PSYCHIATRY SELECTION
Compiled by Ian Berg


Despite the relegation of school refusal to just one feature of separation anxiety disorder in both of the latest DSM and ICD classifications of psychiatric disturbances, the problem of anxiety about going to school is still with us. It is looked on as a condition that requires a particular treatment approach, where outcome is judged by improvement in attendance at school more than anything else. This Australian study has the virtue of being a randomly controlled trial. Using the criteria for school phobia suggested by your reviewer in 1969, the authors assigned 17 children suffering from school refusal to an intensive treatment programme lasting 1 month, whilst leaving 17 cases on a waiting list. Because of the wide age range, 5-15 years, the inclusion of both boys and girls, a considerable variation in the severity of the attendance problem, the variety of DSM-III-R disorders that affected the group, and the small number of cases involved, the evaluation was restricted to the question of whether the treatment group showed greater improvement in return to school, better relief of anxiety symptoms, and less social impairment than controls. It was found that they did. School attendance went up from about 60% to about 90% in those given therapy compared with an improvement from about 40% to about 56% in the controls. It was not possible to claim any benefit for the kind of treatment given. The results could have been a placebo effect. It is surprising how much therapy was given—a blunderbuss approach: six sessions in each instance of: (1) child cognitive behavioural treatment, (2) parental behavioural management, and (3) training teachers in behavioural management. It was rather the case of a sledgehammer used to crack a nut!


Despite its title, this paper uses the term school refusal for the cases studied, namely children who were off school at least 10% of the time over the previous month, who had a DSM-III-R anxiety disorder but had no major depression, and who were not on psychotropic medication. There was random assignment to one of two treatment groups: (1) cognitive-behavioural therapy, consisting of graduated return to school and a method of helping the children to cope better with anxiety provoking situations; and (2) education-support therapy, consisting of supportive psychotherapy for the children and giving them information about their problem, without any pressure or encouragement to attend school. Of 56 children included in the study and randomly assigned to these treatments, 9 dropped out, all in group 1. Treatments were given weekly for 3 months. The age range was wide, 6-17 years, with a mean of 12 years. Almost two thirds were girls. In group 1 school attendance improved from about 26% to roughly 67%, and in group 2 from approximately 30% to 60% after treatment. Neither school attendance nor various other measures of improvement, particularly in anxiety and depression, showed any differences between the groups. Younger subjects and those with less severe attendance problems did best. Improved attendance was maintained a month after completion of the treatments. The results were the same for both kinds of treatment. This is an important study since it suggests that pressure to return to school may not be necessary in improving matters and may even lead to a child discontinuing treatment. The numbers of cases involved were insufficient to allow the authors to identify the features of those children who might have done better with one of the methods of treatment than the other.


The DSM-IV field trials sample of 440 children and adolescents, taken from clinics and institutions, were studied using information obtained from parents, teachers, and the young people themselves. The NIMH MECA general population sample in the U.S.A. also provided 1285 children who were interviewed and whose parents or parental figures were seen. The aim of the investigation was to see whether the age of antisocial conduct was a meaningful method of subtyping conduct disorder. The paper is yet another example of the good-quality substantial collaborative research in North America, which is beginning to justify recent classificatory systems of child and adolescent psychiatric disorder. Age of onset is a simple objective measure and puts the development of conduct disorder as the focus of interest. DISC 2.3 was used with some modification. This NIMH scale produced DSM-IV diagnoses in the field trials group and DSM-III-R diagnoses in the MECA sample. The Children’s Global Assessment Scale gave ratings of impairment of functioning. Physical aggression was used to divide antisocial behaviour into aggressive and nonaggressive forms. Twenty-nine per cent of the field trials sample and 6% of the MECA types group were found to have a conduct disorder. Comorbid ADHD, ODD, and depression were looked at. Both samples showed that early onset of conduct disorder was strongly related to aggressive behaviour. Marked changes in aggression occurred around 10 years of age. It was aggression that characterised childhood-onset, rather than adolescent-onset, conduct disorder. Nevertheless, the point is well made here that subtyping conduct disorder on the basis of age of onset has much to commend it, since it is a straightforward measure which the findings of this study show takes the issue of aggression into account.


It is often thought that children with conduct disorders are likely to show large differences within their IQ profiles and that the Freedom Distractibility Factor (FFD) formed from the Arithmetic and Digit Span subscales points to attention and concentration difficulties relevant to the
diagnoses of ADHD. More than that, the WISC is considered to be a good measure of specific cognitive abilities. This Dutch paper questions all of these things. Perhaps it is not such a bad thing after all that in many clinical situations nowadays, WISC IQ assessments are difficult to come by. The sample considered (349 boys and 116 girls of mean age 12 years referred to the University Department of Child and Adolescents Psychiatry in Utrecht). The use of confirmatory factor analysis was helpful in demonstrating that the accepted factor structures of the WISC applied to their cases. The subscales and factors were much less specific than many people think and for the most part measured general intelligence. No particular WISC patterns such as verbal performance differences were correlated either with DSM-III diagnoses or CBCL factors. The conclusion was that WISC profiles lack predictive validity for psychiatric disorders. This accords with the view that one should only be concerned with the WISC Full Scale IQ.


Coming from the Child Study Centre at Yale, this paper outlines progress in the use of Parent Management Training (PMT) in helping children with conduct problems. Anyone wanting to familiarise themselves with the present state of knowledge about this important therapy should start here. There is good evidence that treatment based on operant conditioning ideas can improve deviant conduct and there is a lot known about how poor parenting practices can influence childhood antisocial behaviour for the worse. The therapeutic method involves antecedents, behaviours, and consequences, referred to as the ABCs. The emphasis is on positive and prosocial behaviours and rewards for them, although mild aversive responses such as time out and loss of privileges play their part. Usually the mother comes for treatment. A course of therapy may last for 2 to 6 months. It has mostly been evaluated on children of primary school age. Many randomly controlled trials have shown that this form of treatment is able to reduce unwanted childhood misbehaviour significantly, and that the improved functioning continues for years afterwards. As well as individual sessions, groups of parents can be instructed in this method and videotaped material can be employed. The sessions can be arranged in the community where the families live. There are some flies in the ointment in considering the value of PMT. Improvement features of conduct disorders such as poor peer relationships and academic achievement have often been left out of consideration in assessing change. Long-term effects have not always been investigated. Much work has been done in schools and outside the clinical situation. In general, about a half of those coming for treatment because of conduct difficulties drop out of therapy, and the demands of PMT could exacerbate drop-out rates. So far little attention has been paid to the applicability of PMT in diverse ethnic groups. Opportunities for professional workers to be trained in PMT are limited and the philosophy of the method may conflict with more traditional treatment opportunities. To effectively carry out PMT one needs to be able to model procedures, role play, and practice and generally encourage learning by doing, not just by understanding. This paper will make the reader more optimistic about the scientific base for the treatment of conduct problems by PMT.


There are two dimensions of ADHD symptoms, inattention and hyperactivity-impulsivity (HI). On the basis of these, DSM-IV includes three subgroups of ADHD, predominantly inattentive, predominantly hyperactive, and combined. Two- to four-year-old children were compared in a Chicago/Pittsburgh study looking at differences between cases of ADHD and matched controls, numbering 259 in all. Various measures were used to obtain information from parents and teachers and the children were psychometrically tested. This cross-sectional study will form the basis of a subsequent longitudinal investigation. Happily, efforts were made to allow for comorbid conduct and oppositional defiant disorder, as well as emotional disturbances. Other factors such as gender and economic circumstances were also allowed for. Somewhat controversially, diagnoses were made irrespective of whether problems occurred at home or at school. Although the subgroups of ADHD showed some differences in their social and educational adjustment and other aspects of impaired functioning, the three subgroups were considered to be valid since they were to a greater or lesser extent found to be linked to functional impairment, poor intelligence, and unintentional injuries.


A new scale is presented which takes DSM-IV items concerned with disruptive behaviour disorders and measures them in the way that DSM-IV suggests. As well as attention deficit/hyperactivity and oppositional defiant items, it includes some conduct disorder items relevant to a 6- to 12-year age group, some anxiety/depression items, and some performance items, e.g. peer relations and disruptiveness, as well as some educational achievement questions. It comes from the Vanderbilt Child Study Centre in Nashville, Tennessee, and it is called the Vanderbilt AD/HD Diagnostic Teacher Rating Scale (VADTRS). The justification for producing this questionnaire, completed by teachers, is that it follows DSM-IV closely. Other scales do not always include DSM-IV items or score them in the same way. It was successfully employed with several thousand school children in one academic year and used again the following year. Exploratory factor analysis on the 40 behavioural items produced 4 dimensions, labelled inattention, hyperactive/impulsive, oppositional defiant/conduct, and anxiety/depression. They had a high internal consistency and correlated to a reasonable extent with the diagnoses that had been made on some of the children. Confirmatory factor analysis showed that the dimensional structure held up very well in the second year. Performance and academic factors also emerged. Anything that puts the recent systems of classifying child psychiatric disorders, such as DSM-IV, on a firmer scientific footing is to be welcomed.

PAEDIATRIC SELECTION
Compiled by Alison Salt

Child Care Health and Development (1997)

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.


The September 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 that 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), which are based around specific areas of practice or types of disorder. The meeting in Washington also promoted the emergence of a new CRG that will deal specifically with psychosocial and developmental problems in children.

There was a preliminary meeting of this potential group in October 1997. Anyone 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 Centre for the Future of Children, 300 Second Street, Suite 102, Los Altos, California 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 then 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: the child 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 assistants in the classroom. The study examines the responses of 713 children (ages 7–14) 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 classes 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 overworked 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 students. He also includes examples from children’s own experiences, which often include long periods of being alone.

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 resisted and where it can lead to further barriers to inclusion.
FAMILY THERAPY SELECTION
Compiled by Jenny Altschuler

Families, Systems and Health (1997)

Whilst much of the earlier psychological literature on HIV/AIDS focused on individuals, this paper provides a review of the growing interest in exploring the impact of HIV/AIDS on the family, an increase coincident with the spread of HIV to the heterosexual community. Drawing on cross-cultural research and research with heterosexual as well as homosexual couples, the paper highlights how this condition challenges the view that the family is determined by blood relationships only, examining the dynamics of receiving support from biological families and families of affiliation. Drawing on research based primarily in U.S.A. and Africa, the paper discusses findings on the process of deciding to whom to disclose HIV status, on changes in family structure over the course of the illness, and on the physical and psychological implications of loss for the surviving partner/parent, particularly where they are HIV positive. This paper therefore raises important issues about the implications of parental illness for families, and has much to offer health professionals who are starting to work in this area.


In his previous work (e.g. 1984, 1987, 1994) Rolland outlined a multidimensional model framework for working with families facing physical illness and disability. The current paper extends this, focusing on the way in which family beliefs evolve over time and influence collaboration with health professionals. Drawing on clinical experience, he highlights how first meetings and the initial crisis of a health problem experience, he highlights how first meetings and the initial crisis of a health problem could impact on clinical practice in child psychology and psychiatry.

CHILD PSYCHOLOGY SELECTION
Compiled by Ken Aitken

Child Development publishes many diverse topics. The papers I have chosen from Volumes 68 and 69 are broad in scope but are linked under the general theme of research papers that have potential to impact on clinical practice in child psychology and psychiatry.

Child Development (1997)


This short paper documents consistencies in sleep in a group of 30 late foetuses who were then reassessed as 2-week-old infants. The authors examine sleep in the late foetal stage (38–40 weeks post conception) and in the newborn at 2 weeks post delivery. They focus on heart rate and eye and gross body movements. Active sleep was found to vary widely and did not show predictable continuities from foetus to neonate, while overall duration of quiet sleep seemed consistent and predictive from foetal to neonatal life. As our understanding of development chronobiology improves, it may transpire that variations from such a normative pattern predict subsequent sleeping problems. Further research is needed to clarify this issue.


This interesting and important study documents the development of 139 singleton infants born to diabetic mothers and the relationship between maternal diabetic control during pregnancy and subsequent neurobehavioural development of the children at age 7–11 years. The results demonstrated no higher rate of significant overall development delay than would be expected in the normal population. However, within the sample, after controlling for other factors such as socioeconomic status, race, and ethnic origin, correlations were found between a variety of measures of cognitive and academic ability and maternal glucose and lipid metabolic regulation in the latter stages of pregnancy. The findings were general effects of diminished metabolic input in utero and were independent of the genetic cause of diabetes. This is one of a number of recent studies that suggest maternal nutrition during pregnancy can have significant effects on subsequent child development, with implications for antenatal care and high risk populations.


This paper presents two studies that highlight a problem for autistic children in the use of direction of gaze of a speaker in learning a novel word for a novel object. The first study compared 17 children with autism to 17 children with learning disabilities not including autism who were matched for sex and for expressive and receptive language levels. All children were able to identify known objects on verbal request. The task was to identify novel objects linked to a new word by using the direction of the gaze of the experimenter. Of the children with autism, 29.4% were successful compared to 70.9% of the matched group. The second study demonstrated that in a mental age matched normal control group (N = 24, age 24.4 months), 79% were successful at the same task. This study suggests that para-linguistic information such as the speaker’s direction of gaze may be an important factor that hampers the autistic child in aspects of language use and acquisition. The obvious next stage is to look at the 29.4% of successful autistic children and
examine whether their language skills develop faster and whether they have greater social abilities, and also to look at the 21% of unsuccessful normal control children. Does a difficulty in using a speaker's direction of gaze lead to any problems with their social or linguistic development?

D. F. Bjorklund. In search of a metatheory for cognitive development (or Piaget is dead and I don't feel so good myself). Vol. 68, pp. 144–148.

This paper is a modified version of a talk given at SRCD in Seattle in 1991. Bjorklund argues convincingly that the current trends in developmental cognitive research, having left the 'metatheory' of Piaget behind as an overall research umbrella, are leading to excessive subdivision and limiting dialogue within the discipline. He makes a plea for the development of a framework for the understanding of the biological basis for cognitive development as the development of 'species-typical behaviour in a species-typical environment'. He sees such a framework as coming from an evolutionary basis to developmental psychology.


This paper presents a series of four elegant studies which, taken together, demonstrate that the 6-month-old infant, although unable to orient consistently towards mother in a preferential looking paradigm, does show differences on an ERP assessment which appear to be related to the degree of physical difference between mother and the other stimulus individual (at least as this was judged by the experimenters). This contrast in discrimination abilities illustrates that the reliance on methodologies such as the Fantz paradigm for assessing infant perceptual capabilities needs to be questioned.


This is the first of a number of recent papers to question the extent to which children with Williams syndrome, while different from normal children in cognitive and phenotypic characteristics, have unimpaired language skills, as has frequently been claimed. These authors set out to critically test this assumption of 'intact' language development. Two studies are presented. In the first, 18 English-speaking individuals with Williams syndrome were assessed on TROG (the Test for Reception of Grammar). Results indicated that subjects showed selective problems with a variety of aspects of embedded morphosyntactic structures. In the second study, carried out with 14 French-speaking subjects, selective problems were seen in the use of systematic gender assignments in speech. Language development is thus clearly different from 'normal' in individuals with Williams syndrome.


This useful paper adds to the emerging literature relating aspects of child development to the emergence of 'theory of mind'. A sample of 152 3- and 4-year-old boys and girls were assessed. All were tested on the PPVS-R as a rough measure of verbal intelligence for their level of pretend play, and they were interviewed concerning fantasy play—imaginary companions, impersonation games, favourite types of play, etc. In a second session, theory of mind 'skills' such as knowledge of false belief, appearance-reality distinctions, representational change, and perspective taking were tested. The results suggest that there is an association between level of fantasy play and the emergence of a model of mind 'skills' that is independent of level of verbal intelligence.


This is at first sight an important contribution to the debate on the relationship between sensitivity (mothers' ability to respond appropriately and promptly to infant signals) and attachment, a subject debated since in the attachment literature. From the set of studies identified, 21 were chosen as most closely approximating the original Ainsworth Baltimore Study of 1978 in nonclinical samples, within which a moderately strong effect was found relating maternal sensitivity to attachment rating.

The study is perhaps weakened by its definition of 'expert' attachment researchers: these were 19 researchers who had on average been involved in attachment research for 5 years (+3.89), half of whom had doctoral qualifications and the rest of whom were graduate students.


Factors which predict parental involvement in early intervention programmes are important for a wide variety of practical and financial reasons. Methods for assessing and thereby targeting and optimising use of resources are scarce. This is a helpful paper setting out one potential approach. The authors first used service provider ratings to classify the level of parental involvement in early intervention programmes with a range of physical and mental disabilities using the Parental Involvement Index. They went on to use a range of self-report measures with the parents (the Family Support Scale; the Dyadic Adjustment Scale; the McMaster Family Assessment Device; the Hassles and Uplifts Scale; the Centre for Epidemiological Studies Depression Scale; and the Coping Orientations to Problems Experienced Scale) to try to identify factors related to the level of parental involvement, and then applied structural equation modelling to test their predictive ability. Different models emerged as predictive of maternal (N = 75) and paternal (N = 67) involvement. However, in both models, family factors were the strongest individual area that affected degree of involvement in the intervention programme.


This paper comes from the U.S. national collaborative study of early development of children with visual impairment (PRISM). It documents a variety of developmental parameters within a cohort of 186 preschool children with heterogeneous visual impairments who were tested longitudinally on the Battelle Developmental Inventory over 566 serial assessments. The children ranged in age from 12 to 73 months. Unsurprisingly, there was an association between developmental outcome and the co-occurrence of learning disability. A further association was seen between degree of visual impairment and outcome, which is also unsurprising given the association between visual impairment and...
various causes of developmental delay such as mitochondriopathy. Most usefully for clinical purposes, the paper plots growth curves for a variety of developmental parameters against chronological age, dividing the cohort by level of functional vision.


This paper presents results from a study that looked at a range of influences on peer evaluation within a cohort of previously unfamiliar boys. The boys were aged 6–12 years, with an ADHD group (N = 73) and a non-ADHD comparison group (N = 60). A range of predictors were investigated: behavioural factors such as level of overt and covert antisocial behaviour; internalising factors such as self-report and direct observations of level of social isolation; and familial factors such as authoritative (warm, responsive, with clear limit setting), authoritarian (harsh, cold, controlling) and permissive (unstructured, child-centred) parenting beliefs. Across the whole sample, children who were rated more positively by peers were likely to have mothers with authoritative parenting beliefs, and to be less socially isolated on self-report and observation. Negative ratings by peers were predicted by three independent factors: aggression, covert antisocial behaviour, and negatively by maternal authoritative parenting beliefs. When the ADHD and control groups were compared, authoritative parenting beliefs were a stronger predictor of peer ratings than they were in the controls. This is an important study, as social difficulty with peers is one of the most powerful predictors of poor social, academic, and behavioural longer-term outcomes in ADHD.


This is an interesting study of children’s early understanding of pretence, which looked at 45 children aged 3–5 years and their inferences concerning observed realistic and make-believe situations watched on television. Interestingly, the ability to recognise pretence was not associated with performance on tasks measuring false belief attribution or appearance/reality distinctions. The ability to infer pretenders’ thoughts in such situations did correlate with task performance. The ability to recognise pretence does not in itself imply that the child has developed meta-representational understanding.


As did the earlier cited paper by Rizzo et al. on diabetic control, this study documents a clear relationship between an infant physiological parameter and psychological development. Iron deficiency anaemia is the most common single nutrient disorder worldwide. The authors cite an extensive literature on mental development in iron deficient anaemic infants which shows them to perform more poorly than control groups on standardised cognitive tests. This study examined 52 Costa Rican 12- to 23-month-old anaemic infants and 139 controls who were otherwise similar on a range of demographic variables. Behaviour was documented, both using videotaped free play to quantify infant–mother proximity, infant activity level, and spontaneous affect, and during assessment on the Bayley Scales of Infant Development (only the Infant Behaviour Record data being presented in this paper). The results add to the literature in indicating that on a variety of parameters anaemic infants differ significantly from those with normal iron status, and that in certain respects they continue to be significantly different after 3 months of effective treatment.