

Editorial

Child health professionals are keen to understand the origins of antisocial behaviour. Ben Lahey and colleagues, in this issue's Annotation, remind us of the evidence that it may reflect individual propensities to be impulsive, to have high activity levels with greater than average physical strength, coupled with low intelligence and a sense of daring. Youths with an earlier age of onset, before adolescence, are more likely than those with later onset to meet criteria for ADHD, but whether ADHD as such predisposes boys to engage in antisocial acts is unclear. Oppositional Defiant Disorder may be the more relevant influence. They discuss the role of "intelligence" in protecting against the development of antisocial behaviour, in particular the importance of reasonably good verbal abilities. Interestingly, Lahey et al. take the view that we are not yet in a position to be sure whether specific cognitive deficits are important predisposing factors for antisocial behaviour. They suggest that a more parsimonious way of looking at cognitive influences is to consider the global trait of intelligence without being more specific until better evidence emerges. For clinicians who wish to identify children who may be at high risk of antisocial behaviour, it is also important to think about parenting variables that may predispose to its development. These include the use of harsh discipline, lack of parental supervision, and antisocial parental attitudes. Finally, they note there is increasing interest in the influence of gender on the development of antisocial behaviour. This article is concerned exclusively with boys, and there is so far no truly convincing explanation for the remarkable differences in prevalence of such behaviour between the sexes. Girls appear to be easier to socialise, and boys have poorer communication skills in the preschool period. This aspect of sexual dimorphism is worthy of further investigation, perhaps from the perspective of gender differences in social cognitive development.

Helen Rushforth offers a Practitioner Review whose purpose is to offer guidance to practitioners who are responsible for communicating with hospitalised children. She presents not only a literature review, which is derived from the theories pertaining to children's conceptualisation of health and illness, but her paper also gives guidance to practitioners on how to communicate effectively with children of different ages, and in different clinical situations. The paper focuses on a range of contemporary issues including pre-procedural preparation, children's health promotion, and the need to convey health promotion messages to young children. She discusses the competence of children to give consent for surgery, and the criteria by which their competence to gain contraceptive advice without parental consent may be judged.

Important comments are made about the way in which children think about death, and about the rights of the

child in hospital to be consulted about the way in which they are to be treated. Health promotion is given due prominence, this being a major plank in the current United Kingdom government's plans for improving the health of the nation.

We then have several papers on the subject of childhood neurodevelopmental disabilities. The first of these is from Denise Vallance and her colleagues. She conducted an investigation of children who have, in addition to their ostensible reason for referral to a child psychiatrist, impairments of language development. She compared the language-impaired children with psychiatric problems with children who had language impairment but no psychiatric disorder, or a psychiatric disorder and no language problem. Her findings have implications for mental health professionals conducting therapy with psychiatrically referred children. The results offer an alternative explanation for some of the difficulties children experience in therapy. Vallance et al. suggest that children may commonly have problems expressing their thoughts concisely or communicating meaning in emotionally loaded situations because of a primary language problem. Rather than attribute these difficulties to such emotional factors as resistance, broader language processing impairments should be considered. They may manifest in difficulties linking thoughts together, or in speaking unambiguously about people, objects, or events. Given these findings, she suggests therapists should think about how they conduct interviews with children whose use of language is subtly impaired, and make due allowances for their difficulties. In this way they may be able to compensate for children's potential communication deficits, for example by giving children more time to respond to questions. For example, "I don't know" could mean the child needs more time to think about what to say. They suggest that it may also be useful for therapists to remember that repeating information for children, and having them repeat back in their own words information that has been discussed, can help ensure that both therapist and child are on the same wavelength.

We have a number of important and potentially influential papers on childhood autism in this issue. The first of these is by Claire Hughes and colleagues, and represents a novel and sophisticated attempt to try and pin down in cognitive terms the impairments we find among the first- and second-degree relatives of autistic individuals. Recent models of autism highlight the importance of viewing childhood autism as a spectrum of disorder rather than as a clearly distinctive phenotype. The word "spectrum" incidentally may turn out to be a misnomer, for it implies a unidimensionality of impairment that is, in this editor's opinion, unlikely to be borne out by the evidence as we learn more about the biological underpinnings of the disorder. Be that as it may, Hughes et al. focus on the "broader autism phenotype" (BAP).

To date, research into the BAP has focused on problems of social contact and communication, which as readers will know comprise two of the three areas of impairment that go to make up the classic phenotype. Far less is known about whether relatives also share some of the problems characteristic of the third area of autistic impairments (repetitive behaviours, lack of flexibility, and poor imaginative skills). The authors have conducted a searching investigation of so-called executive function skills, higher-order cognitive abilities that do not correlate particularly well with general intelligence as measured by standard IQ tests. We know autistic individuals have a variety of problems in executive functions, particularly the ability to plan or to create strategies. The results from this investigation suggest that *a significant minority of autism-siblings also show poor executive function*, supporting the extension of the BAP to include this domain of cognitive ability. Although there is often a tendency to focus on the cognitive impairments associated with autism, there is also some preliminary evidence that autistic individuals may be at an advantage in some ways too, in terms of certain cognitive abilities. This claim is, incidentally, the subject of other papers in this issue, one by Kate Plaisted and colleagues and the other by Laurent Mottron et al., from Canada. Siblings of autistic subjects in the Hughes et al. study showed *superior* spatial and verbal span to siblings of controls, indicating that the BAP may also be characterised by an uneven profile of cognitive abilities. Clinicians ought routinely to look more carefully at the siblings of autistic individuals, in case they have minor social or learning difficulties that are overshadowed by the autistic child's problems.

In a prospective longitudinal study of autistic preschoolers, from 20 to 42 months of age, Antony Cox and colleagues examined the stability of the diagnosis of autism and related pervasive developmental disorders in a sample of at-risk children identified from a community survey. They contrasted the performance of the "gold standard" (the Autism Diagnostic Interview-Revised; ADI-R) with a clinical diagnosis at both ages. The ADI-R was only moderately good at picking up potential cases at 20 months. In other words, it lacked sensitivity in the sense that about half of apparent cases identified at 42 months did not meet ADI-R criteria at 20 months. Specificity was in contrast good; all those meeting criteria at the earlier age still met criteria at 42 months. From this perspective it performed considerably better than the clinical diagnosis alone. A clinical diagnosis of a broader spectrum of related Pervasive Developmental Disorders (PDD), such as Asperger syndrome, was far more difficult to predict at 20 months. Most of those so diagnosed at the later age were missed initially. There are certainly limitations in the generalisability of the present findings to a clinic-referred sample. However, the lesson for clinicians from this important survey is that children with language disorders and developmental delays at 20 months or so that are associated with impairments of social interaction may be at greater risk of later PDD than is commonly realised. Further, the authors found that a subgroup of individuals who later appeared to have a PDD did not develop their repetitive and stereotyped

patterns of behaviour until the social and communicative abnormalities had already become apparent.

Although many young children show initial wariness on meeting a stranger, shyness that lasts into middle childhood may be indicative of clinically significant problems that may amount to a psychiatric disorder. Kathryn Fordham and Joan Stevenson-Hinde address the interesting question of what associations may be found between shyness and the quality of friendships among children in middle childhood, and how these in turn relate to the child's sense of self-worth. They took a sample of shy children at 4 years and found strong continuities in that temperamental trait over the next few years. They found that shyness as rated by observers agreed well with mothers' and teachers' ratings. However, both mothers and teachers significantly underestimated children's shyness relative to observer ratings—a point of relevance to assessment, and an indication of how internalising problems may be overlooked. Observed shyness increased in salience for older children, and by 10 years of age became significantly correlated with trait anxiety as well as low global self-worth. Shy children were more likely to be lonely and anxious, and believed themselves to be less socially accepted by their school-mates. The converse was also true. However, rather surprisingly, just a year or so earlier (at a mean age of 9 years) the authors found no significant relationship between observed shy behaviour and self-perceptions. This lack of consistency between behaviour and perceptions implies that interventions aimed at changing the behaviour of shy children, and encouraging social interactions, may be quite effective at earlier ages—up to about 9 years. But by 10 years of age, the isolated shy child's self-perceptions may be a more appropriate target for intervention.

As scientists and practitioners, we often assume that the measures we use to assess the family "environment" are just that—assessments of environments. However, as the findings by Kirby Deater-Deckard and colleagues suggest, measures of environments may be influenced by genetic factors. Their results, based on data from the longitudinal Colorado Adoption Project, show that within-family variations in certain aspects of the family environment—for instance, parental warmth and negativity and the achievement orientation of the household—include child genetic sources of variance operating via child effects upon that very environment. We need to bear in mind that commonly used measures of the family environment, such as the Parent Report and the Family Environment Scale, are not assessing purely environmental processes. Scores on these scales are, instead, in part reflecting gene-environment processes of interaction. This is a critically important distinction for research and, ultimately, for the way we approach prevention and interventions. We need to think clinically more carefully about the effects children with highly heritable traits have on their parents. By extension, we also need to consider the subtle interplay between parents, who may themselves have a similar genetically influenced predisposition, and child characteristics.

In another paper on the subject of the family, Tom O'Connor and colleagues present data from a major

longitudinal study of a birth cohort from a single city, the ALSPAC Study, which is based in Bristol, England. Our understanding of the long-term effects of divorce on children's psychosocial well-being is limited, but we do know that there is an association between having one's parents separate in childhood and problems in adulthood, including depression. The paper by O'Connor et al. sets out to examine alternative developmental models that may explain the connection between parental divorce and adult adjustment. There is a prevailing view that divorce is just another childhood stressor and can be considered as equivalent to parental death, abuse, and so on. The findings from this study do not support that viewpoint. The conclusions are unfortunately not as clear as they had hoped, but it does seem that the long-term effects of parental divorce are mediated not only by events in childhood but also by life patterns, such as teenage pregnancy, leaving home early, and poor educational attainments. For clinicians who become involved in parental disputes that end in divorce, it is important to bear in mind the longer-term consequences of the family conflict as well as seeking to assist during the time of the most acute crisis.

Behavioural screening questionnaires have traditionally focused on a child's symptoms rather than on the impact that those symptoms have on the child and others. Yet current diagnostic criteria for most child psychiatric disorders insist that the relevant symptoms must result in substantial distress or social impairment for the child. If this dual focus on symptoms and impact is justified, screening questionnaires should function better if they ask about impact as well as symptoms. Goodman provides suggestive evidence that this is so, and also shows that single questions can be surprisingly discriminating. One question, on whether the respondent thought the child had a problem, was almost as discriminating as the rest of the questionnaire. Another question, on whether the child's symptoms imposed a burden on others, correlated highly with a detailed interview. For those interested in psychiatric caseness and the factors influencing service use, the new two-page questionnaire looks promising.

Finally, we have three papers from the developing world, emphasising the aim of our journal to have a wide international presence and to reflect concerns about child development in many different cultures. Richard Hackett and his team were interested to learn about the prevalence of psychiatric disorder in 8–12-year-old children in

Kerala, South India. They wanted to know whether the sorts of association we find in the West, such as with male sex or learning difficulties, would be found also in India. They conclude that there was indeed a striking similarity of factors associated with psychiatric disorder in both cultures. Conditions that are more characteristic of developing countries, such as obstetric complications and malnutrition, were not associated with the risk of psychiatric disorder. This finding should be contrasted with the findings presented by Julie Meeks Gardner et al. on the behaviour of formerly malnourished Jamaican children. Hackett and colleagues observe that it is not the absolute degree of deprivation that is importantly associated with externalising problems in children, but rather the relative level of deprivation compared to others in that population. A full interpretation of that provocative finding must await further studies.

Carolyn McCarty et al. conducted a study that examined Thai–U.S. differences in children's coping across different types of stressful situations. One of the most important findings was that the way that youths responded to various stressors was a function of both the type of stressful situation and the child's cultural background. Contrasting stressors they examined included adult anger, separation, and coping with injury. Cultural norms for appropriate behaviour appeared to call for different coping patterns for Thai and American youth. So there was evidence that Thai children used quite different tactics to U.S. children to cope with an angry adult, and would tend to conceal their feelings. In contrast, U.S. children were rather less direct in dealing with personal injury. Thai children would expect direct intervention for sickness or injuries that U.S. children would try to ignore. In a variety of other situations, no cultural differences were found. This paper illustrates the importance of examining coping as it occurs across different settings, rather than viewing it as a uni-dimensional construct. Moreover, the article provides support for the *cultural salience* notion, suggesting that strength of cultural influence depends on the extent to which the particular situation evokes specific cultural beliefs, customs, or norms. Clinicians who are helping children cope with stressful life experiences may be most effective if they are attentive to the interplay of the children's culture with the specific stressors they confront.

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