Correspondence

RE: Positive models of suffering and psychiatry

Integrating positive and negative models of suffering: a proposal for a unified approach in psychiatric practice

I was prompted by the recent publication in the *BJPsych Bulletin* by Huda, 'Positive models of suffering and psychiatry',[1] to express my views regarding the juxtaposition of negative and positive models of suffering within psychiatric practice. Although Huda provides a nuanced discussion on the traditional approach to alleviating suffering versus a perspective that sees potential value in suffering, the delineation offers a critical reflection yet also suggests a potential area of confusion for both practitioners and patients. The discourse sets a foundational understanding that whereas the alleviation of suffering is a cornerstone of medical practice, as echoed in the ethos of clinical epidemiology,[2] there exists a parallel narrative that suffering may serve as a conduit for personal growth and enlightenment, aligning with broader existential and psychological theories.[3,4] This dichotomy, although enriching, may inadvertently complicate the therapeutic landscape, suggesting a necessity for a more integrated approach that harmonises these models to enhance patient care. Accordingly, I propose the consideration and development of a unified model that assimilates the ethical imperative to mitigate suffering with a recognition of the transformative potential inherent in the experience of suffering. This model would aim to: (a) prioritise the immediate and compassionate alleviation of suffering as a primary objective of psychiatric intervention, in line with traditional medical practice;[2] (b) acknowledge the potential for suffering to catalyse personal growth, transformation and the acquisition of new perspectives, as detailed in the literature on post-traumatic growth;[3] (c) empower patients by involving them in treatment decisions, echoing the principles of narrative medicine and patient-centred care;[5] (d) foster treatment flexibility, recognising the individual's unique experience of suffering and the dynamic nature of their needs and potential for growth.[4] Such a unified model proposes a more holistic and nuanced approach to psychiatric care, one that not only seeks to alleviate pain but also respects the complex, multifaceted nature of human suffering. The implementation of this model would necessitate a shift towards a more integrative psychiatric education and practice, one that values the depth of human experience as much as the alleviation of symptoms. The dialogue initiated by Huda is invaluable, and it is within this context that I propose a further exploration of how we, as a psychiatric community, can better integrate these models to serve our patients. This endeavour would not only clarify our therapeutic objectives but also potentially enrich psychiatric practice with a deeper understanding and respect for the intricacies of the human condition.

Om Prakash, Professor of Psychiatry, Geriatric Mental Health Division, Institute of Human Behaviour and Allied Sciences, New Delhi, India. Email: drjhirwalop@yahoo.co.in

Declaration of interest

None.

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doi:10.1192/bjb.2024.25

RE: Positive models of suffering and psychiatry

The meaning of suffering

The article by Professor Huda and the letter by Professor Prakash focus on the crucial issue of meaning in suffering. This topic could be addressed similarly by many if not all people with varying degrees of insight, lived experience and expertise. We happen to be doctors and in fact psychiatrists, so what can we bring to the table? First, I would say we have to do our jobs! We are doctors whose job is to bring healing, alleviate pain and suffering, and help people to come to terms with their illness and its impact on their lives and possibly what it means to them. To focus on meaning in suffering may be more appropriate for close friends, family or pastors. A person's world view, belief system and social support network largely determine what they consider to be the meaning, cause or message of illness. Psychiatrists who prioritise the meaning aspect and do not treat the illness may not be providing the service they are qualified for and paid to do. Undoubtedly, understanding why suffering is happening can mitigate anguish, confusion and resentment (to mention a few reactions), and as such, insofar as it is within our job spec, we should facilitate this. However, referral to a pastor, friend or confidante may be more appropriate. The humanity, compassion and empathy, and clinical professional skill of the doctor may be our best combination to bring healing to a suffering person. To overfocus on the supportive, meaningful side to the neglect of the doctor's role in curing and treating illness would be detrimental to our profession. First, we are psychiatrists with a definite job spec; then, we are humans with empathy and compassion and expertise to support our curing role; and, finally, we are learners deepening our own grasp of suffering and its causes and cures from the example of our patients. I congratulate both authors and also

https://doi.org/10.1192/bjb.2024.26 Published online by Cambridge University Press

strive to tease out where the golden mean lies in this very human drama.

Eugene G. Breen, Associate Professor of Psychiatry, Mater Misericordiae University Hospital, Dublin, Ireland. Email: ebreen@mater.ie

Declaration of interest

None.

doi:10.1192/bjb.2024.26

RE: In the liminal spaces of mental health law – what to do when section 136 expires?

Beyond the limit of section 136

As a forensic psychiatrist, I read with interest the paper by Hassanally et al about what to do when section 136 expires.[1] Section 136 of the Mental Health Act 1983 lasts up to 24 h. What was the intent of Parliament in setting that limit? A literal reading means 24 h and no longer. The logical consequence is that after 24 h, the patient must be released from detention and their liberty restored. In terms of practical management of the clinical scenario, the doctors should complete medical recommendations for a section 2, as this is within their power. Police should confiscate the large knife. The patient should be released at the 24 h mark as no bed is available and the brother who historically brought the patient to hospital notified if possible. This is an unpalatable outcome, and it needs little imagination to foresee what disaster may ensue in the community. Yet it must have been foreseeable to Parliament, as the scenario described is both credible and realistic. Escalation to the director on-call for the NHS trust and the medical director should also be done. There will be moral injury and moral distress to the doctors involved, in addition to the lack of bed and lack of care for the patient. Alternatively, continuing to detain the patient past the 24 h mark would intentionally break the law via false imprisonment and unlawful deprivation of liberty. This is unethical and would require the complicity of several people, who would be opening themselves up to legal jeopardy. Citing public protection would be insufficient. No common law citizen's arrest is possible, as the patient was already under police arrest using section 136. Another alternative could be to criminalise the patient for possession of an offensive weapon and have him charged and taken to the magistrates' court. But that would be unjust, as the patient clearly requires diversion to in-patient services. Four sections along from 136, we find 140. This basically says that health authorities have a duty to notify local social services authorities, specifying the hospitals in which arrangements are in force for the reception of patients in cases of special urgency. And so, going forward, it would be useful for psychiatrists on call to have knowledge of such arrangements at the start of their shifts. I would be interested to read other arguments about this worrying situation. I agree that the care of the patient is the first concern for medical professionals, but this must be within the confines of the law of the land.

Rafiq Ahmed Memon, Consultant Forensic Psychiatrist, Birmingham and Solihull Mental Health NHS Foundation Trust, UK. Email: r.memon@nhs.net

Declaration of interest

None.

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doi:10.1192/bjb.2024.27

Author's Reply: Positive models of suffering and psychiatry

Beginnings of a dialogue within our profession

I thank Professor Prakash and Professor Breen for their helpful and informed contributions. It is important in the spirit of medicine, which is a profession that is used to working with different professions and different models of care, that we engage with the positive model of suffering if that is the wish of the patient. Professor Prakash outlines a model of how to do so as a medical practitioner. Professor Breen supplements this with both how we can incorporate the positive model in our care and suggestions for working with others who are more experienced in the positive model of suffering. I hope this article stimulates further helpful suggestions and contributions.

Ahmed Samei Huda, Consultant Psychiatrist, Pennine Care NHS Foundation Trust, UK. Email: ahmed.huda@nhs.net

Declaration of interest

None.

doi:10.1192/bjb.2024.28