Children with stool toileting refusal have more behaviour problems than others, don’t they? Well, apparently not, according to this study. This was a case control study of 27 children, 30–48 months old, who had achieved bladder control but refused to use the toilet for defaecation. There were 27 age- and sex-matched control children who were fully toilet trained.

A semistructured behaviour screening interview was carried out with the parents. The Child Behaviour Checklist was completed, as well as the Toddler Temperament Scale for those 30–36 months old, and the Behaviour Style Questionnaire for those 36–48 months old. Child compliance with adult instructions was measured during a room clean-up task.

The results showed no differences between the two groups for any of the scales measured or for the room clean-up task. The children with stool toileting refusal were rated by their parents as having a more difficult temperament than the control children, but no specific temperament characteristic emerged. Not surprisingly, refusers had higher reported rates of constipation and painful defaecation. This study sheds no further light on whether this is causal or an effect of the behaviour.


Children 18–48 months old attending for ‘well child’ visits were recruited from a private paediatric practice. Of these 482 children, 106 (22%) had experienced at least 1 month of stool toileting refusal. There was a weak association with the presence of younger siblings and with an (unvalidated) score of “parental inability to set limits for the child”.

Stool toileting refusers had been trained at a later age than the rest of the group and this difference was very significant. Of those training between 42–48 months, 50% (22/44) were refusers. Of those trained after 48 months, 73% (8/11) were refusers. Of the stool toileting refusers, almost half developed stool withholding during training. For 77 (73%) of the children who were refusers, no intervention was undertaken. Of these, the behaviour lasted more than 6 months in 20. The simple intervention of putting the child back into nappies resulted in the children spontaneously using the toilet to defaecate within 3 months in 24 of 27 children. The importance of using laxatives in constipation was also reinforced.


There continues to be concern amongst clinicians that overuse of bronchodilators is associated with a higher mortality. Whether this merely reflects disease severity or is causal remains unclear. The aim of asthma treatment is to obtain adequate control with preventive medication (usually inhaled steroids) so that Beta 2 agonist use is minimised. This study compares a group of 17 children and adolescents known to overuse Beta 2 agonists with 38 asthmatic subjects of similar age without this history. All the children in both groups had been admitted to hospital for assessment.

The mean age of both groups was 13, with a range of 8 to 16 years. Among the ‘overusers’ there were more males, Hispanics, and children from lower socioeconomic groups. The overusers had lower IQ scores, including Full Scale Wechsler and Verbal and Performance scores. Overusers had a mean IQ of 84 (SD = 13) compared with non-overusers’ mean IQ score of 99 (SD = 10). The various components of the scores were similar.

The authors conclude that it is important to recognise children who are at risk of overusing Beta two agonists and to consider alternative approaches to their education and treatment. They suggest that overusers tend to think more concretely, only recognising the benefit of treatment that can be felt immediately. They make no mention of involving a psychologist in assessment and management, but no doubt such skills would be valuable.


This study set out to explore children’s ability to assess their asthma control and compare this with parental assessments. Baseline data were obtained, including physiological measurements of asthma control, global ratings of symptoms, and, for the children, the Paediatric Asthma Quality of Life Questionnaire. Those children whose asthma was not well controlled were offered an increased dose of inhaled steroid. Further measurements were taken at 1.5 and 9 weeks. There were 52 children recruited: 19 were 7–10 years old, and 33 were 11–17 years. For the younger children there was poor correlation between their perceptions and objective measures of asthma control, but not for the children’s quality of life measures. However, for the older group, the children appeared to be better able to assess their asthma control than their parents.

The conclusion of this study is that clinicians can gain additional information about asthma control from the parents of younger children. However, for children over 11 years old, there is little if any further information to be gained from the parents, children being more reliable at assessing their own asthma control. This is an impressive study and the findings need to be taken seriously.


Sleep problems are a common concern for many parents and children with developmental disabilities and a very major stress for some. These authors from Baltimore describe a group of 14 children, aged 4–14 years, who were inpatients on an assessment unit specialising in the assessment and treatment of destructive behaviour...
problems. Children were included in the study if they slept 90% or less of what would be expected for the child’s age. Sleep problems were characterised by multiple problems of both settling and night waking.

The faded bedtime with response cost procedure consisted of systematic delay in bedtime, removal from bed if sleep was not initiated within 15 minutes (the response cost), and a fading procedure to gradually advance the bedtime. The bedtime scheduling procedure consisted of a consistent sleep and wake time and the prevention of daytime sleep. The sleep of the children in the faded bedtime with response cost group improved significantly more than the sleep of the children in the bedtime scheduling group. The authors note that preventing daytime sleep alone did not have a beneficial effect. The results are discussed in the context of both classical and operant conditioning mechanisms.

Not surprisingly there were marked variations in response to treatment within the experimental groups, although it was not possible to predict from pre-intervention information which children were most likely to respond. The improvements in the faded bedtime and response cost group were modest, with an average reduction in hours of disturbed sleep of 0.8 hours after a treatment duration of 10 days.


By contrast, this study from Nottingham used a behaviour modification package incorporating stimulus control, cueing, and rapid-extinction techniques with a group of 15 children with severe learning difficulties who had chronic sleep problems. The behaviour modification programme included setting a regular bedtime, establishing a bedtime routine, setting the mood for sleep, rapidly settling the child in their bedroom, withdrawing the adult from their bedroom, ignoring the child thereafter, firmly telling the child to return if the child came out of the bedroom again with minimal affective contact, and lots of praise in the morning if night-time behaviour had improved. The author provided telephone support on the three consecutive mornings after the start of the programme and subsequently if needed. Children included in the study were attending schools for children with severe learning disability, were physically fit, and were living in stable, supportive, nonabusive families.

Outcomes were measured by the parents using visual analogue scales, and by the author on a categorical scale derived from Wing and Gould’s Handicaps, Behaviours, and Skills scale. Night-by-night changes were measured using sleep diaries similar to those used by Richman. There were rapid improvements in night-settling and waking behaviours (within a few days), which were sustained in 12 children during an 18-month follow-up. Parents reported a 59% overall reduction in the frequency of night waking. The time to settle reduced from a mean of 58.6 (SD = 24.6) minutes to a mean of 15.8 (SD = 7.8) minutes.

Many of the parents of children with severe learning difficulties with whom I work have not been keen to explore such a rapid extinction technique, but the results reported by Bramble suggest that clinicians should be more enthusiastic about this approach.

**British Medical Journal (1997)**


The BMJ has been running a series on inequalities, edited by Richard Wilkinson. Helen Roberts’ article in the series summarises much of what is known about the effects of socioeconomic inequality on child health. Relative inequality increased more in the U.K. in the 1980s than in other industrialised societies. The rise in the rate of suicide in young men in the late 1980s may be partly a response to their feelings of exclusion and powerlessness in an affluent society. She moves on to address the question “can anything be changed until everything is changed?” to indicate that it is possible to overcome the sense of inadequacy experienced when a clinician faces what is obviously an entrenched sociopolitical problem. She highlights some of the lessons from the U.K. national cohort studies of the protective effects of parental interest in, and enthusiasm for, education of their children. She also refers to the U.S. ‘Highscope’ preschool programme, which has had demonstrable and significant effects on its ‘graduates’ at age 27 years.

**Child Care Health and Development (1997)**

Reviewed by Alison Salt

This journal, with its new editorial board, continues to produce increasingly high-quality articles of interest to a broad multidisciplinary readership. It now includes useful book reviews and a research digest.


In the September edition the Editorial reviews recent developments in the Cochrane Collaboration in the area of child health. The Cochrane Collaboration, founded in 1993, is an international organisation whose aim is to produce systematic reviews in a wide range of areas, which are published on disk with 3-monthly updates, thus ensuring that the most up-to-date evidence is readily available. At a meeting in Washington in May 1997 it was agreed that a Child Health Field should be set up. This is a loose structure within the Cochrane Collaboration, which will ensure that topics of interest to those working in this area will be promoted within the current collaboration groups (CRGs) that are based around specific areas of practice or types of disorder. The meeting in Washington also promoted the emergence of a new CRG, which will deal specifically with psychological and sociopolitical problems in children. There was a preliminary meeting of this potential group in October 1997. Any-
one interested in more information about these developments should get in touch with their nearest Cochrane Centre, or Sharlene Carlson can be contacted for details about the Child Health Field at the Center for the Future of Children, 300 Second Street, Suite 102, Los Altos, CA 94022, U.S.A.


In the same edition, Mulderij from Utrecht University in The Netherlands reports on a literature study and qualitative fieldwork into the way physically disabled children experience friendship. Research cited in this article describes poorly developed social skills, peer rejection, and few friendships as major defining characteristics of physically disabled children and emphasises the importance of friendship in the social, cognitive, and emotional development of children, which links with adult functioning in later life.

The article goes on to explore how, where, and with whom peer relations are made. Physically disabled children can have difficulties in initiating friendships as a result of mobility, communication difficulty, or other problems such as visual impairment. Another important factor is the history of relationships. For example, children with cerebral palsy are often hindered in their social interaction from very early in life. Problems with attachment are also found to be predictive of poor peer relationships.

Children who attend a special school a long way from home are less likely to be able to extend these school friendships outside of school hours and also miss the opportunity of meeting children who live nearby. These children’s preference for friends appears to be more often other disabled children or younger children, but this may simply reflect their problematic contact with peer groups—they may be ‘making the best of a bad job’. Once friendships are established other problems are likely to be encountered in maintaining them, e.g. visiting independently and the home environment of the friend. A potential friend needs to have a number of qualities such as empathy, consideration, flexibility, and helpfulness.

There is plentiful evidence that children with physical disabilities can experience a higher level of social and emotional difficulties than children without disabilities. Mulderij explores the idea that exclusion and loneliness contribute to emotional difficulty. He cites Erwin (1995): ‘Loneliness is associated with negative patterns of self perception and low self-esteem, a self-blaming attributional style, lower expectations of social outcomes, social skills deficits such as inappropriate self-disclosure, excessive self-attention, an inability to establish comfortable intimacy and a tendency to make negative judgements of self and others’. He also includes examples from children’s own experiences, which often include long periods of being alone.

The article finishes on a rather more upbeat note, with recommendations for how parents and carers can help to improve peer relations for these children. He emphasises the importance of making an early start, not allowing treatment to overtake the need to leave room for a child to play with their peers. Although he acknowledges the increased role the parent may need to take in providing these opportunities, he also emphasises the need to avoid interfering in this play. The parental role is often one of creating the right environment. Teachers in school can also help. They may incorporate social skills training in the classroom but friendship is not simply a matter of social ability: children must also be valued by their peers. The teachers’ role will therefore need to include empowering children and ‘building a sense of community in the classroom’. Individual treatment and group work can also play a part in developing a more positive self-concept.


Integration into mainstream schooling may be considered one of the solutions to the above problem. In this paper Bowers reports on a study of children’s perceptions of additional specialist teachers or classroom assistants in the classroom. The study examines the responses of 713 children (ages 7–14 years) attending 27 schools in West London to questions relating to the role of adults supporting children with special education needs in their classrooms, and to the social desirability of being singled out. Bowers cites research by Vaughn et al. (1995) who report that the success of inclusion of children with special educational needs in mainstream class hinges on the teachers’ efforts to make adaptations that are helpful to all students. He notes the work of Burroughs (1995), who explored the dilemmas for children with learning difficulties who are aware of their own needs but may find that the receipt of extra help reinforces labelling processes in the classroom.

In Bowers’ study the amount of contact with learning support staff decreased markedly from primary through to secondary school. Younger students tended to explain the presence of additional adults in the classroom in terms of helping the over-worked teacher. For an increasing proportion of older students any help was seen as pupil focused.

Overall, most recipients of in-class support enjoyed, appreciated, or valued it. However, there was a consistent minority who saw the attention as singling out a student as different. The article concludes by suggesting that further studies are required to examine what discriminates between the classroom environments in which those adults are accepted, welcomed, and valued by all students and those in which their presence can be resented, and where it can lead to further barriers to inclusion.

EDUCATION SELECTION


Inclusivism is defined here as the body of ideas that advocate inclusion. The concept here is not to provide additional special services but to ensure that the needs of all are met as an integral part of the environment. Therefore inclusivism is ‘holistic and systemic’. The social model of disability suggests that it is the discriminatory arrangement of society that disadvantages a disabled person and not the disability per se.

Low argues that the quest for full inclusion denies some of the realities of disability. It would demand huge environmental re-structuring where the needs of various disabled groups may actually come into conflict. The author feels that some people do have needs that are special and it is not practical to think of them otherwise. He contends that ‘a system which attempts to meet everyone’s needs together meets nobody’s’. He argues for an approach which recognises that people with disabilities are both the same as and different from other people. Whilst maintaining inclusion as the ‘lead concept’, he warns against a blin-
ktered idealism which does not recognise
that the special nature of some needs may
require separate provision.

T. Vrasmas & P. Daunt. The educational
and social integration of children and young
people with special needs in Romania: A
137–147.

The article describes the development and
extension of pilot integration projects initi-
ally set up in 1991–92 with the support of
UNESCO. Although the social context in
Romania is not one which obviously favours integration, there are positive fac-
tors which do support the process. The
mainstream school system is not selective
and the 7–14 education system that oper-
ates in most areas is seen as favourable.
The integration of ‘regular’ and ‘special’
teachers in training is also seen as a positive
factor. The existence of teachers’ centres
for ongoing professional development and
the reinstated training of social workers
and psychologists is also viewed as sup-
porting integration. In addition, there is
powerful support for integration amongst
parents and professionals. There is a pro-
fessional movement to be rid of the ter-
minology of defectology and increased
public awareness of the needs of children
with disabilities. The authors commend
the ‘post-revolutionary passion for frank dis-
cussion of intractable problems and ques-
tioning of established assumptions’.

S. Padeliadu & V. Lampropoulou. Atti-
tudes of special and regular education

In this study the views of regular and
special educators were sought on inte-
gration. Although many had neutral atti-
tudes the regular educators were more
positive about integration than the special
education teachers. In addition younger
and less experienced teachers tended to be
more positive about integration but no
gender differences were found, i.e. male
and female teacher attitudes were similar.
Regular teachers tended to favour earlier
integration and special educators tended to
see the benefits to the child as mainly
social.

The authors conclude that intervention
strategies should be focused on changing
teacher attitudes but most particularly the
attitudes of those in special education.

British Journal of Educational
Psychology (1997)

H. Mynard & S. Joseph. Bully/victim prob-
lems and their association with Eysenck’s
personality dimensions in 8 to 13 year olds.

Previous studies had classified children as
either bullies or victims, but in a 1996 study
15% of children had been classified as
bully/victims, therefore redefining the typ-
ology. The study reported in this paper
investigated the personality of bullies, vic-
tims, and bully/victims. It involved 179
pupils in the age range and the following
measures were administered: bullying be-
aviour scale; peer victimisation scale; and
self-perception profile for children. The
latter consists of five scales that measure
scholastic competence, social acceptance,
athletic competence, physical appearance,
and behavioural conduct.

The study found that bullying behaviour
was associated with psychotism and that
peer victimisation was associated with in-
version. Both bullying behaviour and peer
victimisation were linked with neur-
oticism. Bully/victims had the lowest
scores on all self-perception profile sub-
scales except for athletic competence. This
group had the highest scores for neur-
oticism and psychoticism with a low level
of social acceptance. The authors suggest
that having a lack of status amongst peers
means that they may feel the greatest need
to assert themselves.

M. J. Boulton. Teachers’ views on bullying:
Definitions, attitudes and ability to cope.

This study explored how teachers define
bullying, their attitudes towards bullying,
bullies, and victims, and how well they feel
able to deal with incidents of bullying.
Teachers regarded a wide range of be-
aviours as bullying but there was greater
agreement over some behaviours than
others. Social exclusion and laughing at
others were not widely regarded as bully-
ing. Attitudes towards bullying were nega-
tive and teachers were sympathetic towards
victims. Interestingly, sympathy dimin-
ished with length of service. Respondents
were generally not confident about their
ability to deal with incidents of bullying and
87% wanted more training in this area.

J. W. Chapman & W. E. Tunner. A longi-
tudinal study of beginning reading achieve-
ment and reading self concept. Vol. 67, Part
3, pp. 279–292.

This New Zealand study involved 112
children over a 2½-year period, from when
they started school at the age of 5 years.
The child’s evolving self-system (self-con-
cept, self-efficacy, self-worth, attributions,
and expectations) is thought to influence
achievement by its effect on motivation
and metacognition. The authors question
whether there is a stronger predictive re-
lationship between initial reading self-con-
cept and subsequent reading achievement
than between pre-reading skills on school
entry and subsequent reading self-concept.
Reading self-concept is defined as ‘percep-
tions of competence in performing reading
tasks, perceptions that reading activities
are either easy or difficult and attitudes
towards reading’.

Chapman and Tunner conclude that inter-
actions between self-perceptions and read-
ing performance come into play during the
2nd and 3rd years of schooling (at chrono-
logical age 6.5 years) but that there is also
a link between pre-reading skills and initial
reading self-concept soon after children
begin school. They propose that reading
self-concept is more a consequence than a
cause of reading performance.