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Theoretical Inputs on Clinical Psychology

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A B S T R A C T

The current model of practicing clinical psychology seems to be less and less suited to the environment and world standards. This paper tries to reflect on to what and where does clinical psychology fit today, after occurring a pandemic worldwide, going throughout a theoretical review on the main dimensions like clinical observation, multidisciplinary teams, therapeutic relationship and change and some challenges of clinical psychology. Covid-19 Pandemic consequences are emerging in different areas in particular in the mental health field where communication between clients and therapists are changing, new technologies are producing mental health contents, and the main question remains to be seen in the future: can technology, artificial intelligence replace a human therapist? This paper reflects on the main scopes of clinical psychology as one of the first subdiscipline emerging from the main field of Psychology. I do hope interpersonal connection, eye to eye, verbal and nonverbal actions are still in the frontline, considered crucial in understanding human being psychological suffering. Quality of Human Interconnections (QHI): that is how we grow and develop as humans. That is to say that what matters most is the quality of the relationships we develop and maintain throughout our life's. Technology can definitely help towards that goal but can never replace it.

R E S U M O

O modelo atual de prática da psicologia clínica parece ser cada vez menos adequado ao ambiente e aos padrões mundiais. Este artigo tenta refletir sobre o que e onde a psicologia clínica se encaixa hoje, após ocorrer uma pandemia em todo o mundo, passando por uma revisão teórica sobre as principais dimensões como observação clínica, equipes multidisciplinares, relacionamento terapêutico e mudança e alguns desafios da psicologia clínica. As consequências da pandemia da Covid-19 estão surgindo em diferentes áreas, em particular no campo da saúde mental, onde a comunicação entre clientes e terapeutas está mudando, novas tecnologias estão produzindo conteúdos de saúde mental e a principal questão permanece a ser vista no futuro: a tecnologia e a inteligência artificial podem substituir um terapeuta humano? Este artigo reflete sobre os principais escopos da psicologia clínica como uma das primeiras subdisciplinas emergentes do campo principal da psicologia. Espero que a conexão interpessoal, olho no olho, ações verbais e não verbais ainda estejam na linha de frente, consideradas cruciais para entender o sofrimento psicológico do ser humano. Qualidade das Interconexões Humanas (QHI): é assim que crescemos e nos desenvolvemos como humanos. Ou seja, o que mais importa é a qualidade dos relacionamentos que desenvolvemos e mantemos ao longo de nossas vidas. A tecnologia pode definitivamente ajudar a atingir esse objetivo, mas nunca poderá substituí-lo.

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Introdution

What is *Clinical observation* of human behavior in Psychology?

Observation - is a tool that the clinical psychologist develops throughout his/her formation and throughout his/her experience to help them form a comprehensive diagnostic which, thanks to the observation of behavior directly now of its occurrence, enables inference about the mental states of the patient, using a structured framework theory. The observation is formalized and divided into phases of data recording and interpretation. The data recording process depends on the type of observation (in natural or structured conditions) and who carries it out. Participant observation is carried out by a person from the environment, while non-participant observation is carried out by a trained supervisor. Usually, it is impossible to obtain an overall record of the behavior, so the researcher determines the observation periods. These can be constant or random periods, as well as samples of events or situational ones. Observation is most often used in facilities where the patient stays for a long time. Observation is one of the most basic and most frequently used methods in clinical psychological diagnosis. As it is present at every step, throughout the contact between the psychologist and the examined person should we ask ourselves the following question:

What is the difference between perception by a person from the street and perception by a psychologist?

Observation as a specific diagnostic technique has a specific goal, relates to a specific problem, and is based on a psychological theory. What distinguishes professional psychological observation from non-professional observation is the scientific knowledge and the principles and instruments used to record data (Stephens, 1970).

In the method of registration observation four groups of indicators are taken into consideration: i) constitutional indicators, ii) physiological indicators, iii) behavioral indicators and iv) objective indicators. Constitutional indicators are body structure, visible disproportions and various forms of disability.

Physiological indicators are externally observable and correlates with symptoms of emotional states. Behavioral indicators are external expression in the form of mimic behaviors directly linked to chemical observable characteristics of the communication process, like behavior actions characteristic of movements.

Objective indicators include objects belonging to a person, for example their self-presentation, use of make-up, their outfit, and so on. Even the entrance into a room can be a source of important and diagnostic information. On the other hand, the person may be lacking conscious reflection regarding the first impression and may entail into errors of interpretation resulting from unconscious attitudes. To further increase the usefulness and the accuracy and reliability of this method, research studies require the development of more updated observational systems that need to be framed into objectified sheets and observation measured

scales. The main goal is to develop observational skills and behavioral clinical reasoning on students in training.

Clinical psychologists in Multidisciplinary Teams (MDT)

Nowadays we seem to understand stronger than ever that a holistic perspective on patient's health is necessary. Every case is unique and complex, and it takes a lot of knowledge but also integration of this knowledge in order to truly help heal people suffering. As an answer for that need, Multidisciplinary Teams (MDT) increased over the last 20 years. Multidisciplinary teams are built up from a variety of professionals. Each one of them treats the patient's issue, focusing on the specific aspect of the issue in which they are specialized. A multidisciplinary team approach brings all members to work together to achieve the same goal.

Looking into more classical literature we can find that MDT in mental healthcare was strongly recommended in the professional literature and policy documents were elaborated since 1994 (Galvin & McCarthy). The academic literature in the topic of MDT in mental health highly recommends a bio-psycho-social model of mental health- person-centered services which are adapted to the needs of individuals, and which are performed by a range of skilled professionals delivering integrated care plans. In the group of various specialists, we also find the psychologist. The role of clinical psychologists in these circumstances usually is to perform in-depth assessments of aspects of brain functioning and behavior. Psychologists are also performing the assessment of psychological functioning (i.e., personality or intellectual functioning). Psychological ways of critical thinking can be very valuable in teams. Psychologists can provide a different perspective and identify aspects of patient care that medical professionals may not notice. They can offer alternative hypotheses which can enlighten and guide the care planning intervention. This is very important in this holistic perspective. In the paper: *The role of psychology in a multi-disciplinary psychiatric inpatient setting: Perspective from the multidisciplinary team* from 2019 (Wood, Williams, Billings & Johnson, 2019) we can read that psychologists are a valued member of the multi-disciplinary team but psychologists need to ensure that they are fully integrated into their teams, are visible and accessible, regularly promote their skills, educate team members on the role of psychology, and improve dialogue with the team. Indeed, Psychology is seen by MDT members as an integral piece, but not yet seen in first line treatment option in the psychiatric inpatient setting. In this paper, the authors state that both direct and indirect work was valued by multi-disciplinary staff participants, but the multidisciplinary team does not have a clear understanding of the role of psychology and both education and dialogue about this role is required.

Psychologists deliver psychological intervention based on scientific evidenced to patients in individual or in groups. They support and promote the development of patient's

insight and understanding in the context of their symptoms. The patient is also educated about the development of health coping strategies.

Another important role of the psychologist is supporting the staff team. MDT strength is made on the diversity of membership and their interaction, which is making MTD able to achieve their full potential. This is crucial and beneficial to patients. In
Belgium, for example, the Multidisciplinary approach (in case of oncology) is mandatory and regulated by law. The basis is the evidence-based aim collaborative and multidisciplinary decision-making for cancer treatment and patient management. In the *Cancer Plan from 2008*, (Horlait, Dhaene, Van Belle, & Leys, 2019) they included a specific group of clinical psychologists specialized in the field of oncology (psych oncologists). MDT are the best-known practice so far in the management and decision-making for cancer patients. Multidisciplinary Team Members are surgeons, medical oncologists, organ specialists, radiologists, pathologists, oncology specialist nurses and psychologists. Psychologists focus on psychosocial aspects in treatment decisions which are a very important part of the whole treatment. Unfortunately, the authors also point out that worryingly, there is low awareness of the true character of multidisciplinary, among medical disciplines in oncology care. The working culture still needs a change in the way of thinking towards a truly integrated care approach. There is a need for more empirical evidence to integrate how to build a composition of a team, how to understand a hospital culture but also there is a need to understand how organizational and environmental factors affects MDT performance.

Psychologists need to break barriers and overload themselves with demands as the teams hardly recognize their functions and their importance, such as:

- they fight for the principle of integrality with the team.
- for empathic understanding.
- for unconditional positive acceptance and trust with patients, family members and professionals for a good functioning of the team.

They surely need to take care of themselves (mentally and physically) to exercise their functions. A good training in Psychology and post-graduation in a hospital or Health Center preceds competent performance in the team (Wood, Williams, Billings, & Johnson, 2018).

The role of psychologist in the psychiatric inpatient setting is valued by the multidisciplinary team, even though Psychology is not viewed as a first-line treatment option on the psychiatric inpatient setting but as an “add-on” to medical treatment. Nevertheless, clinical psychology support is a valued source for skilling-up and offering insightful space to the multi-disciplinary team. In 2009, some authors already recommended that actions within patient care should involve psychiatry, nursing, occupational therapy, and psychology (Whittington, Bowers, Nolan, Simpson, & Neil, 2009).

Bateman (2018) in his article *psychologists in diabetes care* focus on how psychologists can work with other practices to be fully beneficial to the patient who is facing the specific

challenges in the context of diabetes. He outlines the role of the psychologist, which is supporting the development of a helpful thinking style and coping strategies to deal with health, understanding the role of the patients' early experiences may have in impacting their health in later adulthood, increase confidence and develop skills in their ability to manage their diabetes. He also reinforces psychologists as a part of the MDT support patient in his process of accepting the diagnosis, and to integrate it into their identity and life. This article also highlights the important role of the clinical psychologist towards other members of MDT. It points out actions such us: training colleagues on topics such as communication skills, using motivational interviewing skills within time-limited consultations, guided self-help and psychoeducation, individual therapy, usually offering short-term evidence-based therapies such as Cognitive Behavioral Therapy (CBT) and Cognitive Analytic Therapy (CAT).

Bateman (2018) focuses on how psychologists are perceived by other MDT members. In his study, psychologists were seen as peripheral because they were, comparatively with other professions, in smaller numbers. Psychologists have historically been associated with the greatest ambivalence about teamwork. The author claims however, that this picture has changed over the last decade, and there is a clear tendency in the group of researchers and stakeholders to integrate psychologists into the daily life of teams. He argues that psychologists should care for their identity, but also be flexible between separation and integration. Separation can give, for example, more independent viewpoints, while still getting different perspective from other members. Integration allows them to have more opportunities to influence within the team and also a greater understanding of the nature of the work from other professionals. An important aspect of the work of a psychologist in the public state health service in Europe is that a psychologist is part of a larger team consisting of doctors, nurses and support staff.

Organizations have a hierarchical structure in order to function well, but in practice it generates a lot of problems. One of them is that a psychologist is rarely the head of the clinic or head of the health department. As a rule, it plays a subordinate role towards doctors who work in management positions. That is to say that, in a direct and indirect way, his superiors are people whose level of specific knowledge and scope of work are different from a psychologist's work. Summing up, the situation of a psychologist in these realities is complex and is often exposed to various difficult situations and can become entangled in conflict between different types of duties.

To enhance this problem, we might think about designing regulations and guidelines regarding psychologist's work standards as extremely important and needed for practitioners. Let's debate on the article *Multidisciplinary team meetings in cancer care: is there a psychologist in the house?* (Horlait, Dhaene, Van Belle, Leys, 2019; Leal & Soares, 2024). The authors argue that for psychologists to report to another MDT member, for example, a psychiatrist, that would suggest a subordinate relationship which is not only inappropriate but

also damaging to both parties, because it has the potential to engender a false sense of inferiority or superiority. The ideal, is to work in partnership in a co-constructive way, starting from different points of view, but not necessarily superior or inferior, but complementary.

The contexts where clinical psychologists work

There has been a noticeable increase about the clinical psychology work field from many related sciences (Butcher, 2006). Psychologists as other health care professionals are educated in the paradigm of the biopsychosocial model, which corresponds to the biomedical model, but allows for a broader and more holistic view of the individual and his difficulties in the context of his mental processes and the social environment in which they live (Bray, 2010; Leal, Vieira & Soares, 2024).

Albee in 1970, argued that clinical psychology entered a paradox of its own development in which the problem of identifying and applying its methods was both threatened with extinction and also the possibilities of growth seemed endless. Throughout the development of clinical psychology as a profession and as a scientific field, the biomedical model has become more and more present (Albee, 1970). The current model of practicing clinical psychology seems to be less and less suited to the environment and world standards (Bray, 2010). Where does clinical psychology fit today, after occurring a pandemic worldwide? Saultz et al, (2005) already argued then, that clinical psychology could find its main application in primary care, outpatient, and community psychiatric care, and in public health and mental health intervention platforms.

The next level was hospital care (psychiatric, neurological and somatic) and specialist care, such as psychotherapy or detailed psychological diagnostics. The psychologist skills included the assessment of the patient's functioning, mood, motivation, expectations, personality, intellect, and the severity of disease symptoms, and also, the ability to deal with stress, social competences and temperament (Townsend, et al 2006). Clinical psychologists, in the course of their own education and specialization path, receive preparation in the field of clinical evaluation, diagnosis of dysfunctionality and mental health, as well as the basics of psychological help and psychotherapy (Geczy, Sultenfuss, Donat, 1990).

Clinical psychology was one of the first to emerge from the womb of psychology as an independent sub-discipline. And for a long time, after World War II, its main task and ambition was psychological testing (Schafer, 1948). Currently, clinical psychologists around the world devote less and less time to strictly testing and psychometric research, and selectively and wisely use psychometric methods according to a comprehensive assessment rather than categorizing mental problems. It is also worth noting that the psychometric assessment is less valued by the health company/institution/insurance than, for example, psychological or psychotherapeutic counselling (Butcher, 2006).

The psychological assessment should be an ecological and comprehensive assessment: it should be short, sufficiently accurate and reliable and the best possible for the respondent and the researcher (Kinderman & Tai, 2007). The multiplicity of standardized psychological tools available for the assessment of personality, intellect, temperament, cognitive processes, and many other aspects of the psychological functioning of an individual is widely used in clinical psychology. However, their use without further therapeutic outcomes is not the sole goal of clinical psychology (Butcher, 2006).

Some authors argue that psychological tests are as reliable and accurate as most medical tests, such as computed tomography or X-ray techniques (Meyer, Finn, Eyde, 2001). Despite this idea, the essence of clinical psychology should not be the application and calculation of standardized psychometric tests. Wisely, in addition to psychometric evaluation, therapeutic evaluation has become more and more important in clinical settings.

In the main area of work and functioning of clinical psychologists, i.e. in health care, their main duties have not changed for a long time: counseling, psychological diagnosis and assessment, psychoeducation, consultations, interviews with families and possibly scientific research (Mrdjenovuch & Moore, 2004). In this pos pandemic era, e-health support, using video consultations, e-mails, and apps for supporting mental health has been an increasing economic market that challenges the clinical psychologist classical skills.

Research reports in Great Britain estimated that approximately 70% of patients with mental health problems are treated by medical doctors without any consultation with a psychiatrist or a psychologist (Blount, Schoenbaum, Kathol, 2007) and many patients do not receive appropriate interventions from their doctors (Bray, 2010). Most patients in psychiatric hospitals in times of crisis need counseling, therapeutic interventions, a safe place or emergency care or intervention, instead of costly and often labeling hospitalization (Kinderman, Sellwood, & Tai, 2008). Adams, Wilson and Bagnall (2000) suggested that in such cases, psychological interventions can be provided at three main levels: psychoeducation and psychological support, training of special skills, strategic interventions aimed at restoring homeostasis and optimal functioning of the patient and his family and his contextual environment.

Challenges for clinical psychology

Clinical psychology is a topic involving theory, research and practice. It has been dynamically maturating since the 18th/19th century (Witmer, 1907). In contrast to strictly theoretical areas, the scope of clinical psychology is determined by simultaneous solving research problems and promoting educational and practical tasks. The scientific level of clinical psychology is conditioned by the development of the clinical psychologist own theory and conducting modern empirical research, and this engagement can guarantee the quality of putting into action the scientific knowledge in various forms of social practice aimed at solving health problems and minoring mental disorders of people, groups, and communities.

Challenges from globalization and culture

The dominant psychological research publications have an impact on the actual *Zeitgeist* about globalization on human development, values, identity, and lifestyle (Jensen, 2002; Hermans & Dimaggio 2007; Nieman, 2011). These scientific reports and the actual globalization process have been adjusting our perspective and scientific knowledge concerning human development about adolescence and emerging adulthood. The extension on chronological age as well as psychological maturity of these developmental periods is now observed in a different way than it was in the early 20th century.

Cultural inadequacy, education with multicultural identities, gender identity with multiple identities and the global world movement itself are growing among young people. A social phenomenon has been growing under the so-called *self-selective* culture, markedly based on a cultural foundation (Jensen, 2002; Leal & Soares, 2024).

The relationship between theory and clinical practice is a constant topic for reflection and for taking new actions. It Includes creating conditions for creative dynamism, mobility, the possibility of competition and cooperation, and the rapid dissemination of new discoveries in the field of science and technology, information systems and speed of communication, and wide access to knowledge thanks to the constantly improving Internet. These changes stimulate the development of cognitive spheres and human competences (Friedman, 2000).

The process of globalization has become the subject of attention in psychological paper works. This entails modifying existing concepts, by introducing globalization phenomena into thinking about the patterns of human reaction to universally tendencies in economics, politics, ecology, language, culture and individual self-regulatory development of human identity and lifestyle, which are additionally characterized by a high potential for unification and commitment (Bandura, 2001; 2002). The author proposes new concepts and theoretical models that make it possible to understand the relationship between changes in the organization of social life and patterns of psychological reactions. New interactions from a macrosocial organism, like the process of globalization, and an individual being should be discovered.

Even more crucial and important for a clinical psychologist is the concept of contextualization. Its basic function is to give meaning to one's own behavior in terms of the freedom to choose and maintain the direction of one's own activity in relation to the identified external macrosocial conditions. Such an understanding is consistent with the concept of self-regulating human subjectivity related to globalization, proposed by Bandura (2001).

Challenges for Clinical Psychology in the 21st Century

One of the most important challenges for clinical psychology in future, from socio-cultural changes that generate new problems and tasks in the field of mental health, comes from the need to improve and update clinical theories and practice regarding *E-health* issues.

Scientists are expected to undertake theories and research activities important for the development, maintenance, and enhancement of mental health, which will result in new theories and models of describing and explaining intrapsychic mechanisms of human functioning, the construction of more accurate and reliable diagnostic tools, and the creation of more effective psychotherapy strategies and psychosocial interactions. On the other hand, clinical psychologists when in practice, are expected to have knowledge and specific skills that are necessary to provide psychological services at the highest level, especially in the field of diagnostic, preventive and therapeutic procedures.

Challenges in the field of clinical diagnosis

The greatest challenges faced by theory and clinical practice in the field of clinical diagnosis concerns the development of guidelines on conduct within two models: epigenetic diagnosis and diagnosis in therapeutic management. The results of longitudinal studies show that 2/3 to 3/4 of mental disorders in adulthood could be predicted from some group of childhood anomalies. In the context of these data, Fonagy, Target and Gergely (2006) put forward the thesis that only the developmental perspective, especially developmental psychopathology, allows for a comprehensive understanding of mental disorders and their determinants. The diagnosis of mental health determinants, in accordance with the assumptions of developmental psychopathology, requires knowledge about the size (proportion) of biological, mental, and socio-contextual factors in the genesis of mental problems at various stages of an individual's life (Cicchetti, 2006; Soares, Vasconcelos & Faria, 2023; Soares & Correia Silva, 2023).

Various international and European expert teams (Cicchetti, 2006) are formed to promote evidence-based psychological practice, but further research is required to show the relationship between the initial descriptive and explanatory diagnosis and the objectives and subject of partial diagnosis in the context of individual interventions. The diagnosis should include not only the analysis of the patient's change process under the influence of specific interventions, but the basis for selecting the next intervention in connection with the diagnosis of the patient's response to the intervention, in the context of the therapeutic relationship and the strength of the therapeutic alliance. This very complex issue has so far been studied in a fragmentary way, which does not give a full picture of the dialectical interdependencies.

The therapeutic relationship

An interview, and more broadly, any psychological examination, is primarily an encounter between two people. To properly clinical observe a person we have to meet them and interact with them. Therefore, in addition to the cognitive dimension, there should also have an interpersonal dimension that affects the course of the therapeutic relationship and its

results. Furthermore, a specific psychologist and a specific client are people of a certain age, gender and sexual orientation, nationality, have their own worldview, and they react to each other in a unique and single way. Their therapeutic meetings take place at a specific point in time, often within the framework of the activities of an institution and on its premises. The therapeutic setting is considered to remain an extremely significant factor influencing the course of the therapeutic relationship. Even in a non-standard form as having a conversation on the phone, both parties are specific in space and time, and the remarkable fact that they communicate indirectly undoubtedly influences what they say to each other.

The following reflections related to building up a therapeutic relationship between a clinical psychologist and a client should be further and more deeply studied throughout research studies:

- ✓ The unique ability to critically review the multiple roles, contexts of relationships within which the client and the psychologist assign, and the ability to recognize the impact of these roles, contexts and relationships on the activities undertaken as part of the clinical diagnosis and intervention.
- ✓ The ability to satisfactorily establish, maintain and understand a cooperative
- ✓ professional relationship between the therapist and the client;
- ✓ Adequately understand the complex relationship between accurate diagnosis and intervention planning, the awareness that diagnosis is already an active intervention;
- ✓ Technical diagnostic skills, including:
  - recognizing the problem/goal and understanding the fundamental essence of the clinical case.
  - selecting appropriate diagnostic methods that provide both test and non-test data.
  - effective application of diagnostic procedures, both to the client and to the different social systems in which he participates.
  - information integration, logical inference, and clinical psychological analysis.
  - elaboration of results regarding diagnosis for useful case formulation and clinical recommendations into practice.
  - providing the client with understandable and useful feedback that meets his needs regardless of whether the client is an individual, group, or organization.

Key variables that may affect the effectiveness of psychotherapy may be the resources of the therapist, the patient's pre sources and also the theoretical model of the therapeutic process. Although representatives of various therapeutic approaches differ in their assessment in the importance and influence of the therapeutic relationship on the process of psychotherapy, they all agree that it is a very significant healing factor. This alliance in action is not related to immediate effects in psychotherapy, which means that it does not increase the current satisfaction with life and experiencing positive affect and satisfaction with life. The

empirical data obtained from recent research (Prusinski, 2021) concludes that the alliance in psychotherapy, strengthens the person's ability to enter a deep and trustful relationship with others than the therapist (Oliveira & Soares, 2014). It is then, a contributing factor for well-being and long-lasting element of healthy human development (Prusinski, 2021).

The therapeutic change

Human change. From the psychological point of view, the change occurs when the individual recognizes his behavior as his own activity and take responsibility for it, thanks to which the drive previously directed against himself reintegrates as his own. It is a step towards integrating one's own behavior and promoting actions towards therapeutic change.

In the process of contact with the client, the therapist does not force for the change to take place, but, considering the therapeutic contract, goes in the direction that he agreed with the client and creates a psychological space for the development of the awareness-expanding process. In this process the client becomes aware of his ways of dealing with the environment and may learn a new response mechanism to new situations. Change occurs as a product of the consciousness-expanding process.

According to Perls, (1969) the problem of human is that being dissatisfied with himself, feeling frustrated, he or she tries to change, seeks help from a psychotherapist in getting rid of defects. And yet it is not his frustration that is the way to change. He argues that a human being gains a strong foundation for development if they accept themselves as they are and become aware of their current situation. It is the focus on self-acceptance, instead of the constant pursuit of the ideal self, that is the prerequisite for change. Facing the truth about ourselves that we are not perfect, that we have contradictions within us, that we are internally polarized is the beginning of an authentic
life.

In Gestalt Therapy, change occurs in a paradoxical way. What is this paradox? This is perfectly elucidated by one of the therapeutic questions: if a man accepts who he is, why should he change? According to Harris (1989), during the process of psychotherapy, the client goes through three phases of self-understanding. In the first phase, the individual comes to realize what he is, *i.e.,* accepts himself. Only then, he can move on to the second phase, when he realizes how to be, because he decides so. Responsibility for their own actions, and the very moment of choosing oneself are extremely important at this phase. The last step is to understand that change is possible and depends only on the individual's autonomous decision.

Also, regarding the responsibility for change in the therapeutic process, and introducing the concept of mental health and physical health in 1948, the World Health Organization (WHO) elaborated the concept *Health* as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (Lee, 2008; Kirton, 2009). Since then, there are social factors embraced into such concept. Beforehand, health

was considered under the ancient Latin phrase of the Roman poet Juvenal: *Mens sana in corpore sano* (a healthy mind in a healthy body) as well as the affirmation made by Leriche in 1930s: *health is life lived in the silence of the organs,* (Neves, 2021). After World War II there was a demand to promote politic welfare to people, just like in nowadays, there is a high demand to promote mental health politics after the 2020-2022 Covid-19 pandemic (Santos & Soares, 2024; Soares 2024a; Soares 2024b). Back then, the WHO elaborated a concept of health as a kind of well-being, introducing the social factor in health. Before the war, health was just considered individually. After the war and considering the precarious social condition in it, we start to perceive that collectivity crosses over individuals and individuals cross over collectivity (Neves, 2021). That the social vision benefits individuals and communities beyond selfish thinking about health.

Bearing in mind the WHO definition, physical well-being corresponds to an objective process. Conversely, mental well-being is related to a subjective process. Let´s reflect on these two concepts *objective* and *subjective* as Neves (2021) argues. In the last decades of the XX century *objective* was more valorized, contrarywise to the concept of *subjective*. The concept *objective* is related to object and *subjective* to subject. Thus, society turn out to be very pragmatic, somehow an objectification of human being took place in addition with dehumanization in particularly in medicine. Our recent reflection on this is that Pandemic consequences are emerging in different areas, in the mental health field where communication between clients and therapists are changing, new technologies are producing mental health contents, and the main question remains to be seen in the future: can technology, artificial intelligence replace a human therapist? We do hope not. Let´s hope interpersonal connection, eye to eye, verbal and nonverbal actions and decisions are still in the frontline, considered very important in understanding human being psychological suffering. Quality of Human Interconnections (QHI): that is how we grow and develop as humans. That is to say that what matters most is the quality of the relationships we develop and maintain throughout our life's. Technology can help towards that goal but can never replace it.

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