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From the Editor's desk

By Peter Tyrer

Hanging in there

Relatively early in my consultant career I saw a patient who was persistently depressed and anxious – a clear sufferer from an emotional internalising disorder in Goldberg's terminology (pp. 255–256) – despite being on the surface a successful high achiever. She had long abandoned antidepressants as she claimed they made her feel numb, and although this feeling was not as unpleasant as those of some later compounds,[1] it was distressing as she no longer felt in control. She also felt suicidal at half-predicted times that I could never quite fathom and we sometimes played guessing games as to when the next serious threat would occur, as my fear was that the Russian roulette combination of total despair and suicidal impulse might eventually coincide. She was a great believer in diet as a treatment for depression but could never find the right combination; she would have followed our recent debate over lithium in drinking water[2] with great interest. Despite this, we both acknowledged that much of her mood disturbance was related to her high-pressured administrative position, so anticipating the findings of Meltzer *et al*[3] that concern us today in suicide prevention strategies. I struggled for 5 years to do something that could consistently alleviate her symptoms without any real success, and even though I read an interesting article about a new therapy for depression[4] I wrongly concluded that this could not possibly work for her. Then – relatively suddenly – she improved. Admittedly she did not lose all her symptoms, but most of them effloresced in the warmth of tolerable acceptance, a state that appeared just normal to me but to her was a glorious relief. When the time came for me to discharge her from care she was fulsome in her praise for my help. I said, quite honestly, 'I have really done nothing of importance. I have merely followed your occasional ups and mainly downs but, despite all my efforts, have done nothing to alleviate, manage, predict or treat your condition'. 'No, you are wrong', she insisted, 'you hung in there when everyone else had abandoned me'.

I may have done something, but to this day I still feel I was more a chronicler of events rather than a controller of them. But this issue gives me a better understanding of the value of hanging in there. Computerised cognitive–behavioural therapy (CCBT) now appears to be a cheap and effective treatment option for depression[5] (Gerhards *et al*, pp. 310–318), but as Andrews (pp. 257–258) points out, this mainly economic gain is achieved more by productive work than lessened health service care, and in those with more severe depression (and as Goldberg and I suspect, anxiety) (Gerhards *et al*, p. 316) the combination of CCBT and treatment as usual may be more effective. Treatment as usual is not now a favoured option in controlled studies[6] as it is so heterogeneous, but in the study of Gerhards *et al* it did involve care in general practice, where the longitudinal perspective of the general practitioner (GP) appears to offer greater understanding of depression.[7] This is certainly a necessary component of the treatment of mood disorders as Fernández *et al* (pp. 302–309) show with great clarity, with only chronic pain carrying more of a burden on health in primary care. So in this context the encouraging findings of van't Veer-Tazelaar *et al* (pp. 319–325) are important in suggesting an effective way of intervening before depressive and anxious symptoms in older patients have become fully established. So I think I was acting more like a good supportive GP to my patient, hardly efficiently and certainly not cost-effectively, and if I had a little CCBT on hand, or even better the real live form, I may have justified my patients' gratitude.

The handicaps of peer-review

The dissemination of research findings through publication can be a cut-throat business and the peer-review process has come in for a share of this skulduggery. Stem-cell researchers headed by Robin Lovell-Badge of the MRC National Institute for Medical Research in London have recently claimed that 'some high-quality research is effectively being vetoed from publication by a few powerful scientists'. They are aided in this enterprise by unfair reviewers who have their own agenda: 'We feel that some reviewers are increasingly sending back negative comments, or asking for unnecessary experiments to be carried out, for spurious reasons. This may be done simply to delay or stop the publication of the research so that the reviewers or their friends can be the first to have their research published. By relying on a few 'trusted' reviewers, there is a danger of having a clique where only papers that satisfy this group are published. The problem lies with weak editors, who go along with these reviewers when they are being unfair.'[8]

These allegations are naturally denied but in a highly competitive research environment it is easy to envisage how such unfairness can be created. Do potential authors have any reason to be concerned when they submit papers to the *British Journal of Psychiatry*? I hope not, but to prevent complacency I feel the subject should be aired. It is certainly possible in some areas of rapid advance such as neuroimaging that a small group of researchers could dominate the review process, but we would like to think that we are such a broad church that this is very unlikely. We have over 400 reviewers who pronounce on papers regularly for the *Journal* and I can give an assurance that there is no 'trusted clique' that makes the decision to publish or reject. Two years ago I commented on George Orwell's list of four reasons for writing – sheer egoism, aesthetic enthusiasm, the desire to see things as they are, and political purpose.[9] I hope our columns are satisfying the last three of these more than the first, but unfortunately vanity is often the most common attire of the successful researcher, and at times this needs to be stripped off and exposed for what it is. If any of our potential or active authors feel that any of us at the *Journal* is being seduced by this frippery, please let us know loud and clear.

1 Price J, Cole V, Goodwin GM. Emotional side-effects of selective serotonin reuptake inhibitors: qualitative study. *Br J Psychiatry* 2009; **195**: 211–7.

2 Ohgami H, Terao T, Shiotsuki I, Ishii N, Iwata N. Lithium levels in drinking water and risk of suicide. *Br J Psychiatry* 2009; **194**: 464–5.

3 Meltzer H, Griffiths C, Brock A, Rooney C, Jenkins R. Patterns of suicide by occupation in England and Wales: 2001–2005. *Br J Psychiatry* 2008; **193**: 73–6.

4 Rush AJ, Beck AT. Cognitive therapy of depression and suicide. *Am J Psychother* 1978; **32**: 201–19.

5 de Graaf LE, Gerhards SAH, Arntz A, Riper H, Metsemakers JFM, Evers SMAA, et al. Clinical effectiveness of online computerised cognitive–behavioural therapy without support for depression in primary care: randomised trial. *Br J Psychiatry* 2009; **195**: 73–80.

6 Burns T. End of the road for treatment-as-usual studies? *Br J Psychiatry* 2009; **195**: 5–6.

7 Mitchell AJ, Vaze A, Rao S. Clinical diagnosis of depression in primary care: a meta-analysis. *Lancet* 2009; **374**: 609–19.

8 Lovell-Badge R. High-quality research is effectively being vetoed. *BioNews*, 8 February 2010 (http://www.bionews.org.uk/page_54345.asp). Accessed 22 February 2010.

9 Tyrer P. A journal describing present undertakings, studies and labours of the ingenious. *Br J Psychiatry* 2008; **192**: 1–2.