BJPsych The British Journal of Psychiatry (2008)
192, 400. doi: 10.1192/bjp.192.5.400

From the Editor's desk

By Peter Tyrer

Risky remedies and contentious cures

I think it was Francis Bacon who first articulated 'the remedy is worse than the disease' and indeed, before the 20th century, most that were not placebos probably were. In this issue we have a series of papers examining the effects of common remedies at that most critical time in life, the dangerous months between conception and birth. This should be a time when the developing foetus luxuriates in a constant milieu intérieur preparing gently for the exigencies of the harsh world outside, but it can be an ill time if the mother is unwittingly exposed to foul agents, of which thalidomide is the most notorious example. Foolproof risk assessment tells the clinician not to prescribe in pregnancy, which is very nice when it can be achieved together with a confident, caring and effective mother after birth. But of course clinicians feel justifiably that the latter can sometimes only be achieved by some pharmacological intervention in pregnancy, and are desperate for guidance. Sometimes this can be very clear, as for example in advising avoidance of sodium valproate in those liable to become pregnant (Paton, pp. 321–322), but other therapies remain on the cusp of acceptability and rejection, with an evidence base that has to depend on naturalistic data rather than controlled studies.

Should we be just careful about, or should we avoid, prescribing antipsychotic and antidepressant drugs in pregnancy? The answer is rather similar to that for the question 'Should I drive after feasting on chocolate liqueurs?' as it seems to be, 'Yes, provided you do not over-indulge'. First there seems to be no significant evidence that antidepressants of any sort are teratogenic (Ramos *et al*, pp. 344–350). Second, relatively short exposure to antidepressants in pregnancy is almost certainly safe (Oberlander *et al*, pp. 338–343), but longer exposure may lead to distress at parturition and lower birth weight. By contrast one of the most adverse outcomes of antipsychotic drugs,[1] their powerful appetite-stimulating effects, makes even the developing foetus greedy and birth weight can be increased, with possible attendant problems (Newham *et al*, pp. 333–337). Despite this partial reassurance, it is surely more comforting to turn to psychological management of these problems during pregnancy. In the UK Lord Layard has promoted the massive expansion of the completely safe and effective panacea of cognitive–behavioural therapy so we have a ready answer for mothers and therapists who are fearful of new situations.[2] But have we? In our robust debate this month we hear from Derek Summerfield that such an increase in the availability of treatment will compound Illich's suggestion that the 'more people are exposed to healthcare, the sicker they feel', a proposition that seems to be reinforced by experiences with antidepressants.[3–5] So read these papers, remind yourselves of the likely consequences of non-treatment (Farmer *et al*, pp. 351–355; Ormel *et al*, pp. 368–375) and come to your own decisions. As for the developing foetus, improve your infant's euphoria by taking another liqueur chocolate; I recommend Chartreuse.

The bureaucracy of mental health legislation

Bernard Shaw's dictum 'the golden rule is that there are no golden rules' is not one that is attractive to law-makers and health service administrators, even though variation in life is the norm, illustrated elegantly by King *et al* (pp. 362–367) in suggesting that there are real differences across Europe in the presentation of common mental disorders that should influence practice. One of my patients is currently very cooperative and pleased with his care, but we have kept him on a compulsory order because he can break down very quickly. He had no wish to appeal against this order but the Mental Health Act 1983 insists that a tribunal must be held to confirm that detention is appropriate. This was duly organised but boycotted by the patient so an assessment could not be made. We therefore have to continue making further dates for tribunals if we wish to continue this form of treatment in the hope that contact will be made eventually. The law must run its allotted course, even if the person it is protecting is not on the track. It is doubly concerning that this cost-ineffective requirement is in the context of a successful attempt at rehabilitating a patient who is now fully engaged in treatment and it goes against the advice of Sir John Wood given 15 years ago: 'when there comes a time when the legal requirement of "treatment hospital" can barely be said to exist, there is a strong case for letting the order run its course to ensure protection of the plan.'[6]

My unfortunate impression as I pursue my own erratic course through the jungle of correct practice, blundering into swamps of common sense and sinking deep into the lagoon of risk, is that my administrative colleagues have all been indoctrinated into the Church of Proper Order, where golden rules remain forever golden and completely untarnished, even arousing some to worship:

Teach us Lord to reverence
Committees more than common sense
Impress our minds to make no plan
But pass the baby where we can

And when the Tempter seems to give
Us feelings of initiative
Or when alone we go too far
Chastise us with a circular

Mid war and tumult, fire and storms
Strengthen us we pray with forms
Thus will thy servants ever be
A flock of perfect sheep for Thee

1 Hamer S, Haddad PM. Adverse effects of antipsychotics as outcome measures. *Br J Psychiatry* 2007; **191** (suppl 50): s64–s70.

2 Emmelkamp PMG, Benner A, Kuipers A, Feiertag GA, Koster HC, van Apeldoorn FJ. Comparison of brief dynamic and cognitive–behavioural therapies in avoidant personality disorder. *Br J Psychiatry*, 2006; **189**: 60–4.

3 Helgason T, Tómasson H, Zoëga T. Antidepressants and public health in Iceland: time series analysis of national data. *Br J Psychiatry* 2004; **184**: 157–62

4 Reseland S, Bray I, Gunnell D. Relationship between antidepressant sales and secular trends in suicide rates in the Nordic countries. *Br J Psychiatry*, 2006; **188**: 354–8.

5 Colman I, Wadsworth MEJ, Croudace TM, Jones PB. Three decades of antidepressant, anxiolytic and hypnotic use in a national population birth cohort. *Br J Psychiatry*, 2006; **189**: 156–60.

6 Wood J. Reform of the Mental Health Act 1983. An effective tribunal system. *Br J Psychiatry*, 1993; **162**: 14–22.

https://doi.org/10.1192/bjp.192.5.400 Published online by Cambridge University Press