BJPsych The British Journal of Psychiatry (2017)
210, 83–85

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Edited by Kiriakos Xenitidis and Colin Campbell

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Brexit woes

I feel I must take issue with the first paragraph, if nothing else, of the 'To the Editor's desk' column by Kamaldeep Bhui in the August 2016 edition of the journal.[1] To begin with, I am surprised that 'shock waves of worry' among people fearing social division and financial insecurity have just arisen following the Brexit vote. It seems to me that social division and financial insecurity have been growing in this country for some years, and that divisions in wealth are now at a level not seen since the 19th century. All this has happened while we have been members of the European Union, and the European Union has done nothing to ameliorate it. In fact, in its susceptibility to lobbying by big business, Brussels may even have made the situation worse.

I am also surprised to read about 'better collective interventions to tackle health inequalities', as the European Union has been the problem rather than a solution for large swathes of the European population. It is well known that emergency financial bailouts to Southern Europe have had such stringent conditions attached to them that many people in Greece, Portugal and Spain are suffering from terrible poverty and their health has been declining markedly. Suicide rates have increased in Ireland, Spain, Portugal and Greece, and levels of mental health have declined. Alcoholism and drug addiction have also increased. Malaria has made a reappearance in Greece – a country where it has not been seen since the 1970s. All this should be blamed fairly and squarely upon the European Union.

As for 'greater trust and cooperation' being at the heart of the European project, one only has to listen to the vengeful and threatening comments coming from people in Brussels about making Brexit difficult to realise that they were not our true friends and could scarcely be trusted. I think it is about time we abandoned this starry-eyed idealism about the European Union and got real.

1 Bhui K. Brexit, social division and discrimination: impacts on mortality and mental illness? *Br J Psychiatry* 2016; **209**: 181–2.

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doi: 10.1192/bjp.210.1.83

Paternalism *v.* autonomy

Lepping *et al*[1] rightly point out that autonomy is only one of several important ethical values, which, in the patient–doctor relationship, needs to be weighed against other values such as beneficence and justice. However, they do not seem to be aware of the factors which reduce our autonomy and how limited it therefore is in the first place. These factors include manipulation (think of the Brexit campaign), oppressive socialisation, coercion (e.g. through legislation), overconformity (which in the medical context may mean uncritical acceptance by patients of the suggestions of paternalistic doctors), inner necessity (the strong feeling that we have to do what we want to do – Martin Luther's 'Here I stand. I can do no other') and luck (we often think we are responsible for outcomes which are simply lucky occurrences).[2,3] As a consequence, our autonomy is much more limited than we think it is. For this reason, we need to consider how best to increase our autonomy, and the autonomy of patients, so that it can at least compete with other important values.

1 Lepping P, Palmstierna T, Raveesh BN. Paternalism *v.* autonomy – are we barking up the wrong tree? *Br J Psychiatry* 2016; **209**: 95–6.

2 Kahneman D. *Thinking, Fast and Slow*. Penguin, 2011.

3 Crichton P. *Self-Realization and Inner Necessity*. Kiener Press, 2013.

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doi: 10.1192/bjp.210.1.83a

Attachment, benign paternalism and nuances in autonomy

I would like to share a few thoughts on autonomy[1] from the perspective of a child psychiatrist concerned with attachment theory. Autonomy from my developmental perspective concerns 'balanced dependency', a dependency on others which changes with age and state. When ill, our dependency needs change, and we manage them differently. The only truly 'autonomous' people can be expected to end up in high-security prisons for recidivists.

Attachment theory in current versions emphasises that it is not about 'bonds' but about strategies to handle danger and threat, which develop depending on the contingencies to our distress signals during our earliest years and the ways in which our affective disarray can become soothed: dis-ease gets eased.

Put rather simply, the Type A strategy has a variety of forms, but underlying them is a trend to aim for self-sufficiency and avoid conflict with those in positions of power. Their distress signals are often low-key or not displayed. They appreciate the medical style referred to as 'benign paternalism': the doctor is the accepted expert and they wish to follow the expert's advice. They can feel distinctly out of sorts and rejected if asked to decide between treatment options.

There is some evidence that the previous generation of US doctors also had a predilection for a Type A strategy.[1] Whether this has changed today is unanswered. The doctors' strategies also feed into the dynamic between the different attachment strategies used by patients and understanding their symptom language and needs for varieties of paternalism.[2]

The Type C attachment favours prioritising their own viewpoint (currently the media portrayal of Donald Trump illustrates the strategy well). This can be expected to put the Type C strategists in conflict with doctors who tend to paternalistic approaches.

In order to resolve the issues in your editorial[1] we need to elaborate our understanding of autonomy and how we develop different predilections for degrees of paternalistic medicine – and doctors need to be aware of their own attachment strategies and how these interact with those of their patients. This is the core dilemma for improving medical communication, and,

https://doi.org/10.1192/bjp.210.1.83b Published online by Cambridge University Press

incidentally, can be expected to help resolve the issues around meeting the neglected needs of somatising patients.

1 Lepping P, Palmstierna T, Raveesh BN. Paternalism *v.* autonomy – are we barking up the wrong tree? *Br J Psychiatry* 2016; **209**: 95–6.

2 Wilkinson SR. *Coping and Complaining: Attachment and the Language of Dis-ease* (pp. 230–239). Brunner-Routledge, 2003.

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doi: 10.1192/bjp.210.1.83b

Authors' reply: We are pleased that our paper has started a discussion about the ethics of autonomy for severely mentally ill patients. In our view, this has been long overdue. Both authors replying to our editorial[1] have reasonable reflections, deepening our deliberations about the impact of any immediate reduction of autonomy on severely mentally ill patients and the balance with other ethical pillars that we all rely on in psychiatry.

Wilkinson raises the question of how attachment styles of the doctor could affect his or her communication style towards the patient, possibly increasing paternalism. It is an interesting point. It emphasises how paternalism could occur by the doctor being unaware of a 'paternalistic' communication and decision style. This is a relevant comment regarding how we as doctors interact with our patients, creating a more or less 'coercive' style.

Crichton, on the other hand, elaborates on the issue of how autonomy is in fact already restricted for patients. We acknowledge this aspect as relevant; however, we would equally like to stress that autonomy is not automatically more important than other ethical pillars. In our opinion, there is a danger in over-emphasising *immediately* expressed autonomy in every situation, as it risks compromising both future autonomy and other pillars of medical ethics. We merely discuss the balance between autonomy and the other central pillars of medical ethics in medicine, and particularly in psychiatry. Crichton's call for consideration of the already limited autonomy is justified, but this should be a starting point for a more detailed discussion. Patients may understand their situation and choices, but are not autonomous unless they are able to form value judgements about their reasons for choosing treatment. So stating that autonomy is limited is a judgement which needs to be carefully examined from an ethical point of view. In addition, autonomy will be interpreted differently in various social, religious, judicial, political, philosophical and medical contexts.

We are aware that autonomy is restricted for all of us by several components, and that action should be taken to increase it. But we would like to argue that, in order to increase patients' autonomy over time, there is a need to act upon all pillars of medical ethics. We argue that we should consider that the immediate choices expressed by the patient may occasionally have to be balanced with best interests decisions, both to preserve the integrity of the other pillars of medical ethics (providing safety, protection, treatment) and to promote future autonomy of the patient. Furthermore, we strongly believe that the immediate request for autonomous decision-making expressed by a severely disordered patient should not be a simple excuse to neglect other ethical considerations, just because it is the easiest way to proceed. In our view, this would be a dangerous road to follow, although anecdotal evidence suggests that it is already occasionally happening. It demands nothing of us as psychiatrists, but could have devastating consequences for patients in the end. It could undermine all the ethical pillars we regard as important, not only for the well-being of the patient but also for the patient's future ability to make true autonomous decisions about his or her life. We argue that taking a stand to evaluate all the ethical pillars of medical ethics is the right way to go, but it is also a demanding way along 'a long and winding road'.

1 Lepping P, Palmstierna T, Raveesh BN. Paternalism *v.* autonomy – are we barking up the wrong tree? *Br J Psychiatry* 2016; **209**: 95–6.

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doi: 10.1192/bjp.210.1.84

Measuring outcomes of mindfulness interventions

Wong and colleagues are to be congratulated for the large scale randomised controlled trial on mindfulness-based cognitive therapy versus group psychoeducation for people with generalised anxiety disorder.[1] We have studied mindfulness awareness practice (MAP) amongst elderly individuals in an open-label study[2] and more recently in a randomised controlled trial (ClinicalTrials.gov registration NCT02286791) and would like to share our experiences. Both studies involved community-living elderly people, with the second study involving individuals with mild cognitive impairment.

Wong *et al* highlight the use of self-reported questionnaires as one of the limitations of the study. We do agree and suggest that measurement of 'psychobiomarkers' may be the solution. Self-reports are useful for estimating psychological efficacy with task-based or behavioural approaches.[3] But many of the mental changes achieved even in short-term meditative practice are better measured through the physiological changes associated with achieving mental balance (conative, attentional, cognitive and affective)[4] in contemplative practices. These are at the structural, cellular and biochemical level, and in preliminary findings in our study, changes in functional brain activity, neuropsychological tests, telomere lengths and oxidative stress markers were noted after 12 weeks of mindfulness practice (manuscript in preparation).

Like Wong and his colleagues, we too noted similar improvements in the control group which was provided weekly health education talks. We hold similar views that these resulted from the benefits of the group activity and the time and attention provided. Despite improvements in the control group, the changes were more significant in the MAP intervention arm.

Until we have identified the best biological measurement tools to identify the changes brought about by meditative practices, it may be too soon to dismiss mindfulness-based interventions for our patients. We agree that specific groups of patients with targeted needs would be better suited for mindfulness-based clinical programmes, and the challenge would be in identifying these patients and conditions. Would the authors comment on the implications of cultural factors and religious and spiritual beliefs in the usefulness of mindfulness interventions?

1 Wong SYS, Yip BHK, Mak WWS, Mercer S, Cheung EYL, Ling CYM, et al. Mindfulness-based cognitive therapy *v.* group psychoeducation for people with generalised anxiety disorder: randomized controlled trial. *Br J Psychiatry* 2016; **209**: 68–75.

2 Rawtaer I, Mahendran R, Yu J, Fam J, Feng L, Kua EH. Psychosocial interventions with art, music, Tai Chi and mindfulness for subsyndromal depression and anxiety in older adults: a naturalistic study in Singapore. *Asia Pac J Psychiatry* 2015; **7**: 240–50.

3 Kemeny ME, Foltz C, Cavanagh JF, Cullen M, Giese-Davis J, Jennings P, et al. Contemplative/emotion training reduces negative emotional behavior and promotes prosocial responses. *Emotion* 2012; **12**: 338–50.

https://doi.org/10.1192/bjp.210.1.83b Published online by Cambridge University Press