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## From the Editor's desk

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## From the Editor's desk

By Peter Tyrer

## The end of the psychopharmacological revolution

The time has now come to call an end to the psychopharmacological revolution of 1952. This term is normally a reference to the discovery of chlorpromazine, described recently as 'one of the greatest advances in 20th century medicine and history of psychiatry'.<sup>1</sup> Although this was a clear advance at the time, and was serendipitously followed by the introduction of antidepressant and anxiolytic drugs, the claim that these drugs were responsible for the demise of the mental hospital and the growth of community psychiatry, has been disputed<sup>2</sup> as the wind of social change was already blowing the cobwebs away from the corners of the old custodial institutions. Yet there is no doubt this was a time of great optimism in psychiatry and the new drugs played a major part. But nobody in the 1960s and 70s could have predicted the words in the editorial in this issue by Morrison *et al* (pp. 83–84) suggesting that it is time 'to reappraise the assumption that antipsychotics must always be the first line of treatment for people with psychosis'. This is not a wild cry from the distant outback, but a considered opinion by influential researchers who help to formulate NICE guidelines. And the reasons for the change in view are not just, as some evidence suggests, a consequence of biased representation of drug treatment in the mass media,<sup>3</sup> but an increasing body of evidence that the adverse effects of treatment are, to put it simply, not worth the candle. The combination of extrapyramidal symptoms, dangers of tardive dyskinesia and the neuromalignant syndrome,<sup>4</sup> weight gain and the metabolic syndrome, sedation, postural hypotension, and interference in sexual function (but also note the important balancing paper by Reis Marques *et al*, pp. 131–136, that suggests drugs are not entirely to blame here), would need to be offset by massive symptomatic and social functioning improvement to make the benefit/risk ratio positive. Of course, it often is, at least in the short term, but for many the risks outweigh the benefits.

All revolutions have to come to an end, and the psychopharmacological one now has to meld into a quieter world where drug therapy, which has had quite a battering in recent years and needs our support,<sup>5</sup> will be joined by other approaches as equal partners, preferably working together in harness rather than in conflict. Just as genes and environment interact at critical points in the development of the pathology of autism (Simonoff, pp. 88–89; Bejerot *et al*, pp. 116–123; Magnusson *et al*, pp. 109–115), the introduction of environmental, pharmacological and psychological strategies of treatment at equally critical times in the treatment of psychosis are going to be necessary in the future, and as NICE and other treatment guidelines do not yet have the evidence base to advise on combined therapies much of our information depends at present on clinical skill, judgement, and observational studies of all sorts,<sup>6–8</sup> as well as new approaches to prevention.<sup>9</sup> Working with the preferences of the patient, as Morrison *et al* suggest, is not just a madcap game of pie in the sky; the assumption that such a patient will never choose to take an antipsychotic drug is far from true, and in recent years, with the growth of adherence therapies<sup>10</sup> I have increasingly been impressed by patients taking an active role in not only choosing

their antipsychotic medication, but organising dosage schedules that are specific to their needs. This collaborative approach prevents the creeping invasion of coercion and leverage from across the Atlantic<sup>11</sup> and is particularly necessary when psychotic symptoms are minor or not causing social disruption (Barnett *et al*, pp. 124–130). Seeing the world through a patient's eyes is not always easy, especially if what they see is not quite what you see (Bubl *et al*, pp. 151–158), but it repays the effort. As for the verdict on the place of the psychopharmacological revolution in the long story of psychiatry I can only take refuge in Chou-en-Lai's Delphic reply when asked his opinion about the impact of the French Revolution, 'It's too early to tell'.

## Rising impact

This is the time of year when people sing the Impact Factor Song,<sup>12</sup> not always in the right key and the sometimes plangently as desperation and delight come in equal measure. Until other College journals gain an impact factor ranking, the *British Journal of Psychiatry* alone holds our standard high with an impact factor of 6.619. Our energetic reviewers, board members, editorial staff and authors all deserve credit for this, but especially our authors, as it is their cited papers that make up the metric. But we are still greedy and want more novel and exciting papers to review. Remember the words that you committed to memory last year:

Now's the time to attest  
In the BJP you must invest  
And fan our impact factor flame  
By sending papers you can claim  
Really are the best  
And once published and assessed  
All will be impressed.

Go for it.

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