

## Editorial

This issue starts with a very informative Practitioner Review by Judith Middleton on the psychological sequelae of head injuries in children and adolescents. As many as 2.5% of children may have sustained a head injury leading to attendance at Accident and Emergency during childhood. This is a higher incidence than, for instance, epilepsy. The effects of injury may have wide implications not only for the child but also for siblings, parents, and the wider family. In addition, schools often have little understanding of how a child who now looks unscathed following an accident may have subtle and complex cognitive and psychosocial problems that affect all aspects of daily life, learning, and relationships. Contrary to previous beliefs that the younger the child who sustained a head injury the better the outcome, it is now clear that damage to the brain at an early age may have profound and long-term effects. The argument that the plasticity of the young brain may enable children who suffer from brain injury to develop normally ignores the fact that the areas of the brain that are developing rapidly are the most vulnerable. Both clinical and neuropsychological assessment of children who suffered brain injury can not only help the individual child but also inform and support parents, and help teachers and schools to understand behaviour and difficulties with learning and the application of knowledge. This paper highlights the issues to consider, the questions that clinicians can ask, and how to initiate more complex assessments in order to intervene and manage problems.

Is there an early sensitive period for the effects of malnutrition on cognitive development? It seems from studies among children in developed countries that infants whose growth falters in the first 6 months of life showed poorer cognitive outcomes than infants faltering later in the first year. If there indeed is a specific enduring effect of early malnutrition on infant development then one would expect it to appear in response to malnutrition in any context, even if the reasons for the malnutrition vary in different populations. Drewett et al. studied the cognitive development in three groups of children from south-west Ethiopia: early growth falterers whose weight dropped below the third centile in the first 4 months, late growth falterers whose weight dropped below the third centile at 10 and 12 months, and a comparison group with weights above the third centile throughout the first year. Early weight faltering was associated with the poorest cognitive functioning when children were aged 2 years, then came the children with late faltering, whereas the comparison children performed the best on the cognitive tests. However, after taking weight at the time of testing into account, there was no additional effect attributable to the timing of growth faltering. The fact that this study did not support the specific effects of early malnutrition may imply that it is the covariates of early malnutrition (for instance an organic basis for poor weight gain), which are likely to differ in different contexts, rather than early malnutrition itself, which are responsible for the early effects found in studies to date.

This issue contains two studies on genetic influences:

one on the genetic influences on language impairment and literacy problems in children, and one on the genetic influences on hyperactivity. Reading disability has traditionally been the concern of psychologists and educators, whereas oral language problems are seen as coming under the domain of speech and language therapy. The study by Bishop looks at links between language and literacy difficulties in a genetic study. She points out that there are some cases of reading disability who do not have evidence of additional oral language impairment, and suggests that these cases are likely to be less severe and to have an environmental rather than a genetic basis for their problems. In assessing children with reading disability, it is important not just to look at the pattern of literacy problems, but also to ask whether there are broader difficulties in oral language, which can easily go undetected. The studies by Kuntsi et al. combined a behaviour genetic approach with the testing of psychological mechanisms involved in hyperactivity in a sample of twins. They found that a considerable proportion of the variance in hyperactive behaviour was due to genetic effects. Of the psychological mechanisms they investigated, reaction time seemed to be associated with shared genetic effects. This high variability in speed of responding may indicate a state regulation problem in hyperactive children. In their discussion, the authors indicate that stimulants have a beneficial effect both on hyperactive behaviour and on children's performance on stop tasks. The authors therefore hypothesise that the neurobiological underpinnings of the shared genetic effects on ratings of hyperactive behaviour and the variability of speed of responding may be sought in the biological targets of the stimulants, the dopaminergic and the noradrenergic systems.

Parker et al. report on the development of a brief screening measure of "emotional distress" in children that was modelled on the General Health Questionnaire and that contains items reflecting problems such as depression, anxiety, and withdrawal. The authors stress the brevity of this instrument as the main advantage, and they suggest that the measure may be of some utility as a community screening questionnaire of emotional distress in young children.

Reading this, I realised that "screening" is often mentioned as an application of rating scales in general, especially of brief rating scales. Because rating scales are relatively inexpensive and easy to administer, they are often thought of as handy tools for screening large populations both for research and community health purposes. In the strict medical meaning, screening refers to the examination of asymptomatic people in order to classify them as likely or unlikely to have the disease that is the object of screening. People who appear likely to have the disease are investigated further to arrive at a final diagnosis. Those people who are then found to have the disease are treated. The question then arises whether or not psychiatric conditions meet all the criteria for being subjected to screening. A number of factors argue against population screening for detecting child/ado-

lescent psychopathology. The first is the nature of most (child/adolescent) psychiatric disorders. Screening is a method originally developed for detecting highly specific medical target conditions that are either present or absent. Medical screening usually has a narrow focus, uses one source of information (the subject), and the need for precision of the screening procedure is high. In contrast, psychiatric disorders lack specificity and do not have unitary underlying conditions. They have heterogeneous etiologies as well as phenotypes and there is a need for approaching them in a multidimensional way that is not restricted to behavioural/emotional problems but should include other domains such as the individual's competence. It is therefore by the very nature of psychopathology much harder to arrive at a present versus absent distinction that serves to help children. Also, as yet, no assessment procedure in psychiatry is capable of obtaining the level of accuracy that some medical screening tests have. The second is that most child and adolescent psychiatric disorders do not seem to be characterised by an asymptomatic or benign period in which detection can be reliably and validly performed. Most child and adolescent conditions do not have a clear-cut well-delineated onset, but are either present from birth onward or have an insidious onset. The third factor that makes it not readily evident that mass screening is helpful is that it has not been definitively demonstrated that treatment or prevention of many child and adolescent disorders is beneficial. It is therefore doubtful that if the goal is to arrive at an accurate yes or no answer

concerning the presence or absence of a psychiatric disorder in children or adolescents, any instrument will prove to be good enough. Unrealistically high expectations of the usefulness of a screening measure may then result in disappointment, or worse, they may evoke negative reactions by those who are unacquainted with the diagnostic assessment of child/adolescent psychopathology. However, if the level of precision does not need to be as high as in medical screening, for instance in epidemiological studies where the error is taken into account, or if early assessment procedures are carried out by professionals who have taken some responsibility for the child, and the early assessment is one component of decision making, then there seems to be a place for the use of rating scales as screening instruments.

This issue contains five interesting articles pertaining to individuals with pervasive developmental disorders. Of direct clinical relevance is the study by Gilchrist et al., who reported that young people with autistic spectrum disorders who do not have early speech delay may have as severe deficits in adolescence as those whose speech development was delayed. However, they are often diagnosed late, and parent reports suggest that early communicative and social deficits may not be noted when speech has begun at the normal time. The authors indicate that normal early speech development does not necessarily predict good outcome by adolescence in autistic spectrum disorders.

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