PAEDIATRIC SELECTION
Reviewed by David Cundall

The Lancet (2001)


Amongst the many alternative approaches to therapy, there has been considerable enthusiasm for the use of hyperbaric oxygen as a treatment for children with cerebral palsy, with many anecdotal reports suggesting it is beneficial. This Canadian research group have completed a randomised multicentre trial that compared hyperbaric oxygen to slightly pressurised air. For all outcomes, both groups improved over the course of the study, but without any difference between the two treatments. For example, there was a 3% improvement in Gross Motor Function Measure in the children on slightly pressurised air and a 2.9% improvement with hyperbaric oxygen. The improvement in both groups is unlikely to be due to the slight increase in oxygen in slightly pressurised air or the effect of the pressure itself. The authors conclude that participation in the trial had a clinically important effect on development in the children, irrespective of the treatment they received. This would appear to be an impressive example of the Hawthorne effect, and a salutary reminder of the need for proper studies of new treatments.


Many papers continue to be published on cohorts of extremely low birth-weight (ELBW) babies. It is well known that as well as providing a major healthcare challenge at the beginning of their lives, such children also have much higher rates of disability as they grow up. Those who escape severe sensory, learning or physical disability have higher rates of more subtle attentional, learning and behavioural problems as children. This study has the advantage of using four prospective cohorts of children, from the USA, Canada, Germany and the Netherlands and using measures that have been standardised internationally. Normal birthweight control cohorts were studied from two of the countries: USA and Netherlands. Using the Child Behaviour Checklist when the ELBW children were 8–10 years old, they were found to have higher total problem scores than normative or control children, but this increase was only significant for European children. Narrow-band scores were raised only for the social, thought and attention difficulty scales, which were 0.5–1.2 SD higher in ELBW children than in others. Despite cultural differences it appeared that the types of behaviour problems seen in ELBW children were similar across four countries and two continents. The authors conclude that their findings suggest that biological mechanisms contribute to behaviour problems in ELBW children.

Developmental Medicine and Child Neurology (2001)


This is another cohort study, although not strictly comparable to the study reported above, because this cohort of babies from University College London were less than 33 weeks gestation and so included babies who were much bigger at birth than those in the ELBW study. In the search for biological correlates of the learning and behavioural problems associated with very preterm birth, magnetic resonance imaging holds out a prospect of detailed evaluation of brain structure that can then be correlated with brain function. The findings were generally reassuring. Compared to a group of adolescents who were born at term, very pre-term subjects had impairment only on a measure of word production. On measures of attention, memory, perceptual skill, visuomotor and executive function, the ex-pre-term adolescents performed within the normal range and there was no correlation between performance and MRI scan abnormality (which was present in 55% of the sample).


If the graduates of neonatal intensive care are one relatively new cohort of children at risk of psychopathology, children with ADD/ADHD are another growing, and overlapping problem. We know that children with ADD or ADHD are distractible, but perhaps we have not paid sufficient attention to their sensory modulation dysfunction. This study, from Denver Colorado, recruited 26 children aged 5–13 years by posters in the Children’s Hospital and by word of mouth and compared them to 30 control children. They were tested using a laboratory procedure that gauges responses to repeated sensory stimulation by measuring electrodermal reactivity (EDR). Parental report measures of limitations in sensory, emotional and attentional dimensions were collected. Compared to the control sample, the children with ADHD displayed greater abnormalities in sensory modulation on both physiological and parent report measures. The children with ADHD also displayed more variability in responses. Within this small group with ADHD, levels of sensory modulation dysfunction were highly correlated with measures of psychopathology on the Child Behaviour Checklist.


This is a fascinating paper about correlations between finger lengths and autism. At a time when we are being told about all sorts of possible environmental or dietary factors in the development of autism, it is refreshing to read a paper that suggests a correlation with something as basic and as prenatally determined as finger length. It has been suggested that autism may arise as a result of exposure to high concent-
trations of prenatal testosterone. There is evidence that the ratio of the lengths of the 2nd and 4th digit (2D:4D) may be negatively correlated with prenatal testosterone. The authors measured 2D:4D in 95 families recruited via the National Autistic Society in the UK. They found that the 2D:4D ratios of children with autism, their siblings, fathers and mothers were lower than population normative values. Children with Asperger syndrome had higher 2D:4D ratios than children with autism but lower ratios than the population normative values. There were positive associations between 2D:4D ratios of children with autism and the ratios of their relatives. Children with autism had lower 2D:4D ratios than expected in relation to their fathers’ 2D:4D ratio. It was concluded that 2D:4D ratio may be a possible marker for autism that could implicate prenatal testosterone in its aetiology. How, I wonder, does this fit with increasing concerns about environmental and dietary oestrogens?

**British Medical Journal (2001)**


This is not a paper relating specifically to children and young people, but it does include figures for people of all ages in the United Kingdom where legislation to reduce the number of tablets per pack of paracetamol and salicylates was introduced in 1998. The annual number of deaths from paracetamol poisoning decreased by 21%, and from salicylates by 48%. Liver transplant rates after paracetamol poisoning with paracetamol in any form decreased by 11% mainly because of a 15% reduction in paracetamol in non-compound form. Legislation restricting pack sizes of these drugs, which are available for sale ‘over the counter’ in the United Kingdom, has had substantial beneficial effects on mortality and morbidity associated with self-poisoning. Paediatricians remember the major impact on childhood accidental poisoning morbidity and mortality when child-resistant packaging was introduced. It is worth remembering that simply reducing the availability of potential poisons can make a big difference to those of all ages who self-harm, and we sometimes need legislation to achieve this.

**PSYCHOLOGY SELECTION**

Reviewed by Jenny Walters

**Clinical Child Psychology and Psychiatry (2000, 2001)**


Government initiatives place emphasis on inter-agency working, in particular where child protection is concerned. Working in a CAMH service, which has suffered devasting Social Services cuts, this paper caught my eye. The authors present the development of a model of inter-agency working between Health and Social Services in Leeds, and made me feel less pessimistic about such possibilities. They are clear that effective inter-agency working can often be difficult particularly over decisions regarding procedures, and implementation of agreed action. There is often confusion over what constitutes therapeutic intervention and family support. The all too familiar tale of misperceptions on both sides was reported: health workers see Social Services as inundating them with sometimes inappropriate referrals and there is no time to do anything but place them on the waiting list. Social Services on the other hand perceive Health as providing at best an inadequate, and at worst, a non-existent service. In the meantime, the families receive very little help and in some areas sit on waiting lists for eight or nine months.

Several proposals for change were made. Firstly, for Social Services to review and prioritise all referrals to Health and for Health to agree to offer consultation and/or assessment as soon as possible, within days or weeks rather than months. Secondly, it was suggested that area social work teams should be offered regular consultation from senior mental health professionals regarding complex cases. Thirdly, Health would run a series of seminars for Social Services on child mental health issues.

As a result of the prioritising system individual social workers no longer directly referred to CAMHS. Referrals were discussed with principal social workers, countersigned by the area manager and then forwarded to the prioritising panel (comprising a consultant psychiatrist, consultant psychologist, and a social services manager). Monthly meetings were held and cases passed on where appropriate and seen on average within one month of the panel discussion. Quality of information at referral was greatly improved and this enabled some cases to be managed by area social work teams with specific advice on management. Common themes that emerged in the consultation sessions were attachment, assessment of abuse and its emotional impact on the child, emotional abuse, and contact and behaviour problems.

Social Services appointed a co-ordinator for therapeutic services and now have a large therapeutic social work team from which posts are attached to a multi-disciplinary child mental health team. The authors suggest that these innovations have all led to improved working relationships between Health and Social Services and an increase in therapeutic resources, and have raised standards in child protection practice.


This paper addresses the emotional sequelae following road traffic accidents (RTAs) involving children, an area in which mental health services are not routinely involved despite studies demonstrating that child RTA survivors suffer from clinically significant psychological reactions. PTSD, depression and anxiety are common sequelae. However, the authors state that many children do not develop diagnosable mental health problems and there are likely to be protective factors in these cases.

Five children (three in their teens) are presented as case studies and common themes identified. Individual variation of symptoms is highlighted: for example, two teenagers who had been in the same accident had very different reactions, one perceiving the accident as life-threatening and the other as an apparently exciting event. Girls are more likely to develop symptoms than boys. However, this may mean that boys are using dysfunctional methods (e.g. substance use) to alleviate symptoms. Another variation that occurs relates to the child’s age. For example, younger children may reflect their distress through play whereas older children are able to report frequency and content of bad dreams. Older children may become more socially isolated and younger chil-
dren display more separation anxiety from their primary carer.

Severity of initial injuries is not significantly associated with the development of psychological problems. However, there is evidence that the time taken to recover from physical injuries may be related, with a longer time being associated with greater traumatic symptoms. A predictable list of post-traumatic symptoms can be expected with re-experiencing of the event, avoidance of stimuli associated with the accident, symptoms of increased arousal, and impaired everyday functioning. Importantly, school performance can be adversely impaired with memory difficulties and concentration problems. However, some positive changes are noted in that one of the cases reported found that his heightened awareness of death positively affected his approach to life.

The authors state that the difficulties experienced by RTA victims are often not brought to the notice of child mental health specialists unless litigation is involved. There is a need to educate healthcare staff, especially those in Accident and Emergency departments about significant psychological reactions that may not necessarily be related to the severity of the accident.

The role of families and carers in accidents is highlighted. Where carers are involved and traumatised the outcome may be less good. A ‘conspiracy of silence’ can occur in families, which limits the opportunities children have to make sense of their experience. The authors wonder whether psychological debriefing would be useful for all victims and the question remains an open one. They make an interesting point as to the use of PTSD as a diagnostic category for treatment. Children following RTAs may not always fulfil the criteria but this does not necessarily mean that there is no implication for treatment and the social sequelae from depression and anxiety can be significant.


‘Selective eating’ describes a condition whereby children, usually in middle-childhood or early adolescence, show a highly selective pattern of food intake in terms of the range of foods eaten. These children are typically unwilling to try new foods although they are usually in the normal range for weight and height. The history is of at least two years’ duration. However, the condition is often self-limiting. Prevalence in the adolescent and adult population is unknown. It is, however, common in toddlers (1 in 5).

This paper looks at case notes of 20 selective eaters referred to a local and national feeding team at Great Ormond Street Children’s Hospital. Approximately 10% of the referrals to the team as a whole are selective eaters. Of the 20 there were more boys than girls (ratio 4:1) and the mean age for presentation was 10.9 years. Carbohydrates were the main group of foods eaten. Only six children had no gastrointestinal symptoms (e.g. retching, vomiting). Half showed social avoidance although it was not clear as to whether this was due to eating difficulties or a primary social skills deficit. Most did not wish to change their eating habits. Almost half had rituals or other obsessions. Nine out of 20 mothers were noted to be anxious and five of the children had experienced major life events although not related to selective eating onset.

Treatment was not always offered. In 10 cases the child did not express concern and it was felt that the condition would abate. If the child showed motivation to change or was overtly anxious treatment was offered but three families refused. In half of the children where intervention was offered the food refusal became more marked but where the children worked co-operatively there was a slight to full improvement in symptoms.

A follow-up of all selective eaters identified from the clinic database who were assessed more than one year earlier was carried out. Eleven children from the case note study were also included in looking at outcome. Mothers and children were asked to complete questionnaires. Fifty percent of the children showed no change, 12% were worse and 38% had improved. Good outcome tended to be associated with age and type of treatment received, with CBT being the most effective treatment. The authors include helpful details of CBT approaches to this group with case illustrations. An emphasis is placed on very small changes being introduced to the child for each session and relaxation as an important adjunct to treatment.

An interesting discussion as to how far selective eating might in some cases be part of an autistic spectrum or pervasive developmental disorder presentation follows. Other aetiologies might include oromotor dyspraxia or phobic anxiety, although the latter could be part of the developmental disorder. The authors query whether other eating disorders such as anorexia may in some cases be part of autistic spectrum traits. Longer term follow-up is needed to determine these issues.

Attachment and Human Development (2000)


Not infrequently I refer looked-after children for individual psychotherapy so the ideas in this paper were thought-provoking. Minimising unnecessary attachments and moving adoptive parents into a central therapeutic position is the main thrust of this paper. The authors suggest that for children who are looked-after and who may well have no secure base, excessive child-professional contact has the potential to impede children’s primary attachments. They assert that, for the very children who need to be helped to make and maintain secure attachments, the myriad of professionals involved needs to be minimised. The adoptive parents need to be moved into a central therapeutic position. A model called Parent Co-Therapy (PCT) is proposed whereby the parents are attached to one key professional who mediates with other professionals. The model is particularly recommended for the early years of placement and the authors suggest that it has the potential to strengthen parent-child attachment and, in turn, reduce symptomatology.

A case of a sibship of three children aged 6 years, 4 years, and 22 months is presented. They had been in an adoptive placement for three months when they were referred to CAMHS. No formal support was in place apart from occasional social work visits. However, because of the children’s history and developmental problems, many professionals were involved in their care. The parents were left in the position of managing the involvement of the professionals. These included health visitors, physiotherapists, portage workers, GP’s, educational psychologists, family centre workers, paediatricians, audiologists and teachers. The children were also adapting to a new placement and the extended family and friends of the adoptive parents.

Using the PCT model parents play a dual
role of client and expert. A key professional takes the role of lead therapist who works with the family/parents as co-therapists. Three years is suggested for this treatment model and I wondered how feasible this is in reality. However, the authors feel that short-term interventions for children with such complex needs are out of the question. The lead therapist meets with parents once fortnightly for 50 minutes during term time employing a variety of therapeutic methods including educational, behavioural, psycho-dynamic, problem-solving, insight-oriented and reflective. The lead therapist also acts as an advocate for parents in dealing with other professionals e.g. in the negotiation of statements, respite care, etc.

Treatment strategies were conceptualised as instigating behavioural change, facilitating emotional containment, validating the parents’ intuitive actions and maintaining the parents’ confidence and resilience. One of the main differences in this approach is that no formal evaluation of the children’s psychological state has been carried out.


Infant crying is universal and considered to be a precursor of attachment having a function of maintaining proximity to protective caretakers. In 1972 in Baltimore Ainsworth and Bell carried out a study of infant crying and attachment focusing on maternal responsiveness. They concluded that more responsive mothers had babies who cried less often and that less crying in the first and fourth quarter of the first year was related to more secure attachment. The sample size, however, was small (26) and the current study set out to re-examine Ainsworth and Bell’s findings with a larger sample.

Ijzendoorn and Hubbard’s sample consisted of 50 two-parent families, 27 first-born and 23 second born. Each family was observed at home at 3-week intervals during the first 9 months, constituting more than 20 hours’ observation, with infant crying behaviour and maternal responses recorded. At 15 months the mothers and infants were observed in the Strange Situation procedure. It is interesting that there was a failure to replicate the Baltimore findings: the current study found that the more frequently that mothers ignored their infants’ crying in the first 9-week period, the less their infants cried in the following 9-week period. Furthermore, crying at home was not found to distinguish between secure and insecure attachment classifications and was not related to the Strange Situation crying. Mothers of avoidant infants were found to be those who responded most promptly to their infants’ crying. Mothers of second borns were a little less responsive to their infants’ crying. No differences were found regarding infant gender.

These results are interpreted by the concept of ‘differential responsiveness’; this takes into account the differences in meaning of different types of crying whereby a response is adapted to the contextual cues. The link between avoidantly attached infants and rapid response to crying behaviour by their mothers is an interesting one in that this may lead infants to control expression of negative emotions. Avoidance may also be a strategy by the infant to deal with an experience of overwhelming stimulation from the mother.

The authors conclude that crying behaviour as a global concept is not central to attachment. Crying behaviour indicating severe distress is considered to be attachment behaviour. Furthermore, the authors state that prompt responses to mild crying may prevent the infant from developing coping strategies. It is recommended that future studies should examine more closely differences between types of crying and promptness of response from parents.

PSYCHOLOGY SELECTION

Reviewed by Sophia Mavropoulou


The aim of this study was to carry out a direct and comprehensive comparison of video modelling and in vivo modelling for the acquisition and generalisation of target behaviours across different tasks in a group of five children with low and high levels of functioning (their mental age ranging from 4 yrs 4 months to 6 yrs 9 months). A multiple baseline design across all children and for each child, across the two modelling conditions and the different tasks, was used. Each child was presented with two tasks of similar difficulty; one task was assigned to the video condition and the other was used for the in vivo condition. Target behaviours were nonverbal (independent play, self-help skills), verbal (expressive labeling of emotions, spontaneous greetings, conversational speech, oral comprehension) and social (cooperative play, social play). In both modelling conditions the models were familiar adults who demonstrated the target behaviours at a slow pace.

Overall, the findings suggest that video modelling is an effective procedure for teaching children with autism a number of different skills. Specifically, four out of five children acquired much faster those skills taught through video than in vivo modelling. The most striking finding was that video modelling promoted generalisation of these tasks across different persons, settings, and stimuli, whereas in vivo modelling did not. Moreover, video modelling was found to be more time and cost efficient than live instruction. It seems that video modelling is a promising technique for teaching students with autism.


Although research has shown that children with autism can be trained successfully to apply mentalising skills, it remains unexplored whether they apply them to real life situations. This paper attempts to explore whether successful performance on traditional theory of mind tasks would generalise to everyday social competence in individuals with autism. The primary objective of this study was to examine whether teaching conversational skills to children with autism would lead to a qualitative and quantitative improvement in their verbal communication. The second objective was to examine whether their performance on false belief tasks would change or not.

Three verbal boys with high-functioning autism participated. The training took place in the children’s homes and involved them in conversation with their primary caregivers. Five types of conversation skills were taught to each child: making a conversation, turn-taking, listening, maintaining a conversation topic and changing a conversation topic appropriately. All children were given three false-belief tasks before and after the training. The first objective of the study was successfully implemented: all children showed more
eye-contact and turn-taking behaviour during conversation and improved in their ability to maintain a topic of conversation. With respect to the second objective, children’s performance on the false belief tasks did not change. This finding indicates that children did not incidentally acquire a theory of mind as a result of their conversational skills training. Their training involved learning a set of rules without referring to mental states, and did not include attention to specific theory of mind skills. The duration of the programme was limited to just nine sessions, and a further limitation of the study is that a control group was not included. Nevertheless, the findings indicate that caution should be exercised when one’s performance on false belief tasks is used to infer one’s social behaviour in everyday life.


The purpose of this study was to investigate whether children with high-functioning autism (HFA) understand the facial expression of real and deceptive emotion. Eight children with HFA and a comparison group were given the Real and Deceptive Emotion Task, which involves the identification of real and deceptive emotions from 10 short narratives. Specifically, five basic measures were used for measuring understanding of: (a) emotion labels, (b) prototypical emotion situations and (c) real and deceptive emotion in socially complex narratives. Also, participants were asked to give justifications for the deceptive facial expressions of the story characters.

The children with HFA were successful in understanding emotion labels and relating facial expressions to prototypical situations. However, they were less skilled than the comparison group on understanding emotions (both real and deceptive) generated in social contexts and giving reasons for deception. Interestingly, further analysis revealed that the understanding of real and deceptive emotions was related only to the severity of autism (measured using CARS) rather than to verbal intelligence. Therefore, it seems that even high-functioning children with autism do not perceive facial expressions as tools for social communication, thereby having difficulties in comprehending social deception.

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