


## Correspondence

**RE: Positive models of suffering and psychiatry**

*Integrating positive and negative models of suffering: a proposal for a unified approach in psychiatric practice*

I was prompted by the recent publication in the *BJPsych Bulletin* by Huda, 'Positive models of suffering and psychiatry',<sup>1</sup> to express my views regarding the juxtaposition of negative and positive models of suffering within psychiatric practice. Although Huda provides a nuanced discussion on the traditional approach to alleviating suffering versus a perspective that sees potential value in suffering, the delineation offers a critical reflection yet also suggests a potential area of confusion for both practitioners and patients. The discourse sets a foundational understanding that whereas the alleviation of suffering is a cornerstone of medical practice, as echoed in the ethos of clinical epidemiology,<sup>2</sup> there exists a parallel narrative that suffering may serve as a conduit for personal growth and enlightenment, aligning with broader existential and psychological theories.<sup>3,4</sup> This dichotomy, although enriching, may inadvertently complicate the therapeutic landscape, suggesting a necessity for a more integrated approach that harmonises these models to enhance patient care. Accordingly, I propose the consideration and development of a unified model that assimilates the ethical imperative to mitigate suffering with a recognition of the transformative potential inherent in the experience of suffering. This model would aim to: (a) prioritise the immediate and compassionate alleviation of suffering as a primary objective of psychiatric intervention, in line with traditional medical practice;<sup>2</sup> (b) acknowledge the potential for suffering to catalyse personal growth, transformation and the acquisition of new perspectives, as detailed in the literature on post-traumatic growth;<sup>3</sup> (c) empower patients by involving them in treatment decisions, echoing the principles of narrative medicine and patient-centred care;<sup>5</sup> (d) foster treatment flexibility, recognising the individual's unique experience of suffering and the dynamic nature of their needs and potential for growth.<sup>4</sup> Such a unified model proposes a more holistic and nuanced approach to psychiatric care, one that not only seeks to alleviate pain but also respects the complex, multifaceted nature of human suffering. The implementation of this model would necessitate a shift towards a more integrative psychiatric education and practice, one that values the depth of human experience as much as the alleviation of symptoms. The dialogue initiated by Huda is invaluable, and it is within this context that I propose a further exploration of how we, as a psychiatric community, can better integrate these models to serve our patients. This endeavour would not only clarify our therapeutic objectives but also potentially enrich psychiatric practice with a deeper understanding and respect for the intricacies of the human condition.

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**Declaration of interest**

None.

**References**

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doi:10.1192/bjb.2024.25



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**RE: Positive models of suffering and psychiatry***The meaning of suffering*

The article by Professor Huda and the letter by Professor Prakash focus on the crucial issue of meaning in suffering. This topic could be addressed similarly by many if not all people with varying degrees of insight, lived experience and expertise. We happen to be doctors and in fact psychiatrists, so what can we bring to the table? First, I would say we have to do our jobs! We are doctors whose job is to bring healing, alleviate pain and suffering, and help people to come to terms with their illness and its impact on their lives and possibly what it means to them. To focus on meaning in suffering may be more appropriate for close friends, family or pastors. A person's world view, belief system and social support network largely determine what they consider to be the meaning, cause or message of illness. Psychiatrists who prioritise the meaning aspect and do not treat the illness may not be providing the service they are qualified for and paid to do. Undoubtedly, understanding why suffering is happening can mitigate anguish, confusion and resentment (to mention a few reactions), and as such, insofar as it is within our job spec, we should facilitate this. However, referral to a pastor, friend or confidante may be more appropriate. The humanity, compassion and empathy, and clinical professional skill of the doctor may be our best combination to bring healing to a suffering person. To overfocus on the supportive, meaningful side to the neglect of the doctor's role in curing and treating illness would be detrimental to our profession. First, we are psychiatrists with a definite job spec; then, we are humans with empathy and compassion and expertise to support our curing role; and, finally, we are learners deepening our own grasp of suffering and its causes and cures from the example of our patients. I congratulate both authors and also

