LETTERS

Prescribing Methadone

Methadone masks and never tackles root causes, argues ***Sophia Lamb****, a pre - registration house officer from Ireland, who previously worked in Hong Kong among people with addiction problems.*

Recently I returned to the ward to discover that one of my drug addict patients had been resuscitated after taking a heroin overdose in the bathroom with his friend. He was on methadone. He recovered and the SHO increased his methadone. Subsequently he was discharged. Problem solved?

I agree with Iain Craighead (*Triple Helix* 2004; Winter:21) that we need to help drug users and actively build strong therapeutic relationships. But I disagree with settling for methadone as treatment. Methadone may be effective in harm reduction and symptom management. It does not however treat the problem of addiction any more than morphine treats cancer. Something more radical is necessary.

Before re-entering medicine in Hong Kong I took a year out working in a 24-hour drug rehabilitation centre. The work is Christ-centred. Jesus is the only solution offered. Substitutes for addiction are not given. Our addict brothers are encouraged to look to Jesus while facing the root causes of their addictions. The work is intense, gruelling, tiring, costly and rewarding.

What's the outcome? All experience something of God's love. Some are free forever. Many relapse. Many come back. I don't think I am being naive to say that God can heal the roots of addiction that methadone only masks and never tackles.

I hate to see methadone prescribed for patients when I know they need something more costly and time consuming. They may function better but they will not find life. They need Jesus. I don't think he comes reviewed in the medical literature, but I have seen him giving life to drug addicts and their families.

Child Abuse and ADHD?

Southampton GP ***Paul Burgess*** *writes.*

Figure 2, 'The effects of abuse', in Peter Sidebotham's recent article (*Triple Helix* 2003; Autumn:8-10) lists ADHD as one of the effects of child abuse and seems to suggest that it (and two other problems) have their roots in lack of trust and hope, which in turn have their roots in the adverse affect abuse has on self-esteem. Whilst not wishing to doubt the latter, suggesting that ADHD might result from child abuse, even in only some cases, is surely controversial?

Peter Sidebotham*, Consultant Paediatrician at the Bristol Royal Hospital for Sick Children responds.*

I am grateful to Paul Burgess for pointing out the apparent controversy implied by my linking ADHD with child abuse. As a practising community paediatrician, children with Attention Deficit/Hyperactivity Disorder make up the largest single category of cases I see and methylphenidate is the most common drug I prescribe. I do so in the recognition that ADHD is primarily a disorder of brain dysfunction, for which there are clear diagnostic criteria, and that it is responsive to appropriate therapeutic intervention (both behavioural and pharmacological).

There is a substantial body of literature to support this understanding (I would refer the reader to the Royal College of Psychiatrists Online Knowledge Base [1] for the most up to date and comprehensive details). However, like most behavioural disorders, ADHD presents as a spectrum that merges with normality and for which I believe it would be foolish to think there was just a single pathophysiological pathway.

In listing ADHD as one of the effects of abuse, along with oppositional defiant disorder, depression, eating disorders and other behavioural/psychiatric conditions, I do not mean to imply that child abuse is the root cause of all ADHD, nor even a substantial proportion of it. However, if you turn the equation round, there is a lot of evidence that children who have been abused may develop features of ADHD. [2-6] For example, Cohen et al [3] found that the combination of parental marital disruption and having been physically abused increased the risk of ADHD 15 times.

In one well designed case-control study in Minesota, [4] showed that, compared to controls, physically abused children at 42 months were hyperactive, distractible and lacked self control, this persisted at 4-5 years. Similarly neglected children showed poor impulse control and were extremely distractible. At six years of age the abused children were rated by their teachers as significantly more inattentive, unpopular, aggressive and overactive. The authors found the roots of this to lie in early anxious attachments, a finding that ties in with the hypothesis that damage to a child's hope, trust and self-esteem may underlie some of the genesis of these disorders. This correlation is also supported by Haddad and Garralda. [5] Iwaniec [6] takes this theory further, identifying several developmental tasks that may be affected by abuse. These are, in chronological order, a sense of trust or security (trust), a sense of autonomy (self-esteem), a sense of initiative (hope) and in older children a sense of duty and accomplishment (hope) and a sense of identity (self-esteem). She too points out the links between abuse, insecure attachments and later educational and behavioural problems, including attention seeking behaviour and difficulties in concentrating and attending to tasks.

References

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3. Cohen AJ et al. *Child Abuse & Neglect* 2002;26:277-88
4. Erickson MF et al. In Cicchetti D, Carlson V (eds). *Child maltreatment: theory and research on the causes and consequences of child abuse and neglect*. Cambridge: Cambridge University Press, 1989
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Feedback

We welcome correspondence relating to articles previously published. Space is limited and accordingly most letters are abridged.