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From the Editor's desk

By Peter Tyrer

Spotlight on antipsychotics

The act of prescribing an antipsychotic drug in psychiatry is like sex; it is almost universal in practice yet indiscriminate use can lead to multiple pathologies. Where it differs from sex is that the act is almost completely devoid of pleasure for most parties involved. Patients tend to hate these drugs because of their panoply of adverse effects – not for nothing was chlorpromazine named Largactil – and practitioners, unless they are avid psychopharmacologists, feel their prescription is a necessary evil that is likely to change the relationship with their patients from a cooperative to a coercive one, particularly in a hospital environment.[1,2] We would all feel a lot better if this range of drugs was replaced by one that was at least equally effective and did not have the potential to attack every organ system in the body when it wasn't looking, or even looked for, in clinical and research practice.[3] Six papers in this issue touch on this subject from different angles. After looking at the similarities between the long-term benefits of clozapine and chlorpromazine in schizophrenia (Girgis *et al*, pp. 281–288), Kendall (pp. 266–268) goes for the full frontal assault on the way guidance has been distorted by the pharmaceutical industry, 'a story of fabricated classes, money and marketing', with most changes being no more 'than a cynical tactic to generate profit'. I have to declare my own interest here; I cannot see any justification for separating first- and second-generation antipsychotics and think these terms should be dropped far, far away from rediscovery by gullible psychiatrists.[4] But Leucht & Davis (pp. 269–271) rightly emphasise the variability of antipsychotic drugs and that prescription should follow a 'shared decision-making process' with the patient, provided, some would add, that this is an honest and genuine one.[5] Frighi *et al* (pp. 289–295) show that in those with intellectual disability, adverse effects are not usually major. My own explanation of this somewhat surprising finding is that because shared decision-making is much more difficult with this group than with those of normal IQ and that a minority of patients is unduly sensitive to these drugs, much lower doses are prescribed than in others and so there are fewer adverse consequences. Suzuki *et al* (pp. 275–280) confirm my own impressions from clinical practice that if there is no clinical response to an antipsychotic drug fairly soon after prescription (within 6 weeks) then its further prescription should be questioned, and long-term usage regarded as rare.

It would help greatly if we had better diagnostic markers for the heterogeneous pot-pourri of schizophrenic disorders that might indicate the most appropriate selection of these powerful drugs. We are making rapid progress with a more useful classification of bipolar disorders (Smith & Craddock, pp. 272–274), and here, as with unequivocal bipolar disorder,[6] antipsychotic drugs clearly have specific indications. We certainly need good guidance to regain the value and respect that used to be attributed to antipsychotic drugs when they were first released as the vanguard of the psychopharmacological revolution. But we have a long way to go to convince the doubters, and readers will note that if hypersexual disorder is competing for a slot in the new classifications, neuroleptophilia should have a place also.

No psychiatry without medicine?

Harrison *et al* (pp. 263–265) make a good case for the knowledge of psychopharmacology being an essential part of good psychiatric decision-making, and awareness of differences in antipsychotic drugs illustrates this. This harks back to the debate we had about the future of psychiatry 3 years ago.[7] 'Certain circumstances do, however, require professionals with medical training to diagnose and treat underlying psychiatric or non-psychiatric physical disorders',[7] is one of the strongest arguments for psychiatrists taking the lead in clinical teams, or at least doing so at the assessment phase of management. I well remember a patient with acute intermittent porphyria who escaped by the skin of his teeth from getting into what would now be called 'the schizophrenia care pathway' by getting his urinary test for porphobilinogen back in time, and although such examples are rare, they are still very important in practice. Differential diagnosis becomes critical when there are large costs, both personal and financial, involved in making a diagnosis such as first-episode psychosis,[8,9] or when the understanding of mental pathology, as in health anxiety, is closely linked to medical disease.[10] What I would like to see in the future is all health practitioners, not just physicians and psychiatrists, having at least a reasonable knowledge of the bare essentials of both medical and mental health, so that the unnecessary schisms that have dogged research into conditions such as the one that is called CFS/ME by Clark *et al* (pp. 323–329) because one set of initials without the other would cause upset can be avoided. Advances in knowledge, including the recognition that premorbid psychopathology may be related to this important group of conditions, should be celebrated across the medical spectrum, for in the end we are but one body.

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4 Tyrer P, Kendall T. The spurious advance of antipsychotic drug therapy. *Lancet* 2009; **373**: 4–5.

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8 Friis, S. Early specialised treatment for first-episode psychosis; does it make a difference? *Br J Psychiatry* 2010; **196**: 339–40.

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10 Olatunji BO, Deacon BJ, Abramowitz JS. Is hypochondriasis an anxiety disorder? *Br J Psychiatry* 2009; **194**: 481–2.