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From the Editor's desk

By Peter Tyrer

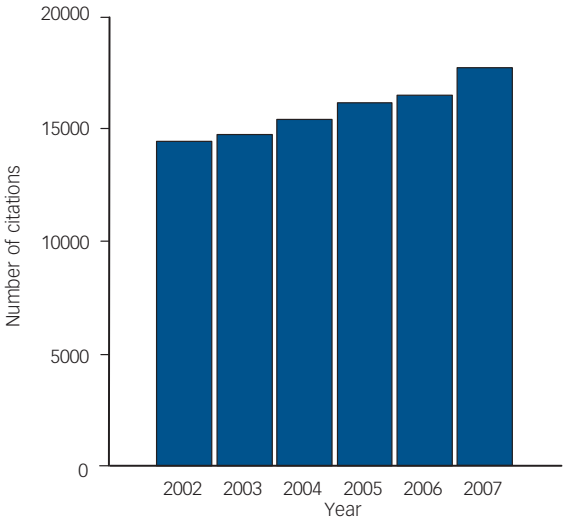
Coercion comes with the territory

Psychiatrists, unless they practise in the outer fringes of the subject, bludgeon sometimes, are coercive often and challenging always. In these roles they naturally arouse the ire of their patients and those who campaign on behalf of their human rights. The core skill of a good clinician is to behave in this way when necessary but not to lose the respect of the patient when so doing, so that when the coercive period is over a good relationship can still be developed or maintained. My fundamental policy is honesty here; if you tiptoe gently round these issues, you are in danger of being accused of double-standards or, much worse, lying. When honesty is linked with feedback the evidence suggests it improves the therapeutic relationship and clinical outcomes.[1,2] The dilemma between choosing selective coercion or temporary condoning of behaviour that constitutes an offence against the patient's health or the rights of others is rehearsed in many of the papers in this issue, most obviously in our good-tempered debate on community treatment orders (Lawton-Smith *et al*, pp. 96–100), and in the evocative painting by Vonn Stropp on our cover. We must remember that the suffering of patients is often because their symptoms too are coercive and that paradoxically a successful unwanted treatment may relieve them. But so many of the subjects of other papers seem to have hidden compulsion (or at least leverage) behind them, and this is not surprising when half of all psychiatric patients share this perception.[3] People with schizophrenia often lack drive and interests and yet plans to persuade them into employment appear to be successful (Killackey *et al*, pp. 114–120),[4] and the (often coercive) treatment of those who are risk of harming others[5] may have something to do with an encouraging drop in the number of homicides attributed to mental disorder (Large *et al*, pp. 130–133). Similarly, the dilemma of the worried parent being aware of suicidal risk in their children (Oldershaw *et al*, pp. 140–144), heightened further if they know of past abuses (Brezo *et al*, pp. 134–139), yet feeling that anything that is suggested may be counterproductive, also has the whiff of compulsion hovering over what should be a warm and supportive interaction. Coercion that is more common in some ethnic groups could be racist, but one treatment commonly associated with coercion, antipsychotic drugs, shows no such evidence of ethnic variation (Connolly & Taylor, pp. 161–162). Added to this is that some treatments that appear to be markedly coercive, such as the magnetic seizure treatment described by Kirov *et al* (pp. 152–155), are desired very strongly by patients; one of my own patients is moving heaven and earth in attempting to receive this treatment.

Of course there are bound to be some psychiatrists and, indeed, other mental health professionals, who are gratuitously coercive and derive pleasure from exercising a degree of control over people's lives not possessed by any other medical discipline. What better than a good and reliable 360-degree assessment of consultants to ensure that such behaviour is identified early and corrected, and Lelliott *et al* (pp. 156–160) may have found the answer. Perhaps before long we can be defining a good psychiatrist as 'a completely rounded physician who can diagnose mental illness reliably, treat it well by consensus and, when necessary, compulsion, and who enjoys both the respect of colleagues and the gratitude of patients'.

Citing and exciting journals

The impact factors of academic journals for 2007 are now published and that for the *British Journal of Psychiatry* has risen slightly to 5.446. We are now third in the list of general psychiatric journals behind *Archives of General Psychiatry* and *American Journal of Psychiatry* and hope that before long when people ask 'have you read the latest article in the *Journal*?' it will not be necessary to ask 'which one?' Our new-style journal will take time to filter through to impact and immediacy ratings but I hope that we can now concentrate on other ways of improving our content outside the league table mentality that we must try hard to dispel.[6] Despite limits on the size of the journal we are able to publish more material and one gratifying consequence is an quinquennial increase of nearly a quarter in our cited articles published in the previous two years (Figure). With a similar increase in the number of hits on the journal website we do not pass unnoticed.



1 Slade M, McCrone P, Kuipers E, Leese M, Cahill S, Parabiaghi A, Priebe S, Thornicroft G. Use of standardised outcome measures in adult mental health services: randomised controlled trial. *Br J Psychiatry* 2006; **189**: 330–6.

2 McCabe R, Saidi M, Priebe S. Patient-reported outcomes in schizophrenia. *Br J Psychiatry* 2007, **191** (suppl. 50): s21–8.

3 Monahan J, Redlich AD, Swanson J, Robbins PC, Appelbaum PS, Petrila J, Steadman HJ, Swartz M, Angell B, McNiel DE. Use of leverage to improve adherence to psychiatric treatment in the community. *Psychiatr Serv* 2005; **56**: 37–44.

4 Latimer EA, Lecomte T, Becker DR, Drake RE, Duclos I, Piat M, Lahaie N, St-Pierre M-S, Therrien C, Xie H. Generalisability of the individual placement and support model of supported employment: results of a Canadian randomised controlled trial. *Br J Psychiatry* 2006; **189**: 65–73.

5 Wong SCP, Gordon A, Gu D. Assessment and treatment of violence-prone forensic clients: an integrated approach. *Br J Psychiatry* 2007; **190** (suppl. 49): s66–74.

6 Tyrer P. Practical impact (letter)? *Br J Psychiatry* 2008; **192**: 69.