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Highlights of this issue

Katherine Adlington

'There is no greater agony than bearing an untold story inside you'

Maya Angelou

'Unchaining from the conviction of invincibility'

As the COVID-19 pandemic persists, the health and well-being of staff in healthcare systems globally continue to suffer. Staff are often left struggling in previously unthinkable conditions while 'pouring from an empty cup' in their attempts to support patients. Burnout and 'moral injury' are now often said to be part of the day-to-day reality of many front-line healthcare workers. However, in her editorial, Tine Molendijk (pp. 1–3) urges caution at the uncritical application of this latter term in research and clinical practice.

Yet seeking support for healthcare professionals' own mental distress remains taboo. In her Analysis, Clare Gerada (pp. 7–9) points to the 'all powerful medical identity' as a barrier to doctors accessing mental health support. We are never 'off duty', we don't get ill and nor do our colleagues. If we do get ill, it feels a failure and we would rather 'heal thyself' than bother others with our distress. Written in black and white, these beliefs seem absurd, yet Gerada argues that they are pervasive and strongly held among us. Shame is powerful and prevents doctors from sharing their 'untold stories'.

Gerada points to the importance of services that can offer confidential, contained and skilful support to doctors, such as NHS Practitioner Health, to help them 'unchain from the conviction of invincibility'. Perhaps one of the successes of such programmes is in the knowledge that other doctors are seeking help alongside you – if not in direct sight through support or therapy groups, then silently, confidentially but in solidarity in the consulting room next door.

Indeed, evidence suggests that direct contact with other individuals in 'the stigmatised group' (here being other doctors acknowledging and seeking support for mental distress) is the most effective way to reduce stigma towards treatment. This was the premise for the research study by Amsalem et al (pp. 14–20), which found that a brief 3 min video-based intervention – involving a female nurse speaking positively about the benefits of social support and psychotherapy for helping her cope with COVID-19 stressors – increased treatment-seeking intentions in other healthcare professionals. Any intervention that encourages us to seek mental health support will become increasingly salient as the pandemic 'meanders and persists'.

Continuing to take stock

This month, *BJPsych* also continues to take stock of the impact of COVID-19 on the public and patients (in which healthcare professionals are, of course, included). Paul and Fancourt (pp. 31–37) find that exposure to physical or psychological abuse was by far the greatest predictor of subsequent self-harm thoughts and behaviours in the first 59 weeks of the pandemic – a particularly worrying finding given the increases in domestic abuse observed internationally due to 'stay-at-home orders'. Many more 'untold stories' are unfolding behind many more closed doors.

We need to be cautious of cross-national generalisations about the impact of the pandemic on self-harm and suicide. Partonen et al (pp. 38–40) report no pandemic-related increase in suicide rates in Finland; indeed, there was a monthly decreasing trend up to December 2020. Suicide mortality has been decreasing in Finland since 1990, and it seems this ongoing trend has withstood the storm of COVID-19, for now.

Gessa et al (refs) take a broader perspective of the effects of the pandemic by exploring disruptions to economic affairs and housing arrangements, as well as healthcare access. Combining data from 12 UK population studies, they found that people with poor pre-pandemic mental health experienced greater overall disruption to their lives across multiple domains, but specifically greater likelihood of economic and healthcare disruptions. A reminder that it is difficult to address mental health if the first rung of Maslow's hierarchy of needs – access to food, water, shelter, clothes – is not fulfilled. Yet this is more likely to be the reality for many of our patients.

Challenging received wisdom

Finally, a chance to challenge our assumptions about suicide and the role of healthcare professionals in suicide prevention. Prior research demonstrating that clinician questions about suicidal behaviour don't increase the risk of such behaviour has been reassuring and influential for conducting safe and good-quality risk assessments. However, no one had explored the impact of repeated questioning – a pertinent issue given the tendency in many healthcare settings, particularly in-patient, to repeated history-taking and risk assessment. Thankfully, this month Coppersmith et al (pp. 41–43) present evidence in a neat short report that finds repeated assessment of suicidal thoughts does not lead to increased suicidal thinking iatrogenically.

Last but certainly not least, I would urge you to read the article by Nicolini et al (pp. 10–13). It has the potential to change the way that we think about suicide, euthanasia and medically assisted suicide and is highly topical given the recent decision by the British Medical Association to drop its opposition to assisted dying. Using data from The Netherlands and Belgium, where psychiatric euthanasia and/or medically assisted suicide (EAS) is permitted, they critically examine the difference between EAS and suicide – arguing that the characterisation of suicide as impulsive or violent is not necessarily an accurate or sufficient distinction from the apparently calm 'death wish' of EAS.

Women account for the vast majority (69–77%) of persons who request and receive psychiatric euthanasia and are more likely to attempt suicide. The authors use this gender imbalance to ask whether suicide and EAS could instead be separated on the basis of suicide 'capability'. Importantly, they point to the importance of universal gender-based interventions – such as addressing the gender-based violence that affects 35% of women worldwide – in preventing women from developing their death wish in the first place, however they then choose to pursue it.

And right at the back of the issue, Kaleidoscope discusses the 'Mozart K448 effect' where music by Mozart – and seemingly only by Mozart – can reduce seizures in those with epilepsy.

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