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# HIGHLIGHTS IN THIS ISSUE

The lead papers in this issue are two meta-analyses of controlled trials in a recently very active area: psychological treatments for schizophrenia. The findings of Pilling and colleagues are clear-cut. There is good evidence of worthwhile benefit from two forms of treatment. Family therapy delivered to people with schizophrenia who are in contact with carers, and particularly in single family rather than group approaches, lowers relapse rates and improves medication compliance. Cognitive therapy improves mental states and may be particularly useful for those with resistant symptoms. By contrast two other psychological treatments, social skills training and cognitive remediation, have failed to show evidence of benefit in controlled trials. The findings of these review articles have important implications for treatment.

Four papers deal with antecedents and origins of disorders, using different approaches. Neeleman and colleagues (pp. 793–803) report longitudinal findings from the 1946 British birth cohort. Among a number of tempermental and behavioural predictors from adolescence, neuroticism measured at age 16 and 26 was particularly strongly and independently associated with both psychiatric and somatic ill-health in later adulthood. In a cross-sectional study Craig *et al*. (pp. 805–816) find that children of mothers with chronic somatization are more likely to have reported health problems and more frequent consultations with family doctors than children of normal mothers or children of mothers with chronic organic illness. In another cross-sectional study, Biederman *et al*. (pp. 817–827) find increased risk for attention-deficit hyperactivity disorder (ADHD) in children of parents with the disorder, irrespective of whether the parent disorder is remitted. There are known to be genetic elements in ADHD but this study does not suggest increased environmental risk from current exposure. However, there were some interactions suggesting that the disrupted family environment of parental ADHD may have particular effects in high risk children with ADHD.

These three studies throw up by implication important challenges to prevention. In a fourth, methodological study Kendler and colleagues (pp. 829–842) use classical twin study methods to compare direct interview with subjects for psychiatric disorder and the family history method of interview with a family member. Their key finding from a sophisticated analysis is that combining sources of information can reduce measurement error valuably.

Three papers deal with assessment. Salkovskis and colleagues (pp. 843–853) report a new self-report questionnaire for Health Anxiety with a good validity. Park *et al*. (pp. 855–861) report a new informant scale designed to measure resistance to engagement in the homeless mentally ill, a key factor limiting successful management. Klein *et al*. (pp. 863–871) report a new screening tool for use in trauma for early identification of those at risk for subsequent psychopathology.

Two studies address psychopathology directly. Cooper *et al*. (pp. 873–880) focus on early onset eating disorder in children. They find a group with early onset anorexia nervosa, closely resembling the classical adolescent form, and a clearly separated remainder, mainly with food avoidance emotional disorder or selective eating. Sullivan *et al*. (pp. 881–888), using latent class analysis, find unexpected symptom continuity between chronic fatigue syndrome and the more questionable syndrome of fibromyalgia.

Two papers replicate findings of high utilization of medical services by those with depressive symptoms. The study by Rowan *et al*. (pp. 903–908) was carried out in Nova Scotia. The report by Herman *et al*. (pp. 889–902) is from a study in primary care settings in six different countries, and includes data on functional status and health dissatisfaction. The universality of these findings in diverse national settings is impressive.



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