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I declare no competing interests.

- 1 Morgan C, Fisher H. Environment and schizophrenia: environmental factors in schizophrenia: childhood trauma—a critical review. *Schizophr Bull* 2007; **33**: 3–10.
- 2 Bentall RP, Wickham S, Shevlin M, Varese F. Do specific early-life adversities lead to specific symptoms of psychosis? A study from the 2007 The Adult Psychiatric Morbidity Survey. *Schizophr Bull* 2012; **38**: 734–40.
- 3 Carr CP, Martins CMS, Stingel AM, Lemgruber VB, Juruena MF. The role of early life stress in adult psychiatric disorders: a systematic review according to childhood trauma subtypes. *J Nerv Ment Dis* 2013; **201**: 1007–20.
- 4 Read J, Goodman L, Morrison A, Ross C, Aderhold V. Childhood trauma, loss and stress. In: Read J, Bentall R, Mosher L, eds. *Models of Madness: psychological, social and biological approaches to schizophrenia*. Abingdon: Routledge, 2004: 223–52.
- 5 Upthegrove R, Chard C, Jones L, et al. Adverse childhood events and psychosis in bipolar affective disorder. *Br J Psychiatry* 2015; **206**: 191–97.
- 6 Catone G, Marwaha S, Kuipers E, et al. Bullying victimisation and risk of psychotic phenomena: analyses of British national survey data. *Lancet Psychiatry* 2015; published online May 21. [http://dx.doi.org/10.1016/S2215-0366\(15\)00055-3](http://dx.doi.org/10.1016/S2215-0366(15)00055-3).
- 7 Kelleher I, Harley M, Lynch F, Arseneault L, Fitzpatrick C, Cannon M. Associations between childhood trauma, bullying and psychotic symptoms among a school-based adolescent sample. *Br J Psychiatry* 2008; **193**: 378–82.
- 8 Arseneault L, Bowes L, Shakoor S. Bullying victimization in youths and mental health problems: 'much ado about nothing'? *Psychol Med* 2010; **40**: 717–29.
- 9 Morrison AP, French P, Parker S, et al. Three-year follow-up of a randomized controlled trial of cognitive therapy for the prevention of psychosis in people at ultrahigh risk. *Schizophr Bull* 2007; **33**: 682–87.
- 10 Upthegrove R, Ross K, Brunet K, McCollum R, Jones L. Depression in first episode psychosis: the role of subordination and shame. *Psychiatry Res* 2014; **217**: 177–84.

Psychopathology after foster care or institutional rearing



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In *The Lancet Psychiatry*, Kathryn Humphreys and colleagues¹ provide an excellent model of how to undertake, analyse, and report findings from a highly innovative study of a complex intervention in a natural environment. They followed up Romanian children placed in institutional care at birth who participated in the Bucharest Early Intervention Project at age 12 years to assess psychopathological symptoms in those who had been randomly assigned to care as usual versus those who had been placed in foster care in the initial trial.² They also recruited children from local paediatric clinics and schools who had never been placed in an institution. This provided a comparator group. To my knowledge, theirs is the only randomised controlled trial of the effects of foster care in counteracting the risks associated with profoundly depriving institutional care in Romania; compared with 55 children assigned to receive care as usual, the 55 children in the foster-care group had fewer externalising psychiatric symptoms (mean 2.89 [SD 3.00] for care as usual vs 1.73 [2.61] for foster care, difference 1.16 [95% CI 0.11–2.22]; $p=0.0255$). The project was planned with careful attention to several features.³

First, for the study to deliver results that could provide evidence for service planning in Romania, the foster care needed to be provided in Romania (and not another country such as the UK or USA). If it was to be useful for service planning in general, the foster care would also have to be of high quality—requiring detailed systematic training of the foster carers.

Second, in the planning of the trial it was decided that children in the care-as-usual group should not be prohibited from being removed from their institutions. This decision was ethically essential but it resulted, almost inevitably, in some children in the care-as-usual group leaving institutional care. Therefore, in addition to using an analytical approach following intention to treat, setting aside the intention-to-treat principle in the follow-up trial became highly desirable. This necessarily involved a loss of the security provided by the design of a randomised controlled trial, but the investigators thoughtfully discussed and provided analyses to examine possible biasing effects. The results were reassuring that bias was unlikely to have been created.

Third, the trial was registered with ClinicalTrials.gov and undertaken according to guidelines from the Consolidated Standards of Reporting Trials (CONSORT) group. These rules were devised to deal with the need to require preplanned analyses and not allow undisclosed flexibility that might give rise to false positives.⁴ It might be supposed that CONSORT registration has now become routine, but evidently this is not universally so.^{5,6} Because Humphreys and colleagues¹ adhered to the CONSORT guidelines, we can trust their intention-to-treat methodology. Although some differences are evident between the findings at age 54 months and 12 years (eg, externalising symptoms significantly differed between groups at 12 years, but not at 54 months), it is clear that the early benefits shown for

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See [Articles](#) page 625

For more on the **Bucharest Early Intervention Project** see www.bucharestearlyinterventionproject.org/

For more on **CONSORT** see www.consort-statement.org/

foster care have persisted, although these were quite modest. The benefits, however, varied according to the type of psychopathology, with attention-deficit hyperactivity disorder symptoms least affected by either the experience of foster care or the passage of time. This is an important negative finding, albeit one in keeping with other findings showing the persistence of attention-deficit hyperactivity disorder symptoms long after leaving institutional care.^{7,8}

Fourth, the investigators describe differences in outcome according to the stability or disruption of foster-care placement. They undertook analyses to determine whether the stable and unstable placement groups differed in terms of characteristics at age 54 months, finding that they did not. They conclude that maintenance of stable, high-quality foster care should be a policy priority, and emphasise the importance of placing children in families rather than institutions whenever possible.

One important limitation of this study is that the findings refer to institutions in Romania that are known to involve profound deprivation. Findings from follow-up studies undertaken in Greece and China in institutions that lacked personalised care but did not have pervasive deprivation showed much better outcomes after early institutional care.^{9,10} An important challenge for similar trials, therefore, is to determine the extent to which these factors apply to other populations. On balance, however,

the study by Humphreys and colleagues provides a model of how well things can be done, even when the societal circumstances are disadvantageous.

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- 1 Humphreys KL, Gleason MM, Drury SS, et al. Effects of institutional rearing and foster care on psychopathology at age 12 years in Romania: follow-up of an open, randomised controlled trial. *Lancet Psychiatry* 2015; **2**: 625–34.
- 2 Zeanah CH, Egger HI, Smyke AT, et al. Institutional rearing and psychiatric disorders in Romanian preschool children. *Am J Psychiatry* 2009; **166**: 777–85.
- 3 Nelson CA, Zeanah CH, Fox NA, Marshall PJ, Smyke AT, Guthrie D. Cognitive recovery in socially deprived young children: the Bucharest early intervention project. *Science* 2007; **318**: 1937–40.
- 4 Simmons JP, Nelson LD, Simonsohn U. False-positive psychology: undisclosed flexibility in data collection and analysis allows presenting anything as significant. *Psychol Sci* 2011; **22**: 1359–66.
- 5 Cristea IA, Kok RN, Cuijpers P. Efficacy of cognitive bias modification interventions in anxiety and depression: meta-analysis. *Br J Psychiatry* 2015; **206**: 7–16.
- 6 Patel MX, Collins S, Hellier J, Bhatia G, Murray RM. The quality of reporting of phase II and III trials for new antipsychotics: a systematic review. *Psychol Med* 2015; **45**: 467–79.
- 7 Kumsta R, Kreppner J, Rutter M, et al. Deprivation-specific psychological patterns: effects of institutional deprivation. Hoboken: Wiley-Blackwell, 2010.
- 8 Rutter M, Kumsat R, Schlotz W, Sonuga-Barke E. Longitudinal studies using a “natural experiment” design: the case of adoptees from Romanian institutions. *J Am Acad Child Adolesc Psychiatry* 2012; **51**: 762–70.
- 9 Vorria P, Ntouma M, Rutter M. Vulnerability and resilience after early institutional care: the Greek Metera Study. *Dev Psychopathol* 2015; published online March 23. DOI: 10.1017/S0954579415000243.
- 10 Feast J, Grant M, Rushton A, Simmonds J, Sampeys C. Adversity, adoption and afterwards: a mid-life follow-up study of women adopted from Hong Kong. London: British Association for Adoption & Fostering, 2013.

“As a parent, there is no rulebook”: a new resource for parents and carers of young people who self-harm

Self-harm (intentional self-poisoning or self-injury, irrespective of degree of suicidal intent or other types of motive) is very common in young people, particularly adolescent girls. At least an estimated 10–15% of adolescents engage in self-harm.¹ This practice can have a substantial effect on the family and the young person’s community. To find out about a daughter’s or son’s self-harm can be emotionally devastating. Other issues often develop, including increased stress levels within the family, financial difficulties, and changes in lifestyle (eg, having to travel to obtain psychiatric care). In some instances, parents and family members might develop depression, anxiety, and other mental health difficulties.^{2,3} The hidden nature of this behaviour

and the stigma associated with it make it difficult for parents to acquire information and social support that could help them to cope.

Parents and carers of young people who self-harm often report that they are reluctant to seek help.³ Perceived isolation and an absence of social support can exacerbate the issues associated with a daughter’s or son’s self-harming behaviour.² Parents have said that they would benefit from hearing about the experiences of other parents of children who self-harmed.⁴ In response, the Centre for Suicide Research at the University of Oxford (Oxford, UK), in collaboration with the university’s Health Experiences Research Group, has developed a new resource for parents and carers in this situation.

For the resource see <http://www.healthtalk.org/peoples-experiences/mental-health/self-harm-parents-experiences/topics>