

Editorial

The Role of the Medical Health Humanities in the Study of Mental Health in Family Medicine

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Editorial

While biomedical journals and medical school curricula have adopted some of the principles of the medical health humanities [1], numerous empirical texts continue to negate the social, political, cultural and economic forces which shape individual choices in the daily lived context. The principles of family medicine furthermore dictate that patient-centered healthcare and the impact of medical treatments permeate beyond the clinical sphere and act as forces upon domestic, familial, occupational and community-based settings. Historically, the patient's mental health status and psychosocial wellbeing, in particular, have been neglected in the clinical interview and as being implicated in the aetiology, pathogenesis and chronicity of both communicable disease, and non-communicable diseases of lifestyle.

Exemplifying the need for a multilevel approach in research and clinical practice related to diseases of lifestyle, recent empirical works extend beyond the stratified biomedical approach, and emphasize that metabolic illness coincides with several endophenotypic markers of cognitive dysfunction [2]. More specifically, poorer indices of cognitive performance are particularly evident for executive function – i.e. complex cortical processes which aid decision making, problem solving, planning, and a range of intricate motivation-related behaviours [3,4] – in obese children and adolescents (4-18 years) and in obese adults (19-65 years) [5]. Further inquiry has shown that, while improvements in memory are seen after diet and/or weight loss, the restoration of executive function does not transpire [6-8]. These works emphasize the notion that innate deficits in executive function are not reversible by way of weight loss or improvements in body composition alone, and that integrated treatment modalities which make scope for social, behavioural, psychological and cognitive rehabilitation are required.

With reference to transdisciplinary work on communicable disease, the act of art production (including, but not limited to fine art, music, crafts and drama) is regularly used as a therapeutic modality. For instance, many researchers and practitioners encourage their participants or patients to draw and be creative as the interpretation of patient-produced art offers a unique avenue to explore the broader impact of illness and medical treatment. In 2001 the University of Cape Town's Aids and Society Research Unit launched its Memory Box Project. Here, a group of HIV-positive women outlined their bodies and, through art, articulated their symptoms and subjective feelings and experiences of deterioration in physical and mental functioning due to the disease in their bodies. These

women were encouraged to express their daily lived reality of being HIV-positive, including feelings of stigmatization and social isolation, revealing an intricate interplay between the biomedical, social, and psychic [9].

Further speaking to the value of patient-produced artwork, several epidemiological studies advocate for the validity of the “tortured artist” stereotype by revealing the intersection of creativity and mental illness [10-12]. More importantly, cultural productions stemming from here can provide critical insight into how medicine does not exist in a silo but, instead, is a force that plays out on the individual impacting more than just their health. Fictional texts like Ned Vizzini's *It's Kind of a Funny Story* (2006) and Sylvia Plath's *The Bell Jar* (1963) – both authors having suffered from psychiatric conditions themselves – provide critical insight into the experience of mental illness and patienthood. Alternative forms of creative expression such as rock musical *Next to Normal* (2009), Theodore Gericault's *Portraits of the Insane* series (1822) and even Ludovic Ondiviela's 2014 ballet *Cassandra* repeatedly provoke uncomfortable, lingering questions on the social context of medicine, stress changes in patient treatment and diagnosis, and unveil broader (often derogatory and misled) public perceptions of psychosis. Darren Aronofsky's hit psychological thriller *Black Swan* (2010) unforgettably captures the protagonist's decompensation and its influence on other, pre-existing conditions, interpersonal relationships as well as the home and work environments. Robust engagement with these texts aims to induce critical reflective and self-reflexive practises which assist medical practitioners in their understanding of the individual in healthcare, and the experience of illness beyond the consultation room.

Further highlighting the need for an individualized approach to treatment in non-infectious disease, data from our laboratory show that executive governance is modulated by different neural circuits in the overweight versus the obese phenotype [13]. This observation supports the idea that interventions for non-communicable diseases of lifestyle (even when seemingly alike) require highly tailored treatment approaches which cannot stem from the biomedical domain alone. Insofar as weight-based stigmatization contributes to poorer mental health adjustment, scholars highlight that clinicians and scientists must take seriously the identification and treatment of depression, psychiatric symptoms, body image dissatisfaction, negative self-esteem and even the patient's own “anti-fat” beliefs at the individual level [14]. Emerging research efforts in the developing world mirror this view, and illustrate that the increasing prevalence of obesity is associated with socio-

cultural, environmental and behavioural factors, particularly in groups which have been historically disenfranchised [15]. As such, influences from the humanities broaden the 'medical gaze' to include the real-world context within which the patient exists, and the various forces, ideas, feelings and expectations which might impact upon treatment.

The end goal of the medical health humanities is to promote transdisciplinary awareness, thinking and understanding in both clinical practice and scientific inquiry. The application of these principles and the 'humanization' of healthcare are of particular importance in developing countries, where issues of social justice and historical disenfranchisement obscure the availability of healthcare. Worth noting is the fact that the clinical encounter includes multiple voices (doctor, medical student, nurse, etc.), central to which is the patient's personal health narrative, and his or her subjective experience of health and disease. It is only once the patient (and/or research participant) is viewed *in situ* (i.e. "in place" or within their legitimate context) that informed decisions regarding differential diagnoses and subsequent treatment options can be made.

In conclusion, the physician-scientist must make provision for the collection and interpretation of subjective and contextual data which may inform physiological records, as this is paramount for the translatability of empirical data into the pragmatic management and treatment of disease. Empathy, and the notion that medicine does not terminate at discharge are important areas of overlap between the medical health humanities and family medicine, suggesting that these disciplines – when aggregated – could aid the family physician in identifying the best scientific evidence available, responding optimally to patients' changing needs, and empowering individuals to take charge of their own healthcare.

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