

Editorial

Recently the editors of the *JCPP* were challenged that there must be a policy within the Journal creating a bias against a particular topic which, it was claimed, was under-represented in the Journal. Our response to this was that there is indeed no editorial policy on specific topics to be included or excluded from the Journal. It is only the scientific merit of the individual papers that determines what gets accepted and what is rejected. The topics of the papers that appear in the Journal are primarily a reflection of the range of papers that are submitted. The editors of the Journal act autonomously in deciding, in the light of referees' comments, whether to accept a paper or not. In a similar manner, the Associate Editors and Corresponding Editors have independence in making decisions about papers to appear in the *Annual Research Reviews* and in the Practitioner Reviews and Annotations.

One consequence of this autonomy is that, as an editor, it is only when an issue is collated that material processed by the other editors comes to your attention. This usually creates a number of pleasant surprises and this issue is no exception. It was not until I received the collection of papers to appear in this issue that I was aware of the Annotation provided by Weiss. These editorials are intended to draw to the reader's attention aspects of the papers appearing in each issue that are of particular salience to clinicians. This annotation by Weiss should be required reading for all clinicians.

It is the task of the researcher to develop our understanding of the world and the task of the clinician to act on the world. For the researcher the central question is whether the account they provide helps to explain what is known currently, with an important but subsidiary question being whether this account helps clinicians act effectively in the world. For the clinician, it is this issue of the effectiveness of their actions that is crucial. With this in mind, I can think of few more directly relevant recent papers in the *JCPP* than the Annotation by Weiss.

In this Annotation the case for the reasons why the routine monitoring of clinical effectiveness needs to be undertaken is laid out with rare clarity. In particular, I would commend the discussion of the vital issue of factors that prevent implementation. One enduring concern that I have had about the evaluation literature on the effectiveness of interventions with children is the need to demonstrate effectiveness in services away from the centres where treatments are first developed. I think all clinicians need to consider very carefully the following quote from the Weiss paper. In this quote, reference is made to nonanalogue studies. These are studies based upon normal referrals and that use nonspecialist clinics:

...effect sizes associated with nonanalogue interventions of child psychotherapy have been found to be essentially zero.

Effect size here refers to the difference in outcome between treated and untreated children. Whatever else clinicians take from this issue of the Journal, the implications of that conclusion should be reflected on long and hard.

If it is beholden on clinicians to demonstrate their effectiveness, it is the responsibility of researchers to provide clinicians with appropriate tools for the task. One particular need is for measures of psychiatric state that are both reliable and sensitive to change. The paper by Granero Pérez provides a detailed appraisal of elements of a standardised psychiatric interview (DICA-R) that are related to test–retest reliability. The child-related characteristics were not important influences on reliability. However, features of the interview were. The following all acted to reduce reliability: longer questions, questions related to internalising symptoms, the presence of time concepts in the questions, questions requiring peer comparisons, and questions requiring judgements.

One noticeable feature of research in developmental psychopathology over the past 10 years has been the impact of findings from experimental developmental psychology. A substantial number of studies have attempted to develop models of the core cognitive deficit for children with autism and related disorders. This current issue provides good examples of the way in which this emphasis on understanding cognitive aspects of child psychopathology has been extended to other conditions. The paper by Hughes et al. attempts to identify the extent to which preschool children with hard-to-manage behaviour showed deficits in three areas of cognitive functioning: theory of mind, emotional understanding, and executive function. The problems identified by Hughes and her colleagues in all three areas are ones that they argue represent a cause rather than a consequence of the behavioural difficulties since they are studying young preschool children. Given the known continuity in the behaviour of these hard-to-manage children, the possibilities of building treatment strategies to compensate for these early deficits in social and emotional understanding are particularly important.

There is not scope within this editorial to comment on all the papers in detail. It is worth noting, though, that the papers by Spencer et al. on Tourette's Disorder and ADHD, by Leekam et al. on gaze-following in autism, and by Hwang and St James-Roberts on behaviour problems in Korean children, all discuss issues concerning the cognitive bases for behaviour problems.

The paper by Dalgleish et al. takes a more focused view on the way information processing biases are implicated in depression in children and adolescents. Their study indicates that information processing biases found in depressed children and adolescents are not found in children and adolescents who have recovered from depression. This suggests that biased processing is a function of being in a depressed state rather than of an

underlying vulnerability factor. Furthermore, the recovered depressed group processed information in a significantly more positive way than matched controls. This so-called supernormality effect may reflect over-compensation in information processing following recovery from depression.

A different facet of cognitive development was also the central issue in the paper by Dowdney et al. They were less concerned with details of information processing and more with the global mental development of children

with short normal stature. Short normal children from an area of extreme social disadvantage had been shown previously to have cognitive impairment at age 4 years. The present paper follows these children to age 11 and demonstrates that they have significant educational difficulties. The authors argue that this is a group of children who are at particular risk for both persistent growth impairment and also educational failure.

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