Chapter 5

Psychiatry from Within and in the Media

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Introduction

In this chapter, I will describe how psychiatrists see themselves and their values as well as how they are seen from the outside. For the former, I will look at both personal and collective values. As for the latter, I will examine the portrayal of psychiatry by the media.

The Values of Psychiatry as Seen from Within

Who we think we are and what we think we do has a major impact on our professional values. The UK's National Health Service (NHS) defines psychiatry as 'a medical field concerned with the diagnosis, treatment and prevention of mental health conditions' (NHS, 2022). The Royal College of Psychiatrists uses a similar definition, stating that 'psychiatry is a branch of medicine dealing with people with a huge range of mental health conditions' (RCPsych, 2025). Although most psychiatrists have a strong medical identity, there are two, to a significant degree related, problems here. Firstly, most clinicians know that to thrive in clinical practice one needs, beyond biomedical knowledge and skills, knowledge and skills that pertain to the human disciplines. Secondly, in spite of this, in psychiatry there is an almost unbridgeable gap between clinical practice and research that is so heavily weighted towards neuroscience and epidemiology that it seems to be 'too often not continuous with the world, in general, and the clinic, in particular' (Stanghellini, 2013, p. 499). Yet, apart from their specialty training, research is one of the main sources of education for psychiatrists. These important problems have an impact on how we see ourselves both as individuals and as a profession.

Personal Values

The Origins of Our Personal Values as Psychiatrists

Where do our personal values as psychiatrists come from? Broadly speaking, we develop them throughout life. We bring many of our fundamental values from our personal history as a son or daughter, brother or sister, father or mother, friend, and member of our community. They are shaped and moulded by influences from those close to us as well as the culture (or cultures) we have lived in. Many of our personal values come from our training; some of these are rooted in current practices, and some are vestiges from the history of psychiatry (Dudas, 2022).

Although it seems intuitive, relatively little research evidence has been published about the influence of personal history on the values of clinicians in general. Autobiographical writings of prominent personalities in mental health (e.g. Clark, 1996; Gask, 2015; Sternberg

et al., 2016) and biographies about them (e.g. Demorest, 2004) allow us a glimpse into how one's own life history can influence clinicians' professional practice. In *The Story of a Mental Hospital: Fulbourn 1858–1983*, David Clark (1996) gives a poignant example of how his own life experiences shaped his professional values. Clark became Medical Superintendent of Fulbourn Hospital near Cambridge when he was thirty-two and worked in that capacity from 1953 to 1971. He led a group of conscientious objectors into action during the Second World War and saw in Germany the horrors of the Nazi concentration camps. In Sumatra, he was in charge of a camp of 2,000 Dutch civilians and negotiated with them and others in order to avoid a massacre. This 'taught [him] something of the perils and responsibilities of command, ... and left [him] with a deep distaste for locking anybody up' (Clark, 1996, p. 39). One of the reasons he took the job in Fulbourn was the wish to improve the conditions on the long-stay wards where, he describes, patients were 'left, neglected, to their hallucinatory ramblings, or worse, locked up in padded rooms, straight-jacketed or mistreated by staff because of their violence' (Clark, 1996, pp. 39–40). His experience in the Army had made him acutely aware of how people's mental health was influenced by the way in which they were led. Under Clark's leadership, the majority of the patients in Fulbourn Hospital were rehabilitated. Many of them were discharged permanently and moved back into the community.

There is a growing body of literature on illness in the clinician and the impact of that on their practice and professional values. The concept of the 'wounded healer', based on the idea that experiencing and overcoming illness personally can make one a better therapist, has a long history (Jackson, 2001). There are examples from both physical and mental health. For instance, doctors with a personal history of migraine were found to have a more somatic view of migraine (Evers et al., 2020). General practitioners' (GPs or primary care physicians) treatment choice for depression was found to be influenced by personal history of psychotherapy or antidepressant treatment, and history of depression in someone close (Dumesnil et al., 2012). Personal history has a profound effect on us as professionals. Psychiatric, psychology, pediatric, and social work professionals who had been sexually or physically abused themselves were found to be more likely to believe allegations of sexual abuse contained in sixteen case vignettes (Nuttall and Jackson, 1994). Interpretative phenomenological analysis in relation to primary care physicians revealed that experiencing disempowerment and vulnerability as a patient was particularly insightful for the physicians and helped them develop more empathy for their own patients (Fox et al., 2009).

Becoming a mental health patient as a psychiatrist is not a prerequisite, but reading about the experiences of those of us who have can certainly inform our understanding of relevant values. In *The Other Side of Silence: A Psychiatrist's Memoir of Depression*, Linda Gask (2015), an academic psychiatrist and clinician, describes how many of her values were shaped by her own illness and her interaction with psychiatry both as a psychiatrist and as a psychiatrist patient. She tells us how, when she was not well enough to treat others, she always sought help to recover first, as it would have been unethical to treat others when she was not herself. As a patient, she wanted to talk to someone who had trained as a psychotherapist: 'Even if I suspected, though with some ambivalence, that I needed first and foremost more medication, it was important for me to talk to someone who would be able to appreciate my story as well as my symptoms' (Gask, 2015, p. 175). She believes that her experience of depression has helped her become a more humane and understanding clinician, but she is aware that she still does not have all the answers.

Although Gask became clinically depressed, her description of becoming and working as a psychiatrist is also applicable to many psychiatrists who have not developed mental illness but may have shared one or two of the elements of her history. Whilst not present in every psychiatrist's upbringing, growing up in an environment where she constantly needed to use her emotional antennae to detect the 'mood' in the house (she had a brother with severe obsessive compulsive disorder) prepared her for empathizing with her patients. On the negative side, this also came with (sometimes crippling) oversensitivity to the actions of others: 'I was able to imagine myself without too much difficulty into the mental world of the people on the psychiatric unit: the anxious, the depressed and even the paranoid. I felt like I had finally reached my destination, not only because I seemed to have some kind of aptitude for psychiatry but because life on the ward resonated with something inside of me' (Gask, 2015, p. 37). She seems to have turned her history to her advantage: 'I was succeeding in my new career and I had something crucial in common with my patients: we had all been wounded by life' (Gask, 2015, p. 74).

Needs, Concerns, and Preferences Related to Working in Psychiatry

It is worth saying a few words on the specific challenges of working in psychiatry as seen by psychiatrists. In his book *The Wounded Healer*, Omar Reda (2022) says that '[e]ntering the landscape of pain . . . is a heroic act, even though caregivers do not see themselves as heroes. To console, hold, and sustain others whilst they are "falling apart" requires heroic skills. Yet that can be a heavy burden' (Reda, 2022, p. 1). Reda warns that '[b]ehind the mask also is a human, not a superhero, and not a machine, but a human who has emotions and has basic needs that deserve to be fulfilled. One way to do this is "not to take your clients home with you"' (Reda, 2022, p. 23). Psychiatrists often have a heavy caseload, work long hours, with little support, and have to drive long distances when on call, leading to fatigue (Till et al., 2018); all of this can make it difficult for them to appreciate other aspects of their lives. Tellingly, as regards the things that could tip her into despair in a matter of days, Linda Gask asks, 'Wasn't it always work? Or at least this is what I found most stressful. It was never the patients who kept me awake at night but my interactions with the system' (Gask, 2015, p. 13). As Reda explains, 'We might feel like a failure and think of quitting. We come close to walking away on multiple occasions, but the field holds a power over us every time we are about to exit its doors. That power, I believe, is love. We love what we do, and we cannot see ourselves doing anything else as rewarding' (Reda, 2022, p. 54). Talking about the needs of people in these demanding, caring roles, Reda (2022, pp. 121–123) draws attention to the importance of deep kindness and physical, sexual, psychological, social, financial, and spiritual safety.

Collective Values

But psychiatrists' values are not only shaped by individual values; they are also shaped by the norms, rules, and expectations of their profession and their regulatory bodies. Training is pivotal; therefore, I will look at the new psychiatric curricula in the UK. The curriculum of an era allows insight into the prevailing thinking around the profession's dominant values and aspirations.

The Values of Psychiatry as Reflected in the Curricula for Psychiatry Training

Values are not always immediately apparent; sometimes they are easier to notice when they are changing. This is why it may be particularly useful to look at differences in the expressed

value content between the purpose statements of the old and the new curricula. The psychiatry curricula in the UK function as an educational plan tied to goals and objectives. They serve as the basis for training programmes to achieve specific knowledge, behaviour, and attitudes for future psychiatrists. They are value-laden and guide trainers in choosing educational activities preferentially. Core training is the first half of the training before trainees start off on their path of sub-specialization. The old core curriculum (RCPsych, 2013, p. 5) says: 'What is set out in this document is the generic knowledge, skills and attitudes, or more readily assessed behaviour, that we believe is common to all psychiatric specialties.' The new core curriculum (RCPsych, 2022, p. 2) emphasizes that this is a multidisciplinary activity with a variety of stakeholders: 'The purpose of the Core Psychiatry curriculum is to train medical doctors to specialise in the assessment, diagnosis, treatment and management of patients with mental disorders in a wide range of clinical settings in collaboration with the patient, other health professionals, and relevant others including families and carers of all ages.'

The new core curriculum then goes further and states that psychiatrists of the future will be well-equipped to (italics are mine):

– Maintain their key focus on *developing and achieving the necessary professional values and behaviours, professional skills, and professional knowledge to build strong therapeutic relationships with their patients, their carers and families* and to *provide safe person-centred care*.
– *Embrace continuing person-centred holistic advances* in Psychiatry, *as well as developments in technology and practice*, which are consistent with the principles of *sustainability*.
– Have the *relevant specialist knowledge and communication skills* to operate effectively in a range of service delivery landscapes. (RCPsych, 2022, p. 2)

Noticeable is the change from the old core curriculum in the order of the words '*knowledge*', '*skills*', and '*behaviour*' and the addition of '*values*' in the first position in the sentence, giving it the most weight.

In order to successfully implement the new curriculum, a document called the Silver Guide was developed. The Silver Guide was based on the Gold Guide, which is a reference guide for postgraduate medical training in the UK, maintained by the Conference of Postgraduate Medical Deans on behalf of the four UK health departments.

The Silver Guide places great importance on the person-centred holistic model of psychiatry. According to this, certain concepts are fundamental to good professional practice. These concepts include the patient as a whole person: body, mind and spirit; a compassionate clinical approach, based on both values and evidence; multidisciplinary working; shared responsibility and shared decision-making with the patient and other stakeholders; a model of the person which draws on the social sciences, neurosciences, and the humanities; and the impact of culture, religion, and social systems on individuals.

The curriculum revision working group engaged in wide-ranging discussions when considering revisions to the curriculum, highlighting the importance of reflecting the equal weighting of the psychological, biological, and social components within the curriculum and taking into consideration the cultural, religious, social, and environmental context. This should mean, at least in theory, significantly greater emphasis in training, compared to previously, on the psycho and the social aspects of the biopsychosocial (BPS) model and regarding them as of equal importance to the biological dimension. This is a very important statement and a welcome change, if successfully implemented. However, whilst

the biological or neuroscience components have seen a major uplift in the UK through the Wellcome-Gatsby neuroscience project and other initiatives, there is no comparable funding initiative for the psychological and the social aspects. A similar effort would be needed to improve the social sciences and humanities content to meet the appropriately high standards of the Silver Guide.

A Closer Look at Values in the New Curricula

Fading and Emerging Values

Values feature more prominently throughout the new core curriculum. In the old core curriculum, the word values was mentioned explicitly only in the context of recognizing the value of diversity within the multidisciplinary team (MDT) and recognizing the value of reflective practice. The new core curriculum gives emphasis to the role of values in what we do by starting its purpose statement with developing our professional values. The other place where values are explicitly mentioned in the new curriculum is the section on communication, which lists as a key capability taking into consideration patients' ideas, values, concerns, and expectations as part of effective communication and shared decision-making. These are the cornerstones of values-based practice (VBP).

The new core curriculum also makes specific reference to professional documents describing these values, such as the Royal College of Psychiatrists' *Core Values for Psychiatrists* (Richards and Lloyd, 2017), which did not exist at the time the old curriculum was created, and the General Medical Council's (GMC) ethical guidance contained in *Good Medical Practice* (GMC, 2024), which describes essential values with a strong focus on communication with all important stakeholders and working in partnership with the patient, taking account of their history and their views and values. *Core Values for Psychiatrists* is a document produced by the Royal College of Psychiatrists. The fact that it was written by Veryan Richards, Patient Representative of the College, and Keith Lloyd, Chair of the Royal College of Psychiatrists in Wales, is evidence of a significant culture change within the profession. Among other sources, it draws on VBP principles. The eight values it lists as core are respect, trust, communication, dignity, empathy, fairness, honesty, and humility. One of the stated aims of this document is to '[provide] a focus for a skills-based approach to decision-making where complex and conflicting values are involved, as a reference point, and as a measuring tool for evaluating practice. It underpins the therapeutic relationship between the patient and the doctor, which in turn influences the quality of recovery' (Richards and Lloyd, 2017, p. 2).

The new core and specialist curricula and the Silver Guide keep the BPS model and emphasize and further elaborate on the holistic, person-centred approach. Although in clinical practice we refer to the BPS model every day to explain mental illness and to formulate treatment, we rarely appreciate the full capabilities of it as a scientific model, or its limitations. George Engel, who developed this model in the 1970s, realized that his was a time when many in psychiatry felt that psychiatry needed to find its way back to medicine, which was rooted in the biological sciences and had been so successful in elucidating the mechanisms of disease and in finding new treatments for (non-psychiatric) medical conditions. He felt that this was misguided and in fact that the whole of medicine was in crisis and needed to adopt a more holistic model of disease that could meet the challenge of the scientific tasks and social responsibilities of both medicine and psychiatry. This is particularly relevant because, as regards psychiatry, much of the criticisms contained in critical and

anti-psychiatry relate strongly to these points. The new curriculum makes fewer explicit references to the BPS approach, especially in the context of treatment. 'Biological' and 'psychological' are mentioned particularly less often than in the old core curriculum. Contrastingly, there are significantly more mentions of *safeguarding* in the new core curriculum, suggesting a shifting emphasis in current clinical practice.

A finer-grained analysis of the content reveals some other interesting trends relating to clinical values. *Person-centred care*, referring to taking into account the whole person by going beyond a narrow focus on their condition or symptoms and also considering their preferences, well-being, and wider social and cultural background, is not mentioned explicitly in the old core curriculum but features prominently in the new. It is mentioned four times in its purpose statement alone, again under the section on professional relationships, and twice under clinical skills. *Co-production*, which means involving patients and carers as equal partners in designing the support and services they receive, appears first in the new curriculum in the context of devising a safe, systemic, effective, collaborative, and co-productive management plan. The clinical skill of understanding the inherent *power imbalance* between doctor and patient is also a new addition. *Protected characteristics*, the impact of social, cultural, spiritual, and religious factors, including the effects of deprivation, discrimination, and racism, also appear for the first time. The understanding of the relevance to our work of the *history of psychiatry*, the evolution of our current diagnostic categories and our treatments, and the historical relationships between psychiatry and society also emerge in the new curriculum. Another significant inclusion is sustainability, which has implications for prevention, patient empowerment, and efficient service delivery, apart from low carbon outcomes.

In general, more reference is made to VBP principles in the new specialist curricula too. For example, the new old age curriculum builds on from the new core curriculum as regards developing further the professional values explained in there. Under the heading of person-centred care, by the end of their training trainees are expected to demonstrate a *holistic and person-centred clinical approach* to older adults that is empathic and compassionate, and that respects their dignity whilst maintaining therapeutic optimism, thus remaining realistically optimistic and honest whilst maintaining boundaries. They should be able to conduct person-centred holistic assessments of older people, including history taking, mental state examination, and relevant psychopathology, that takes into consideration the psychological, social, cultural, spiritual, and religious aspects of ageing, activities of daily living, physical health, medication, frailty and falls, and death and dying. Similar to the new core curriculum, *co-production* appears in the new old age curriculum. Old age trainees are expected to demonstrate an *inclusive leadership style* and *awareness of the impact of hierarchy and power within relationships* with both patients and colleagues. The new old age curriculum keeps the BPS model when considering both aetiological factors and treatment. There are fewer mentions of 'medication', 'pharmacological', or 'drug', and especially of 'medical' than in the previous old age curriculum and there are more mentions of *safeguarding*.

How Could We Further Improve the Coverage of Values in the Curricula?

The new curricula include the values aspect much more prominently and describe the desired outcomes in detail in terms of clinical skills and qualities of care. What appears to be needed is bridging the gap between these ideals and their realization in actual clinical practice. Future iterations may want to include more on questions like 'How do we actually do person-centred care?'. Teaching the VBP skills of awareness, reasoning, and

communication relating to values and resolving value conflicts would be relevant here. We would also need to teach trainees how to argue their point when it comes to values. If we expect psychiatrists to embrace the clinical values mentioned in the previous section, we also need to include more in the training about the evidence-base supporting the person-centred model in terms of efficacy, patient and professional satisfaction, and health economics, so as to provide arguments for its wholesale adoption beyond its intuitive usefulness. Another crucial question is how we can balance the curricula well in order to ensure that each component of the BPS model (and preferably also the existential dimension of mental illness) gets equal weight and the same high-quality coverage. And how can we ensure the same in workplace-based assessment, training courses, and exams?

It is important to mention a set of important clinical values that currently do not feature prominently and are not made explicit in the curricula but nevertheless guide current clinical training and practice. These relate to two main themes: (1) treatment of and recovery from mental illness and (2) challenges we need to negotiate in the current climate.

As regards the first of these themes, *dealing with uncertainty* is a major challenge in psychiatry that features relatively little in the curricula. It is important that we highlight possible sources of uncertainty, such as mental symptoms being *hybrid objects* (Berrios and Marková, 2015) and *overdetermined*, not having laboratory tests for most conditions, the significant unpredictability of human behaviour, and several different treatments all being potentially appropriate for a problem. Clinicians in mental health often look after or work with patients who have extraordinarily tragic life stories that most people would find difficult even to hear, or patients who display behaviours that would drive most people away, or patients who simply do not want to engage with any help. Maintaining *unconditional positive regard* in these situations is a value that is embodied by most psychiatrists but is currently only implied in the curriculum. The recovery movement in mental health has highlighted the importance of fostering healthy coping mechanisms, supportive relationships, empowerment, social inclusion, and meaning, in addition to treating symptoms. *Recovery* in this context does not always mean no longer meeting the criteria for diagnosis; it can involve recovering from the initial shock and learning to tackle mental health problems with hope and optimism, and to work towards a valued lifestyle. The patient's *personal narrative* has always been important in all branches of medicine but has never taken centre stage quite as much as in psychiatry, both in diagnosis making and in treatment. Psychiatry has a lot to offer in terms of improving our understanding of this important aspect of the healing process in the context of any illness (psychiatric or non-psychiatric) but especially in the context of long-term, chronic conditions. Psychiatrists are expert companions in a *systemic approach to help the patient explore changes in their social roles and identities*.

Regarding the second theme, dealing with the *challenges of a changing healthcare system* requires psychiatrists to think about and adopt a new set of values to manage these. The mismatch between ideal treatment and what (often shrinking) local resources allow at any given time makes it necessary to agree on framework values (e.g. minimum standards) and to negotiate these framework values with both the commissioners and the recipients of these services.

From a methodological perspective, it is important to explore the question of *how we can know that we are getting it right in terms of working with both the values of our patients individually and those of our profession*. Indications about this can come from multiple sources. In reasonably well-functioning healthcare systems, compliments usually significantly outnumber complaints, but they can both serve as validation for our chosen values:

people make compliments and complaints about things that are important to them. Patients and relatives rarely complain about lack of knowledge; they complain much more often about communication problems and about being treated rudely, insensitively, or disrespectfully (Pitarka-Carcani et al., 2000). When things have gone really well, patients and relatives praise the personal relationship much more than safety or other aspects. These all argue in favour of taking a person-centred approach (Gillespie, 2021). Job satisfaction and recruitment and retention figures are also a good measure of whether we are getting our values right at work. Last but not least, there is growing evidence that VBP principles can improve clinical outcomes (de Silva, 2011, p. 6).

Psychiatry in the Public Discourse

Why Is It Important?

Media coverage of mental illness and psychiatry serves as a barometer of public opinion (Anderson et al., 2020), shapes public attitudes and stigma (Anderson et al., 2020), and influences whether and at what point people decide to seek help for mental ill health (Nesseler, 2011). The media also provide frames for organizing information and sense-making and a forum for the active construction of everyday knowledge about health and illness by the public (Ohlsson, 2018). Another important function of the media is the examination of psychiatry as a social institution (Ohlsson, 2018). Publicity can protect people from abuse and neglect and various other wrongdoings.

What Is the Public Image of Psychiatry Like in the Media?

Although there has been increasing coverage of the subject in all types of media, most research studies focus on written and/or electronic media. There is a tendency to portray mental illness as something new and affecting increasingly large sections of the population (Nesseler, 2011; Ohlsson, 2018). On the other hand, there are also voices warning about an unhealthy societal preoccupation with health rather than serious health problems, linked to unreasonable expectations of life (Ohlsson, 2018).

Overall, the coverage of mental illness has been improving, offering a more balanced view, since around the 1990s (Gallagher et al., 2023; Grandón et al., 2022; Nesseler, 2011; Oliver et al., 2020), but mental illness still often appears in association with negative attributes, contributing to preserving unhelpful stereotypes, such as that people with mental illness are dangerous or lazy, that mental illness is a threat to public health and welfare (Ohlsson, 2018), and that treatments are cruel and ineffective (Nesseler, 2011). The portrayal of psychotic conditions has been found to be more likely to be stigmatizing (Gallagher et al., 2023; Nawková et al., 2012), whilst articles on depression have gradually become less likely to be stigmatizing (Gallagher et al., 2023). Although suicide is not a mental illness, it is often associated with it. Improvements in the way the media cover celebrity suicides have helped reduce the Werther effect, that is, spikes in the suicide rate following announcement of a celebrity suicide. The association is less clear after non-celebrity suicides, which are also frequently reported but tend to appear in local news outlets as opposed to national or global ones (Niederkrotenthaler et al., 2020). Responsible reporting guidelines recommend avoiding mention of the method used, avoiding repeatedly reporting the same suicide, and including information on treatable mental illness and where and when to seek help.

In the media, there is a tension between the need for objective portrayal and the need to attract readers, and this is reflected in the choice of words used (Nesseler, 2011). Psychiatric care is often pitched as a struggle between individual freedom and the demands of society (Nesseler, 2011). In this context, confidence in and dependence on experts is juxtaposed with (often harsh) critique and expressions of distrust (Ohlsson, 2018). The expertise of psychiatrists is questioned on grounds like psychiatry lacking scientific foundations, practice being based on obsolete ideas, and whether an objective distinction can be made between normal and pathological (Ohlsson, 2018).

The increasingly widespread use of social media has changed the media landscape profoundly: one-to-many communication has been replaced by many-to-many and many-to-one forms (Nesseler, 2011). This means that public opinion can be perceived by the stakeholders much more closely and swiftly. It has become an almost complete free-for-all. Opinion leaders without any specific training, experience, professional regulatory control, or responsibility can enter the conversation at any time. Interpreting a clinical situation is no longer done exclusively by individual professionals, professional organizations, and healthcare providers; rather, their opinion is only one of the many circulating widely within the population. There is much wider participation, but often without the support and oversight necessary for a good outcome. Some levelling out can potentially be helpful in places where there is still an unhelpful power imbalance, but it is likely ill-advised to do away completely with the fact of professionals having power over decisions that require very specific knowledge and skills: nobody would want the passengers to vote on what is wrong and what should be done next when an aeroplane is in difficulty, let alone allow the one with the loudest voice to decide. Research (Ohlsson, 2018) has found that some in the media have expressed that the intermingling of views from experts and those without proper knowledge on the subject may even contribute to the stigmatization of mental illness. It is important to note that this is different from including in the debate the voices of patients and carers who are experts by lived experience, which is of course vital.

Nowadays, patients and carers often look up information on the internet on diagnosis, treatment, and/or likely outcomes. Depending on the quality of the source and the reader's ability to engage with the information in the absence of expert help, this can be very helpful but can also bring a whole raft of potential problems: a totally different range of expectations, incorrect understanding of what one needs in order to get better, and sometimes significant concerns without a good reason. Some patients and carers will just bring the information they collected into the discussion, whilst others will go further and make their own self-diagnosis or demand certain treatments on the basis of that. It has been highlighted that the rapid and widespread appearance of synthetic media (material created by artificial intelligence) poses a new threat by spreading misinformation (Monteith et al., 2024).

Old stereotypes about mental illness and psychiatry are still very much present in the public mind and the media (Nesseler, 2011); there is a significant lag between the public image and current clinical practice (Dudas, 2020). There are, however, some specific positive new developments, too, including self-help chat forums and high-quality documentaries allowing a glimpse into the lives of people with mental illness and into what stigma feels like for those on the suffering end.

Suggestions for the Future

Similar to the guidelines for responsible reporting on suicide, guidelines for portraying patients with mental illness and their care have been called for. In order to make a positive

change in public attitudes, mental health stories would need to be consistently contextualized and use inclusive language (Oliver et al., 2020). Stories illustrating successful interventions should also see the light of day (Oliver et al., 2020). This is particularly important in light of research showing that mental health services and mental health professionals were seen as poorly represented by the news media, which was thought to deter help-seeking and hinder trust (Oliver et al., 2020).

References

Anderson, C., Henderson, C., Hildersley, R. & Potts, L. 2020. Improvement for most, but not all: Changes in newspaper coverage of mental illness from 2008 to 2019 in England. *Epidemiology and Psychiatric Sciences*, 29, e177.

Berrios, G. E. & Marková, I. S. 2015. Toward a new epistemology of psychiatry. In Kirmayer, L. J., Lemelson, R. & Cummings, C. A. (eds.), *Re-visioning Psychiatry: Cultural Phenomenology, Critical Neuroscience, and Global Mental Health*. Cambridge: Cambridge University Press, pp. 41–64.

Clark, D. H. 1996. *The Story of a Mental Hospital: Fulbourn 1858–1983*. London: Process Press.

Demorest, A. P. 2004. *Psychology's Grand Theorists: How Personal Experiences Shaped Professional Ideas*. Mahwah, NJ: Lawrence Erlbaum Associates.

De Silva, D. 2011. *Helping People Help Themselves: A Review of the Evidence Considering Whether It Is Worthwhile to Support Self-Management*. London: Health Foundation.

Dudas, R. 2020. The discontents of psychiatry: What can the history of psychiatry and values-based medicine contribute to resolving them? In Marková, I. S. & Chen, E. (eds.), *Rethinking Psychopathology: Theory and History in the Human and Social Sciences*. Cham: Springer, pp. 145–152.

Dudas, R. B. 2022. Values-based practice: How can history taking help psychiatrists explore the values involved in clinical decision-making? *British Journal of Psychiatry Advances*, 28, 153–162.

Dumesnil, H., Cortaredona, S., Verdoux, H., Sebbah, R., Paraponaris, A. & Verger, P. 2012. General practitioners' choices and their determinants when starting treatment for major depression: A cross sectional, randomized case-vignette survey. *PLoS (Public Library of Science) One*, 7, e52429.

Evers, S., Brockmann, N., Summ, O., Husstedt, I. W. & Frese, A. 2020. Primary headache and migraine in headache specialists: Does personal history of doctors matter? *Cephalalgia*, 40, 96–106.

Fox, F. E., Rodham, K. J., Harris, M. F., Taylor, G. J., Sutton, J., Scott, J. & Robinson, B. 2009. Experiencing 'the other side': A study of empathy and empowerment in general practitioners who have been patients. *Qualitative Health Research*, 19, 1580–1588.

Gallagher, M., O'Leary, C., McGreal-Ballone, A. & Duffy, R. 2023. The portrayal of mental health in Irish mainstream news media. *International Journal of Social Psychiatry*, 69, 467–475.

Gask, L. 2015. *The Other Side of Silence: A Psychiatrist's Memoir of Depression*. Chichester: Vie Books.

General Medical Council (GMC) 2024. *Good Medical Practice*. www.gmc-uk.org/-/media/documents/good-medical-practice-2024—english-102607294.pdf.

Gillespie, A. & Reader, T. W. 2021. Identifying and encouraging high-quality healthcare: An analysis of the content and aims of patient letters of compliment. *BMJ (British Medical Journal) Quality and Safety*, 30, 484–492.

Grandón, P., Fernández Vega, D., Sánchez Oñate, A. A., Vielma Aguilera, A. V., Villagrán Valenzuela, L., Vidal Gutiérrez, D., Inostroza Rovengno, C. & Whitley, R. 2022. Mental disorders in the media: A retrospective study of newspaper coverage in the Chilean press. *International Journal of Social Psychiatry*, 68, 1351–1362.

Jackson, S. W. 2001. The wounded healer. *Bulletin of the History of Medicine*, 75, 1–36.

Monteith, S., Glenn, T., Geddes, J. R., Whybrow, P. C., Achtyes, E. & Bauer, M. 2024.

Artificial intelligence and increasing misinformation. *British Journal of Psychiatry*, 224, 33–35.

National Health Service (NHS) 2022. Psychiatry. www.nhs.uk/mental-health/talking-therapies-medicine-treatments/medicines-and-psychiatry/psychiatry.

Nawková, L., Nawka, A., Adámková, T., Rukavina, T. V., Holcnerová, P., Kuzman, M. R., Jovanović, N., Brborović, O., Bednárová, B., Žuchová, S., Miovský, M. & Raboch, J. 2012. The picture of mental health/illness in the printed media in three central European countries. *Journal of Health Communication*, 17, 22–40.

Nesseler, T. 2011. Narrated truths: The image of psychiatry in the media. *European Archives of Psychiatry and Clinical Neuroscience*, 261, S124–S128.

Niederkrotenthaler, T., Braun, M., Pirkis, J., Till, B., Stack, S., Sinyor, M., Tran, U. S., Voracek, M., Cheng, Q., Arendt, F., Scherr, S., Yip, P. S. F. & Spittal, M. J. 2020. Association between suicide reporting in the media and suicide: Systematic review and meta-analysis. *British Medical Journal*, 368, m575.

Nuttall, R. & Jackson, H. 1994. Personal history of childhood abuse among clinicians. *Child Abuse and Neglect*, 18, 455–472.

Ohlsson, R. 2018. Public discourse on mental health and psychiatry: Representations in Swedish newspapers. *Health*, 22, 298–314.

Oliver, N., Beddoe, L. & Adamson, C. 2020. Mental health and the news media in Aotearoa New Zealand: Key informant perspectives. *Aotearoa New Zealand Social Work*, 32, 158–171.

Pitarka-Carcani, I., Szmukler, G. & Henderson, C. 2000. Complaints about care in a mental health trust. *Psychiatric Bulletin of the Royal College of Psychiatrists*, 24, 372–376.

Reda, O. 2022. *The Wounded Healer: The Pain and Joy of Caregiving*. New York: W. W. Norton and Company.

Richards, V. & Lloyd, K. 2017. *Core Values for Psychiatrists*. College Report CR204. London: Royal College of Psychiatrists. www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr204.pdf?sfvrsn=5e4ff507_4.

Royal College of Psychiatrists (RCPsych) 2013. *Core Training in Psychiatry CT1–CT3: A Competency Based Curriculum for Specialist Core Training in Psychiatry*. www.rcpsych.ac.uk/docs/default-source/training/curricula-and-guidance/curricula-core-psychiatry-curriculum-april-2018.pdf?sfvrsn=881b63ca_2.

Royal College of Psychiatrists (RCPsych) 2022. *Core Psychiatry: Royal College of Psychiatrists Core Training Curriculum (CT1–CT3)*. Version 1.0. www.rcpsych.ac.uk/docs/default-source/training/curricula-and-guidance/2022-curricula/core-psychiatry-curriculum-final-17-august-2022.pdf?sfvrsn=36b5ba25_10.

Royal College of Psychiatrists (RCPsych) 2025. What is psychiatry? www.rcpsych.ac.uk/become-a-psychiatrist/choose-psychiatry/what-is-psychiatry.

Stanghellini, G. 2013. The portrait of the psychiatrist as a globally minded citizen. *Current Opinion in Psychiatry*, 26, 498–501.

Sternberg, R. J., Fiske, S. T. & Foss, D. J. (eds.) 2016. *Scientists Making a Difference: One Hundred Eminent Behavioral and Brain Scientists Talk About Their Most Important Contributions*. Cambridge: Cambridge University Press.

Till, A., Walker, T., Kansagra, A., Bailey, A., Blewett, C. & Milward, K. 2018. *Supported and Valued? Staying Safe – A Trainee Led Review into Fatigue within Psychiatry*. London: Psychiatric Trainees' Committee, Royal College of Psychiatrists. www.rcpsych.ac.uk/docs/default-source/training/training/ptc/supported-and-valued-staying-safe.pdf?sfvrsn=5cbebec6_2.