

Editorial

We commence this, the last issue of the century, nay the millennium, with a timely annotation by Overmeyer and Taylor on one of the most controversial topics in child psychiatry at present. As the diagnosis of ADHD (or, in its more limited diagnostic form, hyperkinetic disorder) becomes ever more widely recognised in all corners of the world, the use of medical management to control young children (mainly boys) whose behaviour irritates parents and teachers alike is growing almost exponentially. The authors provide a valuable review of the use of medication for hyperkinetic/ADHD disorders. They point out that the use of stimulants can reduce the severity of symptoms, although they acknowledge that merely suppressing those symptoms will not necessarily affect the prognosis; there is no evidence that long-term outcome is better for medically treated individuals. It has now been shown by several trials that medication can be relatively more effective than behavioural treatments alone: however, this conclusion should not be taken as a license to prescribe medication as a first line of treatment in all circumstances and at all ages. It is worth bearing in mind that methylphenidate and dexamphetamine are the only drugs licensed in the United Kingdom for the treatment of hyperactivity. The review also discusses the use of pemoline (now unlicensed in the United Kingdom because of risk of liver damage), antidepressants, and clonidine. It does not mention risperidone, which has recently attracted a certain vogue amongst private paediatric practitioners. Risperidone does not yet have an evidence base, but it is less prone to induce extrapyramidal symptoms than other neuroleptics such as haloperidol. It is not, however, free of hazards, which include obesity and endocrinological disorders. Interestingly, the “elimination diet” that every other parent seemed to be demanding for their “hyperactive” child a few years ago has gone out of fashion, presumably because there was hardly any convincing evidence that it was beneficial in the first place.

One of the reasons why such concern is shown by parents about symptoms that are indicative of ADHD is the risk that affected children may become increasingly antisocial, aggressive, and alienated from their peers and society at large. It is often thought this dire outcome could be due in part to academic failure. The paper by Rapport et al. provides an important replication and extension of a conceptual model suggested by earlier studies, in which parallel but correlated developmental pathways exist for children with attention-deficit/hyperactivity disorders and conduct disorder. An important component of this model suggests that attention deficit behaviours are associated with later scholastic underachievement but conduct problems are not, except by their common correlation with attention deficit and intelligence. Their findings supported the view that attention deficit disorders are neither necessary nor

sufficient for the development of antisocial behaviour, although they are independently correlated with impaired scholastic achievements. On the other hand, conduct disorder is necessary and may be sufficient for the development of antisocial behaviour, irrespective of the presence of ADHD or low IQ/academic failure. We might therefore speculate that treating ADHD alone is not going to reduce the prevalence of conduct disorder.

The issue of timing, rather than the content, of parents' strategies for managing young children's behaviour has been relatively little studied. Particularly effective parenting might involve anticipating when a situation is likely to be difficult, and then timing disciplinary strategies so as to prevent conflict arising in the first place. The study by Gardner et al. provides the first evidence from a longitudinal study that the way in which parents time their disciplinary strategies may influence the development of their children's conduct problems over time. Mothers of 3-year-olds with and without conduct problems were observed during a clearing-up task. Mothers of “problem children” tended to respond reactively, after their child had failed to comply with a command, and this was the main difference between them and the comparisons. A subsample of their subjects was followed up and reassessed at 5 years. Mothers who had used helpful persuasion strategies before, rather than after, a conflict had begun had children whose conduct problems improved over the ensuing 2 years.

The findings suggest it may be helpful to incorporate teaching about skills of anticipating and thus preventing misbehaviour into interventions to help parents manage young children's conduct problems. The authors nevertheless caution that, hand-in-hand with developing these skills in practice, it is important to test whether new components of intervention really are clinically effective for the management of difficult children.

Problems in executive function have frequently been associated with ADHD and autism. However, there is little information available on the part that executive function deficits play in the development of externalising disorders such as conduct disorder. Where such impairment has been found it has often been assumed to be simply a correlate of comorbid ADHD. For instance, impulsive behaviour in ADHD could be considered to reflect a lack of normal response inhibition. If an individual has apparently impulsive aggression, is this a reflection of his ADHD, his conduct disorder, or both? Séguin et al. set out to test the hypothesis that the relatively high levels of comorbidity between ADHD and conduct disorder may have confounded the relationship between poor executive function skills and externalising disorders. They studied boys in early and middle adolescence. Contrary to much of the existing literature, they did not find poor executive skills in cases of ADHD. This is arguably because of design characteristics such as task

selection (subjective ordering and conditional association learning, both indicators of working memory in adults). They did, however, find that poor performance on their measures was independently linked to patterns of aggression that had existed from early childhood. The relationship was independent of nonexecutive processes such as general memory abilities and IQ.

Pagani and colleagues conducted a study on association between poverty, academic failure, and delinquency in boys from Montreal who were initially assessed at nursery school aged 6 years. They were then followed up annually for up to 10 years. The authors report that both the duration and the timing of poverty had an impact on both academic failure and participation in serious delinquency at the age of 16 years. Persistent poverty was not the problem; it was instability of income. This relationship appeared to hold independent of maternal education, early childhood behaviour, and family structure. Their results do not support the idea that because boys from poor families are at greater risk of underachievement, they are also more likely to become delinquent. Parental divorce was associated with a greater risk of fighting and stealing during middle adolescence. Of course, even with longitudinal data, disentangling the relationship between so many intercorrelated variables is a difficult task. The interpretation of these findings is not made any easier by the fact that less than half of the original sample was available for follow-up, attrition being greatest in the most at-risk families.

We are publishing in this issue a number of studies on issues to do with children growing up in anomalous circumstances. Brand and Brinich discuss the commonly held view that adopted children are excessively likely to come to clinical attention because of emotional or behavioural disorder. Could this represent a genuine increase in prevalence of problems, or a lower threshold for seeking professional advice in parents of adopted children? They studied a very large sample, drawn from throughout the United States, and included adopted, nonadopted, and foster children. The vast majority of adopted children (nearly 90%) showed similar patterns of emotional and behavioural problems to those found in nonadopted children, as did foster children when clinical disorders that were present before fostering were taken into account. Only a small minority of adopted children showed extremely disturbed behaviour. Adoption as such did not seem to put children at risk of developing behavioural problems. The authors conclude that more should be learned about the reasons why this small subgroup of adopted children develop emotional and behavioural disturbance. In general, there was indeed a lower threshold at which parents who were adopting or fostering sought professional advice, for any given level of disturbance.

Wolff and Fesseha studied a group of orphans in Eritrea, and followed up their progress from an initial age of 4–7 years for a period of 5 years whilst they were raised in an orphanage. Outcomes were not necessarily bad. At follow-up only, their original sample was compared with children who had been raised in two other institutions (of contrasting quality) and who were of similar age. This interesting investigation suffered from the difficulties inherent in conducting research in a war-zone, and there

was inevitable attrition as well as unmeasured variables of potential importance. Children with the best outcome came from the comparison residential setting that respected the individual qualities of the children in it, and which had promoted close personal ties with at least one member of staff. The authors conclude that it was possible for the more serious psychological consequences of chronic exposure to the traumatic experience of active warfare, and the loss of both parents, to be ameliorated. They suggest, although the study was carried out in one particular cultural setting, that the findings may also be a useful frame of reference for providing humane care for the many thousands of orphans of war orphans in other developing countries where adoption and foster care are not widely available.

Parents seeking treatment for transracially or transculturally adopted children may have some difficulty finding clinical advisors who are expert in the particular problems faced by such children and their families. There is not a substantial literature on this subject. One might expect that such children would have a range of behavioural problems of self-identity and self-esteem issues to deal with, which would not be faced by children who were adopted under more traditional circumstances. Cederblad et al. conducted an investigation in southern Sweden, a country that has adopted a large number of refugee and similar children from overseas, relative to its population. Their subjects came to Sweden up to 20 years before the interviews that form the basis of this enquiry. They show that most adopted teenagers develop well, but that questions of identity and about how to cope with the peculiar circumstances of their adoption were still salient issues for them.

Hay and colleagues were interested in the lack of agreement that is often reported between mothers and fathers when they are asked to complete behavioural questionnaires on their children. Many evaluation and intervention studies use checklists of behavioural problems, which are filled in by mothers or teachers and occasionally by other people too. There is often a moderate level of agreement between informants, but there is often substantial disagreement. The authors looked at the way in which mothers and fathers appraise the behaviour of their 4-year-old children. Parents' reports were significantly affected by concurrent depression. Both mothers' and fathers' ratings of their child's behaviour at 4 years correlated with the ratings made by teachers 7 years later. However, although mothers and fathers agreed about many problems at the earlier age, it was unique information provided by the fathers' ratings that accounted for the good predictive validity. This may be in part because fathers were more sensitive to problems that were related to the child's cognitive abilities. In view of these findings, the authors caution that clinicians who are designing studies of child behavioural disorder, in which the respondent may be depressed, should try to interview more than one person about that child.

Relatively little is known about the social and emotional development of children whose mothers suffered from postnatal depression. Previous studies have relied on maternal reports of outcome, which may be biased, and sample sizes have been small. The investigation con-

ducted by Murray et al. used a prospective longitudinal design. It compared a community-identified sample of postnatally depressed mothers with well mothers, after screening at 6 weeks postpartum. The samples were then followed up to 5 years, with little attrition. There were multiple informants and measures, including direct observations of mothers and children in interaction. The children's behaviour was also observed in school. Although maternal functioning was principally affected by current difficulties, several aspects of child behaviour at outcome were associated with the mother's postnatal depression, even when taking into account current adverse circumstances. It is important to note that the observed behavioural differences between cases and controls at home and at school were subtle, and only found in a minority of subjects. However, the authors argue for early detection and intervention in order to manage maternal depression more effectively in the postnatal months.

Eley and Stevenson explored the covariation between anxiety and depression in a large sample of twins, with the aim of discovering how the relationship between the two varied with age and with sex. We know that self-reported symptoms in these domains of disorder correlate quite strongly, raising the possibility that they are simply different manifestations of the same underlying biological (genetically mediated) predisposition. The authors report two findings that may be of clinical significance. First, there was a greater genetic influence on symptoms of depression among adolescent boys than among girls. On the other hand, there were greater shared environmental influences on the adolescent girls, suggesting perhaps that family factors predisposing to depression have more of an

impact on girls than on boys. They conclude that the way we treat depression in adolescence may need to be different according to gender. Caution must be expressed, however; these analyses were not based on clinically identified cases of mental disorder. Second, the authors report that their results are compatible with the hypothesis that the same genes (presumably in the form of QTL polymorphisms) render children liable to both anxiety and depression. They suggest there may be a shared biological vulnerability to both types of symptoms. As they acknowledge, these are preliminary and provocative data, and the study clearly needs to be replicated, preferably with clinically defined disorder as an outcome measure.

Finally, in her review of the assessment and management of somatisation disorders in childhood and adolescence, Garralda points out that there are not very many rigorously conducted trials of treatment of such conditions. They include vague headaches and abdominal pains, as well as more serious problems such as conversion disorders and chronic fatigue syndrome. Inevitably, there is a complex interweaving of physical, social, and emotional factors underlying the presentation to a clinician. Garralda discusses the appropriate structure for a treatment programme. She points out that it is often necessary to undertake a variety of treatment approaches in parallel, which may involve individual psychotherapy with the child, family therapy, and medication, as well as addressing any issues relating to the child's placement at school. Cognitive behavioural techniques are often particularly effective, both with the individual and with the family.

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