

Editorial

What makes young people act in antisocial ways? This question is discussed from several different angles in our current issue. Delinquency is not, of course, a new phenomenon: for those interested in reading a chilling account of life in London in the early years of the last century, Cyril Burt's *The young delinquent*, published in 1925, is worth tracking down. Definitive answers seem as far away as ever, but the idea that delinquency might be influenced to a significant extent by genetic mechanisms is still a controversial one. Taylor et al. conducted a twin study, and found the variance in delinquent behaviour among adolescent boys and girls was associated largely with experiences that were unique to individuals. Family influences accounted for half of the remaining variance in risk; less than 20% could be attributed to additive genetic factors. Their findings imply, they suggest, scope for prevention and/or intervention. On a similar topic, Hawker and Boulton ask, why is it that some children are bullied? What effect does bullying have on children's emotional adjustment? They review the history of research on this topic, going back over two decades to the pioneering studies of Dan Olweus. Using meta-analytic techniques, they conclude victims become emotionally distressed and, in particular, depressed. Clinicians should realise that children who present with emotional problems may be the victims of bullying; interventions that target either bullying or emotional distress may reduce the severity of both problems.

When we consider the origins of delinquent behaviour, we are mindful that the earlier such behaviour appears, the more likely it is to persist into later childhood, even into adulthood. Are there patterns of intrafamilial interaction that increase the risk of behavioural maladjustment, and are they amenable to clinical assessment? Expressed emotion is one of the few measures to have stood the test of time. Although it was first employed in studies of schizophrenia, there are now many examples of the technique being used with the families of young children. Peris and Baker looked at a community sample of 4-year-olds, who were then followed for 2 years. The investigators asked; does high expressed emotion lead, over the preschool to school period, to an increased risk of behavioural disturbance? Although the stability of the measure and its predictive value were modest, the results of this study indicate that parents who are persistently critical are likely to end up with a child who is maladjusted. Jenkins and Oatley also consider the relationship between emotions and behaviour. Their area of interest was not interpersonal interaction as such, but the relationship between children's spontaneous expression of emotion and their social adjustment. By means of an ingenious design, they related measures of children's propensity to display certain emotions, during structured observations at school, to their behaviour—as judged by parents, teachers and peers. Children who readily expressed anger were found to be the most troublesome. Their results imply negative affect observed in the consulting room may reflect a broader pattern of behavioural style. Last, we present a paper on this theme

from Tomblin and colleagues. They were interested in learning more about the association between difficulties with spoken language, reading disorders, and social dysfunction. Preschool children with language delay are more likely to be behaviourally disturbed in later childhood. Using a longitudinal prospective design, they found children who have both spoken language impairment and reading disorder were especially likely to develop behaviour disorders. They suggest maladjustment results from demands for communicative competence that overwhelm vulnerable children in school; if this is so, teachers need to be aware of the potential risk and provide additional support where appropriate.

False-belief tasks offer a quick and simple test of children's capacity to appreciate the fallible nature of mental states. If we do not comprehend false beliefs, we will not be able to interpret jokes, tricks, lies, and misunderstandings. Hughes and colleagues were concerned about the lack of formal investigations of reliability of such tasks. They gave both first- and second-order false-belief tasks to children with a wide range of abilities, as estimated from a brief IQ test, to appraise test-retest reliability. Gratifyingly, most kappa values were moderately good. The authors suggest false-belief tasks may be usefully employed with clinical populations as a means of assessing children's levels of social understanding. False belief is seriously impaired in autistic conditions. In another meticulously conducted investigation from a group who have made a substantial contribution to our understanding of childhood autism, Pickles and colleagues examine the increasingly well-recognised prevalence of autistic-like symptoms among the extended families of autistic children. The existence of a broad spectrum of autistic features among the first- and second-degree relatives of autistic probands is now established by research, as well as by clinical observation. We are only just beginning to unravel the underlying genetic mechanisms that predispose to the broader phenotype, but such understanding would help genetic counsellors provide better information to prospective parents "at risk".

Yule and colleagues have conducted groundbreaking studies of the psychological impact upon adolescent school children of being caught up in a shipping disaster. They showed that post-traumatic symptomatology was more common than many expected, even among children who had not experienced the most serious danger. Here they consider the long-term risk of PTSD, and more general psychopathological disturbance, among the survivors of that tragedy. They managed to recruit nearly two thirds of the original sample after 7 years and show post-traumatic stress disorders, as well as other psychopathology, persist in many cases for several years. In a small, but important minority of cases (about 10%), the onset of post-traumatic stress disorder was not immediate, and occurred some time after the event. There was an interesting bimodality to the duration of symptoms; a substantial minority had symptoms that resolved within a year, but in others they persisted for 5 years or more.

Screening child survivors of major disasters for mental health problems is important, and this study points up the need for preventive work as well as the treatment of overt psychopathology.

Although there have been substantial advances in the treatment of obsessive-compulsive disorder (OCD) in adults in recent years, therapy for children with OCD may be less widely available. Rapoport and Inoff-Germain review progress. Their valuable article discusses both cognitive behavioural and medical interventions, as well as making a cautionary pronouncement on the increasing tendency to use polypharmacy. They draw attention to the importance of distinguishing the clinical disorder from normal developmental rituals, and emphasise the value of having some objective measure of severity so that efficacy of treatment can be monitored over time. They also comment on the intriguing and increasingly well-recognised association between OCD and former beta-haemolytic streptococcal infection, in a proportion of paediatric cases.

Finally, Dykens questions why children with an intellectual disability are at increased risk of mental health problems, in her valuable annotation. Why, she asks, does a low IQ put a child at greater risk? There is no simple explanation. After discussing the various biological, family, and social influences that might be relevant she argues that clinical interventions are likely to be more effective if based on some plausible model of causality. She takes issue with the reductionist approach to diagnosis, which places a child in one category for psychopathology and another for intellectual disability. Drawing on her extensive work with behavioural phenotypes, she suggests we need to place greater emphasis on the individual vulnerabilities of disabled children because these are often meaningfully linked to overt forms of behavioural disturbance. There is much here for the clinician who deals with intellectual disability to mull over.

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