Grange UK incidence of childhood leukaemia.

Taylor GM. In strong of little long bearing Positive tests lability.'

Sheila cough tests with no allergens. Both children with asthma tested positive. Neither child developed definite bronchospasm. For persistent cough a trial of inhaled β agonists or inhaled steroids is logical and potentially less harmful than other common therapies such as antihistamines, or even surgical ear, nose, and throat procedures.

HELEN M LEWIS
Department of Paediatrics, Triborough General Hospital, Moorfields Road, Manchester M41 SSI

Growth standards for infancy

EDITOR,—We fully endorse the views of Wright et al on the need to develop new growth standards for infancy. The comparison of their new data with widely used standards and with the Cambridge Infant Growth Study illustrates this need succinctly. The Cambridge study is not, however, confined to breast fed infants. Although a high proportion (90%) were initially breast fed, this declined to 65% by 12 weeks, 54% by 24 weeks, and 18% by 1 year. Throughout most of the first year, the weights of infants breast fed to at least 24 weeks were similar to those bottle fed from 3 weeks. Both groups showed an increased weight gain compared with standards in the first six months, followed by a more marked relative decline, with only the breast fed boys showing a slight slower growth rate in months compared with those bottle fed. At 1 year, the mean (SD) weights were: boys breast fed (n=54) 9.79 (0.93) kg, bottle fed (n=35) 9.93 (0.97) kg, girls breast fed (n=59) 9.17 (0.82) kg and bottle fed (n=43) 9.18 (0.80) kg, and the Z scores were -0.4, -0.2, -0.5, and -0.6 respectively. Weaning practices are at least as important as mode of milk feeding. Energy intakes during and after weaning are lower now compared with data from the 1960s when the standards were prepared. In view of the differences in feeding practices and social circumstances, it is encouraging to find that the growth of Cambridge infants showed such similarities to the Newcastle data.

A A PAUL
TJ COLE
R G WHITEHEAD
MRC Dunn Nutrition Centre, Milton Road, Cambridge CB4 1XJ


Any book which, in the opening few sentences, can give a name check to Hippocrates, Descartes and Freud, is clearly not going to come easily to the lay reader. Of more importance is whether it can perform equally well — or better — in the areas of elucidation and education.

Happily for the reader, the answer is a resounding yes. This book addresses, both clearly and highly informatively, major developments in the psychological treatments of psychosomatic and physical disorders.

The stimulus for this book was provided by a conference held in Cambridge last year, 'Psychological Treatment in Human Disease and Illness' which was held in 1990. Expansion and updating of original talks enable the editors to proclaim the text as 'state of the art'. Of particular note is the book's emphasis on the psychoanalytic, cognitive, and family Psychotherapy approaches in dealing with psychosomatic and physical disorders. The second section looks at the application of cognitive therapy and its close relatives, most notably the condition such as somatisation disorder, irritable bowel syndrome, chronic pain, brittle diabetes, and anorexia nervosa.

The major strengths of the book are its focus on theory and its own practice, and its ability to bring the two together harmoniously.

Theoretically, there are good outlines of the ideas behind the different therapeutic approaches. Particularly strong is Tom Gossen's description of cognitive therapy, succinctly covering the important aspects of the cognitive model (including dysfunctional beliefs, automatic negative thoughts, and cognitive distortions), and its therapeutic approaches. He makes the important point that especially in physical illness, not all beliefs are dysfunctional and not all dysfunctional beliefs are false. For example, denying the seriousness of illness when in its presence can sometimes serve as a protective function and is therefore not necessarily dysfunctional. Conversely, the belief of 'not having long enough to live to achieve what I want' might be true but might also be dysfunctional if it results in the ill person focusing on nothing other than this belief and giving up trying to achieve anything. Dr Sensky stresses that the focus of therapeutic work in cognitive therapy is to focus on dysfunctional beliefs, not to