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From the Editor's desk

By Peter Tyrer

A humanised inclusive psychiatry

The debate about the place of psychiatry in the constellation of healthcare refuses to go away and in this issue we have many papers that connect to this subject. It troubles me that many readers from across the world will not understand every paper that we publish and will sometimes scratch their heads and ask 'what on earth has this got to do with me and my practice?' It is not easy to explain the reasons for this, apart from the obvious one that our profession is a broad church that covers every aspect of a big subject. But this approach, bringing with it a range of new technologies, can be criticised, and has produced a strong reaction from Bracken and colleagues (pp. 430–434) who argue the case for 'a post-technological psychiatry' that 'will not abandon the tools of empirical science or reject medical and psychotherapeutic techniques but will start to position the ethical and hermeneutic aspects of our work as primary, thereby highlighting the importance of examining values, relationships, politics and the ethical basis of care and caring' (p. 432). This approach is backed up by a powerful editorial from Kleinman (pp. 421–422) attacking what he sees as the failure of academic psychiatry in focusing on areas far distant from the 'routine conundrums of the practising consultant and primary care worker' (p. 422). He argues that saving the profession will not depend on 'biological research but its expertise, experience and success in clinical care and global health' (p.422). Before we analyse this more fully it is useful to turn to an issue of the *Journal* from 100 years ago, following the tradition of our illustrious colleague Henry Rollin (who has ceased his 'One Hundred Years Ago' column as he is now in his 102nd year and doubtless up to something quite new[1]). In 1912 we also come across a profession that is not certain of its place in the world. Greig Soutar,[2] in his presidential address from Gloucestershire, after praising its 'far-stretching lines of hills, its well-wooded valleys, its rich pasture lands' (p. 540) regrets that 'our continental brethren are outstripping us in the study and practice of psychiatry' (p. 541) and speculates on the reasons why. In the course of this he wonders whether 'investigation along the lines of anatomical, physiological, pathological, chemical and clinical research, interrogating the function of every organ of the body' (p. 544) is the best way to proceed.

So when we read in this issue of the possible role of the autobiographical memory retrieval brain network in schizophrenia (Cuervo-Lombard *et al*, pp. 473–480; Watson *et al*, pp. 423–424) are we going off-course, as Kleinman suggests, or in the mainstream of psychiatry? Is the caudate nucleus important in schizophrenia, or is this some distant epiphenomenon that runs the risk of taking us away from the 'ethical and hermeneutic aspects' of practice? But Bracken *et al* do not criticise just the biological technologies; psychotherapeutic interventions come in for some harsh criticism too. Their specific effects are said to be small and the non-specific factors such as the therapeutic relationship are largely responsible for clinical improvement, and this view is supported to some extent by recent publications in this *Journal* in which it is clear that authors often have to strain hard to demonstrate benefits of specific therapies that can be regarded as clinically meaningful, and this includes both psychological[3–7] and biological therapies.[8,9] But the counter-arguments are also very strong. Do we really want to go back to an old version of psychiatry, where the only bastion of care was the therapeutic relationship and other remedies so toxic that the non-science of homeopathy could genuinely claim to be superior, and where all we knew about aetiology and outcome was no more than guesswork and surmise? Many are concerned about the increasing isolation of psychiatrists from other medical disciplines[10,11] and fear that the specialist knowledge about drug treatment emphasised by Patel (pp. 425–427), Barnes & Paton (pp. 428–429) and Howes *et al* (pp. 481–485) will be lost if we separate ourselves too much from the science of pharmacology.[12,13] So we must avoid civil war psychiatry[14] and recognise that while the therapeutic relationship remains central to good practice, patients will prosper most if this essential element is supported by a technological evidence base that is far from perfect but is a necessary handmaiden to serve patient care intelligently and well.

Politicians and mental health

There have seldom been votes in mental health and so the subject generally tends to be ignored by politicians. So it was a pleasant surprise to see our Leader of the Opposition in the UK parliament, Mr Ed Miliband, come and proclaim his support for both mental health services and research at the Royal College of Psychiatrists on 29 October. His aim was to 'match parity of esteem in the NHS with an end to the artificial divide between physical and mental health services', a sentiment that we would all support. He said much else besides, and drew a parallel with the reform of sanitation in the Victorian era to reform of attitudes towards mental health today (www.politics.co.uk/comment-analysis/2012/10/29/ed-miliband-mental-health-speech-in-full). I have to say I quite liked this comparison and feel we could make more use of it in public health, as poor mental health drags everyone down, and should not be forgotten even when other disease is rife (McBain *et al*, pp. 444–450). But Mr Miliband said something else in his speech which was not in the written version. He said 'politicians are well known for supporting a cause and then disappearing so you can't see them for dust. If I do not continue to proclaim the importance of good mental health services please come back and remind me.' Don't worry, Ed, we will.

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