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From the Editor's desk

By Kamaldeep Bhui

Hope and optimism must be at the heart of psychiatric practice

'It's not the despair Laura. I can stand the despair . . . it's the hope!'
John Cleese playing a strict school headmaster, speaking to his pupil in the film *Clockwise* (1986)

A New Year is begun: 2013 was a difficult year. Patients faced cuts in personal benefits and services, and there were new commissioning arrangements, all at the time of a financial crisis; alongside these the Francis Inquiry (http://www.rcpsych.ac.uk/usefulresources/rcpsychenewsletters/enewsletters2013/january2013/francisinquiry.aspx) revealed severe failings in NHS care practices, revitalising the need for compassion in care and exposing shamefully poor care. A more honest appraisal of the quality of care and confronting the limitations of services seem to be the hallmark of 2014. Professionals complain that they had invested much in complex and intensive models of care over decades, for these largely to be remodelled or reorganised because of the economic crisis; and that no evidence-based evaluations preceded these crisis responses. Professionals may be tempted to indulge in demoralisation and despair. They must not. Patients need to know that they will experience safe, evidence-based, and high-quality care from committed and empathic professionals who can help them reconcile the dilemmas of becoming ill, accept available treatments, while protecting dignity and emotional resources.

An essential element of care is to sustain and encourage optimism and hope, while sharing knowledge about how to overcome symptoms and the financial and social implications of developing and living with a mental illness. Studies of hope and optimism in psychiatric care are rare.[1,2] Given the economic crisis, new models of care are needed but new professional attitudes and approaches must accompany these, in order to avoid inadvertently perpetuating institutionalised practices that serve the organisation and not the patient. What is the role of psychiatric research and practice in supporting health systems to adopt evidence-based transitions that protect patients, and eradicate uncaring practices, which undermine hope?

Hope and optimism are essential elements of the therapeutic encounter. Research that helps to stratify the risks of medical disorders is in itself a hopeful activity that encourages patients and the public to commit themselves to prevention and effective early treatment, for example, of breast cancer.[3] In cancer care, much is being done to generate more research funding, reduce stigma, and instil collective optimism within society as well as the scientific community. The prevailing narrative is of improvements in treatment outcomes as a consequence of new research.

The relationship between psychiatry and medicine remains the subject of lively hopeful discussion. The closer alignment of psychiatry with neurology[4] has already been proffered as a solution, yet this is challenged on the basis that psychiatry needs to rid itself of illusory technological solutions in favour of addressing experiences of coherence and meaning, including hope, in the social world.[5] Integration of social/environmental and health services research alongside neurobiological evidence offers better solutions.

New research is forcing amendments to diagnostic and health systems, and consequently the notion of what constitutes an intervention has to change. For example, amid these controversies, researchers are teasing out causal interconnections between what were considered to be discrete psychiatric disorders, revealing shared genetic markers and cortical networks that are causally implicated – see papers by Rees *et al* (pp. 108–114), Rose *et al* (pp. 115–121) and Duffy *et al* (pp. 122–128) in this issue.[6,7] Editorials by Sharpe (pp. 91–92), Craddock & Mynors-Wallis (pp. 93–95) and Barrett (pp. 96–97) grapple with the relationship between psychiatry and medicine (as do Heylens and colleagues, pp. 151–156), and then take up the implications for diagnosis and treatment in a wide range of conditions and contexts.

The research findings in this month's *Journal* take us a step further towards better treatments that do not discriminate between mind and body. These are already instilling hope, hand in hand with the rapidly expanding knowledge about psychological processes, empathy, cognition and neuroanatomical localisation of healthy and unhealthy brain function (see Lloyd *et al* (pp. 129–136), Carnegie *et al* (pp. 137–143), Menchetti *et al* (pp. 144–150) and Gould *et al* (pp. 98–107).[8,9] However, public attitudes perhaps do not fully reflect these advances and we must do a better job of communicating to a wider audience that psychiatric illness is treatable, and that treatment includes instilling hope and restoring meaning as well as the generation and application of new knowledge.

Although deliberations about hope can be restricted to people with multiple forms of stigma, social exclusion and comorbidities,[10,11] its importance is now accepted more widely for all populations and venues of psychiatric practice. Indeed, even in the recently updated edition of Jerome Frank's seminal volume *Persuasion and Healing*, there are elegant neuroanatomical diagrams and in-depth argumentation about the neural and evolutionary basis of hope and its place as a target of intervention.[12] This hopeful enterprise is necessary to promote resilience, creativity, and concern among practitioners, scientists, and the public, and consequently offers direct benefits to patients, so underpinning the future of a hopeful personalised psychiatry.

1 Neugeboren J. Personal accounts: Mental disorders: pathways to hope . . . ? *Psychiatr Serv* 2013; **64**: 950–1.

2 Schrank B, Bird V, Rudnick A, Slade M. Determinants, self-management strategies and interventions for hope in people with mental disorders: systematic search and narrative review. *Soc Sci Med* 2012; **74**: 554–64.

3 Owen DR, Rupprecht R, Nutt DJ. Stratified medicine in psychiatry: a worrying example or new opportunity in the treatment of anxiety? *J Psychopharmacol* 2013; **27**: 119–22.

4 White PD, Rickards H, Zeman AZ. Time to end the distinction between mental and neurological illnesses. *BMJ* 2012; **344**: e3454.

5 Bracken P, Thomas P, Timimi S, Asen E, Behr G, Beuster C, et al. Psychiatry beyond the current paradigm. *Br J Psychiatry* 2012; **201**: 430–4.

6 Bragazzi NL. Rethinking psychiatry with OMICS science in the age of personalized P5 medicine: ready for psychiatome? *Philos Ethics Humanit Med* 2013; **8**: 4.

7 Stefansson H, Meyer-Lindenberg A, Steinberg S, Magnusdottir B, Morgen K, Arnarsdottir S, et al. CNVs conferring risk of autism or schizophrenia affect cognition in controls. *Nature* 2013, Dec 18, doi: 10.1038/nature12818 (Epub ahead of print).

8 Ozomaro U, Wahlestedt C, Nemeroff CB. Personalized medicine in psychiatry: problems and promises. *BMC Medicine* 2013; **11**: 132.

9 Costa e Silva JA. Personalized medicine in psychiatry: new technologies and approaches. *Metabolism* 2013; 62 (suppl 1): S40–4.

10 Eggerman M, Panter-Brick C. Suffering, hope, and entrapment: resilience and cultural values in Afghanistan. *Soc Sci Med* 2010; **71**: 71–83.

11 Siegel K, Meyer IH. Hope and resilience in suicide ideation and behavior of gay and bisexual men following notification of HIV infection. *AIDS Educ Prev* 1999; **11**: 53–64.

12 Vieamontes G, Beitman B. The neural substrate of psychotherapy. In *The Psychotherapy of Hope: The Legacy of Persuasion and Healing* (eds R Alarcon, J Frank): 35–66. Johns Hopkins University Press, 2011.