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From The Editor's Desk

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On moral psychiatry

Morality and moral decision-making require emotional intelligence, cognitive reasoning abilities, honesty, motivation and agency that afford intentionality to change our world for the better. The desire to be virtuous coupled with a sense of collective and shared responsibility for the common good can help address dilemmas that people face in living their lives and flourishing. It may even be better to be moral than smart for achieving group and societal success.[1] Psychiatric practice has to engage with many ethical and moral dilemmas, for example, when patients present with experiences of trauma in war and conflict zones. Traumatised patients struggle with the morality of their actions and actions of others, and how a just and safe world seems to be shattered by abuses of power, or by violence or by war and dehumanising treatment of others and themselves.[2]

Mental health professionals who begin their careers with high moral sensitivities encounter moral distress when their roles and values are challenged, and they need to adapt to the constraints of providing care given the limitations of resources and when they meet with therapeutic failures.[3–5] Honesty and doing the right thing despite institutional or societal constraints are important aspects of moral actions in healthcare and are increasingly recognised as critical leadership qualities. Some people are better at this than others, perhaps because of their moral sensitivities; but there is a cost. Moral sensitivity can lead to moral distress in the face of moral burdens; moral support can mitigate this effect.[4]

The practice of psychiatry is regarded as a moral task of engaging with patients' moral dilemmas and offering support and company in determining how they can live the life they wish; healthcare may even improve their ability to resolve dilemmas and make moral decision.[6] Yet, claiming a moral function or role is open also to misinterpretation and abuses of power, not to mention distress to professionals who defend against, as Kinghorn *et al* argue, dualisms of self, body, experiences and behaviours, and values.[7] There is also a risk that engaging in moral issues leads to paternalism and limits autonomy and agency; much care is needed to ensure professional standards and ethical precedents abound.[2,8] Morally injurious experiences are difficult to reconcile and giving them meaning consistent with one's world view can be difficult; for example, among victims of atrocities such as terrorism or amongst combatants in conflict zones.[2,9]

Moral injury is likely in exceptional circumstances such as war but can also exist in ordinary work settings. A systematic review in this issue (Williamson *et al*, pp. 339–346) shows that potentially morally injurious experiences were associated with poor mental health outcomes, such as post-traumatic stress disorder, depression, anxiety and suicidal thinking, and seemed to influence behaviours such as hostility. Military or non-military contexts did not alter this finding. Fear *et al* (pp. 347–355), find that paternal deployment *per se* is not a hazard for children of veterans, but paternal post-traumatic stress disorder as a consequence of deployment is a major risk factor for the mental health of children. Alcohol misuse is often portrayed as a moral failure in society rather than a chronic and potentially life-threatening condition. It is hopeful that interventions are still being developed. Baclofen seemed to extend the time to relapse in dependence, with or without liver disease, and it may extend the number of abstinent days for patients with alcohol-related liver disease (Morley, pp. 362–369).

There are many social determinants of poor mental health and health inequalities. Societal responses to these can seem unjust, either in depriving people of the sick role and expecting self-managed recovery when experiencing severe illnesses; or alternatively, illnesses can perceived to originate in lifestyles choices (drugs and alcohol) that attract condemnation or lesser priority in health care. Education is a right, and a health and moral resource. Lorant *et al* (pp. 356–361) show that the suicides in those with least education were 1.82 times greater than those with the best educational experiences in the 1990s, and that this ratio increased to 2.12 in the 2000s. Inequalities were sustained for men over this time period, but the increase for women needs better understanding of how gender and power operate to worsen outcomes for women.[10]

Student mental health is a global priority, not least as the developmental and maturation process places them at the highest risk for developing mental illnesses. Students of creative subjects are reported by McCabe *et al* (pp. 370–376) to be at greater risk of developing schizophrenia and mood disorders in adulthood, irrespective of IQ. Special supports are recommended for students taking creative subjects to help inform them and promote and protect their mental health.

Research methods must be constantly tested and improved over time to answer ever more critical and refined questions about effective care for people developing mental illnesses. Levis *et al* (pp. 377–385) report that some structured diagnostic interviews were more sensitive and classified more people as having depression than others, and that semi-structured and structured instruments are not interchangeable. Trials of cognitive–behavioural therapy, medication and placebo show enduring effects that may be a function of spontaneous remissions, or regression to the mean, rather than true treatment effects (Bandelow, pp. 333–338). The moral risks posed by research methods that are not sufficiently rigorous or powerful to show definitive effects (positive or negative) are usually considered in ethical review processes. We also rely heavily on the moral integrity of authors and reviewers to offer transparency in describing their research methods, avoiding protocol violations and outcome switching, and careful manuscript preparation including statements of *a priori* trial registrations and ethical committee reviews before recruitment into research, as well as adhering to standardised reporting frameworks. Patient participant involvement in research produces better outcomes,[11] and is also a way of ensuring moral dilemmas, issues that are at stake for patients, are not overlooked and are transparent. Yet, patient participant involvement can challenge professionals and cause moral distress[12] that must be productively harnessed to improve care experiences and outcomes.

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