

When childhood dies

Few topics are more emotive than child maltreatment. Human societies place a high value on the richness and diversity that parents contribute to their children's upbringing, and bystanders and professionals alike will hesitate to intervene in or undermine the parent-child relationship unless there is definitive evidence that serious harm is being done. Yet the grating litany of child abuse by parents and other carers is familiar to all. The forced child labour endured by children in Victorian England more than a century ago remains common in developing countries today, and in the developed world formal child-protection systems document a depressing range of maltreatment, from deliberate neglect to the vilest sexual abuse. This cruel treatment can lead to serious physical and mental-health consequences, and risks creating a damaging intergenerational cycle of maltreatment, disadvantage, and ill health. Children, the most precious and vulnerable members of our societies, deserve closer attention to their care and education and better protection against abuse.

Child maltreatment can be especially difficult to ascertain—after all, the victim might be unwilling or unable to provide an accurate account of abuse, the perpetrator bent on concealment, witnesses silent, clinical signs equivocal, and professionals reluctant to act owing to uncertainty about the existence or severity of abuse, or concern that the treatment of abuse will itself lead to undue disruption or damage to a child's upbringing. When severe child abuse culminates in death, however, as in the tragic recent cases of Victoria Climbié and Baby P in the UK,^{1,2} the law, news media, and public can be expected to cast a harsh and unforgiving spotlight on social workers and doctors who might be perceived or portrayed as having missed opportunities to help the victims.

It is to clinicians and other professionals responsible for caring for children that *The Lancet's* Child Maltreatment Series is aimed, with the intention of providing them with a rigorous and up-to-date summary of scientific evidence and conceptual work on this complex and demanding topic. Ruth Gilbert and colleagues³ begin by reviewing the literature on the classification and worldwide burden of child maltreatment, and in a second paper⁴ discuss the methodology and challenges involved in identifying abuse. Harriet MacMillan and coauthors⁵

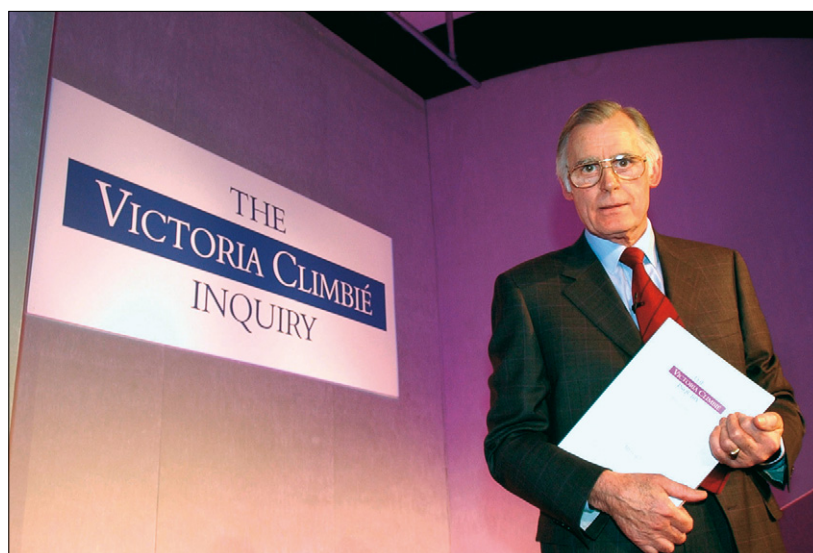
summarise the evidence base on interventions that are available to prevent child maltreatment and mitigate its effects; and finally Richard Reading and colleagues⁶ acknowledge the complexity of social influences and policy involving children, and argue in favour of a human-rights approach to child maltreatment.

Too often, the safety of children is debated in the polarising light of litigation or political division. Whilst this outcome is inevitable because of the public outrage child maltreatment engenders, a damaging consequence is that the evidence surrounding child neglect and abuse often fails to influence serious policy discussion. It is this marginalisation of the science of child maltreatment that we are seeking to reverse.

We would like to extend warm thanks to Patricia Hamilton of the Royal College of Paediatrics and Child Health for supporting this Series, and to the authors and peer reviewers of the accompanying papers and Comments for their unstinting work. This *Lancet* Series will unfortunately not halt the blight of child abuse, because the phenomenon is too common, too surreptitious, and too deeply rooted in deprivation and other social ills—but we nonetheless hope to raise awareness of the scientific evidence that is available, and indeed essential, to guide paediatricians and other professionals in their practice with children who might have been abused; and to help bring a new logic and clarity to public debate about this contentious area.



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Richard Turner, Richard Horton
The Lancet, London NW1 7BY, UK

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The spurious advance of antipsychotic drug therapy

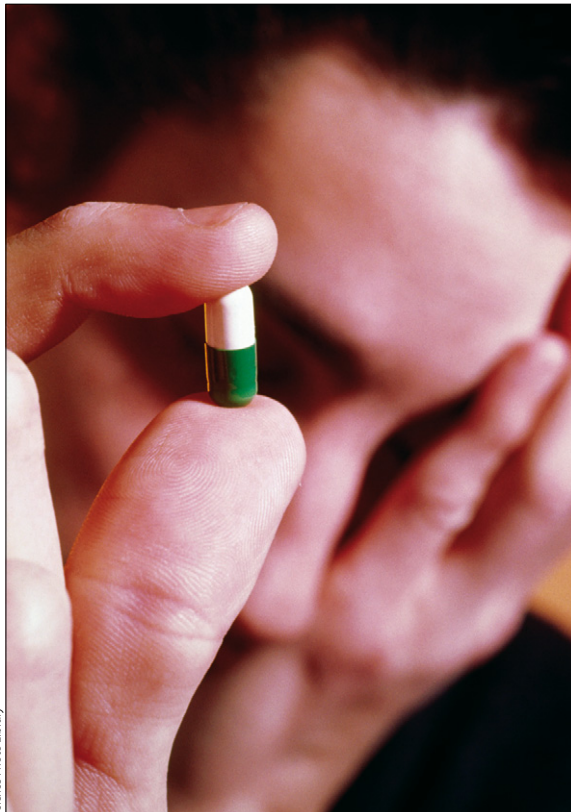
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Clinicians are familiar with studies that claim to show major advances in therapy. They tend to greet early reports of such advances with a touch of scepticism and wait, usually for at least 10 years, for a raft of independent studies that show that the advance is genuine and not just another minor ripple in the treatment stream. In *The Lancet* today, Stefan Leucht and colleagues¹ deviate from this pattern by suggesting that what was seen as an advance 20 years ago—when a new generation of antipsychotic drugs with additional benefits and fewer adverse effects was introduced²—is now, and only now, seen as a chimera that has passed

spectacularly before our eyes before disappearing and leaving puzzlement and many questions in its wake.

Leucht and colleagues' analysis of ten outcomes from 150 randomised trials, supported by some powerful studies,³⁻⁵ shows that the name "second-generation antipsychotics" is inaccurate. This group of drugs is in fact a heterogeneous mix of compounds, with some superior to others. Antipsychotic drugs differ in their potencies and have a wide range of adverse-effect profiles, with nothing that clearly distinguishes the two major groups. Importantly, the second-generation drugs have no special atypical characteristics that separate them from the typical, or first-generation, antipsychotics. As a group they are no more efficacious, do not improve specific symptoms, have no clearly different side-effect profiles than the first-generation antipsychotics, and are less cost effective.⁶⁻⁸ The spurious invention of the atypicals can now be regarded as invention only, cleverly manipulated by the drug industry for marketing purposes and only now being exposed. But how is it that for nearly two decades we have, as some have put it,⁹ "been beguiled" into thinking they were superior?

Leucht and co-workers provide some clues. Of 150 trials in their meta-analysis, in 95 the second-generation antipsychotic was compared with the high-potency first-generation antipsychotic haloperidol. The use of haloperidol as the first-generation antipsychotic in these trials means that they were biased in favour of the second-generation drugs. This bias has been achieved through several routes—eg, by comparing the second-generation antipsychotic with a high-potency first-generation antipsychotic likely to be associated with a high rate of extrapyramidal side-effects. Another obvious way of favouring the second-generation drugs has been to avoid comparison with a medium-potency first-generation antipsychotic, because these drugs are



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