From the Editor's desk

PETER TYRER

MORE THAN OUR SHARE OF HAPPINESS

'The life of man', famously wrote Thomas Hobbes in 1651 in *The Leviathan*, 'is solitary, poor, nasty, brutish and short'. Although this assertion was disputed at length by many subsequently, there seems little doubt that it was a correct description of the life of those committed to most asylums until well into the 20th century. This legacy continues to give psychiatry a depressing image and the time has now come for some to contemplate what may be described as a happiness makeover. Richard Layard, a health economist and Government spokesman in the House of Lords, the curious second chamber of the UK Houses of Parliament where unelected politicians currently hold much more interesting debates than the elected ones next door, has entered the battle as the Happiness Czar. He wants all of us to have a more positive view towards happiness, and regards it as a state not only worthy of attainment but capable of being achieved with the development of extra psychological treatment resources for the population (Layard, 2006).

So perhaps we should join in the happiness makeover and interpret our publications somewhat differently. If we made a start with this issue we could start with the Gilbody blow 'people get happier with enhanced care for depression, but it costs' (pp. 297–308), followed by 'no dose–response relationship for happiness with SSRIs' (Ruhé *et al*, pp. 309–316), 'mums' unhappy eating rubs off on the kids' (Stein *et al*, pp. 324–329), 'if you're happy with your treatment, you'll stay calm' (Elbogen *et al*, pp. 354–360), 'get positive and improve your quality of life after a heart attack' (Dickens *et al*, pp. 367–372), and, a looser interpretation than the authors might have chosen, 'British only happy when manic' (Mackin *et al*, pp. 379–380). So perhaps the move to 'mental health' from 'mental illness' and 'recovery' from 'rehabilitation' is not just political correctness; it may reverse Beckian cognitive distortion (see our July issue) and give us a genuine uplift that is more than spin.

RESEARCH IN THE DAILY LIVES OF CLINICIANS

All clinicians, irrespective of specialty, are now much better informed than they were a generation ago. They are less idiosyncratic in their practice, they keep abreast of changes by continuing their medical education long after they have finished training, and they embrace online learning and peer review appraisal so that blind spots are exposed and corrected. But are they as involved in research as they used to be? I think not. When Bernard Shaw stated in *The Doctor's Dilemma* that all professions (not just the medical one) 'were conspiracies against the laity' he struck a chord in highlighting the preposterous secrecy that pervaded organisations who believed their status would be undermined by disclosure. My worry in psychiatry is that many practitioners have paraphrased Shaw and regard 'all research workers as conspirators against the patient'. Research is acceptable to clinicians if it is covert or naturalistic (i.e. does not interfere with individual treatment prejudices) or involves data already collected such as diagnosis (Kessing, 2004) or prescriptions (e.g. Helgason *et al*, 2004), but when it comes to interventions that could provide evidence to change practice everyone becomes decidedly coy. Good randomised controlled trials that can provide definitive evidence of efficacy of any intervention are unlikely to do so if they have fewer than 100 in each treatment arm (Johnson, 1998). In reviewing all those trials we published in 2005 only four, all drug trials (Bradwejn *et al*, 2005, n=361 (7.2); Kasper *et al*, 2005, n=358 (8.7); Khanna *et al*, 2005, n=291 (36.4); Vieta *et al*, 2005, n=347 (4.6)), satisfied this requirement. The figures in brackets are the mean number of patients recruited at each centre; these suggest that a tiny fraction of those eligible are taking part. The one exception is the Khanna *et al* (2005) study that has provoked ethical controversy (Srinavasan *et al*, 2006); this was the only study not involving recruitment in many countries.

So it seems that if we want to do substantial randomised trials, we have to go international, expect poor returns and recruit from many centres. I do not agree. Psychiatrists have to be more receptive to large studies such as the BALANCE trial, not industry supported, that compares different mood stabilisers in the prophylaxis of bipolar affective disorder (Geddes & Goodwin, 2001). Can clinicians do better? Our service users involved in advising us certainly think so, and their views were reinforced when they heard that of the seven patients recruited to this widely advertised trial in the north-west London area all were recruited by a certain Peter Tyrer in the course of ordinary practice. When the non-participating clinicians ask 'what's in it for me?', we can only reply: 'Better clinical practice. Do you want it or not?'

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Johnson, T. (1998) Clinical trials in psychiatry: background and statistical perspective. *Statistical Methods in Medical Research*, **7**, 209–234.

Kasper, S., Stein, D. J., Loft, H., *et al* (2005) Escitalopram in the treatment of social anxiety disorder: randomised, placebo-controlled, flexible-dosage study. *British Journal of Psychiatry*, **186**, 222–226.

Khanna, S., Vieta, E., Lyons, B., *et al* (2005) Risperidone in the treatment of acute mania. Double-blind, placebo-controlled study. *British Journal of Psychiatry*, **187**, 229–234

Kessing, L. V. (2004) Severity of depressive episodes according to ICD–10: prediction of risk of relapse and suicide. *British Journal of Psychiatry*, **184**, 153–156.

Layard, R. (2006) The case for psychological treatment centres. *BMJ*, **332**, 1030–1032.

Srinivasan, S., Pai, S. A., Bhan, A., *et al* (2006) Trial of risperidone in India – concerns (letter). *British Journal of Psychiatry*, **188**, 489.

Vieta, E., Bourin, M., Sanchez, R., *et al* (2005) Effectiveness of aripiprazole *v.* haloperidol in acute bipolar mania. Double-blind, randomised, comparative 12-week trial. *British Journal of Psychiatry*, **187**, 235–242.