From the Editor's desk

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CHILDREN AND PREVENTIVE PSYCHIATRY

Many years ago Leon Eisenberg (*Pediatrics* (1962), **30**, 815–828) commented on the paradox that paediatricians more commonly seek the advice of psychiatrists than vice-versa, despite the tremendous contribution that paediatrics has made to our understanding of mental illness. This imbalance in consultation could not be justified, Eisenberg commented, 'unless one were to assume that the psychiatrist knows all that the pediatrician does, plus something more – or that what the pediatrician knows is of no consequence for the psychiatrist. No one would seriously maintain the former statement, and the latter is no less patently absurd'.

This issue illustrates the significant inter-relationship between child psychiatry, obstetrics, paediatrics and adult psychiatry, and their need to continue talking. Joyce (pp. 93–95) points out that the precursors of adult schizophrenia may be set at a very early stage, with genetic factors interacting with environmental ones, such as foetal hypoxia, to create anatomical and functional vulnerability to the disorder, and that memory impairment may be a risk factor rather than a consequence of schizophrenia. Niemi *et al* (pp. 108–114) also show the strong relationship between neurological soft signs in childhood and schizophrenia-spectrum disorder; Baker & Skuse (pp. 115–120) show identical features in childhood in those with chromosome 22q11 deletion syndrome. Bipolar disorder, often considered to be a consequence of genetic vulnerability with the episodes precipitated by life events, is shown by Garno *et al* (pp. 121–125) to have a strong association with severe childhood abuse and earlier age of onset. All these findings are making the chronological division of child, adolescent and adult psychiatry increasingly difficult to maintain.

Eating disorders have also been traditionally linked to childhood and have fascinated paediatricians and psychiatrists since the time of Gull. Currin *et al* (pp. 132–135) show that in primary care these disorders are commoner in adult life than in adolescence and that the incidence of bulimia is much more variable than that of anorexia nervosa, with a pleasing drop in incidence in recent years. However, this change may be illusory and the importance of early recognition continues to be emphasised by the National Institute for Clinical Excellence and others, bringing us back to the earliest years of life. Our difficult task is to separate those features that are transitory and truly developmental from those that are the precursors of serious adult pathology. It is reassuring to know that at least some childhood problems do not adumbrate later catastrophe and only distress at the time. As Mark Twain, a genuine family man, noted with feeling, 'Adam and Eve had many advantages, but the principal one was that they escaped teething'.

GUIDE TO THE NOOKS AND CRANNIES OF THE IMPACT FACTOR – THE EFFECT OF IMMEDIATE IMPACT

Since the impact factor has such an influence on medical publication and research careers, I thought a little more information was needed for those lucky souls in ordinary clinical practice who do not need to think about it constantly. Most readers will now know that the impact factor refers to the number of times articles are cited in the literature after publication. What is not so widely known in that the impact factor refers to the number of times an article is cited in the 2 years following its publication, but not in the actual year of publication. This may seem odd to those who believe that the impact of a punch on the jaw is determined more by its force than by the time of its projection, but later citation is deemed to have greater impact. Citations to publications appearing in the year of publication are combined in the immediacy factor, which is hardly ever quoted.

The impact factors of general and specialised psychiatric journals are fairly well known and many will know that the *Archives of General Psychiatry* tops the list and has done for some years. What will come as a surprise is that the immediacy factor table is topped by the *Canadian Journal of Psychiatry*, despite its relatively low impact factor. The readers of the Canadian journal are so keen to cite papers appearing in their journal that they cite them very quickly and so their impact factor suffers as a consequence. In short, they are too impulsive in their responses for their own good and someone (possibly their new Editor, Joel Paris) will have to rein them in. I would not have realised this phenomenon had not an ergonometrician (my preferred name for an expert in the studies of impact) commented that my editorial in last month's issue (pp. 1–3) 'appeared just at the right time'. It includes several citations to papers (from low- and middle-income

Journal	Impact factor – 2003 (rank)	Immediacy factor – 2003 (rank)
Archives of General Psychiatry	10.52 (1)	1.64 (2)
American Journal of Psychiatry	7.16 (2)	1.03 (5)
Biological Psychiatry	6.04 (3)	0.73 (7)
Molecular Psychiatry	5.54 (4)	1.22 (3)
Neuropsychopharmacology	5.20 (5)	0.76 (6)
Journal of Clinical Psychiatry	4.98 (6)	0.64 (8)
Journal of Clinical Psychopharmacology	4.43 (7)	0.59 (10)
British Journal of Psychiatry	4.42 (8)	1.10 (4)
Schizophrenia Research	4.07 (9)	0.49 (11)
International Journal of Neuropsychopharmacology	4.0 (10)	0.45 (12)
Psychological Medicine	3.13 (11)	0.63 (9)

https://doi.org/10.1192/bjp.186.2.175 Published online by Cambridge University Press

countries) published in 2004 – but if it had been published in the December issue it would have contributed to the immediacy factor but not the impact one.

So now you know. Toss in the immediacy factor to those boring conversations about research endeavour; it will have considerable impact.

RISK MANAGEMENT (CONTINUED)

The December issue pointed out the risks of psychiatric practice in verse, with the help of Gilbert and Sullivan. Risk continues to be a problem at all levels of practice, not least in stimulating our medical students to enter psychiatry (Goldacre *et al*, pp. 158–164) and I cannot help noting that my institution, Imperial College, does particularly badly in encouraging psychiatry as a choice of career. Their advice to have 'greater exposure to psychiatry' for medical students seems wise, but in my assertive outreach practice I need continually to protect our students from abuse, personal assault and dismissive rejection and find myself both apologising and insisting that 'most of psychiatry is not really like this'. My solution is to bring the patients on (the risk management) board.

Now there is an era dawning,
Hopes to which we all aspire;
Let's remove the secret awning,
And reveal our plan entire
So embark upon this day
On our great and glorious way

First, we'll start a Patients' Forum,
Pay them with a proper wage,
All risk problems will be for them,
We'll hold hands at every stage
In answer to all our prayers,
They'll relieve us of our cares.

Then all paper that attaches
To risk management despatches,
Will quickly to the dustbin all be sent;
Patients and the staff together,
In collaborative endeavour,
Will our most heartfelt wishes represent.

We won't need busybodies from the courts,
Demanding notes and reports of all sorts
We'll our own mental health administrate
Instead of being governed –
by someone else's date

So our risk assessment entries,
Will add little to inventories,
And our patients will be bustling,
up and down and to and fro,
Making sure our risk aversion,
Protects every single person,
Even those we might not care for –
ever so slightly so

Now the managers may rue,
Of the troubles when they sue
But their worries they are nothing when
our risk solution's come
And our Trusts will get the plaudits,
When they carry out the audits
With the gratifying feeling that their
duty has been done

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