

From the Editor's desk

By Kamaldeep Bhui CBE

Ethical and empowering communications: preventing death, disability and failed expectations

Patients coping with mental illnesses struggle but can live with and overcome disabling symptoms to flourish and find meaning and purpose and coherence in their lives. Yet, the realities of the journey to recovery include minimising and eradicating worrisome symptoms, and tolerating adverse effects of treatments, and surviving unsafe environments. The appropriate balance between promoting hope for recovery alongside understanding but not reinforcing enduring suffering can be difficult. For some patients, this balance is worryingly traumatic and provokes pessimism and suicidal thinking. Verhofstadt *et al*'s findings (pp. 238–245) on psychiatric patients seeking euthanasia provoke emotional and ethically challenging reactions. The findings need clear thinking and reasoned renegotiation of the purpose of formal and professionalised systems of mental healthcare, and why some patients seek an end to their lives. Although more commonly debated in relation to chronic or terminal physical illness, more people in Belgium with mental illnesses and dementia seem to be seeking euthanasia.^{1,2} Although not legal in many countries, where this is permitted, clinicians are in need of training and guidelines to ensure that decision-making is informed, capacity fully assessed, and that all potentially effective treatment options have been fully explored.^{2–5} In countries where the practice is permitted, a range of illnesses or chronic conditions were found, including anxiety, personality problems, post-traumatic syndromes, neurocognitive impairments, psychoses, autism and eating disorders.⁶ In invited commentaries, Kelly (pp. 248–249) and Pearce (pp. 246–247) make a determined case that we should not harm or hurt, or permit euthanasia whatever the circumstances.

How can care be so poor that it may drive people to such despair? The strain on mental health provision is evident in both high- and low-income countries, patterned by differing expectations, very different baseline levels of resources, material deprivation, and variations in levels of awareness about local health systems and entitlements. Perhaps what is less well scrutinised is the assessment and judgement of the clinicians – as therapeutic or as a worrisome communication that can undermine hope, frighten or disempower. Moreover, the make-up and components of services may not match the needs or expectations of patients and carers, and discordant views can be felt as a traumatic betrayal of trust and entitlement to a specific care package. If the clinician's powerful words and judgements are overly engaged with suffering and dispassionately applied evidence, they can reactivate attachment relationships that traumatise, and promote hopelessness, powerlessness and perceptions of injustice. McCrory *et al* (pp. 216–222) show that childhood sexual abuse affects autobiographical memory and more activation of negative emotions, leading to greater vulnerability to depression and post-traumatic stress disorder. Patients unable to access the right care at the right time will rightly be troubled, but may also be deeply distressed as previous failures

of care are reawakened for them. Empathic understanding of patient experiences and discordant perspectives can expose ethical dilemmas and inform improvements in the quality of care.^{7–9} These concerns about safety bring a new importance and urgency to resolve resource shortfalls, improve self-care and promote empowering interactions.

Judgements about mental capacity to make decisions should be dynamic and contemporary, but few have considered how to enhance capacity at times of critical decision-making; Larkin & Hutton (pp. 205–215) show that metacognitive training can improve capacity while symptoms of mental illness impair it. Perhaps suffering might be lessened if more active capacity-enhancing and empowering interventions are fully applied with patients who despair. Ineffective health practices, guidelines and interventions can add to therapeutic nihilism that may trigger experiences of unsafe attachment relationships. For example, diagnostic guidance on pathological and complex grief is contested and risks misclassification and an overemphasis on disabling disorders rather than healthy albeit painful human experiences (Maciejewski & Prigerson, pp. 189–191). Magnetic resonance imaging in first-episode psychosis may improve diagnosis in the future as better technologies emerge, but currently these scans rarely change the treatment (Borgwardt & Schmidt, pp. 192–193). Would such information, irrespective of no changes in treatment, inform patients and support recovery? Routine testing for cognitive decline in children with 22q11.2 deletion with mental disorders appears to be unnecessary (Chawner *et al*, pp. 223–230). Ilyas *et al* (pp. 194–197) argue that primary screening for physical illnesses among patients with schizophrenia is a wasteful activity; better treatment of depression and psychosis and helping patients to stop smoking are more likely to yield health benefits. Yet, the effectiveness of antidepressants in the treatment of depression in people with schizophrenia is not well established, as shown by Gregory *et al*'s meta-analysis (pp. 198–204) and call for larger and appropriately powered studies.

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