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From the Editor's desk

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On *Blackstar*: deaths, dying and dominions of discovery

The New Year has been marked by death announcements of celebrities who had won a place in the hearts, lives and histories of the people around the world. It is remarkable how some of them, suffering a terminal illness, prepared so well for their death. David Bowie's song 'Lazarus', off the album *Blackstar*, depicts him lying in a hospital bed, a scene that was poignantly interpreted as preparation when his death was announced the following week. He made use of art and his talents to prepare and share loss. Alan Rickman also left this world memories of his remarkable edgy roles in films such as *Die Hard*, *Harry Potter*, *Sense and Sensibility*. In *Truly Madly Deeply*, as Jamie, he returns from the grave to be with his wife Nina (Juliet Stevenson), intensifying her wounds by shocking, terrifying and then delighting her, when she realises his presence in the room playing the cello as she played the piano was not a hallucination. He struggles with a dislocated existence, feeling cold all the time, but finding solace in the company of other displaced deceased invited round to watch soccer. Nina is reassured that she is not losing her mind when consoled by a friend who confides that he also talks to his long lost partner, reminding Nina, with reference to Dylan Thomas, that 'death shall have no dominion'. And as their grief is explored, Jamie and Nina together recite Pablo Neruda's The Dead Woman: '. . . my feet will want to walk to where you are sleeping, but I shall stay alive . . . '. Nina eventually begins to mourn and seek a new relationship, to which both are resigned.

Public or extensive grief is taboo, yet grief is a universal form of suffering, so ubiquitous yet so always unexpectedly harrowing when precious, lifelong attachments are lost, conversations severed, and final words said. We are at times of loss reduced to our infant selves, fragile, as if without a protective skin, sensitive, brittle and frail. Society sanctions rituals around mourning, and following these, people return to work and ordinary roles, the breaches of which indicate abnormal or complex grief. DSM-5 recognises the risk of major depression after loss, although surprisingly the criteria of persistent affective symptoms only 2 weeks following loss is sufficient for this diagnosis. This remains a symptom-based rather than a person-centred, or experiential approach, which might yield a more authentic and contemporary account of how people respond to loss.[1] Grief is especially difficult if the death of a person is stigmatised because of preceding illness (perhaps cancer or schizophrenia) and if unexpected, violent or a consequence of extreme circumstances (stillbirth, for example).[2–4] Bereavement by suicide is stigmatised, and engenders severe and intense feelings of isolation, rejection, regret, depression and suicidal thinking.[5] A very public experience of shared grief is Michael Mansfield's. Mansfield, a barrister, who has committed his life's work to fighting injustice, has courageously taken on the stigma, neglect and lack of care for the bereaved and for those suffering depression and at risk of suicide; his daughter ended her life after redundancy and a diagnosis of depression.[6] Rates of suicide are more likely to rise at times of economic recession, and have been rising in England since 2008, the time of the economic crisis; and suicide is now the single biggest cause of death in men aged 20–44 in England and Wales. Much is being done to promote prevention by Public Health England, especially a recent call on local authorities to take suicide prevention initiatives more seriously (see https://www.gov.uk/government/collections/suicide-prevention-resources-and-guidance). Some research on interventions in complex grief is emerging[7] but more is needed, albeit care and concern must drive ethical decisions and study designs.[8]

Research in this issue of *BJPsych* shows that antidepressants do not increase the risk of suicidal outcomes (Valuck *et al*, pp. 271–279), but also that adolescents presenting to emergency departments with self-harm, the single most powerful predictor of future suicide, are not well treated or shown reasonable respect, so compounding the isolation and stigma they feel (Owens *et al*, pp. 286–291). Ventilation in intensive care after a suicide attempt seems to be an important indicator of severity and poor outcome (Baer *et al*, pp. 280–285). Galway *et al* (pp. 292–297) suggest that forensic evidence rarely considers toxicology following suicide and call for a sea change in medical forensics to better consider psychosocial factors and toxicology that considers the role of substance misuse.

Cancer was implicated in many of the recent death announcements of public figures; Ishikawa *et al* (pp. 239–244) suggest that if you have schizophrenia, you are more likely to present with cancer at a late stage, and less likely to access more aggressive treatment and therefore experience higher in-hospital mortality. Hirvikoski *et al* (pp. 232–238) report a markedly increased premature mortality in autism spectrum disorder (ASD), owing to a multitude of medical conditions. The risk was particularly high for females with low-functioning ASD. However, individuals with high-functioning ASD had a high risk for suicide. Adequate medical care and research must involve all medical specialties. Connections between mind and body are proposed as focuses for intervention by Endrighi *et al* (pp. 245–251), showing that sedentary behaviour is associated with depression and a worsening of inflammatory markers, and by Batelaan *et al* (pp. 223–231), who suggest that prompt treatment of anxiety may prevent adverse cardiac events.

Psychological therapies are now central to mental healthcare the world over, and irrespective of cultural origins, socioeconomic status and wealth. Bhumann *et al* (pp. 252–259) provide a worrisome report that cognitive–behavioural therapy for post-traumatic symptoms among refugees is ineffective, and antidepressants only produce a small benefit. Crawford *et al* (pp. 260–265) also suggest more caution and care around the use of psychological therapies, perhaps with more appropriate patient selection and monitoring of adverse effects, which occur in 5% of patients during and after treatment; adverse experiences that might not be manifest in clinical measures of relapse and might therefore be overlooked. Patients given better information about their therapy seemed to be less likely to report adverse experiences. Editorials by Parry *et al* (pp. 210–212) and by Scott & Young (pp. 208–209) make recommendations for future practice and research into adverse experiences during and after psychological therapies.

In anticipation of a brave new world of therapeutics, Hayes *et al* (pp. 205–207) suggest that we take discovery science into digital space and realise the power of social networks, and interventions for both prevention and treatment of mental illness, while promoting mental health. Many clinicians mourn the days of face-to-face and lengthy consultations, when digital records and computer screens did not distract from looking at and conversing with the patient and the family; some still long for the aesthetic of written, albeit illegible, notes and paper files, and the optimism and hope following better investment in mental healthcare. Not all of the past should be idealised. Discovery science has seen much progression in the science of mental healthcare, while retaining art and theatre to effect recovery. As we mourn, we must discover new forms of more effective treatments and services for whole populations and for those presenting to hospitals; we need

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all members of society, from celebrities, clinicians, good Samaritans and citizens, to better recognise the need for and work towards the apotheosis of mental health in every person, family and organisation. It is exquisitely painful to lose a family member, as it is for doctors or health professionals to lose a patient, especially to suicide,[9] and so we must learn to mourn as part of our professional roles and not stigmatise the very ordinary human sentiments, concern and care that seem forgotten at times of loss. This is important for health professionals and their families, who then are in a better position to offer compassionate concern for the cares of life and death.[10]

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