This relatively new journal on the applications of the psychoanalytic method of observing babies first developed at the Tavistock Clinic, London continues to contain much that is relevant to a multidisciplinary readership. Vol. No. 1, Autumn 2000, edited by Judith Jackson and Naomi Shavit, has several articles illustrating infants having to make the best use they can of a mother whose responsiveness is inconsistent. Another interrelated theme is the impact of an elder sibling on the mother-baby relationship. The following may be of particular interest.


This paper describes a mother’s difficulty in acknowledging and dealing with an elder sibling’s aggressive attacks on a younger sister, and in recognising the needs of both siblings simultaneously. She herself has a younger sibling, the age gap between them being similar to that between her own two children. Differentiating this behaviour from the hostility that one might expect as a typical reaction to the arrival of a new baby brother or sister, the author describes this child as pinching, poking, scraping, hitting and pummelling the baby in a horrifying manner. Though capable of loving and protective care of the baby in other respects, the child herself has a second skin, being a very active ‘little tough guy’ to hold himself together and to protect himself from an identification with a frail sister. Difficulties were expressed in separation issues and in problems around weaning and a reluctance to move on to solid food. The situation finally improved when the parents got extra help for the elder child which allowed the mother to spend a bit more time with her son. This gave more room for them both to express hostile feelings so that the child himself could begin to let go. A major value of the observation for the parents was that it enabled them to celebrate this little boy’s individuality and his place in the family.

J. Hopkins, Overcoming a child’s resistance to late adoption: How one new attachment can facilitate another. Vol. 26, No. 3, pp. 335–347.

This paper uses the treatment of a 9-year-old boy presenting with a disorganised attachment pattern and diagnosed as having ADHD to explore the difficulty which many late adopted children have in forming attachments to their new adopting parents. Hopkins emphasises how these children need to reject in order to defend against the pain of another loss or placement breakdown, and how a loyalty to previous attachment figures persists. In this case the child needed to reject and abuse the therapist in the treatment for some time before eventually a capacity to play together emerged. This was associated with the child beginning to take greater emotional risks and develop new attachments in his foster placement. The author discusses how the therapeutic relationship enabled the formation of new relationships in the outside world through allowing earlier, negative attachment figures to be externalised. Frightening and traumatic associations could then be worked through, making room for new relationships.
Kenrick’s paper highlights in particular the plight of children in the care systems that are in transitional placements. Often moving from one placement to another at less than 24 hours’ notice these children suffer effects of trauma that are cumulative. Without the opportunity to mourn previous losses and separations, repeated moves may re-activate earlier trauma; all too often this will ensure the failure of the placement. The author describes therapeutic work which, over a three and a half year period, enabled a 5-year-old boy to develop a greater capacity to deal with separation and reflect on his experiences. This has implications for his capacity to form attachments and tolerate change. The material is contrasted with that from another boy whose traumatic experiences in the home situation had been even more horrific. The latter child had the advantage of much greater continuity of care as he was adopted by his aunt who he already lived with and who was able to bear going over with him again and again details of his past life. Nevertheless, at two years of age, for a crucial period of 24 hours, this child was placed in foster care with strangers he did not know after having observed his father murder his mother and then kill himself. The author describes this traumatic separation and raises developmental implications of the placement. The author describes therapeutic work which, over a three and a half year period, enabled a 5-year-old boy to develop a greater capacity to deal with separation and reflect on his experiences. This has implications for his capacity to form attachments and tolerate change. The material is contrasted with that from another boy whose traumatic experiences in the home situation had been even more horrific. The latter child had the advantage of much greater continuity of care as he was adopted by his aunt who he already lived with and who was able to bear going over with him again and again details of his past life. Nevertheless, at two years of age, for a crucial period of 24 hours, this child was placed in foster care with strangers he did not know after having observed his father murder his mother and then kill himself. The author describes this traumatic separation and raises developmental implications of the placement. The author describes therapeutic work which, over a three and a half year period, enabled a 5-year-old boy to develop a greater capacity to deal with separation and reflect on his experiences. This has implications for his capacity to form attachments and tolerate change. The material is contrasted with that from another boy whose traumatic experiences in the home situation had been even more horrific. The latter child had the advantage of much greater continuity of care as he was adopted by his aunt who he already lived with and who was able to bear going over with him again and again details of his past life. Nevertheless, at two years of age, for a crucial period of 24 hours, this child was placed in foster care with strangers he did not know after having observed his father murder his mother and then kill himself. The author describes this traumatic separation and raises developmental implications of the placement.

My only reservation about this paper is that it is brief: several issues that are mentioned as crucial to the work required a more extended discussion for the reader to learn more. In view of the complexity of multicultural work, and our growing recognition of the need to recognise diversity in constructs of health and illness, a more in-depth analysis of how this staff group addresses issues of difference and respect for cultural differences in a situation of ongoing political conflict would have been valuable.


This paper provides a brief overview of the concept of triangulation, illustrating how this can be applied to the doctor-patient-family relationship. It focuses on a training programme to encourage registrars to extend their thinking about illness to patients’ families. Examples of both negative and positive triangles are provided, with discussion of how one can learn to recognize and work with triangles in a clinical context. The paper discusses the process involved in a range of situations in which, for example, a parent and ill child may link together against a second parent, and a parent and health professional may find themselves locked into a competitive struggle in relation to that child. Whilst there is a focus on how negative triangles may promote unhelpful patterns, Shapiro also stresses that triangles can be more fluid, offering a range of options for combining and recombining.

Although Shapiro’s focus is on the position of the doctor, this can be reframed in terms of other professionals, and this paper has much to offer for all mental health workers. It is also worth reflecting on how, often, there are a series of triangles operating side by side. General Practitioners may often play a central role in the life of families with young children. The level of contact a family has with a GP may mean that we are effectively engaged in co-working without recognising this.


The paper by Bartles and Faber-Langedoen, and the response by Barbara Elliot, break new ground in their focus on family perspectives and raise questions about the extent to which the voice of the family is still absent in much of health care today.

Bartles and Faber-Langedoen present a qualitative analysis of interviews with 21 family members who had experienced facing the death of a loved one following the withdrawal of a ventilator. They explore what families expect from professionals at this crucial transition in their lives, and what has helped them to cope and to maintain their integrity. Key themes emerging from the paper include:

1. A focus on the patient is critical to meeting family needs: family comfort is driven by the patient’s physical and emotional comfort, and there is a need to find a way of using technical processes that minimise discomfort as much as possible.
2. Psychosocial care is extremely helpful in supporting families in their role as decision makers: interactions between families and professionals at the end of life play an important role in constructing a sense of meaning that relates not only to the time of dying, but also to the memory families retain of themselves in the future. Clear information and communication is crucial in decreasing ambiguity.
3. Continuous surveillance of the patient by nursing staff is an important part of the psycho-social care of the rest of the family as well. Bartles and Faber-Langedoen argue that families are both recipients of care and members of the caregiving team, and that more emphasis needs to be placed on incorporating their views in the future.

However, medical ethics has a bias towards patient autonomy and the authors also highlight the ethical complexities of this work. In her response, Elliot extends their discussion. She describes how family members often serve only as witnesses to the decision process or as recipients of information about its outcome, and observes that, when family members refuse to play this role, conflicts arise.
CHILD PSYCHIATRY SELECTION
Reviewed by Ian Berg


The MTA study – that is the NIMH collaborative Multisite Multimodal Treatment study of Children with ADHD – carried out in the USA, has produced some useful facts about ADHD. About 580 children with ADHD combined type, that is with both hyperactivity and attention deficit, were assigned to four treatment groups: 1) medication; 2) behavioural management; 3) both of these; and 4) ‘usual’ – that is whatever was provided locally. Symptoms were subsequently reduced in all groups, but those on medication did better. Associated problems and functioning showed no differences between the groups. In this paper, Peter Jensen of the Center for Advancement of Children’s Mental Health at Columbia University in New York, as guest editor, introduces a collection of six papers from the MTA study. The papers cover severity of ADHD, sex differences, outcome measures following treatment, side effects of medication and how methylphenidate should be used. A continuous performance task was employed to measure inattention. Girls were generally found to be less impaired than boys. Inattention was particularly associated with anxiety disorders and impulsivity with conduct problems. Rather than using a whole range of outcome measures, a composite outcome score could be used. In general, medication was successful and the ‘effect size’ of additional psychological treatment was small. However, less methylphenidate was required when behavioural methods were used. Initial titration of drug dose was not found to be sufficient and continual monitoring throughout treatment was needed. On average, 38mg of the drug per day was used without additional psychological intervention and 31mg with it.


Helping parents to manage pre-school children who have ADHD in a community sample is the subject of this paper. Professor Sonuga-Barke, Professor of Psychology at Southampton University, and his colleagues, evaluated two ways of doing this. Three-year-olds, with the equivalent of ADHD, were randomly assigned to either parent training (PT) or parental counselling and support (PC&S). There were 30 in the first group and 28 in the second. Twenty children formed a waiting list control group. PT consisted of coaching in how to manage the child and PC&S consisted of non-directive counselling. The children’s symptoms and mothers’ well-being were measured before and after the treatment and at follow-up, 15 weeks later. Both measures showed significant improvement in over half those treated with PT, which was much better than the changes in the other two groups. The writers say that there is good evidence from well-conducted trials that methylphenidate medication is effective in improving performance in school, behaviour problems and social skills. However, they note that there is concern about side effects and a lack of evidence of any long term benefits, as well as ethical objections to controlling young children with medication. In any event, they feel that there is still a place for psychological interventions that may turn out to be useful as far as eventual outcome is concerned. They are aware that large scale studies, such as the United States NIMH collaborative Multisite Multimodal Treatment Study of children with ADHD, were not able to show more than a small increase in the effective control of symptoms with behavioural methods over the use of methylphenidate. Nevertheless, since much of the literature concerns school age children, it could be that effective psychological management in the preschool years could forestall the development of problems which result from poor school performance and social exclusion.


The Diagnostic Interview Schedule for children, Version 2.3 (DISC 2.3), produced under the auspices of the American National Institute of Mental Health (NIMH) is a widely used scale administered to child and to parent for the assessment of psychiatric disorders in a child. The scale may be used to diagnose DSM-III-R categories of disturbance. This paper is concerned with selecting some questions from the scale that could act as a screening questionnaire. Chris Lucas and his colleagues at Columbia University Medical Center in New York had a sample of almost 1300 children aged 9 to 17 years from the general population. They used symptoms from DISC 2.3 and DSM-III-R diagnostic criteria, obtained from the child and their main parental figure, during the Methods for the Epidemiology of Child and Adolescent Mental Health Disorders (MECA) study in the USA. ‘Stem items’, that is questions asked in every case from the DISC, were included in a regression analysis with the DSM-III-R diagnosis as the dependent variable. An impairment criterion was included. Having found a full DISC predictive scale for each diagnosis, sets of ‘gate items’ were selected such that no case would have been missed if all had been answered in the negative. The other significant predictors were kept as ‘contingent items’. Two cut-off points were used: 1) any gate question answered positively and 2) a cut-off point from the full scale, obtained by Receiver Operating Characteristic (ROC) analysis. The derived scales were validated on substantial samples of young people in residential care. Specific diagnostic scales were derived for 13 diagnoses, using information from the child and the parent separately. Interestingly, the child and parent gate items showed low concordance. Parents were more inclined to focus on observable behaviours than subjective symptoms. When the child DPS was used prior to a full DISC Interview in 89 instances, only 3 diagnoses out of 75 were not identified. The investigation showed that DISC stem questions for both child and parent could be reduced from 206 to 76 without significantly affecting the value of the diagnostic scales. Lucas and his colleagues conclude that with an administration time of less than 10 minutes, the scales could be helpful, especially to exclude those without a particular diagnosis.

Eric Fombonne and his colleagues, before he moved to work in Montreal and was still at the Institute of Psychiatry in London, carried out a survey of child and adolescent mental health on a nationally representative sample in Britain. The study reported in this paper looked at the prevalence of pervasive developmental disorders (PDD) in 1999 using ICD10 and DSMIV criteria. The diagnostic instrument used by trained non-clinical interviewers was the Development and Well Being Assessment (DAWBA) which had been described by Robert Goodman, one of the authors, previously. It includes measures of psychiatric symptoms and their apparent impact. Three questions were asked about the first three years of life: 1) how the child got on with others; 2) how speech developed; and 3) whether there were rituals or unusual habits that were hard to interrupt. If any were answered in the affirmative, it was further enquired as to whether the problem had cleared up. Detailed parental information on social behaviour, communication and play was obtained. Data from teachers and the children, who were young teenagers, were also used to make a diagnosis. The Strengths and Difficulties Questionnaire (SDQ) was also completed by parent, teacher and where appropriate by the child. Some tests of intelligence and reading were used. The selected sample contained about 12,500 young people, of whom 83%, about 10,500, were included in the study. Nearly 1000 were diagnosed as psychiatrically disordered in other ways than PDD and 29 were found to have PDD, including two girls with Rett syndrome. Boys greatly outnumbered girls. One of the children with PDD was said to have Fragile X. Five were categorised as having Asperger’s syndrome. None had Crohn’s disease. As a group, children with PDD had high rates of motor co-ordination difficulties, soiling and wetting and epilepsy. About half were mentally retarded. Compared to other psychiatrically disturbed children, SDQ scores in the PDD group were higher due to poor prosocial and peer relationship scores. Hyperactive symptoms were particularly prevalent. Parents had high levels of stress. The study has some limitations resulting from a failure to include a fifth of households and those in care, the use of structured interviews given by non-clinicians, and the difficulty in distinguishing subtypes of PDD. Nevertheless, the survey has the distinction of looking at a sample that is representative of the whole country, and its ability to compare PDD with other psychiatric disorders and normal children is a particular feature. Prevalence is in keeping with recent surveys and higher than rates estimated 30 years ago.


David Shaffer of Columbia University Medical Center and his many colleagues should be congratulated on providing such useful guidelines concerning all aspects of attempted and completed suicide in the young. Despite the enormous literature that has been produced on this subject in the last 20 years there are still so many unanswered questions. However, sufficient knowledge is known to enable psychologists and psychiatrists and other professionals who deal with this very common problem to make meaningful assessments and provide useful recommendations on management. Those whose job is to write departmental protocols on ‘overdose’ will find this American document essential. There are clearly differences on the two sides of the Atlantic. Firearms are happily less available in Britain, to mention the main one. Because of the absence of sufficient treatment trials, many of what appear to be sensible recommendations are still based on clinical experience and ‘generally accepted opinions’. At a time when litigation lurks behind every clinician’s back, here are clear ‘minimal standards’ that must be adopted in every instance. Clinical guidelines based on empirical evidence and strong clinical consensus are given. Suicide is happily still exceedingly rare before puberty. As many as 2000 American adolescents kill themselves every year. An important causative factor is the existence of psychiatric disorder, often of some duration. Another major association is the high incidence in boys. Previous suicide attempts are important as a predictor in males. Alcohol and substance abuse increase the risk of suicide. Where there is depression, tricyclic anti-depressants should generally be avoided because of the small difference between therapeutic and toxic, even lethal dosages. The paper deals with prevention. It is good on history and provides an exhaustive bibliography. It also lists useful sources of further information.

Journal of Abnormal Child Psychology (2001)


The answer to this question according to this group of workers from Pennsylvania State University College of Medicine, Department of Psychiatry, is: ‘NO IT DOESN’T’. Since DSMIV specified criteria for Asperger’s disorder in 1994, this diagnostic category has been widely used clinically. DSMIV Asperger’s disorder shares two major features with autistic disorder, namely impaired social interaction and restricted repetitive behaviour. Where the two diagnoses mainly differ is that autistic disorder is characterised by significant delays in language and cognitive development, but Asperger’s disorder is not. The authors looked at 150 children extensively evaluated and previously considered to have either autistic or Asperger’s disorder. The age range was wide (2 to 14 years, with an average of 5 years). There were 3.5 boys to 1 girl. Most were Caucasian. The IQs were also very varied, with a mean of 65. The authors used an IQ of 80 or over to distinguish those without a significant delay in cognition. They used the DSMIV criteria for significant language delay, namely no single words by the age of 2 years. All the children studied met the criteria for autistic and none for Asperger’s disorder. The entire group had had abnormal social interaction or lack of imaginative play, before the age of 3 years, six or more DSMIV symptoms of autistic disorder, including two or more affecting social functioning and one or more of restricted and repetitive behaviour symptoms, as well as one or more communication impairment problems. It was the latter that gave them the diagnoses of autism and excluded Asperger’s disorder. The communication problems that had this effect were either impaired conversation or repetitive, stereotyped or idiosyncratic speech, or both. The authors point out that five other studies have come to similar conclusions.