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Psychopathology and political power: Perspectives on mental incapacity in governmental leadership from forensic psychiatry to constitutional law

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Summary

Emboldened personalist regimes, polarised public discourse, and fast-paced media cycles have brought renewed scrutiny to concerns about mental incapacity and psychological "fitness to govern" amongst political leaders. These issues occupy a complex intersection between psychiatry, law, ethics, and constitutional governance. Despite recurring debates about the mental health of heads of government, no universally accepted framework exists for identifying or managing cases of impaired functional capacity due to psychiatric disorders in high office. Accordingly, drawing on examples from different political contexts, this paper reflects on the feasibility and limitations of psychiatric and neuropsychological screening programmes, health and wellbeing initiatives, constitutional architecture, and alternative models of executive power distribution. A central argument is that psychiatric diagnoses, disorder-related functional limitations, constitutional incapacity, and political undesirability represent conceptually distinct constructs, and that clinical assessments would be better framed around the functional demands of office than around diagnostic labels. The analysis also interrogates persistent tensions juxtaposing medical expertise and sociopolitical legitimacy, alongside competing considerations involving patient privacy, transparency, psychiatric stigma, and the weaponisation of clinical judgements. Possible responses to mental incapacity may further be constrained by sociocultural and structural dynamics in a given polity, as well as the will of other constitutional actors, meaning that no single approach offers a definitive remedy. Hence, any potentially workable solutions must be jurisdiction-sensitive and attentive to broader normative questions about "fitness to govern", which many societies have yet to fully confront worldwide.

Keywords: *Mental incapacity; political leadership; fitness to govern; forensic psychiatry; constitutional law*

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INTRODUCTION

In a volatile world riven by geopolitical crises, debates about mental incapacity and psychological "fitness to govern" in political leadership have become increasingly salient (Smith et al., 2025a). These issues defy straightforward resolutions, not least because they have consistently proven cross-culturally and cross-jurisdictionally ambiguous (Klitzman, 2021). A psychiatrist can evaluate a leader (in consultation or from afar), but holds no authority over who governs; constitutions may stipulate removal procedures, but these presuppose a medicolegal consensus on incapacity that rarely exists; a democratic electorate may vote out an incumbent, but seldom has access to transparent health-related information about them.

In practice, psychiatric disorders at the apex of political power have historically been managed more through improvisation and concealment (or luck) than via coherent clinical or legal interventions (L'Etang, 1969; Post & Robins, 1993). These tensions long predate the divisive politics of today, having recurred across disparate eras and contexts. The cases of Jui of Jin (259-307), Juana of Castile (1479-1555), George III of Great Britain (1738-1820), Ludwig II of Bavaria (1845-1886), and Murad V of the Ottoman Empire (1840-1904) all exposed uncertainties in responding to a sovereign exhibiting apparent psychiatric symptoms (Green, 2005; Smith & Liebrenz, 2022). Similar psychopathological narratives have persisted into the democratic era (Ghaemi, 2011; Owen, 2016); the mental health and decision-making of prominent leaders, including Paul von Hindenburg (1847-1934), Anthony Eden (1897-1977), and Boris Yeltsin (1931-2007), have stimulated many pathographic and psychobiographical analyses (Park, 1986; Davidson, 2010).

Recently, the United States President, Donald Trump, has attracted significant psychiatric scrutiny, in keeping with past occupants of the White House (Davidson, Connor & Swartz, 2006; Renshon, 2020). Since first running for office in 2016, psychiatrists and political opponents have disputed Trump's psychological "fitness to govern", advancing various "at-a-distance" diagnoses (Lee, 2019; Wehle, 2026). At times, this discourse has appeared to contravene the American Psychiatric Association's Goldwater Rule, itself introduced following psychopathological conjecture about Barry Goldwater (1909-1998) in the 1964 election, which proscribes psychiatrists from proffering psychodiagnostic opinions on public figures (Martin-Joy, 2020).

Notably, in a 2026 poll, 61% of American voters believed Trump had grown more erratic with age, echoing earlier doubts that precipitated Joe Biden's withdrawal from the 2024 election (Reilly, 2025; Lange, 2026). Elsewhere, other contemporary leaders have elicited analogous speculation, from Argentina and Cameroon to the Russian Federation and South Korea (Lee, 2018; Kupemba, 2024; Jargin, 2025; Smith et al., 2025b). In turn, this underlines how controversies related to mental incapacity can transcend ideological divides and governmental systems.

These discussions, however, frequently become entangled with broader sociopolitical and institutional complications. Secrecy and stigma towards psychiatric disorders in public office have created fertile ground for media sensationalism and the deployment of mental illness as a political attack line (Weinberg, 2022; Reilly, 2025). These circumstances might deter political elites from seeking help or disclosing any psychiatric vulnerabilities, thereby reinforcing cultures of opacity (Flinders et al., 2020). There can also be a certain reassurance in pathologising harmful leaders as "mad" or abnormal, deflecting attention from the wider societal conditions that enabled them (Jutel & Russell, 2023).

Simultaneously, psychiatric diagnoses, disorder-related functional limitations, constitutional incapacity, and ineffective (or politically undesirable) governance are often treated as interchangeable, when in fact they represent conceptually and normatively distinct constructs (Smith et al., 2025c). A clinically valid diagnosis does not necessarily imply any relevant limitations will materialise, and poor judgement or harmful governance may occur in the absence of psychopathology (Nicholl & Greenhalgh, 2026).

Even so, where symptoms are associated with functional limitations applicable to the essential duties of office, concerns about the possible impact of psychiatric disorders amongst political leaders cannot (and should not) be readily dismissed (Wilson, Thomson & Boyd, 2025). For example, impairments affecting judgement, executive control, sustained attention, or behavioural regulation could entail grave implications, particularly where heads of government oversee crisis management and command armed forces (Forrester, 1988; Liapis, 2024). These risks may be heightened in autocratic settings, in which concentrated power is typically less constrained (Newell, 2019; Khorram-Manesh & Burkle, 2023). Equally, at the individual level, leaders retain legitimate entitlements to health and support. Thus, how jurisdictions anticipate and handle these matters warrants serious consideration.

Yet such questions largely remain unresolved internationally, and are inevitably influenced by structural and sociocultural factors within a given jurisdiction (Smith et al., 2025c). For instance, worldwide, legal arrangements diverge on fundamental matters of who may determine mental incapacity and by what standard (The Law Library of Congress, 2020); that such heterogeneity persists despite centuries of recurring precedents underlines the complexities surrounding psychological "fitness to govern".

Accordingly, this article reflects on the merits and feasibility of several mechanisms for preventing and addressing these inherently interdisciplinary and multifaceted challenges, drawing on illustrative examples from screening protocols to constitutional frameworks. Throughout, particular attention is paid to the distinctions between psychiatric diagnoses, disorder-related functional limitations, and constitutional incapacity, as well as how clinical findings might be related to the concrete demands of governmental office without transforming medical assessments into political judgements.

CLINICAL AND OCCUPATIONAL MEASURES

Psychiatric and neuropsychological screening: more questions than answers?

Routine psychiatric and neuropsychological screening programmes represent an oft-touted suggestion to allay concerns about mental incapacity in high office, and have gained renewed traction, especially amidst uncertainties about Joe Biden's cognitive abilities (Reilly, 2025). For example, the American presidential candidate in the 2024 campaign, Nikki Haley, called for "mental competency tests" for politicians aged seventy five or older (Simon, 2024). These proposals have an extensive history, as illustrated by a 1957 British newspaper column, which

affirmed that "senior politicians and statesmen who bear the destinies of millions […] should be compelled to undergo a rigorous medical examination" (Tilea, 1957).

Building on this logic, governmental leaders can be seen as occupying safety-critical positions, wherein compromised judgement could have far-reaching consequences, potentially justifying periodic checks or regular monitoring (L'Etang, 1995). Indeed, analogous cases could be made for evaluating the mental health of other public officials (*e.g.*, judges and military leaders), alongside calls to screen for aversive personality traits in political domains (Abrams, 1986; Gong et al., 2024; Smith et al., 2025d).

Earlier detection of psychiatric and neuropsychological symptoms, facilitated by advances in assessment technologies and Artificial Intelligence, could theoretically enable timely medicolegal interventions (*e.g.*, appropriate treatment or orderly transitions of power). For example, proponents contend that comprehensive evaluations can reveal incipient indicators of neurodegenerative disease with sufficient sensitivity to be informative in high-stakes political arenas (Gong et al., 2024; Kapur & Begam, 2026). Likewise, developments in neuroimaging and fluid biomarkers have been cited as enhancing the identification of pathological processes, as have structured neuropsychological batteries (Gong et al., 2024).

That said, sophisticated assessment tools can incur significant costs, limiting their viability in low-income countries (Smith et al., 2026a). Crucially, no medicolegal threshold for mental incapacity exists, and clinical cut-offs validated in the general population may imperfectly align with the realities of political leadership (Kapur & Begam, 2026); for instance, demographically, heads of government could well diverge from normative samples in age, education, and socioeconomic status. More fundamentally, any screening programme would need to recognise the dichotomy between the presence of a disorder and its functional implications. These are generally evaluated separately for forensic psychiatric and occupational disability purposes, since diagnostic labels provide scant insight into actual role performance outcomes (Linden, 2017).

This distinction is explicitly reflected in the World Health Organization's International Classification of Functioning, Disability and Health (ICF). The ICF complements diagnostic classifications (*e.g.*, the International Classification of Diseases (ICD)), describing how a health condition relates to impairments in body functions and structures, limitations in activities, restrictions in participation, and wider contextual factors (World Health Organization, 2001). Within this framework, disability is considered as an outcome of a dynamic interaction between an individual's health condition, their functional capacities, occupational demands, and the surrounding environment.

Applied to political leadership, the central clinical question would therefore not be whether an officeholder meets diagnostic criteria for a particular psychiatric disorder, but whether identifiable disorder-related impairments materially constrain the performance of constitutionally relevant tasks (Smith et al., 2023). An operational extension of this approach is provided by the Mini-ICF-APP, a clinician-rated instrument developed to structure the assessment of limitations in activities and participation associated with mental disorders, which comprises thirteen capacity domains (Linden & Baron, 2005; Molodynski et al., 2013).

Several of these domains (*e.g.*, planning and structuring of tasks, assertiveness, flexibility) appear relevant to governmental leadership *prima facie* (Smith et al., 2023). Nevertheless, the Mini-ICF-APP should not be misconstrued as a ready-made test of psychological "fitness to govern"; it was developed principally for clinical, rehabilitation, and social-medical purposes, and its ratings must themselves be interpreted in relation to a defined field of demands (Linden & Baron, 2005). In political settings, its principal value could therefore lie in offering a transparent heuristic for identifying and evincing specific functional limitations.

Hypothetically, a political leader may be diagnosed with a mental illness yet serve with no relevant functional impairments, just as another can govern poorly with no psychopathological cause (Nicholl & Greenhalgh, 2026). Hence, a defensible assessment would need to proceed from diagnosis and symptomatology to functional capacity, and from functional capacity to the concrete responsibilities of the office, instead of inferring incapacity directly from a clinical label. Still, even substantive functional capacity determinations cannot alone resolve more intricate questions about "fitness to govern", which transcend medical spheres and resist the kind of standardisation that clinical screening presupposes (Park, 1995; Smith et al., 2025c).

If a sitting leader who has been diagnosed with a psychiatric disorder or found to exhibit relevant functional limitations during an evaluation retains wider support, public sentiments would likely supersede clinical verdicts. Concomitantly, this raises doubts over what weight medical opinions could (and should) realistically hold for constitutional decision-making. Illnesses themselves can connote different meanings cross-culturally, with psychiatric disorders attracting variable perceptions and stigma (Ahad, Sanchez-Gonzalez & Junquera, 2023). Ultimately, behaviours seen as dysfunctional or pathological by one society or citizen (*e.g.*, verbal aggression or impulsivity) might be interpreted by another as emblematic of an unconventional (but appealing) leadership style (Smith et al., 2025b). This has led some scholars to distinguish

between *medical* impairments and *political* impairments (*e.g.*, Post & Robins, 1993).

Besides these conceptual difficulties, deciding who should conduct such assessments could generate controversies. Previously, physician panels have been suggested as a possible mechanism to help mitigate biases and conflicts of interest (Kesselheim, 2002; Gilbert, 2003; Yamey & Hoda, 2024). Even so, institutional hurdles would likely surface, including around financing, appointments, accountability, and susceptibility to undue political interference (Abrams, 1999; Reilly, 2025). External clinicians may also dispute panel conclusions, engendering a proliferation of competing views.

Worldwide, no singular, well-defined procedure covers what actors (governmental, legal, civilian, or otherwise) could compel a medical evaluation, on what grounds, or at what point in a leader's tenure; where such procedures do exist, they are largely untested (The Law Library of Congress, 2020). In this regard, in 2020, the Speaker of the United States House of Representatives, Nancy Pelosi, advocated for a commission empowered to require annual presidential health examinations. This legislation stalled based on partisan lines, illustrating how readily these measures can succumb to realpolitik (Klitzman, 2021). These arrangements would be harder to envision in autocratic systems, as oversight is weaker (or absent) and information about leaders can be fiercely protected state secrets (Smith et al., 2025a).

The parameters of public engagement are no less troublesome, pitting a societal "right to know" against an individual's right to privacy (Kesselheim, 2002; Nicholl & Greenhalgh, 2026). There is no universal answer to what would be divulged (if anything), and in what form. United States presidents are recurrently bound by custom to publicly release medical records, whereas other societies lack comparable traditions (Smith et al., 2023). Transparency of this kind may offer a more durable alternative to formal requirements, though whether these ideas could take root in jurisdictions without similar precedents remains unclear; suffice to say, it may not be in the interest of political elites to submit to disclosure where no such norm prevails.

Notably, recent health communications from United States presidents indicate that these conventions are vulnerable, having eroded into reassuring platitudes (Yamey & Hoda, 2024). Moreover, releasing medical findings might still jeopardise patient confidentiality, depending on their level of detail, and public interpretations of granular neuropsychological and psychiatric data would demand high health literacy amongst the general population (Gong et al., 2024). Contrastingly, (overly) simplified, curated, or fabricated conclusions risk undermining public trust (Smith et al., 2024). Political rivals could also be incentivised to misuse clinical assessments to discredit their opponents (and possibly the whole process entirely), exacerbating the stigma that mental illnesses already generate in sociopolitical spheres (Weinberg, 2022; Reilly, 2025).

This may deter governmental leaders from undergoing medical examinations in good faith, assuming participation is voluntary. Conversely, compulsory consultations invoke separate concerns about autonomy and the outsized influence of those able to mandate or enact them, particularly where findings are contested or a leader refuses subsequent therapeutic recommendations (Smith et al., 2026a). Meanwhile, established "at-a-distance" leadership analysis methodologies, alongside nascent natural language processing techniques applied to public statements, mean that assessments could occur irrespective of consent, invoking further ethical quandaries (Dekleva, 2018).

Each approach carries significant moral and political complexities, pointing to fundamental dilemmas as to who should be authorised to initiate, interpret, and act upon such evaluations. With little prospect of these ambiguities being settled in the short-term, formal screening programmes are likely to remain aspirational in positions of political power, which partly explains why none have been openly piloted in any polity to date.

Occupational health and wellbeing: preventive and salutogenic alternatives?

Less intrusive (and potentially more politically feasible) approaches could instead centre on improving health and wellbeing in governmental contexts. These measures would be primarily preventative and salutogenic, aiming to promote resilience, facilitate help-seeking, and strengthen adaptive coping skills (Weinberg, 2017; Weinberg, 2022). In turn, this could better support politicians exhibiting psychiatric symptoms before they impinge upon functioning and engender thornier concerns about "fitness to govern" (Smith et al., 2025c).

This rationale is underpinned by literature illustrating the pervasive (and in some cases preventable) stressors characteristic of contemporary politics, such as long working hours, intense public scrutiny, job insecurity, and exposure to violence (Roberts, 2017; Flinders et al., 2020). These risk factors are likely more acute in political leadership positions, whose duties exceed those of ordinary legislators (Smith et al., 2025e). Recently, numerous global leaders have highlighted this "brutal" psychological toll, particularly in their resignation speeches (Kassam, 2024).

Of course, the specific responsibilities (and strains) of high office inevitably diverge by jurisdiction, and

empirical data on psychiatric outcomes in executive political leaders is scarce (Smith et al., 2025d). Nevertheless, relevant strategies might encompass confidential care pathways and stress-management programmes (Weinberg, 2022). More broadly, anti-stigma and public education campaigns could help normalise mental health disclosures in political circles (Poulter et al., 2019), and may thereby encourage more informed discussions about notions of "fitness to govern".

Attention could also be directed towards alleviating institutional stressors in political environments (Weinberg, 2011). From an ICF-informed perspective, these measures hold relevance as functional performance does not arise from individual capacities alone, but from their interaction with environmental demands, available support, and institutional barriers. For instance, schemes targeting poorly defined role expectations and inadequate infrastructural assistance could yield some benefits, alongside more concrete adaptations to accommodate familial and personal commitments and reduce burnout (Cooper-Thomas & Silvester, 2014; Flinders et al., 2020).

Access to trusted advisers, protected periods of recovery, delegation arrangements, and confidential healthcare pathways might similarly reduce the extent to which emerging symptoms translate into impairments in role performance. Comparable ideas have been proposed and successfully implemented within other high-stakes professions (*e.g.*, military forces and healthcare sectors) (Miranda Mayo, Pérez-Cárceles & Fernández-Valera, 2025; World Health Organization, 2021).

Notably, several legislatures have already introduced arrangements to uphold the wellbeing of politicians and staffers, namely the United Kingdom Houses of Parliament and the Parliament of Australia (Smith et al., 2025c; Parliament of Australia, n.d.). Yet there is little evidence that these systems would be effective in other jurisdictions, since insights into their uptake and efficacy (especially for heads of government) are underreported. These models must account for nuances rarely found in conventional workplaces, including constitutional protections and the absence of customary employer-employee relationships, and the financial investment required might also prove prohibitive in lower-income settings.

Moreover, such frameworks, however valuable elsewhere, may be largely incompatible with executive leadership positions as their working conditions and decision-making burdens differ markedly in scale and kind. As extreme examples, standard workplace wellbeing measures alone would only offer limited relief from the pressures facing leaders of major powers, such as the Chinese premier, the French president, or the Indian prime minister; indeed, the structural demands of these roles are not easily amenable to certain salutogenic reforms, above all because the weight of responsibility is inherent to high office itself.

Therefore, these interventions may be best understood as supplementary. Sustained by adequate funding and monitoring, they could mitigate psychosocial risks and enhance access to support, but separate medicolegal mechanisms would still be necessary for cases in which mental incapacity does arise in political leaders. In practice, societies may well be left to trust that their heads of government are able to receive the medical care they need (if they choose to access it), which seems an inherently unsettling reality in a crisis-afflicted world.

LEGAL AND POLITICAL ARCHITECTURE

Constitutional codification and its limits

Worldwide, the legal structures that inform how (and by whom) mental incapacity in high office can be recognised and addressed vary considerably (Smith et al., 2025a). The Twenty-Fifth Amendment to the United States Constitution is one of the most prominent examples. This provision enables the vice-president and a Cabinet majority (or an alternative body designated by Congress) to declare a president unable to discharge their duties.

Several other presidential and semi-presidential systems adopt distinct approaches, ranging from judicial determinations supported by independent medical panels (*e.g.*, Portugal and Nigeria) to those with no established procedure (The Law Library of Congress, 2020). Meanwhile, certain parliamentary democracies (*e.g.*, the United Kingdom and Germany) rely more heavily on constitutional conventions and the discretionary judgement of political actors (Smith et al., 2023; Smith et al., 2025c). This heterogeneity reflects broader sociocultural and disparate constitutional norms, but simultaneously undermines any effort to identify universal best practices.

Nevertheless, given the clinical ambiguities surrounding mental incapacity in politics and psychological "fitness to govern", a natural impulse may be to call for stronger legal protections. Comparable arguments have repeatedly arisen, coinciding with real-life episodes of mental incapacity (Smith et al., 2025a). In this regard, the canonical doctrine of *rex inutilis*, which held that a monarch incapable of reigning could be deposed, represents one of the earliest recorded responses to incapacity (Peters, 1970). Later, the British Regency Act (1811),

introduced governance protocols to manage the psychiatric deterioration of George III (Green, 2005). Looking forward, it may still follow that having some legal framework is preferable to none at all, offering at least a reference point and a degree of accountability.

That said, legal arrangements may still be ineffective and prone to manipulation. This could be especially true within autocratic polities, where constitutional rules, regardless of their apparent stringency, are frequently disregarded when deemed to be inconvenient (Ginsburg & Simpser, 2014). Moreover, even in democracies, codified mechanisms largely depend on the willingness of constitutional actors to invoke them. The Working Group on Presidential Disability, founded by the-then United States president, Jimmy Carter (1924-2024), highlighted concerns about the utility of the 25th Amendment, with successive bodies proposing analogous reforms (Carter, 1994; Abrams, 1999; Toole & Joynt, 2001; Fordham Law Clinic, 2017).

This raises doubts as to whether the provisions of the 25th Amendment are too cumbersome, too politically fraught, or whether the underlying problems they were intended for remain genuinely rare; despite decades of debate and psychopathological commentary about United States presidents, they have never been activated for psychiatric reasons (Davidson, Connor & Swartz, 2006; Smith et al., 2025c). Modern precedents in other jurisdictions are similarly sparse. One of the few documented incidents transpired when the president of Ecuador, Abdalá Bucaram (nicknamed "*el Loco*" -- "the madman"), was impeached by a congressional majority on grounds of mental incapacity in 1997, with no psychiatric assessment or expert testimony (Conaghan, 2012). In essence, this was a calculated political manoeuvre, driven by public opposition and corruption allegations.

Since perceived vulnerabilities will invariably attract political exploitation, the deeper lesson is that any workable mechanism must be designed to withstand such pressures from the outset. However, greater constitutional specificity is not a straightforward antidote to abuse. Psychiatric disorders, unlike a limb fracture for example, rarely present as discrete, easily dateable events. Instead, they more often exhibit a fluctuating (and potentially unpredictable) trajectory that any bright-line legal threshold would struggle to accommodate (Smith et al., 2023; Smith et al., 2025c).

Defining mental incapacity through ostensibly empirical criteria (*e.g.*, lists of eligible diagnoses, symptom duration, or predetermined functional scores etc.) requires translating clinical phenomena into legally operative categories, a task that has previously proven challenging in forensic psychiatry (Brown, 2016). Equally, it risks arbitrary outcomes that could negate the very protections these measures aim to provide. Although an ICF-informed assessment may describe the nature, severity, consistency, and practical consequences of functional limitations more transparently, it cannot establish when those limitations become constitutionally disqualifying. That determination depends on apposite legal standards, the duties associated with the office, the availability of compensatory institutional arrangements, and the authority entrusted to constitutional actors.

If constitutional specificity is not without its drawbacks, vagueness in the law is also not entirely unproblematic (Asgeirsson, 2020). Where political interests prevail, psychiatric symptoms could conceivably be concealed (or ignored) to keep a leader in power, or conversely, relevant mechanisms manipulated to oust one by compliant actors, as the Bucaram impeachment demonstrates. Concomitantly, comprehensive codification carries hazards of its own, including false exactitude, litigation over technical thresholds, and limited latitude for decision-makers confronting unforeseen circumstances (Asgeirsson, 2020; Smith et al., 2023; Smith et al., 2025c).

Therefore, the productive reform target may not be definitional precision for its own sake, but procedural clarity around handling suspected (or confirmed) cases of mental incapacity. Depending on the jurisdiction, this may involve formally empowering deputy or vice-executive positions with automatically triggered interim authority during any period of incapacity, or devising scheduled transfers of critical powers (*e.g.*, military command). Still, even seemingly feasible initiatives could quickly generate complex questions of independence and oversight; ultimately, enshrining any protocol, political or otherwise, in law is no guarantee that it will work as envisioned in reality.

Distributing executive power: a more radical response?

More systemic responses could involve moving beyond refining how mental incapacity is detected or defined and instead interrogating whether personalist structures are part of the problem. Indeed, if the hazards associated with mental illnesses and impaired functioning in political leadership stem from vesting authority in a single head of government, then distributing it across multiple office-holders may offer more fundamental safeguards.

Internationally, different forms of collegial power have been adopted, including in Uruguay between 1952-1967 and present-day Bosnia and Herzegovina

(Altman, 2020). In Switzerland, the Federal Council, a seven-member body elected as equals by parliament, operates according to strict principles of collegialism. The Swiss presidency rotates annually on the basis of seniority (Papadopoulos & Sager, 2024); in practice, this position carries no greater decision-making mandate, and the system was designed, amongst other reasons, to preclude the concentration of executive power (Altman, 2020).

Hypothetically, were one member of the Federal Council to develop disorder-related functional impairments materially affecting the discharge of their responsibilities, the remaining councillors would continue to exercise full executive authority collectively. Consequently, this could reduce the prospect of political paralysis, which has previously accompanied cases of incapacity in highly personalised regimes (*i.e.*, monarchies and dictatorships) (Park, 1986; Green, 2005; Owen, 2016). Equally, the incentives to conceal or weaponise psychiatric symptoms would likely be considerably reduced, as one councillor's temporary withdrawal need not precipitate a crisis of continuity.

Such an arrangement is naturally not without its limitations, nor is its wholesale adoption realistic for most contemporary jurisdictions. Notwithstanding its disputed legacy, the Uruguayan experience of collegialism attracted perceptions of deadlock and inefficiency, contributing to the model's abandonment in 1967 (Altman, 2020). Historically, collegial executives of this kind have depended on distinctive sociopolitical dynamics (*e.g.*, consensus-based systems and constitutional cultures already comfortable with diffuse and deliberative governance). These have typically been found in proportional democracies than adversarial two-party systems (Lijphart, 1999). Geographically large states may also present distinct challenges, given the added issues of regional representation and coordination.

Ultimately, sharing executive power does not eliminate the underlying clinical and ethical tensions surrounding mental incapacity and psychological "fitness to govern". Nonetheless, it may well reconfigure certain risks within a more resilient architecture, in which no one individual's health is solely determinative of a nation's governance. Whether these benefits would materialise remains uncertain, since, to the authors' knowledge, real-world examples of this specific scenario have yet to emerge.

CONCLUSIONS

In this article, we have examined several clinical, occupational, and legal frameworks relevant to mental incapacity in political leadership, exploring their practicability across different contexts. Whilst focussing primarily on formal avenues, it bears acknowledging that incapacity has previously been managed ad hoc or "covered up", with scant transparency or accountability (Post & Robins, 1993; Owen, 2016).

On balance, no single proposal appears to offer an entirely satisfactory or definitive remedy, not least because many have yet to be fully tested; their drawbacks tend to stem from the same ambiguities that make the underlying problems so intractable in the first place. Alongside the inherent complexity of psychopathology and the distinctive dynamics of political environments, a central difficulty lies in the absence of established definitions of "fitness to govern" (Abrams, 1999; Gilbert, 2003; Klitzman, 2021).

From a forensic-psychiatric perspective, the presence of an ICD-classified disorder cannot itself establish incapacity; the relevant clinical task would be to determine whether symptoms give rise to identifiable limitations in activities and participation, whether these limitations materially affect the specific demands of high office, and how they vary in severity, consistency, duration, and susceptibility to treatment or compensation. An ICF-informed approach, potentially supported by capacity domains derived from instruments such as the Mini-ICF-APP, may render this reasoning more systematic and transparent, but cannot establish a medicolegal threshold. Functional impairment is not synonymous with constitutional incapacity, still less with political undesirability.

Other tensions endure as to where psychiatric expertise should end and political judgements should begin, as argued in relation to the Goldwater Rule (Smith et al., 2026b). Physicians may identify serious functional impairments that constitutional actors and voters choose to disregard, since sociopolitical legitimacy does not (and should not) automatically defer to medical opinions. Further complicating this is the disparate commonalities that all societies share, namely their governmental structures, sociocultural customs, socioeconomic circumstances, legal traditions, ethics, and wider attitudes towards privacy and mental illness, all of which can change and evolve. These uncertainties are compounded by broader geopolitical trends, including nuclear sabre rattling and resurgent personalist ideologies, which may heighten the stakes of mental incapacity and erode the institutional resilience that any plausible response depends upon (Lubot, 2025).

Indeed, polities will inevitably diverge in the specific measures they have adopted (or will consider adopting in future), as well as in their prevailing perceptions of what functional (or impaired) political leadership entails. In short, a mechanism that seems workable in one setting may be politically untenable or culturally unintelligible in another. Such inconsistencies can even be evident in

the same jurisdiction; for example, private sector organisations in Argentina and Brazil generally necessitate psycho-physical examinations as a precondition for employment, but no equivalent expectation applies to individuals seeking or holding executive office (Smith et al., 2025b).

This strongly suggests that any recommendations must be jurisdiction-sensitive, and that cross-jurisdictional learning (albeit extremely valuable) should be pursued with considerable humility about efficacy and implementation challenges. Nonetheless, interdisciplinary collaborations have thus far been surprisingly scarce. Psychiatric, legal, and other scholarly literature on mental incapacity in political elites has been heavily concentrated on the United States, largely revolving around the Twenty-Fifth Amendment (Anglim, 2018).

Meanwhile, comparatively little attention has been paid to other jurisdictions, leaving certain polities without the theoretical foundations on which workable ideas might eventually be developed or adapted, especially in transitional democracies and much of the Global South. To that end, knowledge exchanges involving psychiatrists, legal practitioners, policymakers, politicians, and other stakeholders are urgently needed to devise more coherent approaches internationally. These dialogues could also help build a mutual conceptual understanding (*e.g.*, around the distinctions between diagnoses and functional outcomes). They may also clarify where clinical description ends and normative judgement begins and highlight the most consequential gaps in existing arrangements.

More broadly, these conversations cannot remain confined to academic and professional circles; concerns surrounding mental incapacity and psychological "fitness to govern" in high office ultimately belong to populations as a whole. At a minimum, such deliberation should resist conflating psychiatric diagnoses with political disqualification, or political disapproval with psychopathology. Engaging with them will require genuine public deliberation and a willingness to confront uncomfortable truths about political power and the vulnerabilities of governance that history has repeatedly brought to light. The question is not whether these situations will arise again, but whether societies will be better prepared when they do.

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