Guest Editorial

Government Thinks One-Size Fits All in Evaluating Children and Youth

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Two government initiatives in Ontario may be of interest to child psychiatrists. The two ministries concerned with children's mental health issues – the Ministry of Community, Family and Children's Services and the Ministry of Health – have decided to assist health care professionals in two ways. The first is to improve advance knowledge of children referred for mental health reasons, and the second is to track the results of therapy. Initiative number one is the brief telephone intake interview. It takes about 40 minutes and the questioner must have passed a training course. The questions can't be explained since this might skew the answer. The parent is asked about alcohol consumption, religious practices, corporal punishment, and domestic violence, as well as a wide variety of children's symptoms. The results of this questionnaire are fed back to the clinical staff in the form of a series of graphs. The parents are not asked if they would prefer to not answer the questionnaire, nor are they told whether they have a choice. What might be the intended and unintended consequences of this exercise? The intended consequences are to gather an initial impression of the symptom cluster, its urgency and duration, and the families risk areas. The unintended consequences are already being felt all across the province. They include:

1) huge increases in the time required to register new requests for service,
2) parents who are angry or frightened about giving highly personal data to a voice on the phone who might decide whether or not their child will receive service,
3) puzzled clinicians that receive graphed data out of context about a patient/family who has yet to give their story.

A recent report from the Ontario Association of Children's Aid Societies may be a preview of the intensity of the unintended consequences for children's mental health services. The report stated that first line child welfare workers were now spending about two-thirds of their time on paperwork, with the remainder divided amongst staff meetings, professional development, travel, and interviewing children and families. Much of the paperwork consists of complying with mandatory government data-gathering devices.

Is the time well spent? Can the 45-minute brief telephone intake survey prepare the way for more accurate and more focused professional intervention? I have some warnings. First, eliciting intimate and painful information from people usually requires a warm, personal, and trusting relationship. The information comes out in stages, as trust grows over time. A telephone interview with a stranger ranks pretty low in terms of trust based on experience. Second, a very broad-ranging survey (over 80 questions) is likely to be over-inclusive, and will therefore lack focus and context. Possibly the real benefit to the government will be that in case of tragedy and embarrassment, the ministry will be able to say that they asked every conceivable question.

The second initiative, also mandatory, is the Child and Adolescent Functional Assessment Scale, or CAFAS. This is a level of functioning (LOF) scale for serious emotional disturbance (SED). A Michigan corporation sells it to government agencies in the U.S. and Canada, and its purpose is to evaluate changes in LOF. A recent evaluation of this tool, purchased by the Ontario Government for mandatory use in children's mental health services concluded "that empirical evidence is lacking to support its valid use in making the types of treatment decisions for which it is currently being employed across the nation."[1] In the U.S., health management organizations need to control expenses, and they attempt to detect futile therapies and disallow them. The Ontario Government has a similar mandate in mind, and CAFAS, from Michigan, is the selected tool. The intended consequence of a good LOF scale is to demonstrate change so that excellent therapies can be differentiated from less effective ones. Recent reports from the Community, Family, and Children's Services workers in Ottawa indicate that they are using increasing amounts of time completing obligatory paperwork and have less time to interview troubled families.

Chaos theory demonstrates the futility of attempting to predict or control outcomes in highly complex systems. Children develop within their minds and bodies, within families, schools and groups of friends, over time's shifting circumstances. More modest LOF tools exist to track more precise symptoms such as depression, but a tool which claims to measure "all things in all children" deserves to be viewed with suspicion.

CAFAS and the brief telephone intake interview are mandatory procedures with little potential to achieve their intended consequences, and great potential to protect governments from scandal. They will handicap the efforts of countless therapists if they are allowed to go forward.

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[1] Michael P. Bates . "CAFAS: Review and Current States". Clinical Child and Family Psychology Review. Vol. 4. No 1. 2001

(The views shared in this editorial are not necessarily shared by the Canadian Academy or the Editorial staff).

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Adolescent depression, family psychopathology and parent/child relations: a case control study

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Abstract

The objective of this study was to investigate family psychopathology and relationships between family members. Three groups of adolescents were interviewed: 1) currently depressed adolescents who have at least one parent who had/or is still experiencing a mood disorder, 2) currently depressed adolescents whose parents were never diagnosed with a mood disorder, 3) never-depressed control adolescents. Personal interview data was obtained from the proband, their parent(s) and one sibling. Findings suggest that parental psychopathology, parent-child relations and life events are all relevant factors in adolescent depression and should be considered in combination for assessment, prevention and intervention efforts.

Key words: Depression - Adolescent - Family - Sibling - Psychopathology

Introduction

Children of depressed parents are at increased risk for the development of psychopathology (Beardslee, Keller, Lavori, Staley & Sacks, 1993; Cummings & Davies, 1994; Weissman, Warner, Wickramaratne, Moreau & Olfson, 1997). Research findings indicate that children of depressed parents are not only at risk for clinical depression, but are also at increased risk for the full range of adjustment problems, including both externalizing and internalizing disorders (Downey & Coyne, 1990). For example, they are two to five times more likely to develop behaviour problems compared to children of non-depressed parents (Weissman et al., 1997; Weissman et al., 1987).

Research suggests the existence of biological factors that explain the prevalence for depression in certain families (McGuffin, Katz & Bebbington, 1988; McGuffin, Katz & Rutherford, 1991; Roy, 1993). A relationship between age of onset and the density of familial aggregation of depression has been reported. Specifically, late onset depression is believed to be associated with a lower density of depression in family members (Brodaty et al., 1991) whereas early-onset depression, under 20 years of age, appears to be associated with the greatest density of depression in family members (Weissman et al., 1984; Williamson et al., 1995). Furthermore, different dimensions such as temperament, (Chess & Thomas, 1986), developmental factors, (Beardslee, 1996) and the accumulation of early adverse life experiences (Heikkinen, Henriksson, Isometsa, Marttunen, Aro, Lonqvist, 1997), have all been described as contributors to the development of depression.

Problems appearing early in life, such as family adversity and early childhood losses and neglect, may impact on developmental difficulties experienced in some families. These difficulties constitute a particular risk factor in families with depressed parents (Hammen, 1991). Negative patterns of parent/child interactions may have been established very early on, and contribute to the accumulation of family discord and adversity experienced by the depressed child. Moreover, a repetitive sequence of negative family interactions increases the risk of depression in adolescents (Bifulco, Brown & Harris, 1987; Rutter 1966, 1987).

Depression in adolescence is often associated with the absence of supportive and positive interactions with parents and is characterised by elevated levels of conflictual, critical and angry interactions (Lewinsohn, Rohde & Seeley, 1998; Sheeber & Sorensen, 1998). Research indicates that parents of depressed pre-adolescent children display less positive rewarding and supportive behaviours than do parents in comparative families (Shiner & Marmorstein, 1998).

The clinical literature suggests that depressed mothers experience difficulties in their parenting role (Burbach & Borduin, 1986; Coletta, 1983; Davenport, Zahn-Waxler, Adland & Maylield, 1984; Hammen, Burge & Stansbury, 1990; Webster-Stratton & Hammond, 1988). Several studies have shown that depressed mothers often had difficulties with their own mothers (Andrews, Brown & Creasey, 1990; Downey & Coyne, 1990; Mills, Puckering, Pound & Cox, 1985; Murray, 1988). According to Hammen (1991), women's adverse childhood experiences with their own parents predict maternal distress/depression, child-rearing difficulties and psychopathology in their own children. Such findings are consistent with the general literature on the intergenerational transmission of parenting (Rutter, 1989; Van IJzendoorn, 1992; Zeanah & Zeanah, 1989).

Studies have suggested that there is a correlation between insecure attachment and depressive symptoms (Marton, Churchad, Kutcher & Korenblum, 1993). Early separation experiences, and inconsistent care giving, place individuals in an insecure situation, affecting both their feelings of self-worth and their ability to establish stable and secure attachments with others (Bowlby, 1980). Experiences

of loss and separation would interact with attachment relationships throughout the life span to create situations that increase personal vulnerability. According to Brown, Harris, Hepworth & Robinson (1994), early experiences of adversity (e.g. childhood abuse), the lack of childhood care, and the lack of affective bonds with a caring adult, constitute a greater risk factor of depression than even the death of a parent.

Despite the large body of research on depression, there has been little cohesive work done to adequately address the explanatory mechanisms, direction of causality and specificity of etiological factors in adolescent depression (Downey & Coyne, 1990; Hammen, 1991). Explanatory mechanisms are complex and the developmental process of how and when difficulties occurring in a family setting contribute to the development of a depressive disorder is important and requires further investigation. Much is known about how families function but a great deal remains to be understood concerning critical periods for the emergence of those difficulties, many of which have long term repercussions. For example, the developmental stage during which family difficulties occur may have a differential impact on the intensity of depressive disorders. The direction of causality is another factor that has yet to be clearly determined. Parenting may have a role in the etiology of adolescent depression or alternatively, parenting style may be affected by the challenges of parenting a depressed child/adolescent. As well, there is little research speaking to the question of which types of childhood disorders are linked with particular kinds of parenting practices. Finally, the issue of specificity is significant. It remains to be determined if dysfunctional parenting behaviour is actually linked to depression. Interpersonal difficulties may be associated with other types of problems ongoing in the family such as marital difficulties or stressful conditions.

Much past research has been fraught with methodological limitations. Non-standardized measures of parental severity and chronicity of disorder have generally handicapped studies. As well, few studies have controlled for psychopathology in other family members. Furthermore, the effects of having a depressed parent still need to be explored with the relative differences of the depressed parent being the mother or the father compared. There is also a lack of research with regard to the risk factors for siblings living in the same household.

In the present study, three different family contexts were investigated in the hope of differentiating the influences of parental depression from parenting style: 1) families in which there is a depressed adolescent and at least one depressed parent (mother) (DA/DP), 2) families in which there is a depressed adolescent and no-depressed parents (DA/NDP), and 3) families in which there are no-depressed adolescents and no-depressed parents (NDA/NDP).

It was hypothesised that there would be more adverse parent-child relations in families of depressed parents (DA/DP) than in families of non-depressed parents (DA/NDP and NDA/NDP), and more personal difficulties and psychological problems in siblings from families of depressed parents (DA/DP) than in siblings from families of non-depressed parents (DA/NDP and NDA/NDP).

Method

Design: The design was a case comparison with multiple respondents.

Procedure: Depressed adolescents were recruited through various mental health services at the Children's Hospital of Eastern Ontario (CHEO), a regional pediatric health care centre. Patients were referred directly from their clinical programs to the study along with a recent Beck Depression Inventory (BDI; Beck et al., 1961, 1967, 1974, 1988). If the BDI score was 16 or greater, indicating moderate to severe depressive symptomatology, the adolescent was contacted by telephone and invited to participate. Non-depressed adolescents were self-referred. If the adolescent expressed interest in participating, their mother, father, and siblings were contacted and invited to participate. The inclusion criteria required that the proband's biological mother also agree to participate. Interviews were conducted primarily at the home of the participating families with a few being held at CHEO. Each family member was interviewed separately.

All participants were administered the Schedule for Affective Disorders and Schizophrenia-Children's version (K-SADS-P; Chambers et al., 1985)(adolescent) or Structured Clinical Interview for DSM-IV (SCID; Spitzer, Williams, Gibbon, First, 1990)(parent), the BDI, The Parental Bonding Instrument (PBI; Parker, 1979), and the Life Events Checklist (Johnson and McCutcheon, 1986). Upon completion of the interview, each adolescent was given $10.00 for his or her participation. Participants were then assigned membership in one of the three groups based on their own affective state and that of their mothers.

Participants: Adolescents were between the ages of 12-18 and raised by their biological mothers. In all, 117 referrals were received. No contact was made with 37 of those referred due to: low depression screening test scores (n=12), lack of availability (families could not be located or lived too far from the hospital) (n=21), evidence of extreme psychotic behaviour (n=1), or failure to meet age and biological family criteria (n=3). Of the 80 adolescents contacted, only 37 were interviewed, the others being excluded as a result of lack of interest or availability (n=38), or failure to meet inclusion criteria (n=5). Twenty-seven of the 37 adolescents interviewed met all inclusion criteria and were assigned to one of three groups based on the affective state of adolescent and mother. The comparison group was recruited from adolescents visiting the emergency units, Teen Health Clinic, and physiotherapy department at CHEO.

The first group consisted of 11 depressed adolescents whose mothers suffer or have suffered from a mood disorder (DA/DP). Included within this group were 9 females and 2 males between the ages of 13-17. Eight adolescents in this group were diagnosed with a major depres-

sive disorder (MDD) and three received a diagnosis of both MDD and dysthymia (double depression). Of the mothers included in this group, seven were diagnosed with MDD, two with a bipolar I disorder, one with depression due to a general medical condition, and one with double depression. Two probands in this group also had a father who suffered from MDD. The second group contained 7 depressed adolescents from families in which neither parent had ever experienced a major depression (DA/NDP). This group was comprised of six females and one male, ranging in age from 14-18. Six of the seven adolescents in this group suffered from MDD, while one suffered from a dysthymic disorder. The comparison group consisted of 9 non-depressed female adolescents (14-17 years of age) whose mothers and fathers were also non-depressed (NDA/NDP). These adolescents were matched individually on age and gender with adolescents in the DA/DP group.

Measures:

Structured Clinical Interview for DSM-IV (SCID) (Spitzer, Williams, Gibbon, First, 1990). This standardised semi-structured clinical interview establishes current and past adult psychopathology using diagnostic criteria from the DSM-IV. The measure is divided into separate modules dealing with each major diagnosis and determines the presence of Axis I and Axis II diagnoses. It is reported to be a reliable interview with reliability estimates similar to those obtained for other major diagnostic instruments (Williams et al., 1992).

Schedule for Affective Disorders and Schizophrenia-Children's version (K-SADS-P; Chambers et al., 1985). The K-SADS-P is a diagnostic instrument administered in a semi-structured interview format and used to identify and grade ongoing psychiatric disorders in children and adolescents. This diagnostic instrument has demonstrated adequate Inter-rater and test-retest reliabilities (Chambers et al., 1985).

The Beck Depression Inventory (BDI; Beck et al., 1961, 1967, 1974, 1988). The BDI is a 21 item self-report questionnaire describing cognitive and somatic symptoms of depression. It has been reported to be a reliable screening device for major depression and a good measure of the severity of depression in adolescent patients with a diagnosis of depression (Kutcher & Marton, 1989). Moreover, a cut-off of 16 (moderate to severely depressed) minimizes false positives (9%) while retaining adequate sensitivity (68%) and an overall classification accuracy rate of 75% (Marton et al., 1991). Internal consistency reliabilities for the BDI range from 0.8 to 0.9 (Kashani et al., 1987).

The Parental Bonding Instrument (PBI; Parker, 1979). This measure consists of 25 statements about perceived parental behaviours during the first sixteen years of life. A four-point Likert scale is used to assess the degree to which each statement describes the parent in question. The participant answers twice, once for his mother and once for his father. The measure is composed of 2 subscales: parental care and parental overprotection. Test-retest reliability and internal consistency are both reported as high for this measure (Parker, 1984).

The Life Events Checklist (Johnson and McCutcheon, 1986). This 57 item self-report measure requires respondents to indicate events experienced during the past year and to further indicate whether (a) each event is viewed as being desirable or undesirable and (b) the impact of each event on their lives. Impact ratings are made on a 7-point scale (-3 extremely negative to +3 extremely positive). Positive and negative change scores are obtained by summing the impact ratings of events rated as positive and negative respectively. The correlation between the number of positive events and the positive change score is .87, and the correlation between the number of negative events and the negative change score is .92 (Johnson and McCutcheon, 1986). Using the simple unit procedure, test-retest correlations were .71 ($p<.001$) for positive and .66 ($p>.001$) for negative change.

Results

Differences on Background Demographic Data

The matching procedure was successful in achieving equivalence between the 3 groups on the adolescent probands' age, current school grade, gender and number of siblings living in the household. There were no differences between groups on mothers' age, level of education and marital status. The small number of fathers and siblings who participated in the study made it impossible to conduct any meaningful statistical analyses on their data. Table 1 lists the means and standard deviations of the demographic variables for the study participants.

Psychopathology as assessed by the SCID/K-SADS-P

Table 2 summarizes the lifetime prevalence of psychopathology for each family member. As can be seen, the density of psychopathology was greatest in the DA/DP group for both depressive and co-morbid disorders.

Beck Depression Inventory

Separate ONEWAY analyses of variance (ANOVA) were conducted on the BDI scores of the probands and their mothers. Significant group effects were obtained for both the probands ($F(2,24)=11.43$, $p=.000$) and their mothers' ($F(2,24)=9.57$, $p=.001$). Post-hoc Tukey HSD comparisons revealed that adolescents in the DA/DP group and the DA/NDP groups both demonstrated significantly higher levels of depressive symptomatology (26.8 ± 13.4 and 30.0 ± 14.5 respectively) than adolescents in the comparison group (5.8 ± 3.9, $p<.001$). There were no significant differences between the scores of the two depressed adolescent groups. For mothers, follow-up comparisons indicated that scores in the DA/DP group were significantly higher (20.0 ± 12.3) that those in the DA/NDP and NDA/NDP groups (4.0 ± 2.2 and 6.2 ± 5.7 respectively, $p<.05$). No differences were found in the level of depressive symptomatology of mothers in the latter two groups.

Parental Bonding Instrument

Separate ONEWAY ANOVAs were conducted for probands on their scores for each of the two sub-scales (care, overprotection) of the PBI. Each participant completed the questionnaire twice, once on their mother and once on their

father. Adolescents' scores on the overprotection sub-scale of the PBI revealed a significant main effect for maternal overprotection ($F(2,24)=5.83$, $p<.05$). Tukey post-hoc comparisons indicated that adolescents in the DA/NDP group described their mothers as being significantly more over protective than mothers in the DA/DP group (21.3 ± 4.9 and 11.2 ± 8.8 respectively, $p<.02$) and the NDA/NDP comparison group (10.8 ± 5.2, $p<.02$). No significant differences were found on the maternal care sub-scale scores across the three groups. Conversely, adolescent sub-scale scores revealed a significant main effect for paternal care ($F(2,24)=6.0$, $p<.01$).Tukey post-hoc comparisons revealed that adolescents in the DA/DP group had significantly lower care scores than those in the NDA/NDP group (18.1 ±10.7 and 30.9 ± 4.1 respectively, $p<.01$). No significant differences were found on the paternal over protection sub-scale scores across the three groups.

Proportionally, there were far more mothers rated as high on overprotection (scores greater than 13.3) in the DA/NDP than in the DA/DP and the NDA/NDP groups (see Table 3). Fathers in the DA/DP and the DA/NDP groups were distributed approximately equally in terms of overprotection (scores greater than 12.5). No fathers in the NDA/NDP group were rated as high on overprotection. With respect to parental care, there were more mothers in the DA/NDP group rated as low on care (scores less than 28) compared to those in the DA/DP group and the NDA/NDP group. The pattern of results differed for fathers with the DA/DP group having the highest proportion of fathers rated as low care (scores less than 25) followed by the DA/NDP and NDA/NDP groups. Expected frequencies were insufficient to conduct valid 2 by 3 chi square analyses.

Life Events Checklist

Two ONEWAY ANOVAs were conducted separately for adolescents and their mothers on the sub-scales of the Life Events Checklist, one for the negative life events scores, and one for the positive life events scores. Although neither analysis on adolescent scores reached statistical significance, there was a trend for the DA/DP and the DA/NDP groups to have more negative life events (10.9 ± 6.6 and 8.3 ± 5.1 respectively) and less positive life events (4.6 ± 3.9 and 3.0 ± 3.8 respectively) than the NDA/NDP group (negative 5.1 ± 4.5; positive 9.0 ± 6.6). A small effect size ($\eta 2 = .22$) with power of .57 was found for the positive life events. A small effect size was also found for the negative life events ($\eta 2 = .18$) with power of .48.

Analyses conducted on mothers negative life events scores revealed a significant main effect of group ($F(2,24)=5.1$, $p<.02$) with the DA/DP group having considerably more negative life events (9.0 ± 7.9) than the NDA/NDP group (1.7 ± 1.9, $p<.02$). The DA/NDP group did not differ significantly from the other two groups (3.7 ± 2.3). The number of positive life events reported by mothers revealed no significant effect across groups (DA/DP = 3.6 ± 3.9; DA/NDP = 1.3 ± 2.4; NDA/NDP = 2.2 ± 3.2).

Discussion

The present study was designed to assess family psychopathology and parent-child relations experienced by depressed adolescents compared to those experienced by their non-depressed peers. Family psychopathology was elevated in families of depressed adolescents whose mothers were also depressed. In particular, mothers in the DA/DP group were more likely to report having suffered from both anxiety and depression and having experienced past trauma than mothers in the other groups. As well, fathers in this group were more likely to have histories of substance abuse relative to fathers in the other groups. Siblings in this group were also more likely to have experienced a depressive disorder. Overall, the family aggregation of depressive disorders as well as for co-morbid diagnoses was greatest in those families where both the mother and proband had been diagnosed with a depressive disorder. It is important to note that the adolescent's own level of depression and co-morbidity was not indicative of the level of family psychopathology as adolescents in both the DA/NDP and the DA/DP were indistinguishable clinically.

Results indicate that non-depressed probands experienced more positive life events than depressed probands and that depressed mothers have experienced more negative life events than mothers who are not depressed. These results are not surprising. From a cognitive behavioural perspective, depressed individuals are more likely to interpret their ongoing experiences in negative ways (Wilkes, Belsher, Rash & Frank, 1994). This would explain the fewer perceived positive events in depressed adolescents and the greater number of negative events perceived by depressed mothers. It is also possible that an accumulation of negative events over a depressed mother's life have contributed to the maintenance of her depression and to the intergenerational transmission of a sense of hopelessness as well as affective disturbance in the face of such difficulties. The inclusion of a comparison group of depressed mothers whose adolescents are not depressed may have shed some light on this.

Adolescents' perceptions of parent-child relations were evaluated in two domains of attachment: care and overprotection. Results obtained from the over protection subscale of the PBI indicated that depressed adolescents in the DA/NDP group perceived non-depressed mothers as more over protective than the depressed mothers in the DA/DP or the non-depressed mothers in the comparison group. This interaction between maternal depression and depressed adolescents' perceptions of parenting has been reported in earlier studies (Colder, Lochman & Wells, 1997; Crook, Raskin & Eliot, 1981). The observed differences across groups may be the result of parents' differing in affective state themselves. Non-depressed mothers may be concerned about how best to meet the needs of their depressed child and may react with over protectiveness. Depressed mothers on the other hand may be less preoccupied with the affective needs of their depressed child and/or be expending their personal resources on their own adjustment. With depleted coping resources,

they may be less able to give support, and may be more prone to withdraw from their depressed child in order to attend to their own emotional needs.

Perceived levels of maternal care did not differ significantly between the three groups of adolescents although scores were highest in the non-clinical comparison group. A larger sample size may have enabled us to detect a significant difference on care scores, suggesting that depressed individuals, with or without depressed mothers, may perceive lower levels of maternal care. This finding was not anticipated as the literature suggests that depressed mothers would be those most likely to have difficulty with their emotional bond and caring relationship to their child (Gerlsma, Snijders, Marrijtje, Duijn, Emmelkamp, 1997). The fact that both clinical groups showed similar results in the adolescents' perception of the level of care received from their mothers suggests that this dimension may be more susceptible to a perceptual bias on the part of the depressed adolescent respondent. In other words, depressed adolescents may be able to identify the structure and control assessed by the overprotection dimension of the PBI but less able to objectively assess the level of care assessed by this measure. Conversely, parents of depressed adolescents, regardless of their own affective state or history, may be affected by their child's depression in such a way that it truly influences the care dimension of their relationship.

Shiner & Marmorstein (1998) also compared three groups of adolescents: 1) ever-depressed adolescents with ever-depressed mothers, 2) ever-depressed adolescents with never-depressed mothers and 3) never-depressed control adolescents. Their results indicated that ever-depressed adolescents with ever-depressed mothers described poorer family functioning than did ever-depressed adolescents with never-depressed mothers and controls. There is evidence to suggest that maternal depression may well contribute to perceived family dysfunction by depressed adolescents. Although the greatest perceived level of family dysfunction was in the families with greater psychopathology, this dysfunction was not in and of itself sufficient to explain the presence of adolescent depression since depressed adolescents without a depressed parent did not perceive family dysfunction as intensely.

The interplay between biological and environmental influences remains quite complicated. While genetic and biological factors may also be implicated in depression, current research (Lewinsohn et al., 1998; Sheeber & Sorensen, 1998) establishes the importance of family environment and psychosocial factors in adolescent depression.

The model guiding the present research focuses on cycles of events starting with family adversity, which may lead to attachment difficulties and eventually to conflictual parent/child relations. If the difficulties accumulate over time, they may trigger symptoms of depression in vulnerable adolescents. Early childhood adversities, including parental separation or neglect, may affect children negatively, to a point where they experience difficulty in building a stable and positive relationship with a parent, thus increasing family discord and contributing to inadequate parenting styles and practices. These family difficulties increase the risk of depression in adolescents (Bifulco et al., 1987; Rutter 1966, 1987). Once on a path to depression during the developmental course, this trajectory may become self-perpetuating, as the individual provokes or simply perceives, an increasing series of adverse events. This could explain the tendency for many of these individuals to alienate themselves and withdraw from social supports, which decreases opportunities to put an end to the negative spiral of events (Hammen, 1991).

It is clear from recent research findings that parental psychopathology is one of the most important variables in the development of depression in children and adolescents. Parental depression leads to family disruption, which in turn leads to child psychopathology, and impacts negatively on parent-child relations. The greater the number of negative events in a family, the greater the risk of developing a depressive disorder during adolescence. Maternal depression is associated with depression in adolescence through its relation to social disadvantage, marital discord or family adversity.

In the investigation of family dysfunction and the development of adolescent depression, there has been little research on siblings in families of depressed adolescents. It would seem that studying similarities and differences across siblings would be a promising area of investigation, since the siblings of depressed adolescents would experience at least minimal shared environmental influences and would be at equal "risk" to develop depression. While children of depressed parents are at risk for maladaptive outcomes, it is also true that some children may develop to be well adapted. In fact, depressed families most often do not present a homogenous environment to all the children in the household. The difference in exposure to adverse experiences between the siblings might be one explanation in the development of depressive disorder. The present research suggests that the accumulation of psychopathology within families, particularly in the presence of parental depression, is quite significant. The proportion of siblings that are resilient to both the biological and environmental influences may be quite small. Nevertheless, it is not an insignificant number and therefore may provide clues to prevention efforts in those at risk.

Although the present study addressed several shortcomings of previous research, the methodology employed here also had several limitations. Perhaps the most obvious is the size of the sample recruited for the study. Although intended as a preliminary exploration of the various constructs presented, the sample precluded many more detailed analyses of the variables at play. Future research assessing parental depression and parent-child relations as potential factors in the etiology of adolescent depression would benefit from larger scale studies involving a greater number of participants. It should be noted that the present study was designed as a pilot to such a larger scale study. It was difficult to recruit fathers, and more efforts should eventually be made to include more fathers and siblings. As well, more measures should be used in an effort to describe with more detail the family environment and the complex interactions in parent-

child relations. A prospective-longitudinal approach in the investigation of these constructs could also help to clarify some of the causal pathways in the etiology of depression in children and adolescents.

The findings of this study suggest that both parental depression and parent-child relations are relevant factors that should be explored in combination toward a better understanding of the development of adolescent depression, as well as the severity and course of this disorder. Future study should look into gender differences of depressed adolescents and its impact on parent-child relations. In particular, research focusing on possible intervention efforts involving the family unit that could aid mental health professionals in providing assistance for depressed adolescents and their families is imperative. The value of such family-based interventions in the prevention of adolescent depression is also worth some exploration.

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Table 1

Characteristics of study participants by group

GROUP		N	Age in Years M (SD)	Gender (M/F) %	Current School Grade M (SD)	Siblings Yes (%)M (SD)
DA/DP	Mother	11	43.2 (4.0)			
	Father	5	47.6 (3.4)			
	Proband	11	15.7 (1.1)	18.2 / 81.8	9.5 (0.8)	(81.8) 1.5 (1.2)
	Sibling	7	18.7 (1.0)	57.1 / 42.9	12.6 (1.8)	
DA/NDP	Mother	7	44.5 (3.7)			
	Father	3	50.4 (8.4)			
	Proband	7	16.3 (1.4)	14.3 / 85.7	10.4 (1.5)	(71.4) 1.3 (1.0)
	Sibling	3	18.8 (2.2)	0 / 100	13.0 (1.7)	
NDA/NDP	Mother	9	46.7 (2.9)			
	Father	7	48.4 (4.4)			
	Proband	9	16.1 (1.0)	33.3 / 66.7	10.4 (0.9)	(100) 1.6 (0.7)
	Sibling	6	17.0 (3.9)	83.3 / 16.7	11.0 (3.5)	

Table 2

Lifetime prevalence of psychopathology as measured by the SCID (K-SADS) for each family member separately for each group

GROUP	Family Member	Mood Disorder	Anxiety Disorder	PTSD	Substance Use Disorder	Any Other Disorder
DA/DP	Mother	100% (11/11)	54.4% (6/11)	45.4% (5/11)	9.1% (1/11)	36.4 (4/11)
	Father	40% (2/5)	40% (2/5)	0% (0/5)	60% (3/5)	0% (0/5)
	Proband	100% (11/11)	18.2% (2/11)	18.2% (2/11)	54.5% (6/11)	27.3 (3/11)
	Sibling	85.7% (6/7)	14.2% (1/7)	28.4 (2/7)	42.8% (3/7)	28.6 (2/7)
DA/NDP	Mother	0% (0/7)	14.2 % (1/7)	28.5% (2/7)	14.2% (1/7)	0% (0/7)
	Father	0% (0/3)	0% (0/3)	0% (0/3)	33.3% (1/3)	0% (0/3)
	Proband	100% (7/7)	42.8% (3/7)	28.5% (2/7)	28.5% (2/7)	42.9 % (3/7)
	Sibling	0% (0/3)	0% (0/3)	0% (0/3)	0% (0/3)	0% (0/3)
NDA/NDP	Mother	0% (0/9)	22.2% (2/9)	0% (0/9)	0% (0/9)	0% (0/9)
	Father	0% (0/7)	0% (0/7)	0% (0/7)	28.5% (2/7)	0% (0/7)
	Proband	0% (0/9)	11.1% (1/9)	0% (0/9)	0% (0/9)	0% (0/9)
	Sibling	0% (0/6)	0% (0/6)	0% (0/6)	0% (0/6)	0% (0/6)

Note. PTSD = Post Traumatic Stress Disorder

Table 3

Means, standard deviations and proportion of mothers and fathers rated on the Parental Bonding Instrument as high on Overprotection and low on Care

		Overprotection		Care	
GROUP		M (SD)	% (n)	M (SD)	% (n)
DA/DP	Mother	11.2 ± 8.8	18.2 (2)	27.4 ± 10.5	27.3 (3)
	Father	14.9 ± 9.5	54.5 (6)	18.1 ± 10.7	63.6 (7)
DA/NDP	Mother	21.3 ± 4.9	100.0 (7)	25.3 ± 10.9	42.9 (3)
	Father	13.4 ± 10.8	42.9 (3)	25.4 ± 7.8	42.9 (3)
NDA/NDP	Mother	10.8 ± 5.2	33.3 (3)	31.9 ± 5.8	22.2 (2)
	Father	8.0 ± 3.2	00.0 (0)	30.9 ± 4.1	11.1 (1)

An Open Trial of Auricular Acupuncture for the Treatment of Repetitive Self-Injury in Depressed Adolescents

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ABSTRACT:

Repetitive self-injurious behavior (SIB) is frequently seen in depressed adolescents. In addition to it providing relief for dysphoric symptoms there is evidence of an addictive component to this behaviour. Because auricular acupuncture (AA) has been shown to be effective as an adjunct treatment to cocaine dependence, we wished to test the feasibility and potential efficacy of this treatment in depressed adolescents with repetitive SIB. Our pilot results suggest that AA is an acceptable treatment in this group and that it may be an effective adjunct treatment for repetitive SIB. Moreover, decreases in SIB were evident while depressive symptoms remained unchanged.

INTRODUCTION:

SIB in the non developmentally delayed population often develops during adolescence, can be highly repetitive and comorbid with mood disorders and is frequently difficult to treat. The act of self-injury is often preceded by intense feelings of dysphoria mixed with anxiety and/or anger (Favazza & Rosenthal; 1993). Upon cutting, hospitalized adolescents frequently report a release of tension and relief from negative affective states, reinforcing the behaviour. Addictive features, such as increasing the frequency and/or severity of SIB to achieve the same effect since starting have been noted in this behavior, with 97.6% of a hospitalized adolescent sample meeting adapted DSM IV criteria for dependence on SIB. The recognition of addictive features and the potential role of endogenous opiates in SIB's relieving and reinforcing aspects has led to the study of naltrexone in single case and open label studies of adults with mixed results (Godart et al, 2000; Sonne et al, 1996). Results of controlled studies in the developmentally delayed population have also been mixed with the suggestion that certain subtypes, (e.g., those with elevated _-endorphin post injury) may be more responsive to this treatment (Chabane et al, 2000; Sandman et al, 2000). A recent controlled study (Avants et al, 2000) has shown that AA may be a useful adjunct to the treatment of cocaine dependence, an addiction whose response has been less than favorable to traditional treatment approaches. Recognizing that alternatives to traditional treatments deserve further investigation, our group wished to assess the feasibility and potential efficacy of AA in depressed adolescents with repetitive SIB, in light of its addictive features.

METHOD:

Nine adolescents from our inpatient and partial hospitalization programs meeting DSM-IV criteria for a major depressive episode and/or dysthymia and a Beck Depression Inventory (BDI) score of greater than 16 who admitted to repetitive SIB and/or repetitive urges to self-injure (at least 1/week in the past 6 months) participated in the pilot study. The mean age at screening was 15.7 ± 1.5 (8 females and 1 male). Exclusion criteria included any developmental delay, psychosis, active suicidal ideation, substance dependence, acute medical illness, pregnancy, treatment with an opiod antagonist, and allergy to metal or needle phobia.

Acupuncture treatment consisted of 3 treatments, once a week over 3 weeks. Patients would sit together and were instructed to relax while receiving bilateral AA at 5 points (Sympathetic, Shen Men, Kidney, Liver, Lung) as per the original Lincoln protocol (Smith, 1979). The acupuncturist was instructed to have minimal interaction during treatment but the adolescents were permitted to talk. The disposable needles remained in place for 50 minutes and when removed were replaced with adhesive metallic press balls at the same 5 ear sites. Patients were instructed to press on one or several of these balls between acupuncture sessions to see if this may assist in diminishing the urge to self-injure. The addition of press balls and reduction from 5 days a week to once a week needle treatments were modifications made to the Lincoln protocol due to concerns that adolescents would not be compliant with the original 5 day/week, three-week treatment protocol. At the end of each treatment week the ear auricles were examined for any loss of adhesive press balls or possible skin erosion or infection prior to re-insertion of the needles. Participants continued their other treatments including medication and therapy "as usual" throughout the study period.

Treatment outcome was based on comparing baseline measures of frequency of SIB and urges to self-injure obtained from a self report measure with a frequency count obtained through a clinical interview at 1 week and 4 weeks post treatment. Secondary measures included the BDI, the Hamilton Depression Rating scale (HDRS) and a measure of anger expression (State Trait Anger Expression Inventory; STAXI). Participants were asked to complete a brief questionnaire and clinical interview regarding their impressions of AA at the 4-week post treatment follow-up.

RESULTS:

Eight participants completed the treatment, one was withdrawn due to hospitalization for a suicide attempt and one participant did not complete the 4-week post treatment follow-up.

Prior to treatment, almost daily urges to self-injure were reported in 67% (6/9) of the sample while 56% (5/9) self-injured at least once a week but less than daily. Mean BDI and HDRS scores at baseline were in the severely depressed range, while 80% of STAXI anger in and 60% anger out scores were clinically elevated (i.e., over the 75th percentile). 100% of the sample met criteria for "dependence" on SIB using modified substance dependence DSM-1V criteria (see table 1). Two separate repeated measures ANOVAs were analyzed for the urges and acts of self-injury respectively. Means and standard deviations of urges and acts can be found in table 2. There was no statistically significant difference in urges to self-injure over time, however, the mean number of urges decreased from screening to 1 week post-treatment and remained lowered at 4 weeks post-treatment. There was a significant main effect of time for acts of self-injury ($F(2,5) = 8.82$, $p=.023$). A priori simple contrasts revealed that acts of self-injury decreased at 1 week post treatment from screening ($F(1,6) = 20.25$, $p=.004$) and at 4-weeks post-treatment from screening ($F(1,6) = 8.00$, $p=.030$).

While self-rated and clinical ratings of depression did not change significantly at 1 and 4 week post treatment follow-up, mean internalizing anger scores were significantly reduced at 4 weeks post treatment follow-up.

The adhesive metallic balls were not deemed to be a successful addition to the needle treatment as they frequently fell out due to poor adhesive. Feedback from participants indicated that 86% (6/7) would recommend AA to others with SIB. 71.4% (5/7) felt that the treatment was moderately to extremely effective. Comments at follow-up included: "I felt as if the stress was relieved", "I was calmer and didn't have any urges (to self injure)", treatments "three times a week would be better", as well as one person indicated that "it doesn't help". No major or minor adverse effects related to the acupuncture treatment were noted.

DISCUSSION:

These pilot results suggest that AA was accepted and well tolerated in depressed adolescents with SIB. Where repetitive self-injury occurs with addictive features, AA may be a useful adjunct to standard treatments. The fact that SIB urges and/or acts were reduced despite any significant change in levels of depression suggests that any potential "active ingredient" in AA did not target depressive symptoms. The experience of internalized anger and its relationship to SIB and AA merits further exploration. Auricular acupuncture with its relatively low cost, tolerability, ease of administration, and favorable side effect profile deserves further investigation as a potential adjunct treatment for repetitive self-injury in depressed adolescents. While AA mechanism(s) of action have yet to be clearly elucidated, any potential efficacy in the treatment of SIB should be explored. Pursuing this could lead to better understanding the effects of AA as well as any underlying biological aspects related to the development and maintenance of repetitive SIB.

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Table 1

Addictive features

Since you started to self-injure…		Percentage (n)
1.	Your self-injury has increased in frequency	100.0 (9)
2.	Your tension level increases without self-injury	100.0 (9)
3.	You continue the behaviour despite recognizing that it is harmful	100.0 (9)
4.	The behaviour causes problems for you socially	89.0 (8)
5.	The behaviour is time consuming	89.0 (8)
6.	The frequency and/or intensity has increases in order to achieve the same effect	67.0 (6)
7.	The severity of your injuries has increased	56.0 (5)

Table 2

Mean urges and acts of self-injury by phase of treatment

	Screening	1-week Post-treatment	4-weeks Post-treatment	Significance
Urges	4.3 ± 0.9	2.6 ± 1.9	2.6 ± 1.5	ns
Acts	3.0 ± 1.0	0.4 ± 0.8	1.3 ± 1.3	p=.023

Note: higher scores indicate more frequent urges and acts of self-injury (0=none, 5=daily)

Mental Health Sequelae Of Bullying: A Review and Case Report

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ABSTRACT

This paper is a review of the effects of bullying on children and adolescents. We begin with a case report of a young male who presented at a children's hospital emergency room after being subjected to months of bullying. We then proceed to a review of relevant literature, and focus on a definition of bullying, the incidence of this problem, and the characteristics of bullies, victims and those who both bully and are bullied. The consequences of this behaviour, both for the perpetrator and victim, are also examined. We note that all individuals who participate in bullying, whether as perpetrators, victims, or those who have been both the perpetrators and the targets of this particular form of aggression, have in some way been psychologically affected by such experiences. It is hoped that the significance of bullying behaviour, and its psychological cost on the psychological well-being of the children and adolescents involved with bullying, will be a central theme of this review.

Introduction

What is bullying? Who does it involve? Why does it happen? What are the consequences? These are questions, which often arise in the study of bullying behaviour, and highlight issues of violence in our schools and homes, and of under reported victimization and questionable parenting. The tragedy of bullying behaviour is not only that it occurs, but that its effects are long-lasting and often unappreciated (or even ignored) by those who have primary responsibility for the care and welfare of children. Rappaport (2001) pointed out regarding the school site:

> The most overlooked dynamic in bullying is the role staff members may have in escalating a conflict. Often administrators, in the interest of being fair, hand out cookbook discipline that does not give students (and staff) an opportunity to be reflective about their actions but instead reinforces the coercive punitive intent of a staff member. Many times adults/staff are not held responsible for their actions in the context of a public school system that allows employment for life with limited accountability. This may contribute to our reluctance to examine in schools the parallel process, in which students act as bullies, implicitly mirroring the aggressive climate that is sometimes endorsed by teachers.

The following case presentation is a clinical account of the effect of bullying on one young teenager, and the issues identified in the case parallel those reviewed in the literature. The case acts as a springboard to examine the larger issues of bullying, its meaning, prevalence and consequences. Psychological profiles of both bullies and victims are presented, as well as the mental health sequelae for the children involved. We hope that this introduction to the topic will help to raise awareness regarding this all too-frequent behaviour, as well as to the immediate and long-term developmental costs to the children who are both its instigators and its victims.

Case Presentation – GS

GS is a thirteen year-old male and a Grade 9 student at an urban middle school. He presents at the children's emergency room of a tertiary care hospital with his mother, having been referred by his family doctor. The emergency psychiatry service is consulted because the family doctor is concerned about suicidal ideation expressed by the boy earlier in the week.

On enquiry, the boy states that two days prior, he was working on a computer at his school, when the "class bully" and two other boys approached him. GS was alone at the time. The bully told him that he was stupid, ugly and everyone hated him. The bully added that GS was a "waste of space", and concluded: "Why don't you just kill yourself, everyone thinks you're a joke". The other boys laughed and taunted the patient for several minutes before finally leaving him alone.

On his way home from school that day, the patient became increasingly upset, as he thought about what had happened. He began to feel that he was useless, and stupid, and alone. He was also enraged at himself for not responding or defending himself. Suddenly he had the urge to throw himself in front of a city bus, and actually walked to the curb

before turning away, stating: "I was too chicken". Instead, he found a payphone and called his mother at work. She told him to go home immediately and that she will meet him there. By the time she arrives at home, the suicidal feelings had passed.

The next afternoon, there was a meeting at the school attended by the patient, his mother, the vice-principal, the guidance counsellor, and the school psychologist, who was concerned about the possibility of a major depression. As a result, the family contacted the family doctor, who recommended that the patient be brought to the emergency room.

GS told the Psychiatry emergency team that he had been bullied by this boy for the entire school year. The bullying took various forms, including insults, enlisting other boys to taunt GS, physical humiliations such as being kicked or spat on, and painful attacks such as being stabbed with a pencil or geometry compass. The patient explained that when he has complained in the past, the school had done nothing more than reprimand the other boy, which "only makes things worse for me". GS described feeling sad, ugly and useless as a result of the bullying. He stated: "I just wither away in my own little world". He had initially sought help from the school guidance counsellor and subsequently from the school psychologist, whom he has seen bi-monthly for five months, at the school. His family doctor initiated Sertraline at a dose of 25 mg. daily five days before he was seen at Emergency. GS denied changes in sleep, appetite or concentration, or poor school performance.

GS denied prior contact with any mental health professional (apart from the school psychologist) and insisted that he has never before had suicidal thoughts. He was generally in good health, and on no medications apart from Sertraline. There was a significant family history of mood disorders: his maternal great-uncle committed suicide while depressed, and his maternal aunt suffered from depression as well. GS also stated that two of his paternal uncles committed suicide, but noted that: "One of them was involved with drugs and alcohol."

GS lived with his mother and his seven-year old brother. His parents had been divorced for about seven or eight years and he saw his father on weekends. He stated that his father had a gambling addiction, and used to abuse alcohol. GS denied any use of alcohol or street drugs. He stated that his interests included playing on the computer and playing games with Alex, his one friend. He denied any history of legal charges.

On examination, GS presented as a slender, 13 year-old male dressed in torn pants and a dirty jacket. He was not visibly agitated, nor was there evidence of psychomotor retardation. Although there was no notable facial dysmorphism, he did have prominent epicanthal folds and a thin upper lip, raising the question of Fetal Alcohol Effects. He made adequate eye contact throughout the assessment. Speech was normal in volume, rate and tone, and was not tangential. His mood was "sad" and his affect was somewhat flat. Thought processes were clear and logical. Thought content was notable for the absence of suicidal or homicidal ideation, and he described his brief thoughts of suicide as "a mistake, an over reaction. I don't want to be dead". There were no psychotic symptoms such as delusions or thought broadcasting, withdrawal or insertion. There was some evidence of depression, including endorsement of sadness, hopelessness and worthlessness. However, other neurovegetative signs and symptoms of depression were absent. There was no evidence of perceptual disturbances, and judgment and insight were both fair, with good reliability. GS was noted to be alert and oriented, and cognition appeared grossly intact.

The initial diagnostic impression was that of an adjustment disorder with features of depression and anxiety. As he was not suicidal, homicidal, psychotic nor severely depressed, he was not admitted. A referral was made to an outpatient program in the Child and Adolescent Mental Health Program. Both GS and his mother (present during the latter part of the assessment) indicated that they were satisfied with this outcome.

Definitions and Incidence of Bullying

Besag (1989) described bullying as being 'The repeated attack - physical, psychological, social or verbal - by those in a position of power, which is formally or situationally defined, on those who are powerless to resist, with the intention of causing distress for their own gain or gratification'. Olweus (1994) noted that bullying is characterized by aggressive behaviour or intentional "harm doing", which is carried out "repeatedly and over time", in an interpersonal relationship characterized by an imbalance of strength. He noted that there may be individual or group bullying (or victims), and that bullying may be direct or indirect. Indirect bullying includes slandering and spreading of rumours and manipulation of friendship relationships, which is more common among girls. Harassment with non-physical means (words, gestures, threats) is also the most common form of bullying among boys.

Bullying also includes name-calling. Teasing is ubiquitous in life, having both positive and negative effects. It may be playful and fun when done in sport or mischief. Important factors include individual attributional differences, social context and the relationship among participants, thus distinguishing between teasing that the recipient considers playful and teasing that is considered harmful. In addition, cultural differences may exist with respect to conduct that can be considered bullying, and thus unacceptable. For example, Boulton (1999) has found that there are significant differences between English and Swedish secondary pupils' attitudes towards, and conception of bullying. A significantly larger percentage of English than Swedish pupils indicated that name-calling is bullying, whereas the reverse was true for leaving somebody out.

The incidence of bullying varies with the location surveyed, but this behaviour is clearly a significant problem worldwide. In Canada, the incidence of being bullied amongst school-age children in Toronto has been estimated at 20% (Ziegler and Rosenstein-Manner, 1991). Fried and

Fried (1997) estimated that there are 2.1 million bullies and 2.7 million victims in U.S. schools and they stated that 60,000 children do not attend school each day because of fears of attack or intimidation. In Norway, Olweus (1994) found that 9% of school age children were bullied, and 7% bullied others regularly. In Australia (Forero et al, 1999), a survey of nearly 4000 school children showed that 23.7% bullied other students, 12.7% were bullied, 21.5% were both bullied and bullied others, and 42.4% were neither bullied nor bullies.

A British survey (Boulton and Underwood, 1992) of 8-9 year-olds and 11-12 year olds showed 21% reported being bullied, and 17% bullied others. Bullying was more common among boys than girls, and among younger than older children. The most common forms were teasing and hitting/kicking. Most boys were bullied by boys only, whereas girls were more likely to be bullied by either sex. The majority of victims had not spoken to teachers/family about being bullied. Finally, an Italian study (Baldry and Farrington, 1999) of 113 girls and 125 boys aged 11-14 in a Rome middle school suggested that over half of all students had bullied others in the 3 months prior to the survey. Boys bullied more than girls, and both boys and girls tended to be bullied by boys.

Bullies and Victims

Olweus (1994) has reported that bullies are more aggressive towards both peers and adults, and have a more positive attitude towards violence, characterized by impulsivity and a strong need to dominate others. They displayed little empathy towards victims. Male bullies tend to be generally stronger than boys of their own age, and especially stronger than victims. He concluded that bullies display an aggressive reaction pattern combined with (in boys) physical strength. There was a noted increased incidence of anti-social and "rule-breaking" (conduct disordered) behaviour patterns, with increased long-term risk of criminal behaviour and alcoholism.

Attempts have been made to categorize bullies. 'Anxious bullies' were the least confident perpetrators, and appear to have other difficulties such as problems at home or educational failure. A second category was the 'bully/victims', which consisted of 6% of those who were seriously bullied, and 18% of those who were bullied occasionally. This second group was seen to be less popular than the main group of bullies, and appeared to focus on younger children as more vulnerable targets. The third category was the 'passive bullies' (or 'henchmen'), who did not take the initiative for bullying activities. This was a fairly mixed group, which included some of the insecure and anxious students.

Gender differences have been noted. Olweus (1994) concluded that more boys than girls are both bullies and bullied, and that girls were more often subjected to indirect attacks (social isolation, exclusion) rather than direct physical attacks. However, boys and girls were equally exposed to indirect bullying, and boys carried out a large part of the bullying on girls. He also attempted to identify important factors which give rise to bullying behaviour, and described the development of an 'Aggressive Reaction Pattern' characterized by four contributory elements. The first is the emotional attitudes of the caregiver, in particular one who demonstrated a negative attitude, characterized by lack of warmth and involvement. This increased the risk of the child later showing aggressiveness and hostility to others. A second element is permissiveness towards aggressive behaviour: if there are no clear limits on aggressive behaviours towards peers, siblings and adults, aggression is likely to grow. Power-assertive child-rearing methods, such as the use of physical punishment or violent emotional outbursts increase the likelihood of aggression in children constitute the third element. Finally, the temperament of the child is considered, as an active and "hot-headed" child is more likely to develop aggression (and bullying behaviours).

Victims have also been described and categorized. Olweus (1994) expressed somewhat general conclusions that victims are more anxious and insecure, and are often cautious, sensitive and quiet. When attacked, they commonly react by crying when younger and by withdrawal at older ages. They tend to experience low self-esteem, a negative view of self and their situation, and feel that they are stupid, shameful and unattractive.

The first category of victims are the 'passive victims'. They are ineffectual in the face of attack, avoid aggression and confrontation and lack the confidence or skill to elicit support from their peers. They are lonely and abandoned, with few friends at school. They often have a negative attitude towards violence and (if boys) are physically weaker than others. They display helpless, futile anger when attacked. Their behaviour and attitudes signal to others that they are insecure and worthless and will not retaliate if attacked. The second category, 'provocative victims', are much less common and have both anxious and aggressive reaction patterns. They tease and taunt, but quickly complain if others retaliate. 'Colluding victims' take on the role of the victim to gain acceptance and popularity. They may mask true academic ability to avoid being outcast from their group. Finally, false victims complain unnecessarily about others in the group, usually as attention-seeking behaviour.

In addition, there are "special groups", who attract the attention of bullies due to obvious differences. In one study of bullied children in the U.K (Leff, 1999), 17% had learning disabilities, 33% had physical disabilities and 33% were neglected. A survey of 28 children who stutter (Langevin et al, 1998) showed that 59% were teased/bullied about speech, and 69% were teased or bullied about other things. As well, a British study (Voss et al, 2000) found that short boys were more than twice as likely to be victims than age-controlled peers of normal height, and much more likely to be upset by bullies.

Finally, in a recent study of children with Asperger's Disorder and Nonverbal Learning Disorder (Little, 2001), the annual peer victimization rate was 94%. Seventy-three percent of children had been hit by peers or siblings, 75% had

been bullied, 10% had been attacked by gangs, and 15% were victims of nonsexual genital assaults. Bullying remained high regardless of age, and gang attacks were the most frequent in middle and high school. Boys were at greater risk of being bullied than girls, and children with Asperger's were at greater risk of being assaulted than those with Nonverbal Learning Disorder.

The personality dimensions of both bullies and victims have also been studied. Mynard and Joseph (1997) describe 179 children (ages 8-13), who completed a battery of psychological tests. The results showed that 11% of children identified themselves as bullies, 20% as victims, and 18% as both bully and victim. Bullies scored lower on scales that measure lying, but higher on the psychoticism scale. Victims scored lower on the extroversion scale and higher on the neuroticism scale, while mixed bully/victims were characterized by low social acceptance, high neuroticism and high psychoticism.

Finally, a British survey (Boulton and Underwood, 1992) examined children, including bullies, victims and those not involved in bullying, and asked why children bully other children. According to the bullies, the most common reason given was that the victim provoked them, while one-fifth said they didn't know, and 8% said because the victim was smaller, weaker or didn't fight back. These results were reversed when their targets were surveyed. Victims reported that the most common reason for being victimised was that victims were smaller or weaker or didn't fight back, while one-quarter said there was no reason, and 8% agreed that the victim provoked the bully. Of non-involved children, 32% thought that other children were bullied because they were small or weak, or because they didn't stand up for themselves.

The Consequences Of Bullying

One Finnish study (Kumpulainen et al, 1998) surveyed nearly 6,000 elementary school children, their parents and their teachers. Bullies (8.1%), victims (11.3%) and bully/victims (7.6%) were compared to each other and to controls (73.1%). It was found that bully/victims scored highest in externalizing behaviour and hyperactivity, and self-reported feelings of ineffectiveness and personal problems. Victims scored highest in internalizing behaviour and psychosomatic symptoms, anhedonia and negative self esteem (males) and negative mood (females). Bullies scored quite high in externalizing behaviour and hyperactivity. "Psychological disturbance" was found in nearly 25% of victims, using the Children's Depression Inventory (CDI). However, it was the bullies (in particular male and female bully/victims) who were most frequently referred for psychiatric consultation. The reason for this is unclear.

An Australian survey (Forero et al, 1999) of almost 4,000 students aged 12, 14 and 16 asked questions about effects of bullying, including psychosomatic symptoms (headache, stomach ache, backache, irritability, anxiety, and insomnia) and mental health (mood, loneliness, contact, self-esteem). A significant association was found between bullying behaviour, psychosomatic symptoms and smoking, with bully/victims reporting the greatest symptoms. A British survey (Salmon et al, 1998) of 904 students aged 12-17 in two coeducational schools found that bullied children are more anxious, and bullies are equally or less anxious than non-bullied children. Older boys with low scores on anxiety and lying scales and high scores on depression scales were most likely to be bullies.

A Finnish report (Kaltiala et al, 1999) studied 16,410 participants aged 14-16, who completed a questionnaire incorporating the Beck Depression Inventory. Researchers found an increased prevalence of depression and severe suicidal ideation amongst victims and bullies, with depression most common in bully/victims, and suicidal ideation most common in bullies. A companion study (Kumpulainen et al, 1999) reviewed 1268 eight year-old children, who were assessed twice four years apart. The Rutter A-2 and B-2 Scales and the Children's Depression Inventory (CDI) were utilized. Bully/victims were most likely to persist in bullying behaviour four years after the initial survey. The researchers concluded that children involved in bullying have significantly more psychiatric symptoms than those not involved

Discussion

Our case report illustrates the effect of bullying, namely how it marginalizes and traumatizes the victims, while (in some cases) rewarding the bully with increased self-esteem and improved social status. Our patient, GS, is an outsider, alienated from many of his peers. As such, he is an easy target. He displays certain characteristics of a victim. He signals that he will not strike back, is anxious and withdrawn, and with few social supports. His appearance, while not noticeably disfigured, is sufficiently different from his peers that it sets him apart.

The bully in his case, described as a "blowhard", appears in some ways to represent the bully/victim portrayed in the literature. He is not truly dominant, preferring to back away from those who challenge him, and identifying those who will not fight back. He enlists others in his conduct, thus increasing his own status at the expense of his victim. He does not have an independent source of popularity and he is able to identify the needs of the peer group to attack, harangue and alienate a vulnerable individual. He appears to serve a social need, acting out the collective will of the group to identify and punish a scapegoat.

The school, too, is an active participant. On the sole occasion that GS dared to respond to his attacker, both boys were punished with detention. Conversely, the unprovoked and constant harassment that GS endures is to some extent tolerated by the school. If he complains, he is a "rat" and deserving of punishment. If he doe not complain, the bullying can continue unimpeded. In either alternative, GS is potentially condemned to a continuation of his victimization.

GS presents with brief, transient suicidal ideation and evidence of an adjustment disorder. It is difficult and perhaps dangerous to ignore the psychological and physical suffering that GS does endure. A consequence of his predicament is yet further social isolation and withdrawal, the effects of

which are as yet unclear. However, the effect of bullying on this boy's personality formation, his ability to function in social settings, and his capacity to trust and form meaningful relationships is clearly described by his own words: "I just wither away in my own little world".

From an objective distance, and through the screen of conventional psychiatric diagnostic criteria, the long-term effects of bullying are somewhat difficult to accurately assess or predict. However, in subjective proximity to those involved, the consequences of such behaviour and its covert acceptance are indeed frightening. Further study is indicated to assess the incidence of psychiatric morbidity in bullies, victims, and in those who are both perpetrators and targets. Finally, it is essential to identify temperamental and personality characteristics of the children involved, as well as to examine for dimensions of psychological distress, including depression, suicidality, anxiety, obsessive-compulsive traits, aggressive traits and psychotic symptoms. Such study will further promote development of our understanding of bullying and its sequelae at individual, interpersonal and systemic levels, and further inform our treatments of the bullies, bullying recipients and the systemic, community milieus where the bullying occurs.

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A Report from the Advocacy Committee

POLICY STATEMENT: CORPORAL PUNISHMENT

Definitions:

Corporal punishment is the use of physical force with the intention of causing a child to experience pain, but not injury, for the purpose of correction or control of the child's behavior.

In corporal punishment, an adult hits one or more parts of the child's body with a hand, or with canes, paddles, yardsticks, belts, or other objects expected to cause pain and fear.

Spanking is a form of corporal punishment intended to modify behavior usually defined as a physically non-injurious hit administered with an open hand to the buttocks.

Background:

Corporal punishment has been a common practice in many societies both as a method of discipline and as a punishment in the administration of justice in legal systems. Many societies have now outlawed this behavior as components of their justice systems and many have classified the use of force between adults as assault. Some societies have outlawed the use of corporal punishment involving children. Canada has not taken this stance respecting children.

Research:

While the intent of corporal punishment is to correct or control a child's behavior, as with any method of behavioral management, the actual outcomes associated with it should be evaluated.

There are now a number of large scale retrospective and prospective studies examining the relationship between exposure to corporal punishment and a range of outcomes. These studies have mostly been conducted in the United States but some in Canada and other countries. Several of these studies (but not all) have demonstrated some effectiveness associated with the use of corporal punishment in gaining immediate compliance. At the same time, these same studies and others have demonstrated that the use of corporal punishment is associated, in later years, with increased rates of the following:

- impaired parent child relationship (fear, anxiety, anger, avoidance)
- juvenile delinquency
- student violence and murder rates in schools in which teachers are allowed to hit children
- reduced chance of entering higher income categories
- difficulties internalizing moral behavior
- feelings of alienation as an adult.
- depression
- thinking about and acts of suicide
- becoming a victim of physical abuse
- physical abuse of one's own children later in life
- spousal assault and other acts of assault

There are studies that show that even one or two instances of corporal punishment are associated with a slightly higher probability of later physically abusing one's own child, slightly more depressive symptoms, and a greater probability of committing violence and/or other crimes later in life.

There are alternative methods to managing child behaviour, other than corporal punishment, exist (see appendix). There is no evidence that corporal punishment is more effective than other forms of discipline in the short-term, and there is much evidence that it is less effective and associated with harm in the long-term.

At the individual level, corporal punishment potentially signals to the child that a way to settle interpersonal conflicts is to use physical force and inflict pain. Such children may in turn resort to such behavior themselves. They may also fail to develop trusting, secure relationships with adults and fail to evolve the necessary skills to settle disputes or wield authority in less violent ways. Supervising adults who willfully humiliate children and punish by force and pain are often causing more harm than they prevent.

Policy Statement:

Based on a review of this evidence, the Canadian Academy of Child and Adolescent Psychiatry makes the following policy statement:

The Canadian Academy of Child and Adolescent Psychiatry opposes the use of corporal punishment including any forms of physical discipline (and supports eliminating legislation that permits its use).

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APPENDIX

METHODS TO GAIN COMPLIANCE WITH CHILDREN: EFFECTIVE DISCIPLINE

As part of a general child psychiatric assessment, child psychiatrists and allied health professionals commonly ask parents about disciplinary techniques they use or are asked by parents about effective methods of child discipline. Effective discipline, considered broadly, ranges from household routines that promote healthy child development (e.g., developmentally appropriate bedtimes) to consequences or punishment for unacceptable behavior. Often, the term discipline is used interchangeably with punishment.

There are a number of methods to gain child compliance and manage behaviour. Many of these methods also have additional effects of improving self esteem, building trust, establishing accountability and increasing the desire of the child to behave appropriately on his or her own.

GOALS OF DISCIPLINE

Goals

The goal of discipline is to raise children into emotionally mature adults. Discipline is about changing behavior. As children grow, they need:

- to learn socially appropriate behaviors and limit socially inappropriate behaviors,
- to organize themselves, internalize rules, and practice self discipline,
- to self regulate their affect and behavior,
- to develop trusting relationships based on respect for others and for themselves.

The role of the parent/care giver is modeling, teaching and guiding, not just forcing obedience.

Effective discipline

Effective discipline requires:

- a positive, supportive caring relationship between the parent/care giver and child,
- use of positive reinforcement strategies to increase desired behaviors, and
- removal of reinforcement or applying punishment to reduce or eliminate undesired behaviors.

Guiding Principles

To be effective, discipline must be appropriate for the age and developmental stage of the child. However, a number of guiding principles are relevant regardless of the age and developmental stage of the child.

1. Effective discipline may vary with child temperament, developmental readiness and sociocultural milieu, as well as the presence of developmental delay or other special needs.
2. Effective discipline does not instill shame, guilt, a sense of abandonment or loss of trust. It should instill greater trust between the child and parent/care giver.
3. Clinicians can help with prevention of discipline problems, by providing anticipatory guidance to parents, especially those with stress, social isolation, sociodemographic disadvantages and other impairments. They should be aware of resources available in the community.
4. Parental health can influence child behavior and misbehavior and the ability to parent (e.g. parental depression). Clinicians can also suggest parents seek appropriate resources for themselves and facilitate referral of parents as required.

Setting Rules

The following suggestions assist with effective rule setting:

1. Apply rules consistently. This makes the world predictable for the child and for you.
2. Ignore unimportant behaviors.
3. Set reasonable and acceptable limits.
4. State acceptable and appropriate behaviors that are attainable given the age and developmental style of the child and other child characteristics.
5. Prioritize rules.

Applying Consequences

The following suggestions assist with effective consequences:

1. Apply consequences as soon as possible.
2. Small short duration consequences applied each time are more effective than major consequences applied infrequently.
3. Do not argue with the child during the setting of consequences.
4. Make consequences appropriate to the child's age, development, situation and behavior.
5. Say what you mean and do so without raising your voice.
6. Follow consequences with love and trust, so that the child understands the correction is for the behavior, not the person.
7. Model forgiveness and avoid bringing up past mistakes repeatedly.

DISCIPLINARY METHODS

The following list outlines some disciplinary methods, including details for methods that may be less well understood by new parents. This list is not intended to be exhaustive and it is not intended to substitute for much more detailed information, teaching and modeling available from many sources.

Rewarding Appropriate Behavior

It is not enough to use disciplinary methods intended to reduce undesirable behavior if the child does not also learn and gain approval for showing desired behavior. Therefore, all disciplinary methods start with modeling, teaching and rewarding desired behaviors. Rewards that are particularly important to a child over the years include noticing the behavior, providing words of praise and showing body gestures indicating approval (smile, a touch, a pat on the back). Such rewards need to be applied immediately, enthusiastically and repeated often to build and strengthen the behavior and

the self confidence and self esteem of the child.

Rewarding appropriate behavior is the fundamental starting point for gaining compliance from children. Children who do not have this as a basis in the relationship with their parents and caregivers, respond less well to the methods intended to limit inappropriate behaviors.

Verbal Reprimands

Parents may use disapproving verbal statements to alter undesirable behavior. If used infrequently and targeted toward specific behavior, these reprimands may be transiently effective in stopping or reducing undesirable behavior. However, used frequently and indiscriminately, these reprimands lose effectiveness and may reinforce undesirable behavior since they provide undue attention to the child. Verbal reprimands should refer to the undesirable behavior, not the child's character. If the parent/care giver notices that the reprimands are not effective in leading to behavior change, this is a cue that it is time to move on to another method.

Time Out

Time out is an effective form of discipline for parents of young children (approximately 2-10 years of age). Time out is to be a quiet time, allowing the child to reflect upon their behavior.

The following suggestions assist with effective time out strategies:

1. In advance, and when the child and parent are calm, explain the purpose of time out and how it will be used.
2. When using time out in practice, prepare the child by labeling the behavior and connecting it to the time out.
3. Pick the right place, without built-in rewards (no access to TV, computers, toys, family activities and distractions).
4. Once the decision is made to use time out, even if the child then decides to comply, the time out is applied first. This reinforces consistency and clarity on the part of the parent.
5. Time out starts once the child is quiet.
6. The parent should not engage the child in any conversation, respond to questions, comments or requests, or make eye contact with the child.
7. Time out should last about one minute per year of the child's age (to a maximum of 10 minutes).
8. The parent is the timekeeper. The parent must give the instruction that the time out is finished and the child is allowed to leave the time out area.
9. When the time out is finished, the child is expected to comply with the initial rule or request.
10. Do not allow the child to put her/himself in time out. The parent is to control the use of this practice.
11. Once compliance has been attained, look immediately for all opportunities to provide praise and positive reinforcement to the child.

Response Cost and Removal of Privileges

Response cost refers to the removal of items and belongings or the application of a work chore. Removal of privileges refers to the removal of opportunities and activities which a parent makes available for a child. These techniques are useful for all children and assume increasing importance as children grow older, move beyond time out and do not respond to the use of time out.

The following suggestions assist with the use of response cost and removal of privileges:

1. Plan ahead by keeping a list of items, work chores and privileges that can be used when needed. This reduces the chance that the parent will decide out of impulse or anger.
2. Keep the removal of freedom (e.g. grounding the child) short, generally no longer than one day. Longer times ground the parent's activities as much as the child since the parent must monitor the grounding. Longer times make it difficult to reuse the consequence if the child engages in further misbehaviors.
3. Common work chores that take about five minutes include cleaning a sink, sweeping a floor, cleaning a toilet, cleaning mirrors or windows, moving laundry, cleaning a tub or shower, vacuuming.
4. Use common privileges that are noticeably important to the child (e.g. telephone usage, television time, computer or video game time, transportation, bicycle and skateboard, having friends over, stereo and radio usage, curfew times).
5. Institute the chore or removal of privilege as soon as a request is met with non compliance.
6. Do not enter into a cycle of repeated warnings followed by repeated threats.
7. Do not lecture or argue.
8. Follow through and monitor compliance.
9. As soon as the consequence is concluded, look for opportunities to institute rewards and praise immediately.

Advice on additional or alternate methods of intervention for the management of mild to severe behaviour problems may be sought from a number of clinicians working with children and adolescents.

Book Reviews

Accommodations in Higher Education under the Americans with Disabilities Act (ADA) - A No-Nonsense Guide for Clinicians, Educators, Administrators and Lawyers.

Michael Gordon and Shelby Keiser. Guilford Press, New York. 1998. 236 pages. $22.95 (U.S.)

The Americans with Disabilities Act of 1990 has done for U.S. citizens with disabilities what the Civil Rights Act of 1965 has for other minorities. The book addressed the pressures the ADA has brought to bear on institutions of higher learning and on professional testing organizations, in as much as these entities are responsible for providing accommodations to disabled individuals.

As noted by the editors, the numbers of examinees petitioning for test accommodations in colleges and universities across the United States has skyrocketed over the past five years and the vast majority of ADA claims in higher education are based not on physical disabilities, but on learning and psychiatric disorders. Each student seeking accommodations consults a physician, psychologist, or other clinician to establish documentation of a disability. "Why should Canadian psychiatrists and psychologists concern themselves with an American law?" you may ask. Although Canada does not have equivalent legislation in place at this time, the Council for Canadians with Disabilities published, in November of 1999, a position paper entitled National Strategy for Persons with Disabilities recommending the creation of a Centre of Responsibility for the Coordination of Disability Policy within the Federal Government. It is further proposed that such a centre apply an "Access and Industry lens to all federal programs and new initiatives, not just those which are disability-specific." In other words, a Canadians with Disabilities Act is overdue and it will not be long before Canadian clinicians face the same requests for detailed, current and professional documentation of disabilities and accommodation needs of individuals who meet the essential functions and criteria of a job or educational program.

This practical manual offers essential information and guidance for anyone who may be called upon to provide such documentation now, or in the future. It goes far beyond providing a road map to the ADA as it affects higher education, to exposing the morass of confusion, which underlies current definitions of disability in our society.

The first section of this book, entitled "Essential Concepts/Administrative Considerations" reviews key ADA concepts and objectives, underlining the fact that this is a Civil Rights Act, not an entitlement program. Unlike the American Education for All Handicapped Children Act of 1975 and the Canadian Bill 82 of 1985, which entitles children with disabilities to a free and proper education within the public school system, the ADA does not guarantee young adults with disabilities acceptance to a university or position. It simply guarantees that individuals who are otherwise qualified to jobs or educational programs will not be denied access simply because they have a disability.

According to the ADA, the term disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual. What constitutes "substantial limitations" is crucial for clinicians and administrators to determine. Furthermore, "an individual is not substantially limited in a major life activity if the limitation does not amount to a significant restriction when compared with the abilities of the average person." Thus "clinically significant impairment," in DSM-IV language, and "substantial limitations relative to the general population," in ADA-language, may or may not overlap. Another interesting distinction made in section I is the definition of "reasonable and appropriate accommodations," which in turn depends upon the nature of the disability and the demands of the educational program. For instance, the student who suffers from irritable bowel syndrome may make two requests for accommodation: to be seated near the restroom and to have double the allotted time to take the examination. The test organization has no problem granting him the first, but not the second request. While off-the-clock breaks may be justified, it is hard to provide a rationale for expending time working on the test or not. The ADA would argue that it's intent is not guaranteed success in a particular program or endeavour, only equal opportunity for success.

Section II of the book starts with a description of the five sections (or "Titles") of the law that apply to different sectors of the economy. While this particular chapter is not of interest to Canadians, the following five chapters on how to document ADHD, Language based learning disabilities, Mood and Anxiety Disorders, Physical Disabilities and Visual Disorders and Dysfunctions, respectively, provide some invaluable insights into how one might measure and document "significant impairment" in each one of these areas. For example, here are some of the "parting shots" offered by Michael Gordon, one of the editors of this book and director of the ADHD Program at SUNY Health Science Center in Syracuse, New York:

- the consequences of having talents insufficient to attain certain goals should not be labeled ADHD.
- having to work harder than others is not necessarily a symptom of ADHD or a disability.

In conclusion, this well-organized, clearly written and very thoughtful book addresses a number of ethical questions faced by clinicians asked to document disabilities. Although it does not answer all of these questions, the step-by-step guidelines and principles involved in dissecting "significant impairment" from DSM IV diagnosis, on the one hand, and for determining what constitutes "specific and reasonable accommodations," on the other hand, are absolutely invaluable!

Arlette Lefebvre MD, FRCPC

Affect Regulation and the Development of Psychopathology.

Susan J. Bradley. The Guilford Press, New York, 2000. 324 pages. $40.00 USA.

Dr. Susan Bradley is at her best in this landmark contribution to the sciences of developmental psychology, child psychiatry, and clinical psychopathology. The title of this book captures the thesis statement and its most important contribution is to offer a model that integrates biological and psychosocial approaches. In this case, tying up the genesis of affect regulation, its progression in the normal course of events, and how a deviant regulation of affect can be linked with psychopathology.

This is a unique model. There exists several paradigms to explain affect dysregulation (e.g., attachment disturbance, neurobiological, stress reactivity etc.), however this is probably one of the rare works where the clinician is offered this pearl of knowledge and carefully unfolds psychopathology with one consistent thesis, well supported by sound review of scientific studies.

The book is divided into four parts. The first part provides an excellent overview of the model. The author makes it clear that the "model places affect regulation in a central position in the development of psychopathology."

The second part, which is divided in six chapters, is the primer for understanding affect regulation. This part is essential reading to understand the model. The evidence for the support of the model is carefully developed and supported with literature reviews including recent publications. This core section explains how affect regulation occurs in infancy. It also describes the influence of genetic and constitutional factors, the care-giving environment, effects of stress and trauma, and how mastery is achieved in regulating affect. The most captivating chapter was on the neurobiology of affect regulation. The author did not leave any stone unturned. There is a thorough description from neuroanatomy to neurotransmitters linking how affect regulation can be understood on a neurobiological basis.

Part three of this book is the clinician's dream come true. Internalizing disorders, externalizing disorders and psychotic disorders are all explained with the same rigor. The links presented to affect regulation and these clinical disorders all make sense. For example, arousal modulation dysfunction is presented as the main feature in schizophrenia; stress reactivity is implicated in internalizing disorders. In externalizing disorders, a complex interaction of genetic and constitutional psychological and neurobiological factors is implied.

Part four of this book describes future directions.

There are approximately 650 references and a well-planned index.

The author is fully cognizant of the changing nature of scientific evidence, especially in the neurobiological field. In several places she mentions the need to reformulate some of the ideas. This flexibility is not to be seen as a weakness of the model. On the contrary, these statements offer authenticity. The model (affect regulation) is the culmination of best scientific evidence at the time and seems to be flexible enough to modulate itself with new emerging scientific evidence.

This book is useful for adult and child therapists alike. The pyschopathology is explained in developmental terms and applied to adult clinical syndromes as well. It should be read under guidance of senior clinicians for the young entrants in the study of psychopathology. The model has a philosophy that is different from other theories and models to which an average student of psychology or psychiatry will be exposed in an undergraduate training program. This philosophy needs to be incorporated in clinical teaching by indepth examination, and thorough understanding. For senior clinicians, it offers an opportunity to understand their clients/patients in a way that will lead to the use of evidence based, and cost effective interventions.

This book has the potential of becoming a classic reference source and is a must in the postgraduate level of teaching in developmental psychology or psychiatry.

I did find Dr. Bradley's first person narration of many parts the book perplexing. This stylistic approach brings the author very close to the reader, however, one wonders if sometimes extremely high quality of scientific evidence gets buffed with this unexpected familiarity.

My overall ranking, you guessed it, is 10 out of 10.

Prat Reebye MD, FRCPC

Treating the Tough Adolescent; A Family-Based, Step-by-Step Guide.

Scott P. Sells, PhD. The Guilford Press, New York, N.Y. 1998. 320 pages. $35.00 U.S.A.

This book was written by Dr. Scott Sells, who is Associate Professor of Social Work at Savannah State University, and Clinical Director of the Savannah Family Institute, Savannah, Georgia, USA.

The behaviors defined in the book's introduction as severely dysfunctional include: hostile behavior, threats of violence, theft, destruction of property, vandalism, lying, fire-setting, truancy, threats of suicide, and running away. The fifteen-step treatment model is applicable to very difficult teens and their families, but also offers an approach for shaping the behavior of less disturbed youth.

The model is based on a four-year research study with two stated objectives: (1) to develop a treatment manual, and (2) to combine process and outcome research. The result is a treatment model that has been demonstrated to be effective in bringing about lasting improvement in kids with severe behavioral problems. (The population used and methodology is described in detail in the final chapter, which I will outline later in this review.)

The book is divided into four separate parts in order to accomplish the author's three stated objectives: 1.To present the treatment model. 2. To help therapists: engage an uncooperative adolescent, stop the most severe behavior problems, empower the parents to change the existing communication pattern, and to restore nurturance and tenderness between parents and teenager. 3. To describe how process-outcome research was used to integrate theory and research into clinical practice.

The three chapters in the first part of the book introduce the concepts, and give an overview of the fifteen-step model for change.

The second part, 'Specific principles and guidelines', includes chapters about: (1) Setting clear rules and consequences (2) Changing the timing and process of confrontations (3) Neutralizing the adolescent's "Five Aces", and (4) Restoring nurturance and tenderness.

The section about "Five Aces" is particularly strong. It gives clear guidelines for how to work with parents to enable them to stop an adolescent's most destructive and dangerous behaviors (without resorting to institutionalizing the adolescent and thus handing over parental authority to an outside agency such as the juvenile justice authorities or a psychiatric institution).

The "Five Aces" are: (1) Running away, (2) Truancy and poor school performance, (3) Suicidal threats or behaviors, (4) Threats or acts of violence, and (5) Disrespect. They are referred to as such by the author because they are used by the adolescent when the parents are in the process of trying to restore their authority. The "five aces" intimidate the parents into relinquishing their new-found authority, and returning it to the adolescent.

To neutralize the "Five Aces", the parents and counselor must establish consequences that are severe enough that the teen would rather give up the behavior than continue to suffer the punishment. Well-researched strategies for dealing with each of the five aces are given in detail, together with relevant case examples, which bring the material alive.

The Third section, "Special Treatment Issues and Circumstances" addresses specific considerations. There are chapters which discuss: (1) Working with Outsiders, (2) Single-Parent Families, (3) Divorce and Stepfamily problems, and (4) Alcohol and drug abuse.

The final section, "Research Findings and Future Implications" is comprised of one lengthy chapter describing the challenges and controversies in mental health care research, the goals and objectives of the author's project, the development of the 15-step model, and conclusions and future implications.

The author describes how the 15-step model evolved using the "task analysis" method of Rice and Greenberg. The detail provided is in the hope that other counselors will utilize this methodology and provide feedback to the author (via his web-site) when new discoveries are made. The model is seen as a "work-in-progress" rather than a definitive model for treating difficult adolescents.

In summary, I recommend this book for any mental health clinician who works with difficult adolescents and their families. It is an excellent volume outlining a step-by-step approach to effecting lasting change in severely behaviorally disordered adolescents.

Karen Hochman MD, FRCPC

Handbook Of Neurodevelopmental And Genetic Disorders.

Edit. Sam Goldstein & Cecil Reynolds. The Guildford Press, New York, N.Y. 1999. 602 pages. $65.00 U.S.A.

The title is a bit of a misnomer as the book is more of a text, spanning 600 pages. The book lists 40 contributors and, as is not uncommon with multi-author books, the writing styles form less of a cohesive whole when compared to other recent books on similar topics such as Randi Hagerman's 'Neurodevelopmental Disorders' and Daniel Siegel's 'The Developing Mind.' The core of writers come from Utah state in the USA, but there are contributions from experts such as Elizabeth M. Dykens, Neuropsychiatric Unit, University of California, Fred Volkmar, Yale Child Study Centre and Randi Hagerman, University of Colorado. The rather cursory Introduction by editors Sam Goldstein (from University of Utah) and Cecil R. Reynolds (from Texas A&M University) does not do proper justice to the wealth of content in this three part book.

Part I Basic Principles and Applications.

This is in some ways the most rewarding section of the book as it sets an appropriate intellectual frame for the latter two parts. It includes meaty chapters entitled, 'Neuropsychological Assessment in Genetically Linked Neurodevelopmental Disorders,' 'Neurobehavioral Disorders and Medical Genetics' and 'Neuroimaging and Genetic Disorders.'

Part II Disorders Primarily Affecting Learning and Behavior.

This includes chapters on conditions such as Learning Disabilities, ADHD and Gilles de la Tourette Syndrome. The chapter on Learning Disabilities ranges from experimental models of prenatal neural development to the practical use of neuropsychological assessment instruments.

Part III Disorders With Broader Spectrum Effects.

This includes 13 chapters each devoted to a different syndrome. The list includes more common syndromes such as Fragile X, Turner, and Down to less common syndromes: Lesh-Nyhan, Williams and Prader—Willi. The detail in these chapters is more than enough for the average Child Psychiatrist and offers a marvellous reference source. Overall this is a fine textbook and, despite it's lack of literary cohesiveness, should be an important addition to the active library of any child paychiatrist interested in either genetic disorders or neurodevelopmental disorders, or both! One major quibble, it was a pity that the neurodevelopmental legacy of prenatal Alcohol, Cocaine or Nicotine were not acknowledged in a collective chapter.

Finally, the book includes a quote, which many would dispute, from Matt Ridley, author of The Red Queen. However, this quote seems more relevant the further you enter into the book's text. 'Human beings are individuals...just as genes are the only things that replicate, so individuals, not societies are the vehicles for genes…every individual is a specialist of some sort, whether he or she is a welder, a housewife, a playwright or a prostitute. In behavior, as in appearance every human individual is unique.'

Kieran D. O' Malley MD, FRCPC

Essential Psychopharmacology of Depression and Bipolar Disorder.

Stephen Stahl. Cambridge University Press, New York, N.Y. 2000. 175 pages. Paperback $27.95 U.S.A.

This short book provides an excellent explanation of the mechanisms of action of all the major groups of antidepressants and mood stabilizers. It is easy to follow and emphasizes the main points through simple diagrams.

The first chapter gives a very fine overview of the diagnosis and description of subtypes of depression. The explanation of the terminology used in describing the treatment of depression, ie., response, recovery, remission, relapse and recurrence, along with helpful diagrammatic representations, was particularly useful. The monoamine hypothesis of depression is reviewed in this chapter along with the postulated roles of dopamine, serotonin and norepinephrine and each of their receptor subtypes in the pathogenesis of depression. Stahl follows this with a description of how monoamine oxidase inhibitors and tricyclic antidepressants function in treating depression. His inclusion of a neurokinin hypothesis of depression near the end of the chapter, while it was less useful, was only a small section.

Initially, the second chapter explains the metabolism of antidepressants by the cytochrome P450 system in the liver, and describes the importance of drug interactions. It then goes on to describe, in a detailed manner, the mechanism of action of tricyclics, selective serotonin reuptake inhibitors, the selective norepinephrine reuptake inhibitor, reboxetine (not yet available in Canada) and the combined norepinephrine and dopamine reuptake inhibitor, bupropion. The differences and similarities between the SSRIs are well illustrated and explained. The side effects of each drug are also explained based

on the receptors involved.

The third chapter begins with a very nice illustration of the combined action of the serotonin and norepinephrine reuptake blocker, venlafaxine. Stahl very effectively compares and contrasts venlafaxine to SSRIs and tricyclics based on receptor mechanisms and clinical response. This chapter also includes the mechanism of action of mirtazapine, an alpha 2 antagonist which is not currently available in Canada, building on the principles discussed in the first two chapters. The mechanism of nefazodone and trazodone, serotonin reuptake inhibitors along with a serotonin 2 antagonists, is reviewed to understand how they work to increase serotonin transmission. He then very briefly describes possible mechanisms of action of the mood stabilizers including lithium, carbamazepine, valproic acid, topiramate and gabapentin.

The last half of the third chapter describes the mechanisms for augmenting antidepressant treatment using lithium, thyroid hormone and buspirone and rationales for combining antidepressants in treatment resistant patients. This section gives logical explanations based on mechanisms of action for combining drugs for maximal benefit.

Overall, this was an excellent text for explaining mechanisms of drug action. It gives the reader an understanding of the interaction between neurotransmitters and receptors, and helps the clinician to make informed decisions on which antidepressant, or combination of antidepressants would work best. Although it is more theoretical rather than practical, it is essential knowledge for a psychiatrist prescribing these drugs. Stahl has effectively outlined the mechanisms responsible for the therapeutic actions and side effects of each drug in an easily understood fashion. This is a must read!

Jennifer Couturier MD
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Bad Boys: Bad Men: Confronting Antisocial Personality Disorder.

Donald W. Black with C. Lindon Larson. Oxford University Press, Don Mills, Canada. 1999. 240 pages. Paperback. $22.95 Cdn.

With this book, Donald Black and C. L. Larson attempt to publicize and clarify antisocial personality disorder and the intricate relationships between the disorder, criminality and frequently comorbid psychiatric disorders such as substance abuse and depression.

The book is successful in providing a thorough review of the vexing problem of antisocial personality disorder and the evolution of medical and psychiatric thought regarding the disorder. An historical account, through Manie Sans Delire, Moral Insanity, psychopathy and sociopathy, as the disorder evolved through medical literature, provided an excellent background.

The high prevalence of the disorder, the ease with which it is rationalized and the great human and economic costs are well presented.

The chapter on etiology "The seeds of despair" is a particularly informative resource on the possible biological underpinnings of the disorder. The book does well in identifying psychosocial factors that play a role in the genesis of this disorder.

The authors are successful in explaining neurochemical concepts such as "the serotonin story" in a readable and understandable style valued both by mental health professionals who may need a review of this topic, and lay people.

The use of case histories in explaining the origins, diagnosis, possible treatments and natural history of antisocial personality disorder is particularly effective.

The book, unfortunately, does not emphasize enough the value of early prevention of conduct disorders as the most long lasting and likely successful intervention. Spotty mention is made of the continuity of pathology from childhood to adulthood as the title "Bad Boys: Bad Men" suggests but this is not continuously done through the text.

The chapter on serial murderers is helpful to the reader in explaining that most murderers are not psychotic as popular myth suggests and that many are antisocial personality disorders who are legally competent to stand trial.

In an attempt to provide solutions for an eternally vexing problem that defies an easy answer, Chapter 10 provides a list of specific questions and answers for antisocial personality disorder patients and their families. It describes well the scope of the disorder and the cost to families such as domestic abuse and aftermath of substance abuse disorders. It seems unlikely that most individuals with an antisocial personality disorder would be motivated to read anything like this but, for families, this list is certainly useful.

Any clinician who has encountered antisocial personality disorder may find the list reflects perpetual therapeutic optimism, which is often misguided in these patients. It may provide false hope to patients' family members and novice therapists.

Overall, this book is highly recommended as an up to date resource on antisocial personality disorder. It could be improved with a chapter on research supporting the positive outcomes available from studies on prevention strategies for conduct disorders in preadolescent patients. This would be of great value to patients, teachers and also policy makers.

T. P. M. Ulzen MD, FRCPC
Greenville, North Carolina

All about A.D.D.; Understanding Attention Deficit Disorder.

Mark Selikowitz. Oxford University Press, Australia.1995. 199 pages. Paperback $39.95 Cdn.

This interesting book was first published in 1995 and reprinted in 1996 and 1997. Dr Selkowitz, an Australian developmental consultant pediatrician, intends to reach a wide audience of parents, teachers, doctors, psychologists and therapists who work with children with attention deficit disorder. The major aim of the book seems to be to "reappraise" ADD, so that developmental interpretations can be offered.

The book follows a set format in all six sections. There are two additional chapters: Conclusion and Appendix that stand on their own. Each section reviews a specific symptom, management strategy, or aspect of children with ADD and explains it in very simple terms, concluding with "Summary Points." These sections build up a logical sequence in explaining ADD, an approach that one would expect from a developmental pediatrician.

The first section provides an overview of the syndrome of ADD. Section two specifically describes difficulties of children with ADD such as attention difficulties, overactivity, and low self-esteem. Sections three to six describe general aspects of the syndrome, etiology, diagnosis, and treatment issues.

This book was easy to read but provoked troubling questions. The claim that it could be useful to the spectrum of readers from parents of children with ADD to psychiatrists, psychologists and therapists, seemed somewhat far-fetched and at most it is useful for parents of children with ADD. It does not cite references, except for a table outlining beneficial effects of medicine in ADD, and it contains some very debatable statements such as "all children with ADD under-achieve academically" and "ADD is a problem of performance, not of knowledge" which will definitely worry most clinicians who know very well that it is the wide spectrum of achievement and comorbidity that makes the assessment of ADD so challenging.

The author quotes some important studies regarding the etiology of ADD, which again are not referenced, although the authors are mentioned. For example, PET scans of children with ADD, when Ritalin was given, are mentioned (page 82) but not referenced. Further comments about the genetics of ADHD syndrome surprised me when the author made a definitive conclusion that ADD was inherited in approximately 25% of cases from the father and 20% of cases from the mother.

Neurotransmitter theory of ADD is well explained, including the evidence for dopamine and norepinephrine.

The section on diagnosis and assessment is useful and well written in parts. The author describes a four-part assessment: history, examination, psychometric tests, and neurophysiological testing. The descriptions of QEEG procedures and interpretations and cognitive event related potential with ADD are clear and understandable, although the author's statement that the QEEG procedure as an objective measure of ADD is stronger than can be supported by research evidence and knowledge of the pathophysiology of ADD. Unfortunately, there is no discussion of broad spectrum and narrow ADD focussed parent and teacher rating scales.

I liked the discussion about general strategies of management including home management, school management, and behavior modification. Some of the statements regarding medication management do raise concerns as they may oversimplify and lack research support, for example: "Approximately 90 percent of children with ADD are helped by medicines," "The most thorough way of carrying this (medication trial) is by means of a two stage trial," "Computerized testing provides a very precise measure of performance and is often used for first stage testing." Although the treatment of ADD may differ in different countries, to my knowledge even well equipped university clinics do not rely on computerized tests to measure medication response and clinical acumen is still a valued part of the overall management of ADD.

This book provides a simplified version of what ADD syndrome is and at the same time gives rise to controversial points about the assessment procedures and medication management. Even then, one can see why this book has been reprinted several times. The ease of reading, appropriate use of clinical examples and situations and demystification of complex clinical and pathophysiological measures can offer an interested parent of child with ADD important basic information.

While parents will find the book very useful, I do not believe that it is for psychologists or psychiatrists who work predominately with ADD. My main criticism is that it is not well referenced and provides definitive views on controversial, emerging findings of ADD syndrome.

Prat Reebye MD, FRCPC

Asperger Syndrome.

Edited by Ami Klin, Fred R.Volkmar & Sara S.Sparrow. Guilford Press. N.Y. 2000. 489 pp. $45.00 U.S.

This book's 16 chapters range widely. They cover not only Asperger Syndrome (AS) but the many other conditions which may be related to, or overlap with, AS. These include, for example, Autistic Disorder (AD), high functioning autism, Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS), non-verbal learning disorder, "semantic-pragmatic syndrome", "multiplex developmental disorder," "schizoid personality in childhood," "broader autism phenotype," and various categories of developmental language disorder.

A total of 27 authors address just about every conceivable aspect of AS and related disorders. Most work in the U.S. but four are from the U.K. and two (Peter Szatmari and Isabel Smith) are Canadian. Another claims allegiance to both Windsor, Ontario and New Haven, Connecticut.

The chapters are grouped under these five headings: Behavioural Aspects; Family Genetics and Neurobiological Aspects; Related Diagnostic Constructs; Assessment, Treatment and Intervention, and Adulthood; and Perspectives on Research and Clinical Practice, and Parent Essays.

This book contains a lot of information. All who work with children whose disorders fall into any of the categories listed above should certainly read it. Each chapter is followed by an extensive list of references – one of them has 224 taking up 12 pages. Unfortunately many of the chapters are written in execrable prose. For example:

In the first sections of this chapter, we review the background and content of the investigative effort that has been expended in our laboratory with respect to NLD. (Page 231.)

I suppose they are trying to say that they will tell us about their research into NLD. While some chapters are better written than others, it is only when one comes to the four "parent essays" that make up the final chapter, that the book becomes a pleasure to read. These are wonderful. Don't fail to read them.

Many readers will look to this book for guidance in treating AS children. They may be a little disappointed. The chapter on "Treatment and Intervention Guidelines" is written by two of the editors (Klin and Volkmar). The "guidelines" are reasonable but the writing is awful. Sentences of five lines, occasionally more, abound. Also disappointing is the chapter on "Psychopharmacological Treatment of Higher Functioning Pervasive Developmental Disorders." This consists largely of a description of a "naturalistic study" of psychotropic medication use in "100 subjects with AS and related conditions." This found antidepressants (mostly SSRIs) to be the most commonly used, followed by stimulants, then neuroleptics and then mood stabilizers. My response to this was, "So what?" Which of these actually worked? What were they supposed to do? Were they sometimes used as a counsel of despair? Like most of the chapters this one raises more questions than it answers.

After reading this book I was at least as confused as I was before I read it. I wonder if we really should be looking for discreet, well-defined disorders? Or are we dealing with a heterogeneous collection of children who have, in varying degrees and combinations, problems with socialization, verbal and non-verbal communication, motor functioning and so forth? Is it of any real help to label their disorders as AS, AD, PDDNOS, and so forth? Will we find a pot of gold at the end of the rainbow or is what we are seeking a myth? Peter Szatmari, whose excellent chapter (14) stands out from most of the others as a model of clear writing, alludes to this issue, though it remains unresolved. He suggests that, "An alternative to seeing autism and AS as the same or different is to think of different but potentially overlapping developmental trajectories."

There is much poor writing in this book so, by way of contrast, I'll end with a quotation from Walter, the subject of one of the parent essays in Chapter 16.

My intelligence has gotten me out of some situations, allowed me to get good grades, and excel at strategy games. My unsociability has prevented me from joining a mob, or getting into embarrassing situations (if you are unsociable you can't get into an embarrassing situation because you have no social respect to lose). I am not, however, someone to be avoided. I have two good (human) friends and a guinea pig. The guinea pig likes me very much, especially for my magical food-bringing powers. It believes I am made of food, as it has shown many times.

Philip Barker MD.

Children in Therapy: Using the Family as a Resource.

Edited by C. Everett Bailey. Norton Publishers. N.Y. 2000. 529 pp, hardcover $60.00 Cdn.

Most of us are trained in, at best, a limited number of therapeutic methods. So we may sometimes feel the need for an approach other than those in which we have been trained. When we do, this book could be useful. Its 13 chapters provide descriptions of a variety of therapeutic approaches and techniques, with an emphasis on methods involving families.

All but two of the book's 36 authors are from the U.S.A., with just two Canadians included. The book's three sections cover "Theoretical Perspectives," "Content Areas", and "Additional Perspectives". There is much of practical value throughout. Among the topics addressed are the treatment of sexually abused children, children who have been victims of violence, anxious children, depressed children, oppositional children, children of divorce and, of course, children with ADHD.

In his introduction the editor suggests that "the voices of children" are given little attention in therapy (page xxii). He states also that special efforts may be needed to involve fathers who, he says, are often "excluded or resistant to participate" (page xxiii). I found myself wondering how widely this is the case, but no harm will come of the suggestions made in this book as to how these problems may be countered.

The "additional perspectives" section discusses how to engage families, fathers, and parents in therapy as well as the matter of resilience in children, and children's social and emotional development, and its applications for family therapy.

This is a mainly non-medical book. Only one of the authors is a physician and there is minimal mention of pharmacological treatments. Readers of this journal may be surprised, even taken aback, to find that there is little discussion of a role for psychiatrists. A possible role for medication is mentioned in the chapter on the treatment of depression. The authors do, at least, acknowledge that, if a child is on medication for "depressive symptoms or comorbid psychiatric disorders," the family and the therapist should "maintain communication with the psychiatrist to help coordinate treatment." (Page 229.) The psychiatrist is generally presented as a distant figure, not intimately involved in the therapeutic effort. If this book is any indication, it seems that child psychiatrists play a smaller part in the treatment of disturbed children in the U.S.A. than they do in Canada.

Medicine receives a sideswipe in the chapter on ADHD with the statement that, "Unfortunately, many children are medicated by well-intentioned physicians simply upon the "diagnosis" of ADHD by teacher or parent." Can this really be a common problem?

I also found surprising the minimal mention genograms get in this book. Their value is mentioned in the chapter on "Internal Family Systems Work with Children and Families"; and in the chapter on "Engaging Families in Therapeutic Play", the use of "family play genograms" is discussed, but that's it. Personally I find genograms enormously helpful in assessing families and planning treatment. I guess I'm in a minority.

On the whole the book is well written though there are many places in it where points could have been made more concisely. I believe that all who undertake therapy with children will find something of value in it, and it should be in the libraries of centres where disturbed children are treated.

Philip Barker MD

Developmental Health and the Wealth of Nations: Social, Biological and Educational Dynamics.

Edited by Daniel P. Keating and Clyde Hertzman. The Guilford Press. N.Y. 1999. 406 pages. $45.00 US.

The book Developmental Health and the Wealth of Nations arises from the work of the Population Health Program of the Canadian Institute of Advance Research and its founding president, Dr. Fraser Mustard. The twenty-seven contributors from throughout Canada, the United Kingdom and the United States piece together a set of observations, hypotheses and implications that tie the social well-being and economic wealth of societies to the developmental health of children with an emphasis on the mental and emotional well-being. As a result, this book places a very high social and political priority on ensuring the optimal development of our children and youth. This is probably not news to child and adolescent psychiatrists but what matters here is the public stating of the priority and the science to back it up.

The authors introduce modernity's paradox in which we now live in societies generating unprecedented and record wealth yet create a degree of social stress such that even children and families living in apparently secure economic settings are developing difficulties which may undermine the very talents needed to continue with successful wealth production. Although historians can point to statements throughout recorded time about the degeneration of children and youth, the authors are not as dismissive, noting that there is much more scientific evidence of social change now than ever. The book helps to describe the science and choices between blissful reassurance and grave social concern.

Part I of the volume examines the growing recognition of a strong association between the health of a population and the size of the social distance between members of the population. This is "the gradient effect." Societies with sharp social and economic difference (a steep gradient) among individuals in the population have an overall level of health and well-being that is lower than in societies where these differences are less pronounced. This gradient holds for a wide variety of physical (life expectancy, cardio-vascular disease), cognitive (intelligence testing), school (school attainment), emotional (depression, anxiety), behavioral (anti-social, aggressive) and mental health outcomes. The term 'developmental health' describes this full range of developmental outcomes.

Part II examines the possible pathways mediating the effects from steep social gradients to individual health. Three processes with supporting evidence are proposed. The first derives from the observations of neural development and the way in which it takes place in the growing infant to match the environment to which it is exposed. This process is called neural sculpting. The second process, neuroendocrine development, incorporates the development of the endocrine system as it is affected by the experiences of the early infant and child (e.g. trauma and corticosterone release). The third process is psychoneuroimmunology. Early development can affect overall resistance to disease throughout life and to degenerative disorders at the end of life. In addition to these mediating processes, evidence is reviewed that there are sensitive periods in early life for the development of affect regulation, attention regulation and social regulation. Overall these processes are affected by many of the differing characteristics of the socio-economic gradient and constitute the 'biological embedding' of the environmental experience into the developing child.

The steeper the socio-economic gradients, the more the characteristics of the various levels affect individual growth differentially and, for the most part, detrimentally for those on the lower ends.

Parts III and IV shift from the effects of society on the individual's growth and development to the characteristics of a society that could function in a manner to optimize the developmental health of its citizens. This would be a 'learning society' capable of organizing and acting on behalf of human development. An examination of the human developmental conceptual framework created earlier in the book naturally leads to implications for social organization and functioning to support this learning society. As the authors note, we need to "grasp the core dynamics of the system and move it toward greater prosperity and developmental health - which, we suspect, may become fundamentally the same in the not too distant future."

Part IV leads off with Dr. Dan Offord's work on "Lowering the Burden of Suffering" with clinical, targeted and universal approaches. This is followed by examples of programs that lower aggressive behaviors and improve school readiness and academic attainment in school. Lisbeth Schorr's book 'Within Our Reach" would make an ideal follow up to this book as it presents a wide range of evaluated programs, which are effective during various developmental stages and enhance the mental, emotional, behavioural and physical health of children and youth.

As an edited book the writing styles do vary. However, Keating and Hertzman should be congratulated for ensuring that some similarity for format is followed and that this includes clear well written summaries for each chapter and each part. The science can be a bit difficult in some of the chapters but the message of the book comes through loud and clear. If we do not look after the developing health of our children, we will sacrifice the economic wealth of our nation. This is even more crucial with our shift to knowledge based economies, and paradoxically, potentially aided by this knowledge because we can now collect and evaluate the status of our children more accurately than ever. This can set the stage for a learning society in which we must provide the incentives not just for economic activity but for healthy human development. These incentives will need to drive healthier development as powerfully as profits drive economic activity.

While this is not a book that will leave the child psychiatrist with improved clinical knowledge or skills, it is a book that reaffirms the work of child psychiatry. Child development and its affiliated studies is at the cutting edge creating and maintaining a healthy society. This book may not belong on the desk of every child psychiatrist but does belong on the desk of every political decision maker. They are the ones who must set the policies that can enhance child development, shift the socio-economic gradients and build the wealth of the nation. Child psychiatrists who use this book will bring its knowledge to a wider public and enhance the role of child psychiatry in advocacy for children.

Wade Junek MD

Social Work Practice with Children.

Nancy Boyd Webb. The Guilford Press. N.Y. 1996. 390 pp. $35.00 U.S.

This comprehensive text provides readers with a useful resource in the fundamentals of social work practice with children. The author, an educator in social work at Fordham University and a family social work practitioner is an acclaimed advocate for drawing attention to the special needs of children. In addition, the author has been credited with improving the training of clinicians in evidence based methods of helping children that are appropriate to children's developmental age and understanding.

The book begins with the author's ecological-developmental framework and integrates common principles of several different approaches into a practical and seemingly effective model of practice. Unfortunately, due to the publishers' oversight the book provided for the review had 12 blank pages in the first four chapters. Chapter five illustrates the highly readable and 'keep it simple style' of writing that would be most helpful to undergraduate students learning about the essentials of case management: 'contracting, planning interventions, and tracking progress.' Chapters six to nine provide different methods of helping children in the context of individual therapy, working with the family, group work with children and school-based interventions. The format applies case studies, along with theoretical frameworks and corresponding interventions to depict the overall process of helping children and families. Each chapter includes treatment summaries, insightful commentaries, ethical considerations and discussion questions.

The remaining chapters cover a wide range of challenging topics including: helping children in nontraditional families, families affected by illness and death, families coping with substance use disorders, out of home placements and foster homes, along with victims and witnesses of family violence. The idealized clinical examples provide guidance on how to help children in these special circumstances. The closing chapter focuses on global factors of chronic poverty and homelessness, HIV/AIDS epidemic, displaced populations due to war and natural disasters, and social policy development.

The author challenges the reader to adapt to the global changes and to recognize the value of inter-professional collaboration and of parents as

partners in their children's treatment. The selection of cases, list of figures and tables, and resource guide enhances the value of the book as a learning tool for advanced undergraduate and graduate level students interested in clinical practice with children.

Gilbert Egamino M.S.W.

Letters to Children in Family Therapy: A Narrative Approach.

Torben Marner. Jessica Kingsley Publishers. U.K. 2000. 110 pp. Paperback $12.95 U.K.

In Letters to Children in Family Therapy, Marner provides the reader with an enjoyable look at how to use correspondence as a therapeutic tool with children. The text includes a basic theoretical foundation upon which the idea of writing letters to children is founded. For example, Marner, reminds the reader that in narrative therapy the clinician becomes a teammate with the child and provides the opportunity for the child to write a script and fight against the problem. Several examples of letters, which rely on creative images and fantasy as means of tackling various childhood dilemmas, are provided to illustrate the tool's usefulness. The text is a quick and easy read, yet achieves the goal of wetting the reader's appetite to use letter writing when working with children.

One of the book's strengths is that the process of letter writing illustrates and becomes the content. The text itself parallels the strategy being introduced, by writing in letter format. However, this may also be a limitation because it makes specific elements of letter writing difficult to decipher. Marner does clarify necessary points to consider when using letter writing, such as readiness of the child, and timing. Yet because the material is provided in narrative format, it is possible that the reader could be caught in the flow and content of the letters, and miss several aspects of what makes this technique effective.

Marner speaks to an audience which could include newcomers to play and narrative therapy, as well as clinicians who want a refreshing look at what keeps this field inspiring. In general, an excellent addition for the library of any inspiring and strengths based therapist.

Michelle Schurter MSW, RSW

Outcomes and Incomes: How to Market Your Psychotherapy practice by Measuring Outcomes.

Paul W. Clement. Guilford Press. N.Y. 1999. 244 pages. $50.00 US

This "How To" of psychotherapy practice evaluation and promotion is a succinct user-friendly manual for the modern private practice clinician. The book is easy to read and straightforward to use. It is simply divided into 2 sections: the first focus is measurement and the second is a large catalogue of outcome measures with a description of each. In addition, all the scales are included on a CD ROM written in 3 formats.

The first section describes outcome measurement in private practice. Chapter 1 starts with a summary of "survival" tactics for the therapist facing the "industrialization of mental health practice". Here he outlines the focus of this book, which is arming oneself with data to improve care, demonstrate treatment effects and promote one's clinical practice. The simple point made here is that data is now a necessary marketing tool in the 21st century. Dr. Clement goes on to differentiate outcome evaluation from research, to describe meta-analysis, and to outline to uses of data once collected.

Chapter 2 outlines the implementation of series of a 10 level Scale of Functioning as a core outcome measures. These simple patient-tailored measures he outlines are brief and easy to convert to effect sizes.

In Chapter 3, Dr. Clement spells out how to organize your working database. He elaborates on the 64 items he has found useful to include. He outlines the practical value of this system in mailing bills, record keeping and general administration.

The first 3 chapters set up the final chapter of this section: how to use the data to improve and market your practice. He outlines here how to use the database to answer specific questions such as what are the demographics of patients treated and how long did treatment take. Qualitative analysis is elaborated on, with examples of how to extract and define treatment effectiveness across specific patient categories. He goes on to describe marketing techniques that include asking the successfully treated patient at outcome to consider referring friends and family members if they need services.

In Section 2 Dr. Clement outlines 54 problem areas and related rating scales, which may be used for each. For each problem he describes some epidemiology. Where there are scales described, he outlines when to use the scale, the source and background of the scale, the reliability, the validity, how to score and interpret the scores and finally, alternative measurement tools. He outlines how to convert raw scores to standardized Scale of Functioning scores.

The main weaknesses of this book are also its strengths. These include its relatively summarized review of the literature and field of psychotherapy research and its business-like, systematic and logical movement from one section to another. This may seem stilted to some therapist readers, but it is ultimately an efficient march to a desired destination.

In summary, Dr. Clement has done a great deal of legwork for clinicians through this book. I appreciate him sharing his strategies for the rewarding, patient-focused and business-wise task of monitoring, improving and promoting one's practice.

Allan Abbass MD

The Recognition and Management of Early Psychosis: A Preventive Approach.

Edited by Patrick D. McGorry and Henry J. Jackson. Cambridge University Press. N.Y. 1999. 495 pp. $90.00 U.S.

It is fitting that The Recognition and Management of Early Psychosis, the first book to focus on the topic of early psychosis, is edited by Dr. Patrick McGorry along with Henry Jackson, one of his long time collaborators. More than any other single person, Dr. McGorry has provided leadership, inspiration and energy over the past decade for what can be called 'the early psychosis movement,' an effort with no less lofty a goal than to change fun-

damentally the way psychiatry conceptualizes psychotic disorders.

Central to this new paradigm, which Dr. McGorry clearly articulates in the introductory chapter, entitled 'A stitch in time...', is a rejection of the pessimism which has been endemic among clinicians regarding the prognosis for people with psychotic disorders, including schizophrenia. In its place, McGorry offers optimism based on research as well clinical experience demonstrating that psychotic disorders are highly treatable. Perhaps more importantly, McGorry goes beyond the idea of providing access to best practice clinical services for patients once a psychotic disorder emerges, ie secondary prevention. He cogently argues for 'indicated prevention,' meaning treatment prior to the appearance of the full clinical syndrome. Of great interest is the summary, by Dr. Alison Yung, of recent results from Australia demonstrating criteria that identify a pre-psychotic patient group in which 40-50% of the patients convert to full-fledged psychotic disorder within 12 months of detection. The development of the Personal Assistance and Crisis Evaluation clinic (PACE) provides practical information about organizing services for this patient population.

As might be expected, much of the material in the book is drawn from the work of Dr. McGorry and his colleagues in Melbourne, Australia. The Early Psychosis Intervention and Prevention Centre (EPPIC), which they have developed over the past decade, is perhaps the most comprehensive early psychosis program in the world. EPPIC provides service for the entire state of Victoria, and specifically within an 800,000-population catchment area. About 250 persons with recent onset psychosis enter the program each year. Patients remain in the program for 18 months.

Key to the EPPIC approach is the early identification of psychosis. Dr. Yung provides a concise and readable summary of research findings regarding the onset of psychosis and the organization of the EPPIC assessment services, which includes a rapid response team.

The chapter on initial treatment of psychosis, by Drs. Kukarni and Power clearly presents the 'myths' about psychosis which have guided treatment in the past (for example, schizophrenia is a chronic, deteriorating illness) along with a useful discussion of the common fears among patients regarding drug therapy. Additional chapters on psychological interventions, case management, substance abuse, family interventions and day programs provide an in depth review of the components of the EPPIC program and how they relate to the early intervention paradigm.

The sixteen chapters of the book read like a manual for those interested in establishing an early psychosis service. Clinical case vignettes are used frequently to illustrate the practicalities of providing service at the earliest possible point in the course of psychosis.

The final chapter, sub-titled 'Early Intervention In The Real World,' directly addresses the process of creating an early psychosis service and the obstacles that may be encountered. In this, and other chapters, the current state of research evidence supporting an early intervention paradigm is presented in a forthright manner. For example, it is clearly acknowledged that the question of whether a reduction in the duration of untreated psychosis will, in and of itself, result in an improvement in clinical outcomes, remains to be answered. It is noted that studies are in progress in Scandinavia aimed at answering this and related questions. McGorry argues that it is important to proceed in developing services while carrying out evaluative research.

The authors note that as new early psychosis programs emerge throughout the world they will naturally develop in different ways depending upon the local context. If there is a drawback to this book it would be that so much of the content is drawn from the EPPIC experience that the reader may feel overwhelmed by the thought of re-creating the extensive programming that makes up EPPIC or confuse the specifics of the EPPIC program for the essence of the early psychosis paradigm. However, that possibility is a small price to pay for the richness of the presentation in this book. There is no doubt that this text marks a milestone in the growing efforts to take a more optimistic and assertive view of psychotic disorders and their treatment, a change which can only benefit the next generation of young people with psychosis and those who care for them.

Dr. David Whitehorn and Dr. Lili Kopala
Early Psychosis Program
Dalhousie University Department of Psychiatry

CHIEF OF PSYCHIATRY, SENIOR PHYSICIAN HEAD DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY

The IWK Health Centre and the Department of Psychiatry, Dalhousie University, Halifax, Nova Scotia, Canada, invite applications for the position of Chief of Psychiatry / Senior Physician, IWK Mental Health Program and Head of the Division of Child and Adolescent Psychiatry at Dalhousie University. We are seeking an outstanding leader to join a well functioning and comprehensive Mental Health Program which provides a range of secondary and tertiary services to children and youth from Canada's Maritime Provinces. The Mental Health Program has a strong and productive relationship with Dalhousie University in fulfilling the academic and research missions of both the IWK and the Faculty of Medicine. The start date is negotiable; however, the Health Centre and the University would like to have the appointment process finalized by March 2003. A detailed description for this position is available from nancy.steel@iwk.nshealth.ca.

Inquiries should be directed to

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For more information about the IWK Health Centre, see our Web Site: www.iwk.nshealth.ca

FULL TIME ACADEMIC CHILD AND ADOLESCENT PSYCHIATRISTS - EATING DISORDER PROGRAM AND DAY TREATMENT PROGRAM

London Health Sciences Centre and the University of Western Ontario, Division of Child Psychiatry, London, Ontario, Canada have an excellent opportunity for 2 full time academic Child and Adolescent psychiatrists in a newly developed Eating Disorder Program and a newly developed Day Treatment Program. London is a city of over 330,000 people and is located two hours from Detroit, Buffalo, and Toronto.

The Eating Disorder Program consists of inpatient beds, day treatment program, outpatient services and outreach for children and adolescents in South Western Ontario, a region with a population over 1 million people. The successful applicant would be involved with clinical service, education and research.

The Day Treatment Program consists of 10 places for children and adolescents 17 years and under. The following diagnoses will be treated: mood disorders, anxiety disorders, early psychosis, and psychosomatic illnesses. The successful applicant would be involved with clinical service, education, and research.

Successful candidates will be licensed to practice (or eligible for a license) in Ontario. The Division of Child Psychiatry at the University of Western Ontario is an expanding and stimulating environment. The positions offer excellent benefits and remuneration is commensurate with academic rank.

Interested applicants should send a curriculum vitae and letter describing their qualifications and interests to:

Margaret Steele, MD, FRCP(C)
Chair, Division of Child Psychiatry
University of Western Ontario
Physician Lead, Child and Adolescent Centre
London Health Sciences Centre
346 South Street, Room 102D
London, Ontario, Canada N6A 4G5

INSTRUCTIONS TO AUTHORS AND CONTRIBUTORS

Manuscripts or material are welcome on any topic relevant to child and adolescent mental health, including child and adolescent psychiatry, child psychology, pediatrics, pharmacology, adult and geriatric psychiatry, internal medicine, or any other branch of medicine, psychology, sociology and occupational health relevant to child and adolescent mental health practitioners.

Original Articles and Reviews (maximum 3000 words including tables and references)
Descriptive and qualitative articles, quantitative survey or research articles, review articles, case reports and letters to the editor will be considered. There will be a peer review process for submissions, with the principal author being informed of the results of the review within six weeks of submission. Ordinarily, only original articles will be considered. However, reproduction of published material will be considered in extraordinary situations, where the material has a unique value to the membership of the Canadian Academy of Child Psychiatry. Reproduction of material will only occur after explicit permission has been obtained from the primary author and publisher.

Case Reports (maximum 1000 words including references if any) and
Letters to the Editor (maximum 300 words including references if any)

Format of Submissions
All submissions should be made *both* with a hard copy and on a floppy disc using an MS Word compatible format, even when an e-mail submission has been made. Submissions should be in Arial or Times New Roman, *at least 11 point font, with double-line spacing*. Titles and sub-titles should be in bold. The names of *all* the authors, their relevant qualifications and affiliations, the address, telephone number, fax number and e-mail address of the first, or senior author should be clearly indicated below the main title. References should be as follows in the text of the article: Gorman et al (1998) or …….(Gorman et al, 1998). References should be as follows in the reference list at the end of the article: in alphabetical order, in chronological order where there is more than one reference for the same author or authors, and, when there is more than one reference in the same year for the same author or authors the following notation should be used: Gorman et al (1998a, and 1998b). It is the responsibility of the authors to ensure that their work has received ethics approval where required. If an author wishes to submit their article(s) which has/have been published elsewhere, they should obtain and submit the written permission for republication of this work from the publisher who holds the primary copyright.

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