiatry combines symptom-based assessment with biological, behavioural, environmental and other quantitative data to refine diagnosis and identify more homogeneous patient profiles. Predictive models estimate illness course, relapse risk and the likelihood of treatment response or adverse effects, with the aim of selecting interventions better suited to individual patients. Although most models still require prospective and external clinical validation,[1] the field is largely driven by the belief that increasingly precise diagnosis will improve mental healthcare.[2] If psychopathology can be measured with greater biological, behavioural and computational precision, diagnosis should become more accurate, treatment more personalised and outcomes more favourable. This expectation underpins current enthusiasm for biomarkers, digital phenotyping, artificial intelligence and increasingly fine-grained characterisation of mental disorders.[3,4]

There are good reasons for this optimism. Psychiatry has long struggled with diagnostic heterogeneity and variable treatment response. Precision approaches promise to identify clinically meaningful subgroups, improve prediction and tailor interventions more closely to individual patients. The scientific ambition is both understandable and important: to make psychiatry less approximate and more exact.[5]

The prevailing assumption is that better measurements are useful, but that once accurate information has been generated, clinical benefit will naturally follow. The tacit expectation is that a technically refined account of the patient will lead to a therapeutically effective one. This is the point at which conventional wisdom becomes questionable.

The neglected problem: precision is not the same as usefulness

The weak point in the prevailing model is its failure to distinguish between technical precision and therapeutic utility.[6] A diagnosis can be accurate in the narrow sense that it identifies relevant traits, risks or mechanisms. But unless that information changes what the patient can understand, feel or do, its practical value may be surprisingly limited.[7] This problem is not new. Traditional psychological and psychiatric assessments have often followed a predominantly clinician-led, information-gathering model. The patient provides data, the clinician interprets them and conclusions are delivered in a report. Even when performed conscientiously, the patient's role in this process is usually secondary. They are the source of information, not a co-author of its meaning or implications. Reports and diagnoses may

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therefore be experienced as technically competent yet emotionally remote: correct but not illuminating, accurate yet unusable, even alienating or stigmatising.[7,8] Treatment plans are not followed, and patients may become ambivalent, mistrustful, ashamed or less able to use recommendations.

In the era of precision psychiatry, this problem may intensify rather than diminish. The more complex and abstract our methods become, the more likely it is that findings will drift away from the patient's experience. A biomarker panel, algorithmic classifier or digital trace pattern may be compelling to professionals and still leave patients feeling objectified, overruled or alienated.

The field often assumes that objective data speak for themselves. They do not. They require interpretation. More importantly, they require a relational context in which the patient can test whether the proposed account feels true, relevant and safe enough to be taken in. These are not trivial obstacles that can be solved downstream once the science is perfected. They are core determinants of whether psychiatric knowledge has any real-world effect. A recommendation that is not trusted, a formulation that feels alien or a diagnosis that deepens shame rather than understanding may be accurate on paper yet useless in practice. In some cases, it may even worsen the therapeutic situation.[8] We see a threat in straightforward belief in data and prediction, although not one inherent in the aims of precision psychiatry. Moreover, in a context of increasing workloads, reduced clinical time, limited care resources and shortages of adequately trained specialists in many countries, professional judgement risks being relegated to a secondary role and ultimately being perceived as a liability rather than an essential component of clinical practice. Although treatment non-adherence is multidetermined, key contributing factors include the quality of the patient–clinician relationship, insufficient information, limited involvement in decision-making and inadequate discussion of patients' concerns, particularly when prescriptions are perceived as externally imposed or threatening to autonomy; conversely, the way clinicians explain, negotiate and personalise treatment may help counter these barriers by strengthening patients' trust, perceived treatment necessity and sense of autonomy.[9,10]

Psychiatry must ask not only how diagnosis can become more precise, but also how its findings become clinically usable and meaningful for the patient. This question has received far less attention. Once it is considered, patient perspectives, case formulation and their alignment become central rather than peripheral. Precision psychiatry should therefore incorporate approaches that help patients understand their condition, resolve disagreements and tailor treatment to their own circumstances.[11,12]

Collaborative/Therapeutic Assessment as an essential partner for precision psychiatry

Collaborative/Therapeutic Assessment (C/TA) is an assessment paradigm that actively involves patients in addressing referral questions – including diagnostic clarification, treatment planning and patients' own concerns – and thereby addresses limitations inherent in conventional psychological assessment. Our aim is not to introduce C/TA as a new model of assessment, but to show why its principles are increasingly necessary as psychiatric information becomes more technical, algorithmic and distant from patients' lived experience.

Within the C/TA model, levels of patient involvement range from collaborative feedback, in which assessment findings are treated as hypotheses to be explored jointly,[13] to approaches that incorporate patients' perspectives throughout the assessment process, from defining its goals to evaluating its usefulness. In its more structured form, Therapeutic Assessment[7] follows a manualised intervention model,[14] in which potentially threatening information is organised into three levels according to its consistency with patients' existing views and then discussed collaboratively and deliberately. Psychological tests are used to create 'bottom-up' learning experiences that help patients develop and integrate new understandings of themselves. Systematic and meta-analytic reviews support each of these C/TA approaches.[15–17] Overall, the strongest evidence concerns proximal outcomes, including therapeutic alliance, treatment readiness, engagement and self-understanding. Effects on symptom reduction are smaller, and evidence regarding longer-term psychiatric and functional outcomes remains comparatively limited.

Integrating C/TA into precision psychiatry is more consequential than it may first appear. Once the patient becomes an active participant in the interpretive process, objective findings no longer remain disembodied facts. They are examined against the patient's actual life, relationships, symptoms and history. What fits can be elaborated. What does not fit can be reconsidered. Moreover, collaboration does not simply improve acceptance of diagnostic conclusions. By fostering trust and encouraging fuller disclosure, it may also yield clinically important information that might otherwise remain unavailable, thereby improving the quality of diagnostic formulation itself. The result is not a dilution of scientific rigour, but a transformation of how rigour becomes useful.

A case illustration: Therapeutic Assessment and diagnostic engagement

The implications of this collaborative approach are illustrated by the following clinical example, in which diagnostic precision alone proved insufficient to achieve engagement, whereas collaborative assessment transformed both the patient's understanding of the diagnosis and their willingness to participate in treatment. Taknint et al reported on the Therapeutic Assessment of a man diagnosed with a psychotic spectrum disorder after a rigorous psychiatric assessment.[18] The patient did not accept the diagnosis and was reluctant to engage in treatment or disclose personal information to treatment staff. He was also extremely distrustful of the psychiatric team because of previous negative experiences during an in-patient hospital stay. The assessor took the patient's doubts seriously and agreed to focus on his questions, including: 'Do I really have schizophrenia?', 'How can I be sure what I have experienced is psychosis?' and 'Are my symptoms more similar to bipolar disorder than a psychotic disorder?' During the assessment, the patient became an active co-investigator while relevant psychological tests were administered. As findings emerged, he was encouraged to question them, express disagreements and consider alternative interpretations. Through this collaborative process, the patient came to understand and ultimately accept the

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diagnosis. Increased trust in the assessor also led the patient to disclose important information that had not emerged during the previous psychiatric evaluation. These additional developmental data strengthened the diagnostic formulation and informed revised treatment recommendations. By the conclusion of the assessment, the patient accepted that he had a psychotic spectrum disorder and was willing to engage in appropriate treatment.

Realising potential

Psychiatry does not need to choose between scientific refinement and human understanding. Rather, it must reject the assumption that the former automatically produces the latter. Objective findings become clinically powerful only when they are integrated into a process that patients can experience as meaningful, trustworthy and relevant to their own lives. That process requires dialogue, shared interpretation and respect for the patient's perspective as more than a source of clinical data.

C/TA's involvement of patients as collaborators is not unique in mental healthcare. It is consistent with broader developments such as shared decision-making,[19] the World Health Organization (WHO) QualityRights initiative's call for collaborative and rights-based services[20] and the WPA–*Lancet Psychiatry* Commission's emphasis on the therapeutic alliance as a central component of psychiatric practice.[21] Although C/TA commonly employs standardised psychological tests, its broader principle of collaborative interpretation extends well beyond psychological assessment and is applicable whenever diagnostic findings are discussed with patients.

Precision psychiatry has enormous potential to improve mental healthcare. Realising that potential, however, requires more than increasingly sophisticated methods of measurement. It also requires equally sophisticated methods for helping patients understand, evaluate and use what those measurements reveal. C/TA offers one well-developed approach to meeting that challenge by treating diagnostic findings not as the end-point of expert authority but as the beginning of a collaborative process of meaning-making. By firmly grounding diagnosis, treatment planning and intervention in an intersubjective framework,[22] C/TA helps transform technical accuracy into knowledge that patients can recognise, trust and use.

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Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

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F.A., Q.S. and S.E.F. contributed equally to all the aspects of this submission (conceptualisation, writing and supervision).

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