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From the Editor's desk

By Peter Tyrer

Current psychiatric practice: creeping devaluation or leaping emancipation from medicine

Two cheers for psychiatry on its 200th birthday (Marneros, pp. 1–3). Some might give it three, but the article by Craddock *et al* (pp. 6–9) explains why to others the glad sound of celebration would stick in the glottis. We have always been very good at self-reflection in psychiatry and this often obscures the joy we should feel at our achievements. Like the young Jewish lad, writing a postcard to his parents on his first holiday away from home, 'having a wonderful time' has to be followed by 'why?' so everyone can wallow in uncertainty. The growth of community psychiatry in countries with universal healthcare systems has changed the role of the psychiatrist enormously and it has not been easy to adapt. The editorial we publish on clinical pathways in psychiatry (Evans-Lacko *et al*, pp. 4–5) would have led to bemusement 60 years ago by those decamped on the single royal road to the asylum, and the concept of clinical teams would have been equally alien. What is more, in these new teams the psychiatrists are often relegated to sitting on the bench and coming on only when the team is in difficulty in the hope they might weave a little magic and score a late goal. On several occasions in my career as a community psychiatrist I have been hissed at for 'giving away our power' as doctors and lowering the status of a noble profession. So I can understand why Craddock and his cognoscenti want to reclaim the territory of psychiatry for medicine. Psychiatrists have special skills and abilities; these should be recognised and respected and allowed to be exercised in a proper manner, and with the growth of neuroscience, psychopharmacology and neuroimaging these skills will become even more important. The continuation of a hotch-potch of general psychiatry linked to community teams dealing with all-comers, including those who may not belong,[1] is counterproductive and off-putting for the physicians we should be attracting to the profession, and this 'new way of working' has been accomplished by default, not design.

This may be true, but so many of the apparent advances of the science of psychiatry are not yet converted into success in clinical practice. Time after time we need colleagues from other disciplines to reduce the risk of violence (Abderhalden *et al*, pp. 44–50), and avoid unnecessary seclusion and restraint,[2] to assess and give specialised treatments such as cognitive–behavioural therapy (Keen & Freeston, pp. 60–64), and to rescue us from foolishness when we adhere too closely to what is still termed, unsatisfactorily, the medical model, but which we cannot seem to do without.[3,4] And we have another problem: there are not enough psychiatrists to go round, particularly in the UK where for common conditions such as depression a psychiatrist is less likely to be consulted than in other European countries.[5] So I suspect that for many readers the Craddock *et al* wake-up call will be replaced by the snooze alarm, and Johann Christian Reil's heaven will have to wait. But don't allow this to happen without a fight, and go for the correspondence columns of the *Journal*.

Botanical psychiatry

I am at heart a botanist and on an expedition many years ago managed to combine both psychiatry and botany when I became an honorary witch doctor, or *njanga*, in central Africa when collecting plants used as herbal medicines for a variety of diseases. The trouble was that for every digitalis of potential value there were 100 toxic belladonnas that were saved from disaster only by being converted into inactive placebos by repeated pummelling, evisceration, boiling and denaturing. So instead of our pharmacological analysis yielding valuable insights into the effects of drugs derived from plants such as those demonstrated by Daglish *et al* (pp. 65–72), we entered the highly complex world of the placebo effect. My view has always been that phytotherapy is the place where this effect is most strong and every *njanga* worth his salt exploits it to the full. This may explain why the pharmacological benefits of most botanical therapies such as ginkgo, hydergine, passion flower, valerian, a myriad of Chinese plants and St John's Wort (*Hypericum perforatum*)[6–9] seem enormous at first glance and yet over time seem to be whittled away to almost nothing. The evidence of effectiveness, like a leaf of *Hypericum perforatum* itself, is full of holes. Yet the benefits remain enormous and the more treatment that is given the greater appears to be the value, and although as this is the same as with placebo the phenomenon is commonly called the Hawthorne effect,[10] is it not time for this clear botanical effect to be reclaimed for the discipline and called the hawthorn effect after the *Crataegus* genus from which it must surely have come?

So what begins as the science of what Reil would have called phytopsychiatry seems to have taken us into the murky world derided by Craddock *et al* of 'non-specific psychosocial support with extremely limited therapeutic ambition' (p. 7). I think I'll have another doze and wait for the alarm to go off again.

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3 Tyrer P, Steinberg D. *Models for Mental Disorder: Conceptual Models in Psychiatry* (4th edn). John Wiley & Sons, 2005.

4 Shah P, Mountain D. The medical model is dead – long live the medical model. *Br J Psychiatry* 2007; **191**: 375–7.

5 McCracken C, Dalgard OS, Ayuso-Mateos JL, Casey P, Wilkinson G, Lehtinen V, Dowrick C. Health service use by adults with depression: community survey in five European countries. Evidence from the ODIN study. *Br J Psychiatry* 2006; **189**: 161–7.

6 Werneke U, Turner T, Priebe S. Complementary medicines in psychiatry: review of effectiveness and safety. *Br J Psychiatry* 2006; **188**: 109–21.

7 Linde K, Ramirez G, Mulrow CD, Pauls A, Weidenhammer W, Melchart D. St John's wort for depression – an overview and meta-analysis of randomised clinical trials. *BMJ* 1996; **313:** 253–8.

8 Linde K, Berner M, Egger M, Mulrow C. St John's wort for depression: meta-analysis of randomised controlled trials. *Br J Psychiatry* 2005; **186**: 99–107.

9 Rathbone J, Zhang L, Zhang M, Xia J, Liu X, Yang Y, Adams CE. Chinese herbal medicine for schizophrenia: Cochrane systematic review of randomised trials. *Br J Psychiatry* 2007; **190**: 379–84.

10 McCarney R, Warner J, Iliffe S, van Haselen R, Griffin M, Fisher P. The Hawthorne effect: a randomised, controlled trial. *BMC Med Res Methodol* 2007; **7**: 30.