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Highlights of this issue

By Kimberlie Dean

Euthanasia and the concept of 'unbearable suffering' in psychiatric patients

While euthanasia is legally supported in a number of jurisdictions internationally, the central concept of 'unbearable suffering' has been understood mainly in relation to terminally ill patients. In a small number of jurisdictions, euthanasia is made available to those without terminal illness or chronic untreatable pain. Verhofstadt *et al* (pp. 238–245) undertook a qualitative examination of the suffering experienced by a group of psychiatric patients requesting euthanasia in Belgium. Five domains of suffering were identified: medical, intrapersonal, interpersonal, societal and existential. The authors call for the development of instruments to assess the suffering of psychiatric patients making requests for euthanasia, and highlight the need to address those identified determinants of suffering which might benefit from intervention.

Two invited commentaries in response to the paper by Verhofstadt *et al* are published in the *BJPsych* this month. Pearce (pp. 246–247) raises concern about the notion of making euthanasia available to those without terminal illness or chronic untreatable pain, given the particular ethical issues raised by the paper. In particular, concern is raised about potentially modifiable factors, such as poverty, identified as contributing to suffering, and the acknowledgement that an individual's ability to assess their future may be directly affected by the symptoms of mental illness. Kelly (pp. 248–249) concludes that euthanasia should not be made available to psychiatric patients, pointing to the difficulty in ever concluding that suffering arising from psychiatric illness is untreatable. The need to address factors, such as low income, directly if they are contributing to suffering is again highlighted.

In an unrelated but relevant paper, Ilyas *et al* (pp. 194–197) focus on improving the life expectancy of people with severe mental illness. The authors focus on the potential role for assertive primary prevention, including smoking cessation, dietary and exercise interventions, to reduce risk from cardiovascular disease. The authors comment on the failure of physical health monitoring to either be done reliably or to positively impact life expectancy when done.

MRI screening, depression, and decision-making in psychosis

In the context of doubt concerning the role of routine magnetic resonance imaging (MRI) screening in first-episode psychosis, Falkenberg *et al* (pp. 231–237) examined reports from MRI scans in two first-episode psychosis samples, each containing a healthy control group. The authors found the scanning to be logistically feasible and identified a rate of radiological abnormality of 6% in the research and 15% in the clinical sample, with none of the findings requiring a change in clinical management. The authors comment on the potential consequences of failing to identify a serious neurological abnormality despite the rarity of such findings. In a linked editorial, Borgwardt & Schmidt (pp. 192–193) also support the routine use of MRI in first-episode psychosis for the detection of gross abnormalities and also highlight the potential of developing technology to ultimately identify the underlying neural substrates of primary psychosis. The paper by Falkenberg *et al* is further discussed on the Mental Elf blog at https://elfi.sh/bjp-me8.

Depression is common in schizophrenia and is known to be associated with poorer outcomes. Gregory *et al* (pp. 198–204) undertook a systematic review and meta-analysis of the effectiveness of antidepressants in schizophrenia. Finding 26 moderate- to low-quality trials, the authors concluded that antidepressants may be effective but that sufficiently powered high-quality studies are still needed. In another systematic review and meta-analysis, Larkin & Hutton (pp. 205–215) sought evidence for factors which might help or hinder treatment decision-making capacity in schizophrenia. The authors found that those with psychosis who had limited education, severe psychotic symptoms, poor verbal cognitive functioning and/or who had disagreed with their clinician about being ill, were more likely to be perceived as having poor treatment decision-making capacity. With regard to improving treatment decision-making capacity, the authors highlighted in-patient care, information simplification, shared decision-making and metacognitive training but stressed the need for robust evidence from randomised controlled trials.

Childhood cognitive development and maltreatment

In a sample of children with 22q11.2 deletion syndrome and their unaffected siblings, Chawner *et al* (pp. 223–230) found evidence for cognitive deficits in all domains but no evidence of deterioration in cognitive functioning over time. The authors conclude that recommendations for repeated monitoring of cognitive functioning to identify children with 22q11.2DS at high risk of developing schizophrenia is not supported by current evidence.

In a functional MRI study, McCrory *et al* (pp. 216–222) found that childhood maltreatment was associated with altered autobiographical memory functioning, with specific evidence of reduced activation in brain areas encoding positive memories and greater activation of the salience network for negative memories. The authors suggest that such altered functioning may increase risk of later development of psychiatric disorders such as depression and post-traumatic stress disorder.

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