From the Editor's desk

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ANOTHER GLOBAL ISSUE OF THE *JOURNAL*

There is a nice mix of international and local messages in this month's *Journal*. Nine contributions refer to the causes, features and treatment of depression, ranging from George Szmukler's (pp. 457–460) reminder of the importance of Brown and Harris' work on life events in depression, through studies showing that both prematurity and child sexual abuse may precipitate depression (Patton *et al*, pp. 446–447 and Spataro *et al*, pp. 416–421) and that alcohol use may lead to suicidal behaviour (McCloud *et al*, pp. 439–445), somatisation as a depressive symptom (Okulate *et al*, pp. 422–427), and accounts of variation in depression and its associated burden both in the European Union and across the world (Marušič, pp. 450–451; Crawford, pp. 379–380; Üstün *et al*, pp. 386–392; and Chisholm *et al*, pp. 393–403). It is pleasing to report that none of these articles is weighed down by the undoubted burden of this highly prevalent condition; but although we now have clear ways of preventing and treating it, it is a matter of some concern that, hydra-like, it returns time and again in so many different forms. But although common factors are invariably present, local differences can tell us much, and Peet's (pp. 404–408) challenging thesis on diet as a cause of this variation in both depression and schizophrenia is bound to stimulate further enquiry, as indeed will the bothering evidence from Tolmac & Hodes (pp. 428–431) that adolescent psychotic disorder is more common in people from Black ethnic groups. The attraction of biological psychiatry is that local variation should not occur, and if Jensen *et al* (pp. 409–415) are correct that glycerophosphocholine levels are increased in the anterior cingulate gyrus in first-episode schizophrenia, this should be similar across the world. Or perhaps there might be variation, and that's when we go back to Peet's hypothesis.

THE ALPHABET OF DEPRESSION CONTINUED

(With thanks to Gordon Parker, Kay Parker and Kerrie Eyers, who continue their detective enquiry into the eminence of those with surnames beginning with K.)

As most studies commence with some reference and deference to DSM, our initial analyses considered the Mood Disorder Work Group Advisers to DSM–IV. Here, surnames beginning with K were the commonest (13 of 105; 12.4%) and in sharp contrast with the 'K-rate' of advisors for other conditions, such as for the schizophrenic (2 of 54; 3.7%) and cognitive (1 of 28; 3.6%) disorders. The validity of the finding was further supported as, in line with the low representation of mood disorders in children, there was a low K-rate for child and adolescent DSM group advisors (2 of 90; 2.2%). Further, reflecting the well-recognised overlap of mood disorders with certain other conditions, clear 'K-morbidity' was demonstrated – with the K-rate being high for DSM group advisors for the anxiety (10 of 108; 9.3%) and personality disorders (10 of 114; 8.8%). Such raw data findings are even more impressive when the minority status of the letter K is respected (often requiring a preceding O to boost esteem). For example, the letter K has only-child status in SCRABBLE (along with the other singletons J, Q, X and Z). Respecting the importance of controlling for status in most psychiatric studies, DSM representation was therefore checked using the SCRABBLE distribution of letters as the 'normal distribution'. Whether the two blank tiles were included or excluded, whether an intention-to-cheat analysis was undertaken or resisted, the K-rate for mood disorder advisors was distinctly above normal. The definitive Goodwin & Jamison (1990) *Manic–Depressive Illness* text was also inspected. Here – counting the first author of every referenced article in this volume – the K-rate occupied fifth position (n = 220), being exceeded only by S (360), M (315), B (260) and C (230). However, many of the referenced researchers and theoreticians had backgrounds in specialist domains (e.g. genetics) rather than being primary mood disorder specialists. So a more refined depression reference was sought, the *New Oxford Textbook of Psychiatry* (Gelder *et al*, 2000), and analyses undertaken on its nine individual chapters dealing with mood disorders. (The mystery of K continues and more results will be presented next month.)

QUALITATIVE ANALYSIS EXCLUDED

The *Journal* is not a favoured location for papers using qualitative methodology. Crawford *et al* (*International Journal of Social Psychiatry* (2003), **49**, 308–311) found that no primary qualitative papers were published in the *Journal* in 1990, 1995 or 2000, while the *BMJ* increased its rate from 0% to 3.5% and *Family Practice* from 6.7% to 17% over these time periods. We are now considering qualitative papers in the *Journal* and instructions for these will appear in a future issue. But please do not rush; the rejection rate is still likely to be high because there are still too many papers looking desperately for a home. But is this fair?

It's always understated
Research that's qualitative
Much more prefer to cater
For quantitative data
Shown by hard statistics
Instead of prose ballistics

But how is this, my questions pounce
I ask with no frivolity
Which word refers to crude amounts
And which refers to quality?

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