

Editorial

We are pleased to publish, soon after its delivery, the 1998 Emanuel Miller lecture by Michael Rutter on the subject of autism, a masterly review of the history of clinical practice in this condition and the way in which it has both informed and been informed by research. It is now 55 years since Kanner's seminal paper, and that is over half a century of controversy which shows no signs of abating in intensity, although perhaps the focus is changing. Nowhere is this more clearly evident than in the field of clinical practice. As Rutter's review article brings out, empirical research findings have been crucial in bringing about such change. Nevertheless, he emphasises that the traffic has been far from one-way. Many research advances were prompted by astute clinical observations and some extravagant research claims were given a more balanced perspective by being viewed in the light of clinical experience. Progress takes place through a series of fits and starts, and the two-way interplay between research and clinical practice is essential to ensure that the gains are real, rather than misleading. We are still a very long way from having an effective means of preventing or treating autism but the lessons of the past provide a useful guide on how best to move ahead in the future.

Several articles in this issue consider both theoretical and empirical research issues in childhood autism. A report by Michelle Turner finds that individuals with autism are significantly impaired relative to age- and ability-matched control subjects on open-ended tasks that require the subject to generate multiple responses to a single cue. This deficit was especially marked for the high-functioning autistic subjects, who were found to produce significantly fewer correct and novel responses than globally learning disabled control subjects despite a mean verbal IQ that was some 40 points higher. It is easy to see how an impaired capacity to generate novel ideas and behaviour may underlie some of the essential features of autism such as an impoverished imagination, a restricted range of interests, and poverty of speech and action. Clinically, these results suggest that individuals with autism will perform poorly when there are few cues to prompt and guide behaviour. They support the trend toward the use of structured environments in programmes for children and adults with autism at all levels of ability. Perceptual processing among those with relatively high abilities and autism is considered by Motttron et al. They discuss the evidence for impaired central coherence, which proposes that there is a deficiency in integrating information at a local level of organisation into higher-level holistic processing. Or, to put it crudely, a tendency to focus on the trees and to ignore the wood. Surprisingly, the prevailing theories were not supported by their results, although theirs is not the first study that has failed to replicate earlier experiments. Whether this is due to selection differences in the samples tested, or to the design

of the instruments used, or to differing experimental techniques, has yet to be established. The relevance for clinical management of the alleged difficulty autistic individuals have in interpreting the "big picture" may not yet be explicit but it cannot be far away.

A paper by Baron-Cohen et al. provides evidence that the prevalence of Tourette syndrome in children and adolescents with autism could be as high as 8%. They suggest that the finding, if confirmed on a larger sample, may be of some relevance to aetiology. Furthermore, it is important for the clinician to be on the lookout for currently undetected signs of Tourette syndrome in autistic children, in case they are of sufficient severity that they should be treated. The signs of Tourette syndrome in the cases they describe had gone unnoticed, and could easily have been confused with autistic stereotypies or repetitive behaviours.

Further discussion about the early clinical characteristics of autism is found in the article by Stone et al., in which they ask "can autism be diagnosed accurately in children under 3 years of age?" They observed that a diagnosis of autistic spectrum disorder at age 2 is reliable across clinicians and stable over time. They state that the suspicion of autistic features in an infant indicates the need for referral for a diagnostic opinion. The results suggest that referral to clinicians who are experienced in the assessment of very young children with autistic spectrum disorders may lead to more accurate distinctions between autism and other pervasive disorders. For professionals involved in diagnostic assessment, it may be more important to recognise and to discuss with parents the more variable outcome for children with a diagnosis of PDD-NOS relative to autism. For those involved in evaluation or intervention the present results emphasise the relative importance of social and communicative behaviours in the early recognition and diagnosis of autism.

Other studies in this issue consider the issue of personal relationships within the family, and their relevance to emotional disorders. In their investigation of adolescents with depression, Gunilla Olsson et al. discuss the social perceptions of a group of 16–17-year-olds, selected from a population screen of high-school students. They found that in those with depression that had been of short duration (less than a year), family climate and social interaction did not differ from that of controls. When the depression had been longer lasting, and especially if it was combined with disruptive behaviour, family relations and social interaction are described by the adolescent as unsatisfactory. Their conclusion is that adolescent depression should be treated without delay. Depressed adolescents need help with their family relations and support for their social interaction. In another study of social relationships, Hart et al. report on consistencies in the social interaction style of mothers with their infants and

with their boyfriends. Two subgroups of mothers are discussed; those (most of whom were depressed) who were both withdrawn with their infants and quiet or bored with their boyfriends, and those (some of whom were depressed) who were controlling and intrusive with both their infants and their boyfriends. The findings reported in the paper make three main points. First, that in addition to the direct effect of exposure to depressed mothers, infants are also affected indirectly. This is an important but often overlooked point. Infants can become distressed in the presence of a mother who seems depressed. Second, infants are affected differentially; having a depressed mother puts infants at risk in a variety of different ways, depending on the mother's psychiatric state (e.g. withdrawn or intrusive). Third, effective interventions must recognise both the heterogeneity of depressive symptomatology, and the diverse ways in which infants and family functioning are influenced.

The way in which mothers manage their infant's behaviour is discussed by Morrell in a paper on the role of maternal cognitions in infant sleeping problems as assessed by a novel questionnaire. Problems that mothers have about setting limits on their infants' behaviour, anger at the demands infants place on them, and self-doubts about their own abilities to be effective parents are all associated with infant sleeping problems. Mothers with these cognitions appear to be those who find infant night waking most aversive. The presence of these cognitions may explain why some parents find behaviour modification therapy for infant sleeping problems very difficult to carry out in practice. Consequently the problems persist. For example, the cognition "my child will feel abandoned if I do not respond immediately to a cry at night" could present difficulties to the parent who is being asked to use extinction for the sleep problem. The questionnaire may have a useful clinical role in guiding the clinician to the conditions that could militate against successful treatment, and assist in the development of more effective individually tailored treatments.

Overmeyer et al. consider the association of psychosocial adversities with the hyperkinetic syndrome. They used a semistructured interview which was designed to allow a quantitative assessment of the V axis of ICD-10 (psychosocial adversities) in samples of hyperkinetic and conduct disordered children. Two sets of raters were employed, one set who knew the clinical diagnosis and another set who did not. The raters who were blind to the clinical diagnosis found a similar frequency of psychosocial adversities in both disorders, whereas clinical raters who did know the diagnosis of the patients rated adverse psychosocial situations as being much less frequent among hyperkinetic children than among children with conduct disorder. Knowledge of the clinical diagnosis seems to have biased the diagnostic assessment in terms of reducing the perception of psychosocial adversities among those with a hyperkinetic disorder rather than enhancing perception among those with conduct disorder. The study does not tell us anything explicit about aetiology, but it does indicate the importance of asking about intrafamilial relationships even in a neurodevelopmental condition that is considered to have a primary biological substrate. A study from Australia considers the diagnostic validity of ADHD (as defined by

DSM-IV) and uses a data-reduction technique to separate three subtypes of the disorder; Inattentive, Hyperactive-Impulsive, and Combined, based on parent and teacher ratings. Although such an approach is of interest, it must be borne in mind that the results merely reflect the data that were put into the analysis, so there is a degree of tautology here. In other words, if one uses a confirmatory factor analytic technique on a questionnaire based on conventional DSM-IV definitions of ADHD, one will inevitably get from the analysis factors based on those clinical features. Subtyping of the complex set of conditions currently included under the rubric "ADHD" is likely to require a more wide-ranging and imaginative approach than this.

Another paper on the subject of attention deficit and hyperactivity is provided by Hazell et al. They consider the "can't or won't" debate, the often heated controversy between those who believe the primary deficit in the condition is conative and those who believe it is cognitive. They provide additional evidence of the elusiveness of the so-called attentional problems of boys with ADHD. In this study unmedicated boys with ADHD invested effort in a visual information processing task at a level similar to normal controls. Performance under reward conditions suggested a similar capacity to improve. These data suggest that boys with ADHD are unlikely to have greater reserves of untapped attentional capacity than normal children. For the boy with ADHD, the report comment "could try harder" is probably incorrect. In contrast, boys with learning disability did invest greater effort in the task, suggesting the existence of some compensatory mechanism for their cognitive deficit.

Jane Hurry has written a provocative Annotation on children's reading levels, asking the rhetorical question: Has there really been a decline in children's abilities to read in the past few years, or is this impression merely the result of media hype? Relevant and often fascinating data suggest a substantial improvement occurred in the 100 or so years up until 1961, following which there may have been a small decline during the turbulent 1960s. Subsequently more sophisticated methods of measurement were introduced and these appeared to show a continuing trend of little change, or even a further period of decline, up until the early 1990s. Although the figures are inevitably open to interpretation, given the complexity of the task, there seems little doubt that literacy is not improving dramatically in England and may barely have changed at all in the past 70 years, despite all the other changes that have taken place in society. Regrettably, no international comparisons are made.

Finally, Clark and Harrington discuss the pitfalls associated with the use of screening instruments in the diagnosis of rare psychiatric disorders. Clinicians are increasingly using questionnaires and other instruments as part of their diagnostic assessments. The study highlights the need to be aware of the predictive properties of any such instruments. Without this awareness, there is a danger that clinicians might attribute undue weight or significance to the results; in many situations the majority of individuals who score "above the cut-off" do not have the disorder in question.

David Skuse

