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ADOPTIONS, FAMILIES, CHILDHOODS

Editors: Esther Grau, Diana Marre & Beatriz San Román
Authors: Neus Abrinés & Sami Timimi
Layout editor: Sofía Gaggiotti
Dissemination: Maria Galizia
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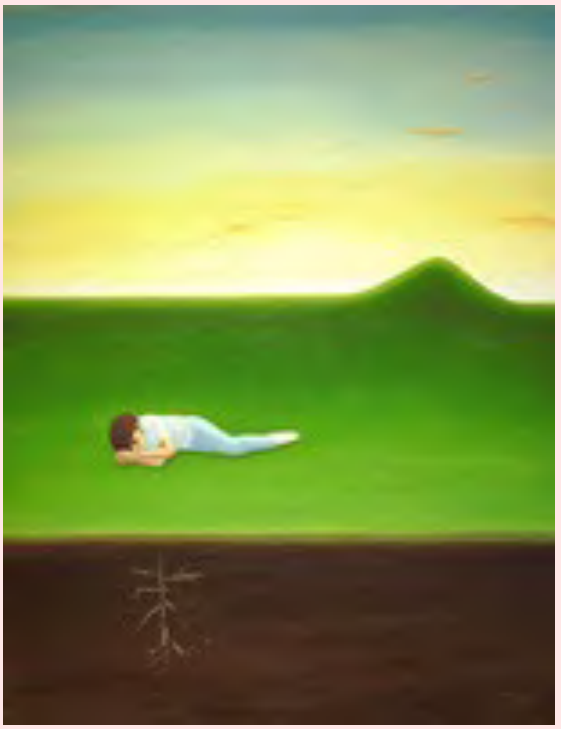
What's behind hyperactivity?

When some kind of mental distress is experienced by any child (or his parents and teachers) in our society, the most frequent approach chosen by mental health professionals includes assessing the severity of the symptoms, making a diagnosis and recommending a treatment. However, mental health is not as simple as that and a wider approach should be considered.

First of all, we should consider the influence of the culture on the way we interpret distress or behavioral symptoms. Culture can be described as a set of beliefs and a "way of doing things" that a certain group of people have in common and the social construction is described as the process by which different cultures develop a set of beliefs and values that guide the way they behave in the world. Taking into account these concepts, the causes of a child displaying poor behaviour could be interpreted very differently in different cultures, and consequently, each society would try to change these behaviorus in a different way. As individuals, we can also interpret the behaviour of a child in many different ways.



Marta Gómez-Pintado
El sueño

Given the example of a child who is not behaving as expected by their parents or teachers, a doctor could decide that this child is experiencing problems because they are suffering from a medical condition affecting the nervous system, which can be remedied by medication.

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info.afin@afin.org.es

On the other hand, the doctor could interpret the problems as being due to nutritional imbalances, and then recommend a change in diet instead. However, the doctor could chose to interpret the same behavior as being within the normal spectrum expected for children of that age, in which case this could lead to work with the parents and teachers to try to influence their perception of the child and so reduce the amount of worry or concern they have.

The more you examine different cultures across the world and across time, the more difficult it becomes to know what is meant by a normal childhood, and therefore, it becomes very difficult to define what is an abnormal psychologically or psychiatrically disordered child.

In our present society, rates of diagnosis of psychiatric disorders and prescription of psychotropic medication to children have increased dramatically over recent years, accelerating sharply over the last decade in most Western countries and more globally, with children from as young as two being prescribed psychiatric medication in increasing numbers. The most reassuring reason for this change in practice is that it is the result of the discovery of new psychiatric diseases in children that were unknown before, followed by the subsequent discovery of new ways to treat these.

However, there is no evidence that any of these disorders, (such as Attention Deficit Hyperactivity Disorder (ADHD) or childhood depression) are the result of specific genetic, biochemical, developmental or other brain abnormalities that cause the behaviours by themselves. This means that there are no blood tests, x-rays or brain scans that exists that can demonstrate something physically wrong in the child and therefore, the tests used to assess these disorders are pencil and paper exercises, where a caregiver is asked a series of questions about their child. All such a test can measure is the caregiver's perception about that child at a moment in time. Whilst this is of course valuable information, it hardly amounts to a "medical" test because it cannot measure something intrinsic in the child and as a consequence, the diagnosis is mainly based on the subjective opinion of others.

Despite the lack of evidence and the subjective methods used to make a diagnosis, these diagnoses (such as ADHD and Autistic Spectrum Disorders) are increasingly viewed as biological conditions.

As a result many who get these diagnoses are treated with "biological" treatments, such as drugs, which give the impression of providing a quick and rational solution to the problem. Such a model often makes the broader context of the child (such as their emotions, familial circumstances, school, cultural background, peer relationships and so on) invisible or not important.

Unfortunately, those who end up on medication do not necessarily get any lasting benefit from this. Indeed, the evidence shows that the three main classes of psychiatric drugs used with children – antidepressants, stimulants, and antipsychotics – are not effective (in the long term) or safe, and therefore should not be used as a first-line treatment. Psychotherapy in contrast is in general effective and safe. However, there is little evidence to support the idea that particular psychotherapy techniques make a big difference to achieving a positive outcome and much evidence to suggest that the quality of the relationship between therapist/doctor and patient does.

Current diagnostic categories used in child psychiatry tell you very little about cause, treatment or outcome. This doesn't mean that child psychiatric diagnoses aren't useful for some people and in certain circumstances, but it does mean that these diagnoses should be viewed as a "social construct", rather than a concrete entity that a person "has". In other words, whilst we can say someone who has been diagnosed with diabetes "has" diabetes, and we can show a physical test that proves it, we cannot say that someone "has" ADHD or show any physical test that tells you something physically abnormal is happening in that person's body/brain that is causing their behaviour problems. However we may still choose to describe their behaviour as "ADHD" for other reasons (to communicate with other professionals, for research purposes, to access particular services, etc).

Marta Gómez-Pintado
Subconsciente

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is a diagnosis from the American 'Diagnostic Statistical Manual (DSM)' and describes a constellation of poor concentration, hyperactivity and impulsiveness that has been present from an early age. In the DSM criteria these behaviours must be present in at least two situations (e.g. home and school), associated with impairment of social or academic functioning, present before the age of 7 years and not better explained by another disorder. The World Health Organization (WHO) uses the International Classification of Diseases (ICD). ICD criteria are more stringent; unlike the DSM, however, the ICD has a category for 'hyperkinetic conduct disorder' as well as ADHD, reflecting the common association of hyperactivity with antisocial behaviour.

The OO-CAMHS project

The National Health Service (NHS) is the name of the publicly funded healthcare system in England and it includes the Child and Adolescent Mental Health Services (CAMHS). On the 1st of January of 2011, a CAMHS team from Lincolnshire (Lincolnshire Partnership NHS Foundation Trust) launched the Outcomes Oriented project (OO-CAMHS). This project is based on 4 main principles that can be summarized by the acronym 'CARE':

1. Consultation: When more than one agency is involved in the case, professional meetings are required in order to: (a) avoid that two different professionals or agencies work on the same problem, which could lead to confusion for the patient; (b) avoid over-complicating the problem by involving more people than needed and (c) avoid giving the message to the family and other professionals that the problem is severe, and more help is needed.

2. Alliance: Evidence shows that within therapy, the biggest influence on outcome is the relationship between the patient and the therapist, as measured by the patient. Research has also shown that therapists are not good at knowing how good an alliance they have formed with their patients. To help the clinicians monitor this relationship, at the end of each session, both the child and their parents are asked to mark on the 4 item Session Rating Scale (SRS), how well understood and respected they felt during the session, whether the issues they wanted to talk about had been covered, whether they were happy with the therapist's approach, and how satisfied they felt in general with the session. This ensures that the patient always has a voice and the clinician can get guidance from the patient about what is meaningful for them.

3. Regular review: Evidence shows that people receiving feedback on how they are doing in treatment improves the outcomes. Each child and/or their parent is asked to rate how they perceive they are doing at the beginning of each session. Using the 4 item Outcome Rating Scale (ORS) they rate how they are feeling, how they are getting on at home, how they are getting on at school and finally, how they are doing overall. Each item scores out of 10, giving a total score out of a maximum possible score of 40. At each session the child and their parents can then compare their ratings with previous ones. As some evidence has found that about 90% of cases that has not shown any improvement after 5 sessions, will not improve with the selected approach, then if no significant improvement has been observed after 5 sessions, the treatment is discussed with the family and with the team in order to see if a change in the therapy or therapist is needed. This shouldn't be seen as the therapist being a bad professional - quite the opposite: a good therapist knows that "nobody is good for everybody" and he/she is able to recommend a change when they realize that they are not being helpful.

4.Ethics of care: A whole team ethos is needed. Like patients, clinicians need to feel listened to, respected and supported. As this approach can make the therapist feel judged by families, the philosophy that the team is supportive of all the clinicians is promoted.

Marta Gómez-Pintado
El pequeño Shliemann

Marta Gómez-Pintado
Ilustración Alicia y Gulliver

REFLECTIONS

Reflections by Dr. Sami Timimi in a fragment of: Timimi S (2005) Naughty Boys: Anti-Social Behaviour, ADHD and the Role of Culture Basingstoke: Palgrave Macmillan.

A new category of childhood – The ADHD child

Childhood in Western society is increasingly viewed through a biological "genetic" framework and this holds several dangers for children. Schools are struggling with being under-resourced, using labour-intensive "modern" educational methods in highly stimulating colourful classes, under pressure to demonstrate ever-improving academic achievement in their pupils, with ever less methods for behavioural control of children at their disposal. John, one of their more distractible and boisterous children gets a diagnosis of ADHD and starts taking Ritalin. He is no longer a big problem; he does as he is told. The school has saved money, instead of having to provide extra input for this "special" needs, the teachers realize that John had a medical disorder and now that is being treated he is fine. John's teacher realizes that John's friend Paul seems to be similarly distractible and boisterous. She meets with Paul's parents and tells them that she wonders if Paul too has this ADHD and advises them to see their general practitioner. Paul gets a diagnosis and starts taking Ritalin too. Soon other teachers have started identifying children in other classes like John and Paul. A process has been set rolling. A year down the line John's old pattern of behaviour seems to be returning. Teachers agree that there could be many reasons for this (his parents have split up and he has started with a new teacher) but wonder if it could be due to the treatment for his new medical condition (ADHD) not being adequate. The school writes a letter that John's mum takes to his consultant and John's dose of Ritalin is increased. Soon Paul's dose also goes up. Other teachers talk about this and become aware that some of the children in their class may not be getting adequate medication. Another process is set in motion.

Marta Gómez-Pintado
En el bosque

Meanwhile John's consultant has attended a couple of drug company-sponsored seminars, has been contacted by a drug company representative and has been given parent and teacher information booklets by this representative (which describes ADHD as being caused by an inherited chemical imbalance in the brain and has pretty pictures of nerve cell synapses to "show" exactly what is going on in ADHD brains). This literature now goes into local circulation and others parents start contacting their doctor expressing concern that their child may have ADHD. A local parents' support group is set up and they join a national consumer pressure group (who organize every year yearly conferences with drug company's financial helps). The local paper interview's the parents' group who talk about "hidden disabilities" and how for years they struggled but no one recognized the psychiatric problem their children had. By now ADHD is firmly established in local culture with economically and politically powerful groups (drug companies, doctors, teachers) having had a major, but often unacknowledged impact on local communities' conception concerning the nature of childhood. A new category of childhood has emerged – that of the ADHD child.

In the last three years I have inherited man children who were diagnosed with ADHD and prescribed a stimulant at the time I took over their care. One of the most obvious impacts of the ADHD diagnosis of the previous professional's views about these children was the almost complete lack of attention to context. Thus I saw children who were missing their absent father, I saw parental discord, I saw children from failing schools that were under special measures, I saw depressed mums who were not coping, I saw families with poor support network, I saw children with attachment issues, I saw adopted/fostered children who were used to rejection, I saw children who could not grieve a lost relative, I saw very bright children who used their intelligence to get round a system, I saw frightened parents whose children knew what buttons push, I saw busy parents who didn't have the time to get to know their children, I saw frightened teachers who were unsure how to handle the boys in their class, I saw tired and worn-out teachers who had had enough of teaching and so on. I looked in vain to see if the previous doctors had noticed the strengths and abilities of these children and their families.

I seriously wondered why the doctors get paid so much. For what? If we have lost the ability to work with and take account of even the most basic "barn door" obvious psychosocial issue, how, as consultants, could we be expected to deal competently with complexity and the common but subtle problems that arise in interpersonal family life? These children were now on toxic addictive drugs, whilst the problems in their psychosocial context had yet to be tackled. What sort of medicine is this?

I started as a consultant child-and-adolescent psychiatrist in Lincolnshire some three plus years ago. In my first two years I was working in a community patch that was part rural and part inner city urban. I inherited 26 children who at the time of my starting in this patch were taking stimulants. Many of the clients I inherited had been seen by a consultant child-and-adolescent psychiatrist (who still had a local community patch that overlapped mine) and who was a strong believer in the ADHD diagnosis and use of psychopharmacology (often multiple prescriptions and in high doses) in children. The local community paediatrician was also a firm believer in the diagnosis and use of stimulants in children. Consequently, the local community had already been "cultured" into believing in ADHD and the merits of drugging children to control their behaviour. Amongst the 26 children on stimulants I inherited at the time I took over, the average age was 12,7 years, the average daily dose these children were taking was 41 mg of Ritalin (or Ritalin equivalent, the maximum licensed dose for Ritalin is 60 mg per day, the maximum I inherited was a child on 100 mg a day) and the average number of years the children had been taking a stimulant was 3,5 years.

Marta Gómez-Pintado
Tres en uno

By the time I moved jobs after two years, only 6 of the 26 I inherited remained on a stimulant, 16 children had come off the stimulant through a co-operative effort with

the child's parents, two children had their prescription discontinued through persistent non-attendance (in the United Kingdom Ritalin prescription requires that the child is followed up by a specialist) and two children were lost to follow up by me after I raised child protection concerns. Of the six who remained on stimulant medication at the time of my departure, the average daily dose was about half the dose they were taking when I inherited them. During the time that I was working in this community patch I commenced medication for five children on a low dose of stimulants, two of which had discontinued by the time I left. Many families expressed their dissatisfaction at previous intervention feeling that the medication-centred approach was too narrow and did not take into account their history and particular situation. I continue to discover that many families have a far more sophisticated understanding of psychosocial causes of behavioural problems than most psychiatrist and paediatricians I met these days.

I then moved to a smaller community patch that is predominantly rural and had been working there for just over a year when I audited the number of children under my care who were or had been taking a stimulant. Prior to my starting in this patch, this area had not had a permanent consultant child-and-adolescent psychiatrist for the two years prior to my arrival. Instead a succession of locum consultants had been covering the vacancy including several stints from a consultant whose main practice was in Canada. Despite my new patch having a much smaller population than my previous one (this being only part of my current responsibilities, the other being the Lincolnshire in-patient adolescent unit), I inherited 28 children on stimulants. At the time I started seeing these children the average age of these children on stimulants I inherited was 10.2 years, the average daily dose of Ritalin (or Ritalin equivalent) was 18.9mg and the average number of years the children had been taking a stimulant was 1.7 years. Just over a year on, only four children remained on stimulants. Two children (siblings) are now seeing another doctor (after I raised child protection concerns). I have not needed to start medication for a single child on a stimulant and am hopeful that the remaining four will be able to come off their medication within a year. The local community paediatric service are much more cautious prescribers than that in my previous patch and having met with them I am aware that they are prescribing stimulants to no more than eight other children in my area.

Reflections by Neus Abrines

Empowering the patient

Collaborating with professor Timimi's team and observing the way they see the families that attend to this service has made me reflect on the lack of power that mental health patients are given in our society. It is easy to see that when a mental health label is given, the responsibility for recovery is placed on the doctor or the psychologist. The professional is pictured as someone who knows which is the most appropriate treatment, how many sessions are required and in what frequency, which technique will be most useful, etc…

However, during the months I have spent in this placement I have observed how important it is to empower both the parents and the child to aid the recovery of the child. I have observed very disorganized families deciding the frequency of the sessions (normally less than two per month), deciding whether they want to be discharged or not, deciding which professional they want to see, if the plan suggested by the therapist fits with them or not, etc. I have seen children deciding if they want to be in the session or not, or if on the other hand, they want to be seen without their parents. Most importantly, I have observed how these families get better from one session to another because they believe they have the power to do it. The therapist can help providing the family with ideas and a better understanding of the situation, but it is the family who has the power to change. And it's this "empowering of the patient" that is the task of the therapist rather than that of taking responsibility for the patient's life.

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Ilustración Alicia y Gulliver 3

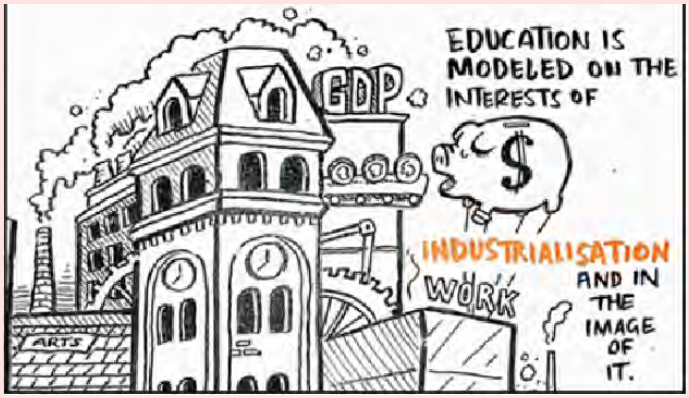
...FURTHER VIEWING

- Brother's little helper, The Simpsons, Season 11, episode 2.

- Timmi 2000, South Park, Season 4, episode 3

- The truth behind medication. BBC, Panorama. Video: part 1, part 2, part 3

- Ken Robinson Changing education paradigms



...FURTHER READING

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- Timimi, S. (2007) Mis-Understanding ADHD: The Complete Guide for Parents to Alternatives to Drugs. Bloomington: Authorhouse.
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- Timimi, S. and Leo, J. (eds.) (2009) Rethinking ADHD: From Brain to Culture. Basingstoke: Palgrave MacMillan.
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LINKS

- http://www.criticalpsychiatry.net/
- https://www.myoutcomes.com/
- http://heartandsoulofchange.com/

RECOMENDATIONS

'No More Psychiatric Labels' campaign:

- Campaign article
- Support the campaign

RECENT EVENTS

Grupo de trabajo de la Guía de Práctica Clínica sobre el Trastorno por Déficit de Atención con Hiperactividad (TDAH) en Niños y Adolescentes. Fundació Sant Joan de Déu, coordinador. *Guía de Práctica Clínica sobre el Trastorno por Déficit de Atención con Hiperactividad (TDAH) en Niños y Adolescentes.* Barcelona: Plan de Calidad para el Sistema Nacional de Salud del Ministerio de Sanidad, Política Social e Igualdad. Agència d'Informació, Avaluació i Qualitat (AIAQS) de Catalunya; 2010. Guías de Práctica Clínica en el SNS: AATRM No 2007/18.

FUTURE EVENTS

- Adopción, adoptados y famílias adoptivas. Retrato de la postmodernización de la vida familiar española. Universidad de Alicante, Alicante, 16-17 junio 2011
- 2nd International Conference on Child Friendly Asia Pacific. Surakarta City, Central Java, Indonesia, 30 June-2 July 2011
- Atención socioeducativa dirigida a la protección del menor y su familia: prevención e intervención. Los Alcázares, Murcia, 19-23 septiembre 2011.
- The Alliance for the Study of Adoption and Culture announces: The 4th International Conference on Adoption and Culture. Mapping Adoption: Histories, Geographies, Literatures, Politics. The Claremont Colleges, Claremont, California, March 22-25, 2012
- 26th ICCP World Play Conference Tallinn, Estonia, 18-19 June 2012

ABOUT THE ILUSTRATIONS

Marta Gómez-Pintado

was born in Madrid in 1967, were she studied Fine Arts. She works as a painter, drawer, portrait artist, illustrator and teacher. She has done many exhibitions on graphic and pictorial work. Her latest works as an illustrator are "Alicia en el país de las maravillas". L. Carroll and "El extraño caso del doctor Jekyll y Mister Hyde".R. L. Stevenson for Nórdica Libros publisher; "Comiendo en Hungría" P. Neruda and M. A. Asturias for Capitán Swing publisher; and "El Lazarillo de Tormes" for Hermes Editorial. She identifies herself with André Bretón when she affirms "I am everything that I have done and everything that I haven't done".

www.martagomezpintado.com

Marta Gómez-Pintado
Autorretrato

ABOUT THE AUTHORS

Dr. Sami Timimi

is a consultant child and adolescent psychiatrist and director of medical education in Lincolnshire Partnership NHS Foundation Trust and a visiting professor of child and adolescent psychiatry at the University of Lincoln in UK. He writes from a critical psychiatry perspective on topics relating to child and adolescent mental health and has published many articles and books on many subjects including eating disorders, psychotherapy, behavioral disorders and cross-cultural psychiatry.

Neus Abrines

is a child psychologist, member of the AFIN group, doing her PhD in the Health and Clinical Psychology Department in the Autonomous University of Barcelona. She has been involved in several research projects about Inter-country Adoption and her PhD is focused on Attention Deficit Hyperactivity Disorder.

She has an interest in the relationship between parents and their children and has attended several trainings in national and international centers, such as the New School for Social Research in New York, and the Tavistock and Portman Foundation Trust in London.

Since February 2011, Neus Abrines has been on a clinical attachment with Dr. Sami Timimi in CAMHS as well as collaborating with the Outcomes Oriented project (OO-CAMHS). Her placement is funded by the Generalitat de Catalunya (Beques per a estades de recerca fora de Catalunya – BE-DGR 2010).