

## From the Editor's desk

By Peter Tyrer

## Extending the vermilion glow

Inorganic chemistry does not have many links to psychiatry but one of them is what Allan Young calls the magic ion (pp. 336–337), the curious case of the simple element, lithium, with its incredibly complex effects on the psyche. I always remember the nervousness with which I approached the 6th stage of analysis in the qualitative examination of inorganic cations in my chemistry studies. The main cations were identified early in the process so by the time I came to this last stage I was worried that I might have missed an element in an earlier phase. So it was in a state of nervous excitement that I dipped a platinum ring into the unknown solution being tested and then placed it in the flame of a Bunsen burner. The relief I felt when I saw the yellow of sodium, or the mauve of potassium was always trumped by the glorious vermilion glow shining forth whenever it was the lithium ion that was present, and was reflected in my own vermilion response of childish self-satisfaction. Ah, how atomic spectroscopy has taken the joy out of inorganic analysis. But now the vermilion glow seems to surround us all in psychiatry like a Turner sunset. Lithium is currently the best form of prophylaxis available for bipolar disorder<sup>1</sup> and still has an important role in other mood disorders as an adjunctive treatment of depression,<sup>2</sup> but now it is increasingly being recognised as both a highly subtle as well as a deceptively simple ion. With such a good pedigree behind it, there may be scope for lithium's expansion into other areas of psychiatry. But, as I commented recently,<sup>3</sup> apparently new advances are always first placed on the roundabout of progress; we do not know which of them will lead on to a major highway and which will end in a cul-de-sac. So it will only be in 20 to 30 years' time that we are likely to know whether lithium in small quantities in drinking water, claimed to have special anti-aggressive properties for nearly 30 years,<sup>4–6</sup> is genuinely anti-suicidal (Kapusta *et al*, pp. 346–350) or not (Kabacs *et al*, pp. 406–407) and whether it could become a routine prophylactic against the development of Alzheimer's disease or other dementias (Forlenza *et al*, pp. 351–356).

The role of a scholarly journal is to present the evidence in all its forms, together with the stimulating correspondence and comment that has enlivened this subject,<sup>7–9</sup> without any favour. So this explains why we have chosen to present contradictory papers in this issue which will serve as data to the court of evidence and so help the jury of practice to decide in time what clinicians should recommend. If indeed the evidence does suggest a role for lithium, we will need to reassess its therapeutic levels in ordinary practice and may also need to ask about suicidal feelings a little more in our routine assessments; it seems from the paper by Crawford *et al* (pp. 379–384) that we should not feel inhibited by doing so as it is unlikely to do any harm. And if we do eventually find that lithium in higher than normal concentrations in drinking water (note the difference in levels between our two papers) is helpful for preventing both mood swings and intellectual loss, perhaps there will be a role again for my old inorganic analysis procedure. Just dip the ring into the drinking water, put it in a gas flame, and look for that fantastic vermilion glow.

## Is psychopharmacology heartless?

This, I hope you agree, is a rhetorical question, but it is raised by Cowen (pp. 333–335) in his challenging editorial. He has a good right to grumble. There is something unbalanced in the media's handling of drugs in psychiatry at present, as unbalanced as it was 40 years ago when every new compound was trumpeted as a wonder drug that would 'cure' psychiatric disease. Now things are different; everything to do with drug treatment is regarded as just a little dodgy. The assumption is often made that the underlying message behind the prescription of a drug is not the correction of illness and the alleviation of distress and suffering but an invidious agenda involving corruption by the pharmaceutical industry. Thus, a drug-prescribing psychiatrist is assumed to have been either 'bought' by the industry in some shady underhand deal or to have given up on 'real' (i.e. psychological) therapy through burn-out or laziness.

The main trouble in recent years is that truth has often been lost, not in the science of drug development, but in pharmaceuticals marketing, and there is a critical period between the initial sale of a drug and the expiry of its patent when there is a serious danger that each drug will be oversold. During this period negative data may be suppressed, positive results overstated, and expansion of use suggested far beyond the original scope of the drug's ability to deliver. The danger here is that old drugs well past their patent expiry, such as lithium, will be underused in favour of newer, less effective, drugs,<sup>10</sup> or that patients will be diverted into taking alternative therapies of doubtful value (Sanders *et al*, pp. 357–364), with the consequent impairment of good practice. The ability to provide both psychological and pharmacological treatments should be a necessary component of good mental healthcare and should be aided by the simplification of psychological treatments so they are short and free from unwieldy jargon and baggage (Colom, pp. 338–340; Shimazu *et al*, pp. 385–390). In this exercise I agree with Cowen that keeping the patient within the same treatment programme is much better than specialised referral elsewhere and that his ideal of a 'clinical relationship characterised by continuity as well as warmth, kindness and hope' can apply to all, irrespective of their preferred modality of treatment.

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