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From the Editor's Desk

Political and ethical dilemmas for psychiatrists in the media

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Digital, social and print media, as well as radio and television have transformed the reach of health professionals to inform the public about self-care and health promotion, as well as about the signs and symptoms of a range of illnesses including cancer, heart disease and mental illnesses. The information provided is usually based on the latest research or a synthesis of previous research offering particular new recommendations or reinforcing old messages, especially around lifestyle management. Knowledge is shared about when help-seeking is appropriate and who might be able to provide appropriate care. These schema or scripts have been described as illness perceptions or explanatory models when focused narrowly on health services, and could be useful to consider in population approaches where the range of potential pathways is greater, more variable and closely linked to social and cultural assets. Media is also used now in anti-stigma campaigns, involving leading and well-known sports personalities, actors or political leaders acknowledging and sharing their personal stories with the wider public in the hope that others will not hesitate to seek help.

There are also media reporting guidelines encouraging sensitive and careful reporting of incidents of self-harm or suicide, or of violence and riots, and even of terrorism as behaviours and ideas spread and lead to epidemics. Television programmes in particular, but theatre and performance generally, also depict the harrowing dilemmas and suffering faced by many with mental illnesses, to share this with the wider public but also to foster empathy and intrigue when placed within a good plotline. Television dramas frequently depict simplified and somewhat sharper characterisations of specific mental illnesses and their consequences, making good use of dramatic licence, yet risk stereotypical or stigmatising portrayals that may do more harm for public mental health. The language used, whether descriptive, behavioural or diagnostic, also needs care so as to not overly emphasise psychiatric diagnoses as totally discrete and mutually exclusive, or that each is allied to unique care pathways and interventions to promote recovery. Mental health experts inform, advise and even take part in campaigns to improve mental health and to encourage self-awareness and appropriate help-seeking, demystifying much of medical practice for the public so shared decision-making is the norm rather than an exception.

An area less well explored is whether psychiatric experts have a role to play in political discourse, leadership and decision-making. It is well established that top negotiators must have emotional intelligence and know how to escalate and de-escalate tension to avoid impasse. This expertise is not dissimilar to that needed resolving political violence in Northern Ireland, or what is being applied now within the Brexit negotiations. The ease with which negotiations become polemical, personalised and politically polarised is not difficult to see in everyday political discourse around the world.

Should psychiatrists, and mental health professions more generally, have a privileged voice or status when concern is expressed about the mental health of public figures, especially those in positions of power and authority? The American Psychiatric Association supports the Goldwater principle that it is unethical for psychiatrists to comment on the mental health of public figures, unless there is proper authorisation including consent from the person and there is a comprehensive assessment.[1,2] The Royal College of Psychiatrists endorses this position, yet there is much heated debate given what is at stake, especially when considering the current political crisis facing the US President. This is not the first time a political leader who adopts strong opinions that promotes nationalism and isolation attracts criticism for fear of not learning historical lessons about atrocities that can be committed in a political climate that oppresses freedom of speech or criminalises the opposing political parties, neither of these being directly relevant to the USA.[3] There is concern that professional narcissism or hubris must be mitigated or guarded against.[4,5] The debate in this month's *BJPsych* makes for a riveting read. Experts from the USA and from the UK thoughtfully and robustly rehearse arguments and counterarguments on what is acceptable and what is actually necessary on the basis of what is at stake or 'a duty to warn' (see Gartner, Langford and O'Brien, pp. 633–637).

Returning to more conventional scenarios facing clinicians, Adshead *et al* emphasise ethical and legal dilemmas around consent to treatment, where dialogue is needed before shared decision-making is possible (pp. 630–632). The principle of shared decision-making is not optional and is not sufficiently well applied they argue. Shared decision-making should be an ethical imperative for high-quality care and professional practice, so that patients' interests and perspectives are not neglected. Although not framed in terms of ethics, how do advances in the diagnostic practice for bipolar disorders and mood disorders influence tools used to assess symptoms and procedures for diagnoses, and ultimately care pathways (see Scott & Murray, pp. 627–629)?

Premature mortality of those with serious mental illness is a well-recognised challenge for prevention, public health and care services. Hosang *et al* show that childhood neglect, abuse or any sort of maltreatment are associated with greater medical morbidity among patients with bipolar mood states when compared with unipolar mood states or no mood state; there was a dose–response relationship showing the highest risks among those experiencing at least two forms of maltreatment (pp. 645–653). The findings argue for more assertive prevention and care interventions for medical illness among people experiencing maltreatment in childhood, especially if they are at high risk of developing bipolar illnesses.

Dementia presents a major public health challenge with significant neuropsychiatric and medical morbidity. Two studies show that those with depressive symptoms and anxiety are at higher risk of cognitive impairment and vascular dementia, respectively (Zheng *et al*, pp. 638–644 and Becker *et al*, pp. 654–660). The social and relational isolation faced by people with dementia is known to be associated with more disabilities. There is some evidence that cognitive stimulation, through mentally engaging interventions that are enjoyable and help socialisation, reduce cognitive decline. An analysis of data including those aged 50 or more from the English Longitudinal Study of Ageing shows a lower incidence rate of dementia at 10-year follow-up among those visiting museums (Fancourt *et al*, pp. 661–663). The association was independent of demographics, socioeconomic conditions, sensory impairment and depression, as well as vascular conditions and other form of community connections. We need to better understand the mechanisms that may mediate these effects before promoting museum attendance *per se* or closely related influences as preventive interventions.

1 Appelbaum PS. Reflections on the Goldwater Rule. *J Am Acad Psychiatry Law* 2017; **45**: 228–32.

2 Martin-Joy J. Interpreting the Goldwater Rule. *J Am Acad Psychiatry Law* 2017; **45**: 233–40.

3 Owen D, Davidson J. Hubris syndrome: an acquired personality disorder? A study of US Presidents and UK Prime Ministers over the last 100 years. *Brain* 2009; **132**: 1396–406.

4 Gureje O. Nosological changes in psychiatry: hubris and humility. *World Psychiatry* 2012; **11**: 28–9.

5 Vogelstein E. Professional hubris and its consequences: why organizations of health-care professions should not adopt ethically controversial positions. *Bioethics* 2016; **30**: 234–43.

psychiatry in literature

Reflection on: *Madness and Modernism: insanity in the light of modern art, literature, and thought (revised edition)*

Giovanni Stanghellini

We need a psyche for psychiatry. *Madness and Modernism* is an exemplary essay in this sense. Louis Sass's book (first published in 1992, now in a revised edition from Oxford University Press) is a work of comparative phenomenology: it gives attention to two domains: one is madness, or more exactly schizophrenic subjectivity; the other is the modernist or avant-gardist orientation in culture and the arts that came to prominence around 100 years ago. The main purpose of matching these two domains is to use modernism as a way of illuminating madness. Through the analyses of modernist (and so-called postmodernist) style and sensibility, and its cultural and aesthetic characteristics, one distinctive property is brought to the fore: hyperreflexivity, the exaggerated tendency to direct focal and explicit attention to the otherwise implicit background of experience. Hyperreflexivity, the rendering-explicit of the implicit conditions of possibility of experience, has a revelatory power in the arts (for instance, in Magritte's surrealist paintings) and in culture (for instance, in phenomenological philosophy), as it uncovers aspects of human experience that would otherwise go unnoticed.

Yet it also has an alienating power, since it involves detachment from common-sense experience and disengagement from everyday pragmatic concerns, and even from one's own bodily reality – often inspiring an unusual interest for theoretical or metaphysical questions about the 'reality of reality' or the 'secret workings of the psyche'– or what one of my intellectually oriented patients termed 'what remains hidden to the majority beyond Maja's veil'.

Having identified hyperreflexive awareness as a key feature of modernism (one that offers a unifying vision of otherwise disparate cultural and artistic trends), this construct can be used to shed light on the experiential dimension of certain forms of alienated consciousness in mental disorder – where the reflexivity in question may often have a more automatic, affliction-like quality. In this way, it offers rare insight into both altered modes of experience (for example of space, time and language) and the personal meaning that patients often attach to these experiences. This is obviously a great achievement for all those who believe that psychiatry is first and foremost, although not exclusively, about understanding 'what it is like' to suffer from abnormal mental conditions.

Developments in psychiatric research have certainly extended our knowledge about the causes of mental disorders, but mental disorders have meanings in addition to causes; they involve alterations of experience as well as of the brain and nervous system. Of course, this project – which is that of phenomenological psychopathology – is a very different research programme for psychiatry than that of neuroscientific research. The two programmes are not incompatible, however, since in order to correlate any given abnormal experience to brain functions, one must first be able to define such experiences with sufficient precision. We should remember that we as psychiatrists do not sit in front of a broken brain – we confront a suffering person. Indeed, mental disorders just are primarily disorders of the human psyche. If a crucial task of psychiatry is to understand abnormal human existence, then psychiatry needs to consider psychopathological conditions in terms of basic anthropological categories that capture the *a priori* norm or framework within which a given phenomenon of human existence occurs. Some philosophers and psychopathologists have already taken this direction. One of the first was Hegel, who sensed that 'something akin to philosophy' was often struggling within madness –indeed, Hegel defined psychosis as the unhealthy twin of authentic idealism. 'Double bookkeeping' (Bleuler), the understanding of schizophrenic autism as loss of common sense (Blankenburg) and 'epistemological delusions' (Sass) demonstrate philosophy's ability to help us re-think certain psychopathological conditions, and to alter some of our most taken-for-granted assumptions (such as the notion that schizophrenic delusion is necessarily a matter of 'poor reality-testing').

This is the contribution that human sciences can bring into the field of psychiatry. Yet the rapport between psychiatry and the human sciences can be reciprocal. Philosophy and the humanities can contribute to the understanding of mental disorders, but abnormal mental conditions can contribute to the understanding of human existence – and this by revealing, in starkest terms, some key potentialities and paradoxes of the human mind. In this vein, philosopher Paul Ricoeur has developed the concept of 'importance' – which refers to the way a phenomenon's meaning may exceed or transcend its initial context. An *important* phenomenon reveals meanings that can be actualised in situations beyond the one in which it occurred. We as psychiatrists are locally responsible for caring for the individual person who seeks help. We may, however, also have a certain more global responsibility for considering how a patient's condition can shed light on human existence as such. The unavoidability of guilt, inescapability of freedom or loneliness of one's existence; the fragility of one's body or sense of reality: these are but a few examples of fundamental human issues that abnormal mental conditions both exemplify and reveal. Psychiatrists, along with knowledge about the brain, should also be ready to explore such issues to illuminate the feelings and meanings of their patients. *Madness and Modernism*, certainly one of the outstanding books illuminating madness written in the last century, is an exceptionally rich source of ideas and materials for such a project.

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