Editorial

Practicing Child Psychiatry: Life in the Clinic Since June, 2003

Mary K. Nixon, MD

Theses days one could say that practicing child psychiatry has its share of challenges. As child psychiatrists we are not unfamiliar with dealing with child and adolescent mental health issues that get extensive reporting in the media. The use of newer antidepressants in the treatment of pediatric major depression has become a controversial issue both in the media and amongst professionals since June of 2003. This occurred with the release of the report by the Medicines and Healthcare products Regulatory Agency in the UK regarding the safety and efficacy of paroxetine in children and youth: paroxetine "must not be used for treatment of children with depression." The UK release was followed shortly thereafter by a release from the Food and Drug Administration (FDA) in the US: there is "currently no evidence that Paxil is effective"

A barrage of media reports (and misreports) on the safety and efficacy of antidepressants in children and youth ensued. A wave of concerned parents requested, understandably, that their child or adolescent's antidepressant prescription be reviewed by their physician or specialist. Another natural consequence has been that general practitioners and pediatricians, often the front line for mental health care in this age group, have increased their requests for psychiatric consultation regarding the use of antidepressants. Referrals to outpatient consultation services are often taxed at the best of times. Already long waiting lists continued to expand. The chronic shortage of child and adolescent psychiatrists and the limited resources for therapies such as cognitive behavioral therapy has not helped the situation. Parents of depressed children and adolescents are often reluctant to consider a trial of antidepressant medication when it may be indicated and physicians have become wary themselves as the results of published and unpublished data became suspect.

Carrey and Virani published in the Review a commentary on "Suicidal Ideation Reports from Pediatric Trials for Paroxetine and Venlafaxine" in our November 2003 issue during the early period of the controversy (Carrey and Virani, 2003). Their list of "starting points" for prescribing the newer antidepressants in this age group have helped guide some of us over the past year. More recent events, including the re-analysis of safety data from the FDA based on the Columbia University reclassification of suicidal behaviours, has lead us to the need to again review this topic.

In this current issue of the Review, Cheung and colleagues give their commentary on the safety and efficacy of antidepressants in children and adolescents and provide an update for readers. In their paper they review a number of the major studies and possible factors associated with the interpretation of these results. The reclassification data from the FDA is also presented. They list a number of suggestions for prescribing based on the available data.

With the addition of the black box warning by the FDA in October 2004 in the United States, many clinicians and researchers have expressed concern regarding how this will affect their clinical practice as well as the future of pediatric psychopharmacology. Funding resources such as industry may shy away from supporting pediatric drug trials for major depression. I am aware of at least three further studies that are pending completion including one on treatment of resistant depression in adolescents, one on the treatment of suicidal adolescents, and the other on discontinuation of citalopram in depressed adolescents. Stay tuned as the practice of evidence based treatment in child psychiatry continues to evolve.

Also in this issue, I have the pleasure of introducing our new president of the Academy. Dr. John Leverette is Deputy Head and Chair, Division of Child and Adolescent Psychiatry in the Department of Psychiatry, Queen's University and has served on the Executive and Board of the Academy. John's interests include postgraduate medical education research, enhancing resident competence in self-directed learning, the teaching of community/rural child psychiatry, collaboration in shared mental health care models with family physicians, cognitive marital therapy, forensic child psychiatry, the psychiatry/government interface and medical administration. His report to the membership highlights some of the challenges as well as new directions of the Academy.

I would like to extend my thanks to those who have contributed their original articles, book reviews as well as to my guest editors and theme issue contributors over the past year. Thanks also go to our hardworking reviewers. In addition to thanking past and present members of the editorial board I would particularly like to acknowledge the contribution of our outgoing editorial assistant Ms. Tena Roebuck. Thank you Tena for all your efforts and dedication to the Review and all the best in your new position.

To our readers , all the best in 2005 and happy reading.

Sincerely, Mary Kay Nixon

REFERENCE

Carrey, N. & Virani, A. (2003). Commentary: Suicidal ideation reports from pediatric trials for paroxetine and venlafaxine. *Canadian Child and Adolescent Psychiatry Review*, 12(4), 101-102.

Report to the Membership

John Leverette, MD, President CACAP

I am grateful to our Editor, Mary Kay Nixon, for the opportunity to introduce myself and provide you with an update of the Board's activities and directions on your behalf.

In October, we emerged from a most successful year that saw us, with stabilized finances, delivering to the membership an Annual Conference of the highest quality thanks to the leadership of Harriet McMillan, the Scientific Committee and the combination of Philippe Lageix and Luc Morin who delivered the Local Arrangements. Notably this was an independent, financially successful meeting attended by well over 200 registrants demonstrating this Academy's coming of age. As well and due to the efforts of Mary Kay Nixon, additional revenues flowed to the Review.

The Board has been engaged in considerable brainstorming in the two months and is becoming quite proficient at email decisions and teleconferences. This communication provides an opportunity for the membership to share the goals that the Board has developed and the strategies used or under consideration to achieve them.

Driven by our development, the current goals are to improve the benefits of membership for an academy of some 400 members and to have CACAP play a strong role on the national scene - particularly in the debates and decisions that are underwriting the matter of subspecialty recognition.

A context for this has arisen through several developments. It has been partly created as the Board has worked to improve and stabilize our financial position. The finances for the Annual Conference and the Review are now independent of the Operating Budget with the latter's revenue derived primarily from annual membership fees. These deliverables look now to generate their own revenues to cover expenses and generate surplus for their ongoing activity. It is recognized that this will be harder for the Review but revenue neutrality remains the goal over time. Furthermore, change is upon us. Liz Manson, who has so capably provided administrative leadership for us, has announced her 'retirement'. We need to find a new Administrator and a new home for the National Office. Finally, subspecialty recognition discussions have continued under the umbrella of the Canadian Psychiatric Association (CPA) and CACAP is actively engaged.

GOALS

Membership Benefits

- Stabilize and Develop the Organizational Infrastructure
  This includes relocating the National Office, hiring a new Administrator, and attaining a high quality website
  Strategies
  - *The funding necessary for these initiatives will exceed the current revenues in the Operating Budget. It is anticipated that an increase in membership fees will be required in addition to exploring industry support for the website as has been done by some national medical associations.*
  - *We are exploring moving the National Office to Ottawa and sharing space as an independent organization in the new CPA Head Office.*
  - *The position of Administrator has been recently advertised with a very gratifying applicant response. An interview team of Wade Junek, Liz Manson and I will begin interviews in Ottawa in early December.*
  - *Our webmaster Umesh Jain, on the advice of our ad-hoc Website Committee, is investigating options for website development including purchased service from CPA and an industry sponsored site with CACAP contracting out the development itself. The quality and effectiveness of the website will be determined by the funds available to support its development and maintenance.*
- Maintain and Enhance Member Benefits
  This initiative includes a continuance of high quality CE through MainCert accredited Annual Conferences and the Review, increased Board involvement in professional practice issues, and an exploration of new Standing Committees to improve services to members.
  Strategies
  - *Planning is now underway for the AACAP/CACAP conjoint meeting in Toronto in 2005. The Board has also taken a long term planning view for the Annual Conferences and is exploring the venues for 2006 and 2007 with an eye to ensuring an absence of conflict in dates between the AACAP and the CPA meetings. It is discussing the possibility of overlapping meetings with CPA in Toronto and Montreal for these years. Arrangements have been made to have Lily Hechtman continue as Scientific Program Chair from 2005 through 2007 and Umesh Jain will remain as Local Arrangements Chair through 2006.*
  - *The Board has endorsed the CPA Position Statement on the SSRIs that will be released in December 2004. This endorsement will provide guidance to Academy members and continues in effect until June 2005. The position statement will be reviewed at that time and CACAP is negotiating direct involvement in that process.*
  - *At its last meeting, the Board created an Industry Liaison Committee chaired by Umesh Jain. For some time now the pharmaceutical industry has been supporting our annual conferences with unrestricted educational grants and sponsored events and recently there has been industry support for the Review's supplement. Guidelines for managing CACAP's relationship with industry have been developed. The Board believes there is a need to consolidate and perpetuate the corporate experience in managing our relationship with industry and to explore the limits of support available for CACAP initiatives. Clearly the expected benefits of membership exceed the ability of members to generate*

the resources for these from membership fees alone. The creation of this committee is central to the Board's review of revenue generation involving a consideration of the necessary balance in the derivation of that from the membership and from the pharmaceutical industry.

- *Two new Standing Committees are being considered – a Professional Standards and Practice Committee and an Economics Committee. Informal canvassing indicates that the Academy has interested members who could lead and serve in these areas. Terms of reference are being drafted for review by the Board.*

SUBSPECIALTY RECOGNITION

- Developing the Core Competencies for the General Psychiatrist

  The Co-Chairs of our Education Committee, Margaret Steele and Ruth Russell, formally represent CACAP on the CPA's National Strategy for Postgraduate Education Subcommittee on this matter. Several other child psychiatrists are also present bringing expertise from CPA's Standing Committee on Education and the RCPSC Specialty Committee in Psychiatry. I co-chair this Working Group with Emmanuel Persad. Defining the core competencies for the generalist in contemporary practice will inform the knowledge, skills and attitudes required from the subspecialties and other areas and ultimately the nature and length of training. Submissions have been received from the Academies and other practice and educational groups. A web-based survey will be extended nationally to all psychiatrists in December and will assess the thinking of general psychiatrists on this matter as well as identifying additional views of sub specialists, trainees and psychiatric educators. A recommendation to the RCPSC Specialty Committee in Psychiatry is required by April 2005 leaving only a short time for further response from CACAP's Education Committee and, if necessary, the Board.

  Strategies

  - *all CACAP members who are also members of CPA will receive email notification and access to the survey through the CPA Website. Quebec members will be identified via email as well through membership in the AMPQ. An additional portal for CACAP members who are not CPA members will be created to ensure that all our Academy members can have input and the membership will be notified of this access point via a Canada post mailout.*
  - *CPA has agreed to provide funding to assist the Academies in reviewing their submissions subsequent to an analysis of the results of the national survey.*
  - *The Board will be ready to rapidly review the implications of the content, nature, and length of training in child and adolescent psychiatry for the generalist and to consider the impact of these on models for subspecialty training and subspecialty recognition.*

- Developing Models for Subspecialty Recognition

  The RCPSC is well aware of Psychiatry's frustration the absence of movement forward in this matter. The leadership of the RCPSC has indicated to CPA that, following the determination of core competencies for the generalist, it would look to respond with greater flexibility to modeling put foreword for subspecialty recognition by organized psychiatry.

  Strategy

  - *the Education Committee and Board will be ready to participate in model development and the analysis of such in respect to meeting the needs of children, youth and their families who require service and the aspirations of child and adolescent psychiatrists.*

This is then a busy, active agenda. It is my hope that the membership will appreciate the importance of remaining knowledgeable and informed on these matters as the Board moves forward on the goals articulated.

In closing, I extend to you the best of wishes for 2005.

Yours truly,
John Leverette

The editorial staff would like to sincerely apoligize for the mispelling of one of the author's names in the article entitled "Construct Validity of the Adolescent Borderline Personality Disorder: A Review," included in the August 2004 issue of the Canadian Child and Adolescent Psychiatry ReView. *The correct spelling for the first author's name is Helen Bondurant, MSc. It should also be noted that Dr. Brian Greenfield, MD, is affiliated with the Department of Psychiatry, McGill University, and Sze Man Tse is affiliated with the School of Medicine, McGill University, Montreal, Quebec.*

Thank you

Commentary
Efficacy and Safety of Antidepressants in Youth Depression

Amy Cheung, MD[1,2], Graham J. Emslie, MD[1,3], Taryn L. Maynes, MSc[1,3]

Since the early 1990's, antidepressants have been increasingly prescribed to youth with depression by both specialists and primary care providers in the US and Canada. However, recent warnings initially from the pharmaceutical industry, and then from Health Canada, the Food and Drug Administration (FDA), and the Medicines and Healthcare products Regulatory Agency (MHRA) have raised concerns about both the efficacy and safety of these medications in children and youth.

The warnings have also led to the increased public availability of both published and unpublished clinical trials data about antidepressants in youth. With the barrage of information and many differing opinions about the possible interpretation of the clinical trials results, many clinicians are struggling to understand and interpret what these warnings and label changes may mean for their individual practices and patients. Therefore, this article will provide a synopsis of the currently available data on the efficacy and safety of antidepressants in youth with depression and some suggestions of how clinicians may wish to incorporate this new information into their practices. These comments are based on a more extensive review completed by the authors (Cheung et al., In Press).

Depression in children and adolescents is a cause of substantial morbidity and mortality, and timely recognition and treatment is important. However, there has been a relative lack of clinical trials data available regarding this population. In order to address this lack of pediatric data, the FDA Modernization Act required pharmaceutical companies to provide pediatric data on new compounds, and provided incentives (6-month extension on patent life) for existing medications. This has lead to an increase in the number of pediatric patients with depression studied in randomized controlled trials (RCT's), from a mere 250 in 1995 to more than 2000 in 2004. In fact, only in the past 5-10 years have large clinical trials been completed for both psychopharmacology and psychotherapy specific to children and adolescents. The increased available data has also resulted in difficulties in interpreting the data.

Previous reviews, including one published in this journal in November of 2003, have outlined the evolution of the current controversy which began in 2003 when the MHRA released warnings regarding paroxetine. By December 2003, the MHRA had released a statement noting that, "the majority of SSRIs... are not suitable to be used by under 18s", with only fluoxetine considered to have an acceptable risk-benefit ratio. The FDA followed in March 2004 by issuing a statement requesting a warning label recommending close observation of patients treated with antidepressants (fluoxetine, sertraline, paroxetine, fluvoxamine, citalopram, escitalopram, bupropion, venlafaxine, nefazodone, and mirtazapine) for worsening of depression or the emergence of suicidality. The label specifically warns for patients, families, and providers to watch for signs of worsening of depression, increased suicidality, anxiety, agitation, panic attacks, insomnia, irritability, hostility, impulsivity, akathisia, hypomania, and mania in patients in all age groups. After a lengthy re-analyses of all suicide-related data from 24 randomized controlled trials (RCT's), the FDA issued a black box warning regarding the risk of increased suicidality for all current and future antidepressants used in those under the age of 18. It is of note that the not all of the data from the 24 trials are available to the public.

Since the last update in this journal in November 2003, Health Canada has convened an expert panel to examine the available clinical trials data and issued 2 warnings regarding the use of antidepressants in youth. The current Health Canada warning (June 2004) advises Canadians that "patients of all ages taking these drugs may experience behavioural and/or emotional changes that may put them at increased risk of self-harm or harm to others" (Health Canada website). As of November of 2004, Health Canada has not issued a warning in response to the FDA re-analyses and black box warning.

For extensive reviews of the efficacy and safety data, please refer to the MHRA and FDA websites, and several systematic reviews (Whittington et al., 2003; Juredini et al., 2003).

EFFICACY

Three large randomized controlled trials have been conducted with fluoxetine (Emslie et al, 1997; Emslie et al., 2002, March et al, 2004). The first was a single-site trial of 96 outpatients with major depressive disorder (MDD), aged 8-18 years. Following a 1-week single-blind placebo run-in, subjects were randomized to fluoxetine, 20 mg (n=48) or placebo (n=48) for 8 weeks. Primary outcome measures were global improvements on the Clinical Global Impression Scale (CGI-I) and changes in the Childhood Depression Rating Scale Revised (CDRS-R). Based on CGI- Improvement of 1 or 2 (very much or much improved), 56% of subjects receiving fluoxetine and 33% of subjects receiving placebo responded to treatment at exit from the study ($p=0.02$). Weekly CDRS-R scores were also significantly different between the two groups at the end of the 8-week study (fluoxetine 38.4 +/- 14.8 verses placebo 47.1 +/- 17.0; $p< .008$).

The 1997 study was replicated in 2002 in a multi-site trail involving 219 children and adolescents with MDD. 219 subjects were randomized to fluoxetine (n=109) or placebo (n=110). After a 1-week placebo run-in, subjects were randomized to fluoxetine (10 mg for 1st week, increased to 20 mg for weeks 2-9) for 9 weeks of acute treatment. The prospectively defined response criterion of 30% reduction in CDRS-R was not significant

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(p=0.093). Mean CDRS-R scores at endpoint was significantly lower in the fluoxetine group (35.1+/- 13.5) than the placebo group (40.2 +/- 13.5l p< .001). Rate of improvement based on the mean change in CDRS-R was also significant at week 1 and continuing for the remainder of the study (p< .05).

An earlier study by Simeon et al. studied 40 patients aged 13 to 18 years in a placebo-controlled double-blind study of fluoxetine. Fluoxetine was not statistically superior to placebo on any of the outcome measures. However, the results of this study is difficult to explain due to the small sample size and the methodology was not clearly described (Simeon et al., 1990).

A more recent multi-site trial, TADS (Treatment for Adolescent Depression Study) (March et al., 2004), compared 12 weeks of fluoxetine (10 to 40 mg), cognitive behavioural therapy (CBT), combination treatment of fluoxetine and CBT, and placebo in 439 patients aged 12 to 17 years. Placebo and fluoxetine alone were administered double-blind while CBT alone, and CBT with fluoxetine were administered unblinded. This study confirmed the efficacy of fluoxetine both alone and in combination with CBT for treating adolescent depression. Rates of response, based on CGI-I of 1 or 2, for fluoxetine with CBT was 71.0% (95% CI, 62%-80%); fluoxetine alone, 60.6% (95% CI, 51%-70%); CBT alone, 43.2% (95% CI, 34%-52%); and placebo, 34.8% (95% CI, 26%-44%).

Three double blind, placebo-controlled trials (1 published, 2 unpublished) have been conducted with paroxetine with mixed results. The published report involved 275 adolescents (aged 12-18) with MDD at 12 sites across North America (Keller et al., 2001). Adolescents were randomized to paroxetine, imipramine, or placebo for 8 weeks. No statistical difference was found between paroxetine, imipramine, and placebo on response on the HAM-D (66.7% vs. 58.5% vs. 55.2%. respectively) or change in the HAM-D total score (-12.2 ± .88 vs. -10.6 ± .97 vs. -10.5 ± .88). Secondary outcomes such as the CGI, however, were positive for paroxetine.

Two other double-blind, placebo-controlled trials of paroxetine have been conducted, but data remains unpublished. However, GlaxoSmithKline has posted the study reports for these trials on their website. Both of these trials did not show benefit of paroxetine over placebo in children and adolescents with MDD. In a study of adolescents aged 13-18 (study #377), conducted in 33 international sites, 275 (ITT) subjects were randomized to paroxetine (20-40 mg), or placebo for 12 weeks. No differences were found between paroxetine and placebo on the primary outcome variables (≥50% decrease from baseline MADRS and change from baseline in K-SADS-L depression subscale).

The second unpublished study of paroxetine with youth aged 7-17 years (study #701) was an 8-week trial conducted in 41 centers across the US and Canada. Subjects (N=203) were randomized to paroxetine 10-50 mg/day (n=101) or placebo (n=102). Neither the primary outcome measure (change from baseline on CDRS-R total score) nor the secondary outcomes measures showed paroxetine to be more efficacious than placebo.

Wagner and colleagues reported on 2 identical studies conducted in 53 centers in the US, India, Canada, Costa Rica, and Mexico to compare sertraline and placebo on 376 children and adolescents (aged 6-17) with MDD. Subjects were randomized to sertraline (n=189; 50-200 mg/day) or placebo (n=187) for 10 weeks. Based on the primary outcome measure (change from baseline in CDRS-R), sertraline subjects showed significantly greater improvement (-22.84) than placebo subjects (-20.19; p=.007) over the course of the study. Responders were defined using 2 measures. First, based on a 40 % decrease in CDRS-R at end of study using the last observation carried forward, 69% of sertraline treated subjects and 59% of placebo treated subjects were considered responders (p=.05). Second, based on CGI-I, 63% of sertraline treated subjects and 53% of placebo treated subjects were considered responders (p=.05). Although only a 10% difference was found between active medicine and placebo, due to the large number of subjects in this trial, the difference is statistically significant. One criticism surrounding the sertraline data is that the results of the 2 studies individually were negative while the pooled results was positive. However, such statistical methods are frequently used to take advantage of the increased power provided by pooling of data such as in meta-analyses.

Two studies have been conducted comparing citalopram and placebo. However, only one has been published (Wagner et al, 2004). This study was an 8-week multi-site study of 178 outpatients (ages 7-17) with MDD. Following a 1-week placebo run-in, subjects were randomized to citalopram (20-40mg/day) or placebo. Primary outcome was change in CDRS-R score from baseline to week 8 or early termination. Subjects on citalopram showed significant improvement over placebo. The change scores were -21.7 vs. -16.5 (p=.038; MHRA report). Additionally, more citalopram treated subjects met the defined response criteria of CDRS-R ≤ 28 than placebo treated subjects, (36% versus 24%, respectively, p<.05).

The second citalopram study was a 12-week trial comparison of citalopram (10-40 mg/day) to placebo (MHRA website). Two hundred and thirty-three adolescents (aged 13-18), both inpatients and outpatients, who received at least 1 dose of medicine and were included in the analysis. No significant differences were found on the primary outcome measure (change from baseline on K-SADS-P total score) or any other outcome measures. Because this study has not been published, it is difficult to interpret the results. Two clear limitations stand out about the study. First, both inpatients and outpatients were included, which may suggest increased severity of MDD. Second, there was a significant drop-out rate with only 74% of subjects in citalopram group and 79% in the placebo completing the study.

Two double-blind, controlled trials of venlafaxine have been conducted in children and adolescents (age 7-17) with MDD but both are unpublished. The data from these two studies were pooled and presented at the American Psychiatric Association Conference in 2004 (Emslie et al., 2004). Subjects (n: 334) were randomized to venlafaxine 37.5-225 mg/day (n=169, ITT) or placebo (n=165, ITT) for 8 weeks in 52 centers across the US. The primary outcome measure was CDRS-R total score at endpoint. No differences were found between venlafaxine and placebo on the primary or any secondary outcomes (HAM-D total, MADRS total, HAM-D depressed mood item, CGI-S, and CGI-I). Analyses were conducted based on 2 age groups (7-11,

12-17). In the child group, no differences were found; however, in the adolescent group, there was a significant difference found between drug and placebo on the CDRS-R change score (-24.4 vs. -19.9; p=0.02), suggesting that adolescents may show more response to venlafaxine treatment than younger children. The individual studies were underpowered to evaluate age group differences.

One other underpowered study (n=40) has compared venlafaxine to placebo with no differences found between active treatment and placebo (Mandoki et al, 1997)

In reviewing the efficacy data for antidepressants in adults and children, the response in youth does not appear to be different from adults. With up to 50% of adult trials failing, it frequently takes up to 4-5 studies to achieve the required 2 positive trials with an antidepressant in order to meet the requirement of 2 positive trials from regulatory agencies to declare a medication effective.

Given the wide range in response/remissions rates with different antidepressant trials, many have suggested there may be differences in efficacy among the different SSRI's as well as other antidepressants. However, in the different clinical trials, placebo rates varied from 33% to 60%, and yet we do not assume that the placebo pills have different levels of efficacy. Therefore, one must consider whether the differences seen in outcomes across the pediatric studies are a result of methodological differences rather than true differences in efficacy.

There are several methodological issues to consider when reviewing the efficacy data on antidepressants in youth. First, the number of sites selected for the studies vary. Obviously, the more sites used, the more variability in the conduct of the study, which impacts outcome. Table 1 shows the number of sites in the different trials. Larger number of sites in a single trial poses a range of problems including differences in the training and experience of investigators which may affect response/remission rates.

Second, inclusion/exclusion criteria and recruitment strategies of subjects may also impact on outcomes. Factors, such as age, severity of illness, comorbid disorders, treatment history, and ongoing psychotropic and psychotherapeutic interventions also varied across studies. In fact, some of the negative studies have shown a difference between active medication and placebo in the adolescents, but not in the children (Emslie et al., 2004; Wagner et al., 2003). Furthermore, the recruitment of subjects from tertiary care settings who may have more severe illness versus primary care settings may also impact on the study results.

Third, the outcomes of trials may also be affected by the study design. Differences such as duration of baseline evaluation, use of placebo run-in, duration of acute treatment, and dosing, all impact results. For example, dosing of medication for all trials have been conducted based on extrapolations from adult studies. No dose-finding studies have been conducted in the pediatric population.

Fourth, rating scales for depression severity specific to this age group were limited initially. As such, many trials utilized rating scales designed for adults. In some cases, these scales may not have yielded adequate clinical information. Some trials have used cut-off scores (e.g. CDRS-R ≤28), while others use percent change from baseline. Depending on the percent change selected, remarkably different response rates for placebo can be seen. An example is the Emslie et al. study from 1997. Even the 30% decrease in the CDRS-R was significantly different between drug and placebo, but the reported rate in the published manuscript was calculated incorrectly. The CDRS-R has a minimum score of 17, and the response rate calculation that corrects for the non-zero minimum should be used. Unfortunately, in this study, 30% change in CDRS-R score was the primary outcome variable and was reported as negative in the manuscript based on the incorrect calculation. Furthermore, secondary outcomes should be considered when reviewing study results. A decision about whether a study is positive or negative should not be made strictly based on the primary outcome measure. All outcome

TABLE 1

NUMBER OF SITES IN ANTIDEPRESSANT TRIALS IN YOUTH WITH DEPRESSION

	# Subjects	Age	# Sites
PUBLISHED			
Fluoxetine (Emslie 1997)	96	7-18	1
Fluoxetine (Emslie 2002)	219	8-18	15
Fluoxetine (March 2004)	221	12-17	15
Paroxetine (Keller 2001)	275	12-18	12
Sertraline (Wagner 2003)	376	6-17	53
Citalopram (Wagner 2004)	174	7-17	21
Venlafaxine (Mandoki 1997)	40	8-18	1
PRESENTED			
Paroxetine #377 (GSK Website)	275	13-18	33
Paroxetine #701 (GSK Website)	203	7-17	41
Venlafaxine #382 (Emslie 2004)	161	7-17	16
Venlafaxine #394 (Emslie 2004)	193	7-17	37
Citalopram (MHRA Website)	233	13-18	UNK

UNK = Unknown

information should be synthesized so that clinicians can make informed decisions about the efficacy of medications.

SAFETY

Most of what we know about the safety of antidepressants were based on data from clinical trials, and it is this data which started the current controversy regarding the use of antidepressants in youth. Although there are many adverse events reported in clinical trials for both active medications and placebo, the two types of adverse events that need to be considered when evaluating the safety of antidepressants are adverse events leading to discontinuation, and serious adverse events (SAE's). Two particular psychiatric adverse events also need to be considered: suicidality and switch to mania. It is important to remember that the reporting of these events may overlap; that is, the same adverse event may be reported as both a SAE and a reason for discontinuation.

ADVERSE EVENTS LEADING TO DISCONTINUATION

In the single site fluoxetine trial (Emslie et al., 1997), 2 subjects (4%) on placebo and 5 on fluoxetine (10%) discontinued the study due to adverse events. One subject on placebo developed mania and 1 had a suicide related event. Three of the fluoxetine subjects developed manic symptoms, 1 developed a rash, and 1 had a suicide related event. In the multi-site fluoxetine trial (Emslie et al., 2002), rates of discontinuation were not statistically different between the active treatment group (4.6%) and the placebo group (8.2%), but was higher in the placebo group. In the fluoxetine group, 1 each discontinued for rash, agitation, constipation, hyperkinesias and manic reaction (n=5). In the placebo group, 1 each discontinued for rash, abdominal pain, alopecia, anxiety, dizziness, headache, kidney infection, aggressive behavior, and self-mutilatory behavior (n=9). Three of the placebo subjects who discontinued treatment were also considered SAEs because the event required hospitalization (kidney infection, aggressive behavior, and self-mutilatory behavior).

In the published paroxetine study, discontinuation due to adverse events occurred in 9.7% (n=9) for paroxetine and 6.9% (6) for placebo (Keller et al., 2001).

The GSK website also provides details about adverse events for the 2 unpublished trials. In the international adolescent only trial (#377), discontinuation due to adverse events occurred in 11% (20/187) of subjects in the paroxetine group and 7% (7/99) of subjects on placebo. These rates are not statistically significant. In the child and adolescent trial (#701), 9 subjects (8.9%) in the paroxetine group and 2 subjects (2%) in the placebo group discontinued due to adverse events. Four paroxetine subjects had worsened depression and 1 had a suicide attempt ("emotional lability"). In addition, 1 discontinued due to agitation and irritability ("nervousness"), 1 for hostility, and 2 for medical problems. In contrast, 2 subjects on placebo were discontinued: 1 for suicidality ("emotional lability") and 1 for mood swings ("emotional lability"), insomnia, and restlessness ("nervousness"). No statistically significant differences in discontinuation due to adverse events were found between the two groups.

In the sertraline study, 9% (17/189) of subjects in the sertraline group discontinued due to adverse effects; 2% (4/187) of those on placebo discontinued due to adverse events (MHRA website). The majority (13/17) of subjects who discontinued from the sertraline arm due to adverse effects were children (Wagner et al., 2003). The commonest reason for discontinuation was psychiatric adverse events. These included suicidality, aggressive behavior, agitation, and hyperkinesias (Wagner et al., 2003; MHRA website).

In the published trial of citalopram, the rate of discontinuation due to adverse events was similar for citalopram and placebo (5.6% vs. 5.9%)(Wagner et al., 2004). Discontinuation due to agitation was reported in 2 subjects and discontinuation due to worsening depression was reported in 2 subjects (all 4 on citalopram). In the unpublished trial reported in the MHRA report, there were 13/121 (10.7%) discontinuations in the treatment group and 9/112 (8.0%) in the placebo group. Five of the discontinuations in the treatment group were due to suicide-related events compared to 2 in the placebo group.

In the combined trials of venlafaxine, 18 (10%) on venlafaxine and 5 (3%) on placebo discontinued due to adverse events. Reasons for discontinuation from venlafaxine were physical symptoms (n=8), psychiatric symptoms (n=5: 2 hostility/aggression, 2 manic, 1 hallucination), and suicide-related event (n=5: 4 suicidal ideation, 1 attempt). Reasons for discontinuation from placebo were medical (n=2) and psychiatric symptoms (n=3: 2 nervousness/hostility, 1 manic). In addition, there were 5 subjects who discontinued during the placebo run-in period for adverse events: 1 with depression, 1 hostility, 1 suicidal ideation, 1 accidental injury, and 1 unexpected pregnancy) (Emslie, personal communication).

SERIOUS ADVERSE EVENTS(SAE)

Determining whether an event is an SAE and whether it is related to the active treatment is made at the site level by the investigator. Psychiatric adverse events, such as worsening of mood or suicidal behavior are often difficult to categorize, as it is unclear if the event is related to the medication or to the illness. Suicide related events are reported as SAE's if they meet any of the 7 SAE definition requirements; however, some suicidal behaviors (i.e., cutting) would not qualify as a SAE. As mentioned, classification is problematic because many of the psychiatric adverse events or SAE's may be a result of the illness, rather than the active treatment. Therefore, placebo arms are needed to evaluate whether there is increased incidence in such events in active medication over placebo.

In the single-site fluoxetine trial, no SAEs were reported in the manuscript (Emslie et al., 1997). However, 1 subject on fluoxetine and 1 subject on placebo were hospitalized due to suicide-related events (Emslie, personal communication). In the multi-site trial, 5 SAE's were reported: 1 fluoxetine and 4 placebo subjects.

In the published report of paroxetine, 11 (12%) patients on paroxetine and 2 (2%) patients on placebo were reported to have SAE's (Keller et al., 2001). Of the 11 SAEs with paroxetine, 1 was a severe headache and the other 10 subjects had various psychiatric events including worsening of depression (2), emotional lability (e.g. suicidal ideation/gestures 5), hostility or conduct problems (2), and euphoria (1). Seven of these patients were hospitalized. Only the subject with headache was considered to have a drug-related SAE. In the placebo group, 1

subject developed 'emotional lability' and 1 had a worsening of depression.

In the international adolescent trial with paroxetine (#377), 8% (15) of paroxetine and 4.3% (4) of placebo subjects had SAE's. Three of the paroxetine subjects had agitation and 6 had "emotional lability." In contrast, none of the placebo subjects had agitation and 3 had "emotional lability."

In the child and adolescent trial (#701), SAE's occurred in 6/101 (5.9%) subjects in the paroxetine group and 1/102 (1%) patient in the placebo group. In the paroxetine group, 3 subjects had worsening of depression, 1 subject had suicidal ideation (termed "emotional lability"), and 2 had suicide attempts (termed "emotional lability") with subsequent medical conditions (1 hypertension, 1 arm laceration). Four of these subjects were discontinued following the SAE. In the placebo group, 1 subject had suicidality (termed "emotional lability"), and was discontinued from the study.

In the combined sertraline study, 7 subjects (4%) on sertraline had SAE's: 2 with a suicide attempt, 3 with suicidal ideation, 1 with aggressive behavior, and 1 requiring hospital admission for medical problems (Wagner et al., 2003). In contrast, 6 (3%) of subjects on placebo had SAE's: 2 with suicide attempt and 4 with hospitalizations due to medical conditions.

In the published trial of citalopram, no SAE's were reported in patients treated with citalopram (Wagner et al., 2004). In the unpublished trial of citalopram, specific information about SAE's was not provided in the MHRA report (MHRA website).

In the unpublished venlafaxine trials (Emslie et al., 2004), 14 (8%) on venlafaxine and 5 (3%) on placebo had SAE's. Medical SAE's occurred in 4 subjects on venlafaxine. Other SAE's in the venlafaxine group were due to psychiatric symptoms (1 agitation/hostility, 1 manic, 2 worsening of depression, 1 hallucinations) and suicidal behaviors (4 suicidal ideation and 1 suicide attempt).

SUICIDALITY

Suicidal events may or may not be classified as a SAE or a reason for discontinuation. On the other hand, a serious attempt that requires hospitalization and removal from the study would count as both a SAE and a reason for discontinuation. One difficulty in interpreting suicidal behaviors in depression studies is that suicide and suicidal ideation are a symptom of depression and occur commonly in teens. The other major difficulty in interpreting data on suicidal behavior in these studies is terminology. For example, in the paroxetine trial, "emotional lability" included suicidal ideation and suicidal gestures. Furthermore, an event such as cutting may be labeled as several different things: suicidal gesture, self-mutilatory behavior, suicide attempt, etc. Therefore, the FDA conducted a blinded re-analyses of suicide-related events to re-categorize them consistently across all studies for all diagnoses. Even with all of the suicide-related events taken together (i.e., suicidal ideation, self-harm, attempts), the number of reports remains quite small. Table 2 shows the results from the FDA re-analyses of suicide-related events in 24 RCT's. Although the risk ratios are above 1, all confidence intervals cross over 1 (with the exception of paroxetine and venlafaxine) which indicates a high probability of no increased risk with medication compared to placebo. It is of note that with more than 4000 youth enrolled in the 24 RCT's (all diagnoses/indications), there have been no deaths reported in any of the studies.

SWITCH TO MANIA

In the citalopram trials, none of the subjects developed mania (Wagner et al., 2004;MHRA website). In the sertraline trial, there was no mention of the risk of switch to hypomania/mania (Wagner et al., 2003). In the fluoxetine trials, 1 subject (1%) on fluoxetine in the 2002 study, and 3 subjects (6%) on fluoxetine and 1 subject (2%) on placebo in the 1997 study developed manic symptoms (Emslie et al., 1997; Emslie et al., 2002; Emslie personal communication). In the published study of paroxetine, 2 subjects on paroxetine developed euphoria (GSK website). In the unpublished paroxetine studies, there is only limited data on switching. One subject on placebo discontinued due to mood swings in study #701, and there were no reports of switching in study #377 (GSK website). Finally, 2 subjects (1%) developed manic symptoms during the venlafaxine trial.

As with the differences in efficacy, it is unclear why the rates of adverse effects should differ among the SSRI's. One explanation is the impact of methodological differences between the clinical trials. Several methodological issues have been raised including the method of evaluation of adverse events, and the method of reporting adverse events in these trials.

First, the evaluation of adverse events in the placebo-controlled trials have been variable and inconsistent. The different methods used to evaluate adverse events included 1) standardized side effect scales, 2) required serious adverse events reporting and 3) general inquiry or dependence on spontaneous reporting by patients. Although the majority of the studies simply depended on the spontaneous reporting of side effects by patients on general inquiry, one of the studies included the use of a standardized checklist to elicit adverse events (Emslie et al.,

TABLE 2
OVERALL RELATIVE RISK FOR SUICIDE-RELATED EVENTS IN CLINIC TRIALS OF YOUTH BY DRUG

Drug	Relative Risk (95% CI) MDD trials	Relative Risk (95% CI) All trials
Celexa	1.37 (0.53, 3.50)	1.37 (0.53, 3.50)
Luvox	No MDD trials	5.52 (0.27, 112.55)
Paxil	2.15 (0.71, 6.52)	2.65 (1.00, 7.02)
Prozac	1.53 (0.74, 3.16)	1.52 (0.75, 3.09)
Zoloft	2.16 (0.48, 9.62)	1.48 (0.42, 5.24)
Effexor XR	8.84 (1.12, 69.51)	4.97 (1.09, 22.72)
Remeron	1.58 (0.06, 38.37)	1.58 (0.06, 38.37)
Serzone	No events	No events
Wellbutrin	No MDD trials	No events

MDD = Major Depressive Disorder
95% CI = 95% Confidence Interval
Source: Hammad 2004, FDA Website

2002). Clearly, the latter method would increase the number of adverse effects reported in these trials and may account for the lack of difference between the treatment and placebo groups in that trial (Rabkin & Markowitz, 1986).

Second, there are several methodological issues that arise from the reporting of adverse events in these trials. Adverse events have generally been reported in isolation from the subjects' previous behaviors or history. Only 1 trial had collected and reported this important information (Emslie et al., 2002). As discussed above, the selection criteria for the publication of adverse events are also quite variable. Some studies only reported adverse events in the treatment groups while some studies only reported adverse events if they occurred in more than 5% of the subjects and with an incidence in the treatment group of at least twice that compared to the placebo group (Wagner et al., 2003; Wagner et al., 2004). The inconsistency in reporting has made it difficult to compare adverse events that occur in patients treated with either active medication or placebo across different studies.

CONCLUSIONS

Clinicians need to be cautious in their interpretation of research data from pediatric antidepressant trials. There is no evidence from adult data that any of the SSRIs are different from one another. Although the FDA re-analysis of the safety data has been completed, the re-analysis of efficacy data across trials is still lacking. The high variability in placebo rates across trials, from 33% to 59%, does suggest that the differences may be the result of methodological differences in the trials.

The recent controversy surrounding the efficacy of SSRIs in depressed youth derives in part from the fact that regulatory agencies require 2 positive trials for a medication to receive an indication. In recent years, up to 50% of adult trials failed and frequently up to 5 studies are conducted to achieve the required 2 positive trials. There is no likelihood that more than 2 studies will ever be completed in the pediatric population with a single medication and therefore, it is unlikely that these medications will even be given a chance to be adequately evaluated. Although it would be helpful if regulatory agencies, who have access to all unpublished clinical trials data, to conduct a meta-analyses examining the efficacy of antidepressants in youth with depression, the small number of trials completed may still pose a significant barrier. Therefore, clinicians are obligated to make their own interpretations of the limited data available.

It is well known that adverse events are common with the use of antidepressants in youth. However, the burden of illness of youth with depression and their families are also significant. The FDA re-analyses have only confirmed the need for patients and families to be fully informed about the risk of adverse events associated with the use of antidepressants, and the need for clinicians to be vigilant about monitoring youth with depression and especially in those treated with antidepressants.

Perhaps the most controversial issue is around the rates of suicide related events. There are several issues to consider when evaluating the current available data. First, suicide events are a common occurrence in the general population and even more common in youth with depression. Surveys of youth suggest that up to 19% had suicidal ideation and 9 % actually attempted suicide in the previous 12 months (MMWR, 2002). Second, contrary to these reports, epidemiological data show an association between increased use of antidepressants and decreased rates of completed suicides in youth (Olfson et al., 2003).

Several points must be considered by clinicians using SSRI's in youth with depression:

1. Recent analyses of antidepressant trials have suggested a link between antidepressants and suicidal thinking and behavior in children and adolescents with depression or other psychiatric disorders. Suicidal behavior is a symptom of depression, so determining the cause of ongoing or increased suicidal behavior in youth who are depressed is somewhat difficult. However, antidepressants may be associated with worsening of depression or increased suicidality in some patients. Patients who are started on antidepressants should be closely monitored for clinical worsening, suicidality, or unusual changes in behavior.
2. In addition to monitoring for the worsening of depression and suicidality, patients should also be monitored for agitation, irritability, and other behavioral changes (anxiety, hostility, impulsivity, akathisia, etc.), particularly during the initial few months of treatment and at times of dose changes (increases or decreases).
3. Families and patient need to be fully informed about the possible risks associated with the use of antidepressants. However, they should also be informed about the risks of not being treated for a major depressive disorder (functional impairment, suicide risk) and in the case of suicidality, the epidemiological findings of lowered suicide rates with increased rates of antidepressant use. Families should be advised to closely observe the patient for any changes in depression, suicidality, and other behavioral changes, and should communicate any concerns to the clinician immediately.
4. Patients should be evaluated for risk and/or presence of bipolar disorder. It is possible that treating such patients with an antidepressant alone may increase the likelihood of precipitating a mixed or manic episode. In the event that clinicians suspect bipolar disorder (either initially or during a trial of medication), documentation of how treatment was subsequently adjusted should be made.
5. The FDA has recommended that treatment visits be frequent during the initial weeks of antidepressant treatment (weekly for 4 weeks), slowly reducing the frequency of visits over time (every other week for the next month and then again after 3 months of treatment). In addition, patients and families should be informed that making medication adjustments without consulting the clinician can cause complications, and all medication dose adjustments should be made by the doctor.
6. Although no monitoring schedule has been suggested by Health Canada, "doctors are advised to carefully monitor patients of all ages for emotional or behavioural changes that may indicate potential for harm, including suicidal thoughts and the onset or worsening of agitation-type adverse events." (Health Canada Website)

7. The Health Canada advisory applies to the following antidepressants:
   - Bupropion (Wellbutrin and Zyban)
   - Citalopram (Celexa)
   - Fluoxetine (Prozac)
   - Fluvoxamine (Luvox)
   - Mirtazapine (Remeron)
   - Paroxetine (Paxil)
   - Sertraline (Zoloft)
   - Venlaflaxine (Effexor)
8. Physicians may choose to communicate the following components of the Health Canada warning to patients and their families:

   Patients, their families and caregivers should note that a small number of patients taking drugs of this type may feel worse instead of better, particularly within the first few weeks of treatment or when doses are adjusted. For example, they may experience unusual feelings of agitation, hostility or anxiety, or have impulsive or disturbing thoughts that could involve self-harm or harm to others.

   Should this happen to you, consult your doctor immediately. Do not discontinue your medication on your own. It is very important that patients do NOT stop taking their medication without first consulting with their doctor due to the labelled risk of discontinuation symptoms with all of these drugs, except bupropion. Treatment with these types of medications is safest and most effective when the patient communicates well with the treating physician about how he or she is feeling.

   It is important to note that Health Canada has not authorized these drugs for use in patients under 18 years of age. The prescribing of drugs is a physician's responsibility. Although these drugs are not authorized for use in children, doctors rely on their knowledge of patients and the drugs to determine whether to prescribe them at their discretion in a practice called off-label use. Off-label use of these drugs in children is acknowledged to be an important tool for doctors.

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Overview of Ontario's Screening and Outcome Measurement Initiative in Children's Mental Health

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ABSTRACT

Introduction: Ontario's mental health practitioners strive to provide the best services for the most children and youth in the face of limited resources and increasing demand. **Method:** To do this efficiently and ethically necessitates identifying those at greatest risk, determining which services are most effective for a variety of children, and demonstrating improved functioning post-treatment. Standardized screening can assist in triaging those at greatest risk and outcome measurement can demonstrate improvement and treatment effectiveness. **Results:** To this end, Ontario has initiated systematic screening and outcome measurement for children ages 6 to 17 years receiving mental health services in selected hospital-based and community organizations. **Conclusion:** Standardized screening and outcome tools are key building blocks for improving the quality of service and promoting the use of evidence-based practices across the system. The lessons learned to date suggest there is a need to build individual and organizational readiness for change, to improve the state of technological literacy and infrastructure across the sector, and to improve the exchange of knowledge among stakeholders regarding the clinical benefits of the tools and the data they will produce regarding the state of children and youth receiving mental health service in Ontario.

Key words: children's mental health, outcome measurement, mental health screening, evidence-based practice

RÉSUMÉ

Introduction: Les intervenants en santé mentale de l'Ontario cherchent à procurer les meilleurs services au plus grand nombre possible d'enfants et de jeunes tout en tenant compte des effectifs limités et de l'accroissement de la demande. **Méthodologie:** Afin de rencontrer cet objectif de façon éthique, nous devons d'abord identifier les personnes les plus à risques, déterminer quels sont les services les plus efficaces et ce, pour le plus grand nombre, et également démontrer en postcure qu'il y a eu amélioration. L'évaluation standardisée est utile pour le triage et l'identification des personnes plus à risques alors que certains instruments de mesure peuvent servir à démontrer que le traitement a été efficace et qu'il y a eu amélioration. **Résultats:** La province de l'Ontario a entrepris d'évaluer et de mesurer systématiquement les résultats des interventions auprès d'enfants de 6 à 17 ans qui reçoivent des soins de santé mentale dans un certain nombre d'hôpitaux et d'organisations communautaires. **Conclusion:** L'évaluation standardisée et les outils de mesure de l'intervention sont les éléments-clefs d'un processus d'amélioration de la qualité et de promotion d'un système de soins reposant sur des données probantes. À date, les données recueillies suggèrent qu'il faut d'abord préparer les changements organisationnels au niveau des individus et des structures, améliorer les compétences et le substratum technologiques, et favoriser les échanges de connaissances parmi tous les intervenants, particulièrement en ce qui a trait aux avantages cliniques liés l'utilisation de tels outils et données.

Mots-clefs: santé mentale chez les enfants, mesure des résultats, évaluation en santé mentale, pratique basée sur des données probantes.

Ontario's mental health practitioners strive to provide the best services for the most children in the face of limited resources and increasing demand. To do this efficiently and ethically requires that we establish service effectiveness for children with diverse problems and determine how the sector can provide for a greater proportion of children in need given the resources at hand. Standardized screening practices can help us to manage long waiting lists by identifying children at greatest risk. Outcome measurement can demonstrate which treatments are effective and for whom, and the proportion of children who improve as a result of service. To this end, Ontario initiated systematic screening and outcome measurement in 1999 as part of a four-point plan for children's mental health that also saw development of intensive child and family services, mobile crisis services, and telepsychiatry. An overview of the initiative and the tools being implemented is provided.

EARLY HISTORY AND GOALS

With few evidence-based treatments in use in clinical practice, little data regarding the types of disorders with which children present for service, and no systematic evidence of outcome, the system is hard-pressed to move forward in a rational way. In response, Ontario commissioned a review of outcome measurement tools for children's mental health (Raphael, Weir, Weston, Lines & Pettingill, 1999). Based on report recommendations, service provider interviews, and results of a feasibility study (Boydell, Barwick, Ferguson & Haines, in

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press) two instruments were selected for implementation: 1) a standardized intake instrument to screen morbidity (Brief Child and Family Phone Interview / BCFPI; Cunningham, Pettingill & Boyle, 2000), and 2) a standardized outcome instrument to assess level of functioning and monitor the effectiveness of treatment (Child and Adolescent Functional Assessment Scale / CAFAS; Hodges, 2003). Children's Mental Health Ontario, an advocacy organization that promotes the well-being of children, youth, and their families, oversees BCFPI training and implementation with support from BCFPI Incorporated and the Offord Centre for Child Studies at McMaster University. CAFAS training and implementation is provided by professionals from the Community Health Systems Resource Group at The Hospital for Sick Children, in consultation with an advisory group of service providers.

SCREENING: THE BRIEF CHILD AND FAMILY PHONE INTERVIEW

Screening can assist in identifying a client's need for service and the likely presence of particular disorders. Its' value lies in enabling clinicians to efficiently identify, with a fairly high degree of confidence, areas of disturbance and severity of risk (Maruish, 1999). Over time, use of the BCFPI will allow us to determine shifts in referral trends, providing objective evidence that, as many clinicians suspect, we are seeing more children with mood management problems and severe impairments. Various organizations in Ontario are using the BCFPI to assist in making triage decisions, to connect families to interim services (e.g., readings, videos, groups), to formulate assessment plans, to obtain standardized measures of treatment outcome for comparison to "benchmarks" in the clinical literature, to support strategic organizational and regional planning, to determine whether children most in need are receiving service, and to examine the distribution of child problems for which services must be developed.

The BCFPI is a structured computerized interview administered to the parents (or teachers) of 3 to 18 year olds at the first point of intake, prior to clinical assessment and treatment. An adolescent self-report form is available. The instrument is also used in Sweden, British Columbia, and Alberta, and is available in French, English, and Swedish. Administration takes 30 to 45 minutes and begins with a narrative overview of client concerns. Given the instrument's ability to capture both narrative and more structured interview data, it is designed to replace rather than add to the traditional intake interview. The instrument gathers standardized information on demographics, common behavioral and emotional problems, impacts on child and family functioning, risk and protective factors, family readiness for service, and potential barriers to service utilization. Online data entry, scoring, and report generation create efficiencies for wait list management and triage (Cunningham, Pettingill & Boyle, 2001).

The BCFPI's standardized questions were derived from the survey measurement tools of the Ontario Child Health Survey (Boyle, Offord, Racine, Sanford, et al, 1993). Subscale scores are based on normative data from the Revised-Ontario Child Health Study Scales (Boyle, Offord, Racine, Fleming, Szatmari & Sanford, 1993a) for boys and girls aged 6-12 years or 13-18 years in both population and clinical samples. Seven subscales measure common childhood problems and aggregate to form composite scales: (1) Externalizing Behaviour (Regulating Attention, Impulsiveness and Activity Level, Cooperativeness, and Conduct); (2) Internalizing Behaviour (Separation from Adults, Managing Anxiety, Managing Moods). A Total Problems scale is derived from the 36 items comprised in the Externalizing and Internalizing scales.

The extent to which problems have adversely affected the child's social participation, quality of social relationships, and school participation and achievement are captured in subscales that combine to inform Impact on Child Functioning. Family Functioning is measured by a Family Activities subscale (the extent to which the child's problems have influenced the family's relationships with friends and family and/or mobility in the community); a Family Comfort subscale (the extent to which the child's problems are a source of conflict and anxiety within the family); and a Global Family Situation composite scale (combined items from the Family Activities and Family Comfort subscales. A Barriers to Service Utilization scale determines whether work schedules, transportation difficulties, or language barriers limit the family's ability to participate in treatment. A Readiness for Change scale determines parental interest in a list of potential service options, such as topical literature or video programs, parenting skill building groups, or support groups. New versions of the tool include brief, standardized measures of parental mood and a checklist of concerns such as specific phobias, fire setting, and thought problems.

The psychometric properties of the BCFPI have been evaluated with a community sample of 1,741 children and a clinic referred sample of 1,727 (Cunningham et al, 2001). The factor structure derived from the Ontario Child Health Study Scales – Revised for population and mental health clinic samples was replicated in a large field trial involving 10,916 6 to 18 year old children referred to 74 children's mental health organizations in Ontario. With the exception of Conduct problems (.68), reliability coefficients for subscales in field trials ranged from .75 to .85 for Problem Behaviour scales and .75 to .77 for Functional Impact scales. The instrument has adequate test-retest reliability, good evidence of sensitivity to change, and good concurrent validity, with correlations between the BCFPI's subscales and the extended scales from the Ontario Child Health Study's (OCHS-R) survey diagnostic instrument ranging from .88 to .96. Discriminant validity is evident on comparison of the means of clinic and non-clinic samples that yielded significant differences on all BCFPI subscales.

OUTCOME MEASUREMENT: THE CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE

Outcome measurement leads to improved treatment, enhances clinical science, provides accountability, and maintains the ethical responsibility of practitioners to examine service quality (Barlow, Hayes & Nelson 1984; Ogles, Lambert & Masters, 1996). All too frequently, children receive care that is based on outdated practices and narrowly defined outcomes as opposed to care that is based on increasing evidence of effectiveness and a wider spectrum of desired functional and quality of life outcomes (Huang, Hepburn & Espiritu, 2003).

The field continues to rely on practices that have little supporting evidence or, at worst, have poor outcomes (Busch 2002; Dishion, McCord & Poulin, 1999) despite evidence that most children who receive an empirically supported treatment get significantly better and do so more quickly than with other treatments or no treatment (Chambliss & Ollendick, 2001; JCCP 1998).

Global outcome measures, such as the CAFAS, help to standardize the measurement of quality and provide a common language and metric for comparison across programs, regions, and client populations (Busch 2002). This makes them particularly relevant for system-wide application. Global outcomes provide an index of overall severity that is easier to aggregate than specific measures. They also put into practice NIMH criteria regarding the importance of measuring the impact of interventions on day-to-day functioning in the client's real life (Newman, Ciarlo & Carpenter, 1999).

The CAFAS (Hodges 2003) is designed to rate impairment in children and youth who have or may have emotional, behavioral, substance use, psychiatric, or psychological problems. It consists of behavioral descriptions, (e.g., expelled from school) arranged into four levels of impairment - severe, moderate, mild, and no or minimal impairment – across eight domains of functioning (subscales): school or work, home, community, behavior towards others, moods and emotions, self-harmful behavior, substance use, and thinking. The rater reads the items in each subscale, beginning with the severe items, until a description of the client's functioning is found. The score on each subscale is determined by the level of impairment under which the item appears: severe, 30; moderate, 20; mild, 10; no or minimal, 0. Subscale scores are combined to form a total score. Each subscale has an accompanying list of strengths and goals. Available in both paper and electronic form, raters familiar with the software take about 10 minutes to complete the scale. Work burden is not increased as the clinician uses information typically collected in clinical service as the basis for rating the CAFAS, and the software produces information required for practice (e.g., assessment and outcome reports, treatment plan).

Training can be accomplished independently by rating 10 reliability vignettes from the CAFAS Self-Training Manual (Hodges, 2003). This ensures that all raters use the same "rules' and definitions of terms. In Ontario, reliability training takes place in 2-day training workshops. Software and train-the-trainer workshops are also provided. To guard against "rater drift," booster exercises are completed annually. In a study of rater drift among Ontario users interrater reliabilities for 315 raters proved to be in the moderate to high range (.848 to .995). Booster reliability training conducted one year later showed interrater reliabilities improved statistically on 3 subscales and drifted on 4 subscales but remained in the moderate to high range (.82 to .99). The feasibility of a train-the-trainer approach for establishing interrater reliability among practitioners new to the field demonstrated high correlations for 140 practitioners trained by on-site practitioner-trainers (.84 to .99) (Barwick, Omrin & Basnett, under review).

Knowing something about the client's initial level of disturbance and early response to treatment helps clinicians to identify potential treatment failures, to improve outcomes, and reduce deterioration in the client (Lambert, Whipple, Smart, Vermeersch, Nielsen & Hawkins, 2001). As such, best practice in Ontario involves rating CAFAS (1) periodically to manage outcome and assess progress; (2) to assist with assessment, formulation, and planning, and (3) to measure overall outcome. As a multi-dimensional measure of global functioning the CAFAS demonstrates better reliability in the field than unilateral measures, such as the GAF and CGAS that are prone to rater bias (Herman, 1990). Previous research has demonstrated the reliability of the CAFAS (Hodges & Wong, 1996) as well as its' concurrent and predictive validity. High interrater reliability has been reported across different sites and with both layperson and clinician raters (Barwick et al, under review; Hodges & Wong, 1996). Studies of concurrent validity have found greater impairment on the CAFAS to be associated with: more intensive level of care, more restrictive or therapeutic placement, more serious psychiatric disorders, more problems in social relationships, involvement with juvenile justice, school related problems, and child and family risk factors (Hodges & Wong, 1996; Hodges, Doucette-Gates & Liao, 1999; Manteuffel, Stephens & Santiago, 2002). Studies of the CAFAS' predictive validity has demonstrated that CAFAS score at intake predicted: cost of services, service utilization, contact with law, poor school attendance, and recidivism at either 6 or 12 months post intake, depending on the study (Hodges et al 1999; Hodges, Doucette-Gates & Kim, 2000; Hodges & Kim, 2000; Hodges & Wong, 1997; Quist & Matshazi, 2000). The CAFAS has been successfully used to assess outcome for youths varying in degree of impairment, referral source, and diagnosis (Manteuffel et al 2002; Duchnowski, Hall, Kutash & Friedman, 1998; Rosenblatt & Furlong, 1998 Walrath, Mandell & Leaf, 2001). No differences have been observed for the total CAFAS score on gender, race/ethnic group (i.e., comparing Caucasians, African-Americans, and Hispanics), or caregivers' education level (Hodges & Wong, 1997).

In Ontario, a supplemental rating guideline has been developed for rating CAFAS with Aboriginal children and youth (Barwick, Ojibway Child and Youth Services, Hodges 2004). Hodges has recently published a compilation of resources and guide for matching CAFAS profiles to evidence-based treatments (Hodges, 2004). There is also a screening interview (15 minutes) that inquires about the youth's functioning and is administered to a caregiver (or other adult informant). A newly developed CAFAS Advanced Child Management Scale examines caregiver functioning in the areas of: providing directions and follow-up; encouraging good behavior; discouraging undesirable behavior; monitoring activities; connecting positively with youth; and problem solving orientation. Lastly, both paper and software versions of the CAFAS scale are available in French.

IMPLEMENTATION

Initially conceptualized as a training endeavor, Ontario's measurement initiative involves substantial organizational and practice change. Changing practice is a formidable task that occurs slowly, often requiring changes in clinician behavior, program restructuring, and an infusion of resources (Huang et al., 2003). To support the use of the tools, computer hardware is provided to service providers along with ongoing support.

Organizations have incurred costs and disruptions related to substantial technological upgrading, while seeing a rise in computer literacy skills among clinicians and improvements in triaging, assessment, and monitoring of treatment response. Implementation of new practices is especially difficult in an environment of shrinking budgets and competing priorities. The simultaneous implementation of CAFAS and BCFPI, although aimed at different functions of the organizations, has been challenging, particularly for those faced with accreditation, amalgamation, staff turnover, and rising demand for service. In recognition of these challenges, CAFAS and BCFPI teams have provided support through consultation, regional community of practice meetings, clinical guidelines and manuals, web site support, and sustainability and capacity building activities (Barwick, Boydell & Omrin, 2002).

As we approach the middle of the fifth year, over 600 intake workers and administrative personnel in 114 organizations have been trained in the reliable administration of the BCFPI, and 98% have implemented this instrument. Over 3000 child and youth workers, social workers, psychologists, and psychiatrists have been trained to reliably rate CAFAS. As of last spring, 102 of 110 eligible organizations (98%) reported "using" the CAFAS, yet an estimated 70% reported using the software version of the tool as mandated. The 2004-2005 fiscal year marks the first time the data from both tools will be analyzed in an aggregate report for the Ministry of Children and Youth Services. Challenges for the year ahead include achieving full implementation for both instruments, continued training and support regarding the clinical utility of the tools through community of practice meetings held quarterly in each of the province's nine regions, and working with government and service provider organizations to develop policies and procedures for the collection, analysis, and reporting of aggregate level data.

CONCLUSION

There is much to be learned here beyond the mental health status of Ontario's children. We hope to learn how best to bring evidence-based practices to the field and how to support the adoption of new and innovative approaches to mental health care for children. The lessons learned to date suggest there is a need to build individual and organizational readiness for change, to improve the state of technological literacy and infrastructure across the sector, and to improve the exchange of knowledge among stakeholders regarding the clinical benefits of the tools and the data they will produce regarding the state of children receiving mental health service in Ontario. Anecdotal reports suggest appreciation for what the tools contribute clinically is growing with practitioner experience, yet real and imagined barriers remain to be dealt with. Whether we are successful in developing a culture that is receptive to evidence-based practice and service delivery innovations remains to be seen; the journey continues.

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First Nations children and youth were not included in the OCH study and, thus, there are no norms for this population. The current measurement initiative will provide the first ever aggregate data on the mental health well-being of First Nations children in Ontario.

Romanian Adolescents: Literature Review and Psychiatric Presentation of Romanian Adolescents Adopted in Romania and in Canada

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ABSTRACT

Introduction: This article presents an overview of literature on the psychiatric sequelae of institutionalization from an attachment perspective in children adopted from Romanian Orphanages. **Method:** We compare the psychiatric presentations of Romanian Canadian adoptees to same age Romanian adoptees within Romania. **Results:** 10 Canadian and 24 Romanian cases were combined to form a composite of a number of adolescents presenting to the Child and Adolescent Psychiatric Division in Cluj Napoca, Romania and in Kingston, Canada. **Conclusion:** Early institutionalization in conditions of neglect and deprivation has a major impact on subsequent biopsychosocial development of children whether they are adopted in Canada or in Romania.

Key words: adolescents, psychiatry, adoptees, Romanian, orphanages

RÉSUMÉ

Introduction: Cet article présente un survol de la littérature sur les séquelles psychiatriques liées au vécu en institution d'enfants roumains subséquemment adoptés dans différentes familles. **La perspective d'analyse est celle des liens d'attachement. Méthodologie:** Nous comparons deux groupes d'enfants de même âge, le premier étant celui d'enfants roumains adoptés au Canada et le second, celui d'enfants roumains adoptés en Roumanie. **Résultats:** Au total, il a été possible de regrouper les cas de 10 enfants canadiens évalués à Kingston (ON), au Canada, et ceux de 24 enfants roumains évalués dans la Division de psychiatrie de l'enfant et de l'adolescent de Cluj Napoca, en Roumanie. **Conclusion:** L'institutionnalisation précoce alliée à la négligence et à la carence affective a une influence majeure sur le développement biopsychosocial ultérieur des enfants, qu'ils soient adoptés au Canada ou en Roumanie.

Mots-clés: adolescents, psychiatrie, adoption, Roumanie, orphelinats.

INTRODUCTION

The individuals' development is continuous, genetically determined and environmentally structured and responsive. Institutionalization of infants and young children in 'adverse conditions' provides an environment with low emotional tones and poor stimulation with lack of sufficient responsive caretaking (David Myriam, 2001). John Bowlby's seminal work "Child Care and Growth of Love" written in 1951 and later updated in 1965 with two additional chapters by Mary Ainsworth states deprivation results from lack of substitute mother, inadequate, inconsistent care and lack of sensitive nurturing. In early institutionalization, we can speak about "parental deprivation" instead of "maternal deprivation" as the paternal figure can successfully substitute that of the mother (Ainsworth, 1965; Bowlby, 1951). Studies on the effects of maternal deprivation in the first year of life demonstrate that children show delayed psychomotor and speech development, lack of novelty seeking, poor emotional expression, lack basic trust and they do not seek adults when in distress. (Ainsworth, 1969; Ainsworth, 1979; Ainsworth and Bell, 1970). These effects are also evident in observations of children institutionalized between 1 and 4 years of age who show the three phases of Protests, Despair and Detachment (Bowlby J, 1980). In deprivation through separation the phase of detachment is constantly present in addition to other problems such as inattention and over activity, social and cognitive developmental delay which may not return to normal levels even when a nurturing environment is provided (Kaler and Freeman, 1994; Kreppner et al, 2001; Farruggia, 2003;). A fifteen year follow-up study of institutionalized children demonstrated the appearance of great difficulties in establishing mutually satisfactory relationships (Robertson & Robertson 1972). Trasler asserts that in the early years of childhood, humans tend to interpret the separation from the parents as a withdrawal of affection, which causes difficulties in reorganizing other and later attachments to the caretakers in foster homes (Trasler, 1960).

Biologically, the right brain participates in the processing of social-emotional information, in the facilitation of attachment functions, in the regulation of bodily and affective states, in the control of the vital functions that allow us to survive and in the body's ability to handle stress actively and passively. All these are projected in the developing limbic circuits and right hemisphere (Schore, 2002) The maturation of these capacities of the right brain depend on experiences, which are encoded in the attachment relationship between the infant and the primary attachment figure (Schore 1997). Maternal care in the first year of life helps to organize behavioral responses to later stresses. This 'senior executive of the emotional brain' acts as a regulatory system, and is expanded in the right hemisphere, which is dominant in human infancy and centrally involved in inhibitory control. "Attachment theory is essentially a regulatory theory, thus disturbances in early attachment lead to maladapted regulatory systems leading to dysfunctional mental state" (Schore, 2000).

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Children institutionalized before 2 years of age but adopted later, experienced severe learning and interaction disorders, lack of a social model under the age of one in the institutionalized child leads to inability to 'build' affects such as facial expression and adequate verbal or non-verbal communication, thereby impeding ability to relate satisfactorily and posing a major affective limitation. Attachment disorder behaviors and quasi-autistic behaviors constitute institutional privation patterns and are associated with duration of privation (Rutter et al., 1999; Rutter et al., 2001). A three year follow-up study of attachment and indiscriminate friendliness, compared children who had spent at least 8 months in Romanian orphanages to Canadian non adopted non institutionalized children and children who had spent less than 4 months in an orphanage There were problems evident in indiscriminate friendliness, sociability and insecure attachment patterns (Chisholm, 1998; Zeanah et al., 2002). Children adopted from institutions are at dramatically increased risk for disturbances, although the majority of such children do not demonstrate problems. Both the duration of deprivation and the post institutional caregiving environment seem to be importantly related to outcome. Inhibited/ Withdrawn Reactive Attachment Disorder is exceedingly uncommon in children adopted from institutions but Disinhibited/Indiscriminate Reactive Attachment Disorder is quite persistent. Long after children become attached to adoptive parents, a number of them continue to exhibit indiscriminate sociability (Zeanah, 2000). A recently published epidemiological study examined the prevalence of mental and behavioral problems in children and adolescents in children's homes and found 54% of 4 to 18 year old children and adolescents in these homes have mental or behavior problems (Pluye et al., 2001). But the fact that the others do not present these kinds of problems perhaps speaks to their environmental and cognitive resilience. The later is supported by a more recent follow-up study of adoptees to the UK that shows even of those with longest duration of deprivation at least one fifth have no major problems (Rutter et al 1999).

In 1947 Romanian Communist Party decreed all families to have at least four children, forbidding birth control and abortions. The peasants and the gypsies had large families, while others avoided conception by other means or terminated pregnancies by self-induced or back street abortions. This led to many unwanted pregnancies, high maternal mortality, increased congenital malformations and frequent abandonment of children. In 1989, after the collapse of the Communist regime, there were 47,000 children in orphanages. These children were not only victims of general economic disaster and the lack of qualified staff, but also of the effects of insufficient heating, light, food, medicines, and lack of single use syringes, which led to increased frequency of AIDS. In most cases, there was no communication from the natural family, no names or identity papers for the children. The orphanages were grossly understaffed by under-qualified staff that had their own adversities to contend with. The colleges of psychology across the country had been forced to close; there were no psychologists and no special education teachers or social workers. This is the background of the adolescents presented in this article.

CASES

We have developed a composite from a 10 of cases seen at a Child and Adolescent Psychiatry Division in Ontario and 24 cases in Transylvania. All These adolescents were between 13 and 16 years of age at presentation to psychiatry. They had been adopted between 6 month and 3 years after being in Orphanages in Romania. There was no contact for any psychiatric problems during their latency years. All were seen at adolescence as emergencies due to suicidal threats, noncompliance with parental rules and externalizing behavior problems.

Romanian case: Radu is 16 years old boy brought to hospital by his adoptive parents due to behavior disorders. Early history is not known, his known history begins around the age of two, when he was adopted by a childless professional couple. The mother is a civil engineer, however after adopting Radu she worked as a decorator so she would have more time for child rearing. At two years of age, the child could utter only a few simple words, 'walked' on all fours and was not toilet trained. However, he was able to say 'mother' and to cling to the future mother, so that she proudly says: "the child chose us." His development proceeded within normal limits, surrounded by caring parents who met all his emotional and material needs. Radu developed age appropriate social, behavioral and academic skills. As adolescence set in, this seemingly well adjusted boy started having major problems with parental authority and rules, lying, staying away at nights, drinking and substance abuse, making indiscriminate friends with other adolescents with behavior disorders, truanting and when confronted showed no remorse. The parents were bewildered by this change and tried every way of engaging Radu into prosocial behaviors. He stole money from the house, sold family things and he constantly threatened to kill his mother. The parents asked "What could have happened to our baby? What have we done wrong?" Radu is always searching for something, unhappy, hostile, impulsive, explosive, and incapable of being reassured that he would not be abandoned.

Canadian case: Miki is a 14-year grade 9 girl who was seen in the urgent consultation clinic at the request of her group home for "suicidal behaviors and aggression". Miki had been in the Group Home for 4 weeks and her behavior had been escalating. She had been removed from her adoptive family pending investigation into her allegations of sexual and physical abuse by the adoptive parents. Miki was oppositional and resistant with the staff and also with the interview. Her arms showed multiple superficial scratches old and new. She described herself as feeling unloved and empty inside "nobody cares anyway". Miki had been adopted by a white Canadian nuclear family at two years of age from a Romanian orphanage where she had resided from the age of three months. When adoptive parents went to see her she was very friendly and immediately became very familiar by sitting on their laps they "felt charmed" by her immediate affinity to them. She was deemed to be physically healthy, no comment about problematic behaviors. There was not much family or birth and infant history available. The adoptive family had no biological children and no other adoptions, they were comfortably off and seemed to be "caring as parents". Miki's development within the adoptive family showed no

abnormalities apart from some language delay for which she had speech therapy. She seemed to change friends frequently becoming close and distant within very short period of time. In school she did reasonably well through to Grade 7 but started having problems with academics, peers and parents in Grade 8. Since then her academic performance had declined considerably, a major conflict within the family. Miki's parents had contacted a local Children's Mental Health Agency to ask for help with managing her increasing defiance, lying and stealing. She had been skipping school and there were some concerns about drugs and alcohol and possible sexual involvement with older boys. Miki was uncooperative with the CMHA counselor and soon after made the allegations, which led to her being removed from the home. Behavior continued to escalate in the Group Home. At admission MSE showed a girl who looked her stated age was sullen and defiant but answered questions. Speech was articulate and coherent. Mood was angry, affect dysphoric and irritable. There were problems with chronic insomnia, poor self soothing behaviors, appetite was normal, concentration and attention were impaired and she showed poor frustration tolerance and impulse control. Low intent, low lethality risk taking behaviors. She denied active suicidal plans but admitted to frequent death wishes. No social isolation or withdrawal. There was no evidence of anxiety, no Obsessive Compulsive signs and symptoms, no psychotic symptoms. Problem solving skills were poor with frequent episodes of aggression and selfmutilatory behaviors. No evidence of dissociative episodes. She showed little distress and was egocentric, showed little insight and questionable judgment. Cognitive testing showed low average IQ with Learning Difficulties for reading and writing.

DISCUSSION

The case histories of Romanian adolescents adopted in Romania and in Canada show many similarities in their psychiatric presentations despite cultural and socioeconomic differences. These similarities are explicable on the basis of their early histories of deprivation neglect abuse and disordered attachments. The adopting families bring with them their own myths about the way a child should be which may be unrealistic for children who have extremes of physical , social and emotional deprivation. These deprivations may explain the stages of development , the initial 'phase of flattery' and dependent behavior followed by uninhibited attention seeking, non-discriminatory friendship and eventually a personality characterized by lack of feeling of guilt, inability to respect rules and to form durable relationships (Rutter M, 2001). Thus behavior problems appear, however these very behaviors may be a mechanism of adaptation, of survival. Frequently we are unaware of depth and breadth of negative experiences these children have brought with them. Perhaps these very experiences led to the development of undesirable behaviors that ensured their survival. Despite subsequent nurturing caring environment these behaviors continue and the expectations of their caretakers may surpass their repertoire of responses. Their behavior is a response to their historical context in which survival was the main stake. Spitz asserts that severe early deprivation can have permanent effects (Spitz, 1968), however, if deprivation ceases and the child is cared for correctly, his/her situation can improve, despite degree of severity. The remaining effects become obvious in certain situations later in life such as 'psychopathic behavior disorder' a term used to associate the clinical syndrome that was found in children who experienced severe early deprivation (Bender et al., 2001). Evidence from research of attachment theory informs us of the importance of the ability and propensity of human beings to make strong affectionate bonds to particular others, paves the way for many forms of emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment, to which unwilling separation and loss give rise (Bowlby 1977). Institutional upbringing that does not respect the wisdom of protecting affectionate bonds makes some children vulnerable to delinquency, prostitution, abandonment, depression, lack of moral values and lack of trust (Cline, 1979; Kaler and Freeman, 1994). Risk and protective factors interact complexly; linear models of cause and effect are of little use in understanding the development of psychopathology. Refining our markers of risk and demonstrating effective preventive interventions are the next important challenges (Zeanah 1997).

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The Dalhousie Family Therapy Training Program: Our 6-Year Experience

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ABSTRACT

Introduction: Training in family therapy for general psychiatry residents during their child rotation is either not taught or the objectives not well described in psychiatric curricula. **Method**: Based on the combined experience of 4 family therapists over a 6 year period with 56 students (psychiatry, social work, psychology), we describe our experience with training general psychiatry residents in an introduction to an interdisciplinary family therapy, systemic-reflective course during their child psychiatry rotation. The model was based on experiential training, where both trainees and supervisors could build skills as they reflect on their process as learners and teachers. **Results:** Residents' ratings at the end of rotation indicated extremely high satisfaction with the course. **Conclusion:** We advocate that an experiential interdisciplinary course serving as an introduction to family assessment and systemic/reflective principles are valuable skills that have lasting value to general psychiatry residents.

Key Words: psychiatry residents, family therapy, reflective, systemic.

RÉSUMÉ

Introduction: Durant leur stage obligatoire de six mois en pédopsychiatrie, les résidents reçoivent peu de formation en thérapie familiale. **Méthodologie:** Fort de leur expérience avec cinquante-six étudiants de formations diverses au cours d'une période de six ans, quatre thérapeutes familiaux décrivent leur expérience en enseignement de premier niveau en thérapie familiale d'orientation systémique auprès de résidents de psychiatrie durant leur stage en pédopsychiatrie. Le modèle proposé en est un de discussions et d'échanges entre étudiants et superviseurs visant à l'amélioration des compétences de chacun. **Résultats:** À la fin de leur stage, les résidents se sont montrés très satisfaits de la formation reçue. **Conclusion:** Nous proposons la mise en œuvre de ce type d'échanges entre superviseurs et étudiants pour la formation en thérapie familiale des résidents en psychiatrie car, croyons-nous, les habiletés acquises leur seront très utiles dans l'exercice de leur profession.

Mots-clefs: résidents en psychiatrie, thérapie familiale, approche systémique, pédopsychiatre et professions affiliées.

INTRODUCTION

As psychiatric residents are squeezed for time by competing demands in their program, training in a modality specific to child psychiatry such as family therapy may appear unnecessary. The explosion of knowledge in neurosciences, genetics, psychopharmacology and developmental psychology as applied to child psychiatry impose demands on training programs to keep residents up to date within the narrow time limits allocated to child training. Competing demands on the time of clinicians as teachers and supervisors is an added factor in deciding the potential cost/benefit of family therapy in terms of scarce teaching resources. Current Royal College guidelines in Canada (RCPSC) mandate that residents rotate through six months of child psychiatry but do not specify the content--especially in areas related to a specific psychotherapeutic skill such as family therapy.

It has been validated through research studies that family therapy as a therapeutic intervention is effective and has been applied to a variety of mental health disorders including schizophrenia, anxiety disorders, attachment difficulties, eating disorders, behavioral disorders, substance abuse and medical conditions with psychological factors (Diamond & Siqueland, 2001). However, even within larger programs that have the professional resources to teach family therapy (ie: programs with child fellows), educating students on competing models of family therapy schools would take an extended period of time to cover adequately. In addition for students to become competent in skill development, they need extended training in longitudinal follow-up and treatment of families.

While teaching in family therapy in psychiatric programs has received less emphasis in the last decades (Celano, Croft & Morrissey-Kane, 2002), the field of marriage and family therapy (MFT) is one of the fastest growing fields in mental health. It currently boasts over 50,000 practitioners in the US alone (see American Association of Marriage and Family Therapy or AAMFT, website www.AAMFT.org) who have an overlapping mandate to treat the same clinical populations as psychiatrists. Approximately 24,000 MFTs are certified with the AAMFT, a rigorous certification process that requires a minimum of 2 years after a Masters degree with 1000 hours of MFT clinical hours of which 200 must be under the supervision of an AAMFT approved supervisor. Therefore, psychiatrists not only have less training in family therapy and systemic principles but also need to familiarize themselves about collaboration with a parallel field of mental health practitioners who treat the same clinical population. Under current training schemes the potential for divergence already in existence between psychiatry and MFTs could become even greater.

In a literature search focusing on how family therapy is integrated in general psychiatry programs (Pubmed with key words family therapy training, psychiatric residents, child and adolescent residents), the extant literature was scant and over 20 to 25 years old except for one study (Celano, Croft & Morrissey-Kane, 2002). Harbin (1980) described the University of Maryland four year psychiatry residency program where residents received over 70 hours of family didactic seminars,

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500 hours of family and marital therapy and 175 hours of one to one supervision by a family therapist. One of the family therapy supervisors in this program was Jay Haley. Sugarman (1980) reviewed some of the advantages and difficulties in integrating family therapy training in general psychiatry training, including controversies about the definition of the field, elective versus required teaching, curriculum content and who/when/where to teach family therapy. Feldman and Feldman (1982) identified programmatic resistances to family therapy teaching as due to identity problems (non-congruent with the medical model), competency problems (motivation to graduate, institutions geared towards individual treatment) and bureaucratic problems (economic and administrative). Celano, Croft and Morrissey-Kane (2002) integrated psychiatry residents and psychology interns within a family evaluation clinic. Most trainees found the experience valuable in their current practice whether working with individuals, families or systems.

Our challenge as educators of family therapy was to decide what principles of family/systemic therapy were important to teach and then how to provide this teaching to general psychiatry residents with no previous experience in child psychiatry. The supervisors had extensive experience in teaching different schools of family therapy (strategic, structural, systemic). We decided to offer a 14 week half-day experientially based course focusing on systemic-reflective principles using the reflecting team as a core teaching element. The choice of this model reflected our underlying philosophy that students needed to: 1) focus on the broader interpersonal and social context of families, 2) experience themselves as part of the system, 3) use reflectivity as a basic tool for self-supervision and 4) be able to experience and reflect on the effect of multiple realities and perspectives in co-constructing their encounter with the family. Therefore our model borrowed elements from systemic, narrative and reflective principles but was congruent with the post-modern philosophy of social constructivism (Foucault, 1980; Gomez, 1996; Rober, 1999; Shapiro & Ross, 2002).

As a result of our group experience and based on questionnaire feedback received from residents over the last 6 years, we advocate that an experiential interdisciplinary course serving as an introduction to family assessment and systemic/reflective thinking, provides valuable skills that have lasting value to general psychiatry residents.

METHOD

Description of the Course

In terms of logistics, during their 6 month child rotation residents receive 14 half-days of the family course and 10 half-days of didactic seminars. Each resident is required to rotate 3 months on the inpatient unit and 3 months in the outpatient clinic. Residents receive additional supervision during their child inpatient and outpatient rotations from staff child psychiatrists.

There are four supervisors available (two child psychiatrists, two AAMFT accredited family therapists) in the program, and supervisors work in pairs. There are from four to eight learners for each six month period. Learners, in addition to psychiatry residents, include masters level students in social work and psychology. Child mental health staff (social work, psychology) also have the opportunity to join the training. Each pair of supervisors has three to four students. Each student interviews 2 new families in the 14 week program after they observe each supervisor demonstrate a live interview.

The emphasis in early sessions is to establish the rationale for a family approach and focus on the reason for referral in terms of who, what, when and why (Haley, 1976; Tomm & Wright, 1979). The family genogram as a technique for creating rapport with all family members and mapping intergenerational influences and psychopathology is introduced at this stage as well (McGoldrick & Gerson, 1995). Genograms help map out intergenerational patterns where family myths, beliefs and meanings can be generated and mapped out against trauma, loss or serious psychopathology. Genograms also help students think in terms of family patterns of functioning (boundaries, roles, emotional support, communication patterns).

Students are invited to shift their thinking from linear (intraindividual) to systemic (inter-relational), narrative (multiple perspectives, effect of pathologizing) and reflective (self in relation to system) styles. This may be a challenge for residents to shift from a linear perspective since most of their training to date has been in the individual assessment of symptoms and treatment in psychotherapy. All interviewers are taught how to assess for safety risk and crisis intervention when a situation requires it (such as in cases of suicidality, family violence, psychosis).

The Reflecting Team Process

The reflecting team is a relatively new therapeutic tool that embodies the technique and philosophy of a collaborative healing dialogue between therapist and family. Our teaching is embedded within the reflecting team experience. We adopted the guidelines provided by Andersen (1991; 1995) for the reflecting team interview but modified the last stage to emphasize the "self in relation". The skills we mention above (ie: such as genogram interview) are embedded in the reflecting team interview.

The first stage of the reflecting team process is the student having a conversation with the family about their problem and the influence of the problem on the family's life. The supervisor and the rest of the reflecting team are behind the one way mirror. The team observes the interview without any dialogue between members so that each team member can offer reflections from his perspective rather than a group consensus or the supervisor's perspective.

The therapist and family then reverse positions (second stage) as they now observe the reflecting team in dialogue about how the family is burdened by, but in other instances, has escaped the influence of the problem. The team members situate and contextualize their comments in their own experience. This "near experience" level of discussion helps the family to reflect on strengths and possibilities to engage in new patterns of change and defeat old patterns. The students are asked to emphasize change (growth) rather than symptom decrease. Therapists are also asked to state their comments from a position of "not knowing" (Anderson & Goolishian, 1986; 1988) which simply means being aware of the influence of ones biases on the therapeutic process (biases in privileging certain stories, points of views or information) and offering reflections as possibilities rather than defined truths.

The therapist and the family switch positions again with

the reflecting team and the therapist asks the family if any of the comments by the team were helpful, upsetting, or were sources of disagreement (third stage). This idea of watching and being watched serves to remind therapists and trainees to couch their comments in simpler language and more personal ways that eliminate hiding behind professional distance and power relationships (Friedman, 1995). For some families this is the first time they have heard themselves talked about in such intimate and familiar way. Over 95 percent of our families find the reflecting team experience helpful as they are asked this question at the end of their interview. The family, if they need to be seen again, are given another appointment with the supervisor.

The family then leaves. In the fourth stage, which we have modified to enhance reflectivity and "self in relation to the system", the therapist is asked by the reflecting team why he/she chose to ask certain questions because during the interview there can be "branch points" where the therapist chooses to go in one direction or another. This can lead to "reflection-in-action" (Schon, 1987) where the interviewer leaves him/herself open to surprises or unexpected outcomes but also decides on a course of action or a line of questioning to pursue based on his/her professional and personal experience. The supervisors deliberately chose the "self in relation" stage as a reflective skill to focus on in this course.

During this group discussion, emphasis is placed as well on narrative principles of the effect of gender, race, sexual preference and pathologizing or language of deficiency (Gergen, 1990a; 1990b) as the therapist is asked to reflect on the relative influences of these factors on the interview he/she just conducted. For most residents this is their first experience in reflective group supervision and interaction with another discipline. This invites discussions about hierarchies and the power differential between professions as well as differing professional beliefs about client realities.

When families cancel appointments, this time is used to review tapes from previous sessions, or students can present the genograms of their own families. Tape reviews as homework are encouraged but not enforced. The students are given articles throughout the course to illustrate theory and technique in relation to setting up the context of the interview (Haley, 1976), the genogram (McGoldrick & Gerson, 1995), interventive questioning (Tomm, 1987a; 1987b; 1988) the narrative approach (Rober, 1999; White & Epston, 1990) and post-modern philosophy (Foucault, 1980). These articles are discussed in varying detail before and after the families are seen depending on the time available.

RESULTS

A questionnaire was distributed at the end of the 14 weeks to ask if the goals set out at the beginning were accomplished. In addition, focus groups were held to elicit feedback not covered by the questionnaire. Fifty-six students completed an anonymous questionnaire (34 psychiatry residents, 20 social work and 2 psychology students; not all figures add up to 100 per cent as there was overlap in the questions).

Results from the questionnaire were divided into four domains of Cognitive (knowledge), Skills, Affective and Reflective Learning, and a sample question from each domain is given below.

1) Reflective Domain: Did the course achieve its goal of inviting you to be a reflective practitioner?

- 98 percent said yes

2) Affective Domain: Has the experience in family therapy met your learning needs (interviewing more than one person, being comfortable with families etc)?

- 94.5 percent said yes

3) Skills Domain: Has the experience in family therapy increased your skills (genograms, rapport with several family members) for family therapy?

- 86 percent said yes whereas 30 percent said no (total exceeds 100%) since some students said they acquired skills in assessment but wanted more long term experience with families.

4) Cognitive Knowledge Domain: Certain concepts were emphasized such as systemic thinking, narrative stories by the articles and discussion. Were we successful in teaching these?

- 84 percent said yes and 14 percent said no.

All students agreed (100 percent) that the three key practices of the reflecting team, group interdisciplinary experience and observing supervisors doing interviews were very useful.

The most frequent negative comment (30 percent) was that students did not see therapeutic intervention or follow-up. A few students requested more specific feedback on skills.

Here are some unsolicited comments from the questionnaires:

- "I have never had so much opportunity to observe and be observed in my whole training."
- "best learning experience of my residency."
- "one of the highlights of my psychotherapy training."
- "a wonderful and useful course that I hope to make use of throughout my career."
- "I was left feeling vulnerable-the lone wolf out there." (three students),
- "they are nice people after all!" (Referring to myths between psychiatry/social work).

Since many of the residents tend to stay within our geographical area, we were able to solicit informally the following feedback about the training over the years. Two years later two students, now adult psychiatrists who supervise residents, stated they now realized what we were talking about. (ie: the systemic perspective). One student (now the director of postgraduate education) suggested the program be extended over the residency. Five students became child fellows.

DISCUSSION

The majority of students benefited from the training and our goals as teachers matched our intentions at the beginning of the course of increasing awareness of reflective/systemic principles. For most students it was their first interdisciplinary experience and appeared beneficial for psychiatry residents with an orientation to adult or child psychiatry and social work students planning to do family work. This interdisciplinary perspective led to increased awareness of socio-cultural issues in psychiatry

residents and increased awareness of individual-biological factors for social work students. Psychiatry residents previously exposed to individual and group psychodynamic approaches welcomed the addition of the family/systemic perspective as complimentary rather than conflicting.

While rewarding, the group experience is not a benign technique. Students may feel vulnerable since the family therapy context may elicit some of their own family of origin issues. Supervisors needed to be vigilant to help them work through this. The major criticism of the course was the lack of opportunity to witness therapeutic intervention and follow-up of families. The course should be modified to provide this experience or students should be given this opportunity outside of the course. For supervisors, taking the time to reflect is necessary and provides a forum to grow in their own reflective skills so that the learning experience is a two way street.

There are other models of teaching family therapy but we chose reflectivity as a basic tool to self supervision and clinical practice since it can be applied to professional learning and teaching regardless of theoretical orientation and stage of learning (Schon, 1987). In the reflective model, students are met at their own level of motivation and anxiety for learning these principles. Teaching and learning are fostered in an environment of mutual safety and risk-taking where the student reflects on the self in relation to surrounding systems (the therapist, his/her family of origin, the supervisory relationship, the residency, the culture). Once the appetite is whetted, if students want a more in depth experience then electives in family therapy are available.

Some evidence exists that family and systemic training has lasting value for psychiatric practitioners after they graduate. Celano et al. (2002) collected survey data for general psychiatry residents rotating through a family evaluation training program. The trainees indicated that the program was helpful and valuable to them in their current practice. Guttman, Feldman and Engelsmann (1999) indicated in a survey of 291 psychiatrists who had completed couple and family training in their residency, that the training had beneficial effects on their roles as therapists and teachers, supervisors and program directors. Carter (1989) reporting on a follow-up survey of 87 psychiatrists who had training during their residency in marital and family therapy found similar effects.

Since our questionnaire falls more in the category of "consumer satisfaction", this survey does not claim to be measuring core competency skills as required in psychotherapy training. Weerasekera et al. (2003) outlined their program's approach to evaluating competency assessment in the McMaster Psychotherapy Program. For subspecialty training, Sexson et al. (2001) and Sargent et al. (2004) as part of the Work Group on Training and Education of the American Academy of Child and Adolescent Psychiatry have developed sample core competencies in six areas for training the child and adolescent psychiatrist but the guidelines are vague about incorporating systemic teaching.

The lack of literature discussing either content or process of family/systemic therapy teaching in psychiatry programs is concerning. First year trainees are taught the biopsychosocial model (Engel, 1979; Marmor, 1983) but practical ways to model skills, attitudes or core knowledge through systemic training are not readily available or widely discussed. There will never be enough child psychiatrists to meet service demands (Leverette & Massabki,1995) so many children, adolescents and families will be seen by generalists. With trends toward growth in mental health fields such as Marriage and Family Counseling, psychiatrists are called upon to do more collaborative work with other professionals and systems of care but are receiving less training in systemic issues. In addition, psychiatrists often are called upon to be clinical leaders or consultants but have little experience in systems theory or lack the necessary reflective skills.

Our enthusiasm and advocacy for this type of teaching should in no way indicate that this brief training is a substitute for either a full child psychiatric training program or an intensive family therapy training program. The program we propose is a beginning to help residents think systemically in a biopsychosocial model incorporating interdisciplinarity and reflective skills.

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Letter to the Editor

MANIA CURING FEVER?

The case of Ms. "B" illustrates interesting management challenges, and physiological surprises! Ms. B., a 14-year-old girl who presented to the Emergency Department with a one-week history of persistent insomnia, increased goal directed activity, pressured and circumstantial speech, provocative behavior, grandiosity, irritability, auditory hallucinations, delusional ideation, lack of appetite, and suicidal ideation. She was previously diagnosed with a major depressive disorder 1 1⁄2 years prior and treated with paroxetine. She also described symptoms suggestive of obsessive compulsive disorder since a young child.

At presentation, mental status examination revealed a well-groomed, provocatively dressed, and extremely hyperactive young lady. She described her mood as "great", affect was euphoric, speech was pressured and circumstantial and she displayed flight of ideas. Thoughts illustrated over-valued ideas, grandiosity, delusional content and auditory hallucinations. She had suicidal ideation. A provisional diagnosis of bipolar disorder, manic phase with psychotic symptoms, was made. The family physician changed her antidepressant medication venlafaxine to paroxetine and lorazepam prn, three months prior, due to increased irritability.

Ms. B. was admitted to hospital and initially treated with risperidone, divalproex sodium and temazepam. Ms. B. was extremely manic and psychotic. By day 8 the patient was complaining of joint stiffness. This was interpreted as a possible dystonic reaction to risperidone (0.75 mg po bid). benztropine (1.0 mg po bid prn) was added. Visual hallucinations presented after benztropine was added, thus both benztropine and risperidone were discontinued. Chlorpromazine was started for its antipsychotic and sedative effects. There was some progress in symptomatology (thought content was less delusional, frequency of auditory hallucinations decreased and behavior was more settled). The patient's family was approached to consider olanzapine, despite numerous discussions. Ms. B.'s mother remained reluctant to a trial, and Ms. B. continued on chlorpromazine. The manic symptoms worsened and she was becoming more agitated secondary to delusional ideation. A pediatrician was consulted for abdominal symptoms (GI reflux and abdominal pain), and ranitidine (150 mg po bid) was added. Laboratory investigations including LFT's, amylase, and CBC were all normal. Medications on day 18 included divalproex Sodium (500 mg po bid), ranitidine, garamycin drops, ventilin prn, temazepam, docusate Sodium, diphenhydramine prn, acetaminophen prn, lactulose, and chlorpromazine (150 mg po od) in divided doses.

Mental status exam on day 19 illustrated pressured speech, vivid auditory hallucinations, delusional thinking, mood lability, flight of ideas, and increased goal directed activity. On day 19, Ms. B. developed a temperature (38.8 degrees), complained of being cold, shaky, headache, stomachache, and overall feeling unwell. She was thought to have a viral infection. On day 20, she developed nausea and vomiting, rhinitis, sore throat, and headache and fever continued. Mental status exam continued to reveal significant mania and psychosis. Later that evening, jaundice was noted and she was medically reassessed. LFT's were repeated, (increased: AST 101, ALT 194), total bilirubin 32, and GGT was 94 (normal 6-23). All medications were held. amylase was 28, within normal limits. Mono spot was non-reactive. IV fluids were started. On day 21, (still no medications) her mental status exam had all but normalized. She denied any delusional thinking or hallucinations. Thought form and content were normal. There was mild pressure of speech with only mild agitation. Insight was judged to be very good. LFT's were followed closely, and normalized over 2-3 weeks. Within several days, Ms. B.'s throat swab returned positive (Influenza B Virus).

Two days later (day 23) manic symptoms returned and lithium carbonate was started. Oxazepam was added for agitation and sleep. Ms. B. responded well. She was not restarted on an antipsychotic. She was eventually discharged with manic symptoms under very good control 2 1⁄2 months after admission. All other investigations during admission were normal, including a cranial CT, EEG, pregnancy test, urine toxic screen, and TSH. This patient is VDRL negative.

The pediatrician thought the hepatotoxic effect was likely due to a combination of Influenza B and medication. It was felt necessary to be very judicious with use of any psychotropic medication. This proved to be challenging, given the patient's ongoing difficulties with comorbidity of obsessive compulsive disorder, depression, and social anxiety.

The temporary but dramatic resolution of the patient's manic and psychotic symptoms with fever is very interesting. A literature search on fever and psychosis resolution revealed only the classic reference on the temporary cure of neurosyphilis associated with fever, as discussed by Wagner-Jauregg. This resolution of the patient's phenomenology and brief return to normal mental status with excellent insight was remarkable, but short lived, lasting only two days. Was this "cure" by fever, or Influenza "B"?

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Book Reviews

Building Positive Behavior Support Systems in Schools: Functional Behavioral Assessment.

Deanne A. Crone, Ph.D. and Robert H. Horner, Ph.D. Guilford Press, New York, NY. 2003. 171pp. $28.00 USA.

This is a how-to book, but not one designed for the clinician first learning about functional assessment of behavioural problems. Many resources are available to introduce the basic theoretical and practical aspects of positive behavioural management. Here, Crone and Horner provide a brief, clear description of functional-based behavioural assessment and intervention and address perhaps an even more challenging primary task, how to implement systems to provide positive behavioural support to students within the school context.

This book was spurred by staggering statistics on the prevalence of behavioural problems in schools, by the American legal requirement (embodied in the Individuals with Disabilities Education Act) to address them, and by the dearth of resources with which to do so. Citing evidence of the enhanced effectiveness of interventions that are based on functional behavioural assessment (FBA), Crone and Horner argue convincingly that what schools need are trained, well-organized teams that can assess and intervene rapidly with problem behaviours as they arise. They propose a field-tested model by which this can be accomplished.

The authors acknowledge that the use of FBA technology requires a philosophical shift for most educators. The FBA approach entails the identification of factors that foster inappropriate behaviours and the rearrangement of conditions within the environment both to reduce problem behaviours and to build a repertoire of appropriate alternative skills. This is a dramatically different approach than that which has resulted, for example, in 'zero tolerance' policies in many school districts that dictate the suspension or expulsion of students with aggressive or other antisocial behaviours. Blanket application of these policies has often resulted in suspensions of students with developmental disabilities, whose aggressive behaviours can most frequently be ascribed to communication deficits. Rather than this prescriptive (and punitive) approach, behavioural support using FBA principles determines the purpose that inappropriate behaviour serves for a student before designing an intervention that meets those individual needs.

The book is extremely clearly written and logically presented. Ample references are provided to the empirical literature that supports the authors' position, yet the book does not read as an abstract academic text. The professional reader who is versed in FBA methodology and who understands the school context can use this book to begin a systematic team approach to solving behavioural problems. Concrete examples are provided of the range of behavioural problems that can be addressed, of the steps required to address them, and the potential solutions generated by FBA. Thirty-six pages of forms are provided to assist in this process, although the limited copyright permission provided for these may pose an ethical challenge to the school-based teams to whom the book is directed. The real virtue of Crone and Horner's model is the integration of empirically-grounded procedures with a realistic appreciation of school resources and routines.

I recommend this book highly to all professionals involved in mental health and behavioural management services to schools, and their administrators.

Isabel M. Smith, Ph.D.

Helping Children to Build Self-Esteem: A Photocopiable Activities Book.

Deborah Plummer. Jessica Kingsley Publishers, Vancouver, BC. 223 pp. £11.16 UK.

Stars lead off, Moonbeams bring up the rear, with precious metals and gems along the way! This activity-based workbook is designed to assist children in moving from head information on self-esteem to heart experiences that have the potential to impact deeply on their sense of themselves. A Speech Language therapist by training, Deborah Plummer uses imagination and empowerment to move children and adults from discouragement to success. The activities assembled in this workbook were devised and tested by the author with children who perceive themselves as individuals who fail. She shows again what people such as Ignatius Loyola and Virginia Satir knew – imagination can be a powerful tool for change.

The underlining premise of the book is: a) that internal images mold our thoughts and our functioning; b) that new images can be developed, practiced, and inserted to remake the conscious mind, and, in time, the unconscious mind as well. What psychotherapy might do cognitively by re-framing, the author does by encouraging images and imaginative responses. The activities engage the right/imaginative brain to challenge old ideas and to help the child write a new script.

The book is divided into three sections. The first half is theory and instruction, intended to help the user put into action the second half of the book, i.e. activity work sheets on eight themes. The themes are given picture-word names easy for children to remember. For example, Theme II is Who Am I or Rubies, while Theme VII, Solving Problems is Rainbows. Each theme section begins with learning objectives and ends with additional activities to expand further on the theme if needed or desired. The book concludes with six appendices designed to assist the therapist and other adults to augment the therapy sessions. A subject index allows the user to find specific topics easily.

In the section on theory, the author reminds us that our images are very personal and that they form us. In therapy, the child can be helped to name their images and then respectfully helped to re-form or transform ones that are not helping them to grow. We are reminded that images of self are bound closely to experiences and that adults play a vital role, both in formation and in transformation of self-image in children.

Choose a child or group of children who exhibit the warning signs of poor self-esteem and/or anxiety found in Appendix B and turn to Theme I, Stars & Emeralds. You are in for some fun as you work!

Delores S. Doherty, M.D.

Hyperactivity and Attention Disorders of Childhood. Second Edition

Seija Sandberg, editor. Cambridge University Press, NYC, 2002. 504 pp. $65.00 USA.

If you haven't kept abreast of developments in the area of Attention Deficit Hyperactivity Disorder (ADHD) and would like a relatively quick yet comprehensive update this book is probably for you. Moreover, it embodies a balanced perspective between European and North American viewpoints.

The introductory chapter by Sandberg and Barton is particularly enjoyable. It offers a detailed and well-referenced tour de force of the historical developments in syndrome definition and characterization, as well as attributed causality over the course of the past one hundred and fifty years. Chapters 2 and 5 addressing epidemiological aspects and classification issues respectively should be read side-by-side. There is a substantial degree of overlap between these two chapters; albeit, on a positive note, the content is complementary and provides a good contextual understanding of how we got to the current classifications in the Diagnostic and Statistical Manual, IV Ed. and the International Classification of Diseases, 10th Ed.

Chapter 9 is a well-written account of developments in genetics of ADHD, comprising a discussion of progress in genetic epidemiology and molecular genetics ending with a knowledgeable discussion of future directions. In Chapter 10 a comprehensive insight into the neurobiology of ADHD addressing recent developments in brain imaging, neurophysiology, chemistry and neuropharmacology of the disorder is presented in less than 20 pages. Chapters 6 and 7 are also complementary: the first one addresses the neuropsychology of attention from an experimental psychology point of view and the latter addresses the relationship between ADHD and learning disorders. Chapter 4 discusses gender differences and their significance in the identification of ADHD "caseness." Attempts were made to incorporate developmental and psychosocial perspectives; however, in contrast to biologically informed chapters, it became clear that there is ample room for progress in these areas.

The main weakness of the book is the relative lack of information pertaining to therapeutic interventions. Chapter 13 is devoted to the Multimodal Treatment of ADHD (MTA) study as a model of treatment; however, the book fails to address therapeutic options in the context of developmental changes, and a broader discussion of management strategies would have increased its usefulness.

Overall, while parents and lay readers may find the text to be too technical and detailed, this is a good book, It is best suited for mental health professionals seeking a deeper understanding of the syndrome and has some excellent chapters..

Abel Ickowicz, MD

The Development of Emotional Competence

Carolyn Saarni. The Guilford Press, NYC, 1999. 381 pp. $21.95 USA.

Carolyn Saarni's book is one of a very practical series of titles by Guilford Press examining emotional and social development. The author stated a number of goals for the book including: writing about emotional development in mid-childhood and adolescence, examining emotion as a part of culture, and establishing a pattern of studying emotion within the lives of children. The book was organized into three parts: research and theories of emotional competence; skill levels of emotional competence and the clinical application of emotional competence.

In the first part, Dr. Saarni defined emotional competence as the functional capacity wherein a human can reach their goals after an emotion-eliciting encounter. She defined emotion as a building block of self-efficacy. She described the use of emotions as a set of skills achieved which then lead to the development of emotional competence. Attainment of the skills of emotional competence is crucial to self-efficacy. Dr. Saarni outlined her theoretical position in relation to theories of emotion and social learning and cognitive development. Her approach to theory in each of these fields was integrative and focussed on self-development with a strong social-contructivist perspective. I enjoyed the culture and folk theories of emotional regulation in chapter three. Also, chapter three contained an interesting section on parent and peer influences on emotional regulation, very useful for child psychiatrists who work to discern abnormal emotional regulation and mood patterns in context.

The bulk of the book was devoted to the eight emotional competence skills:

- Awareness of one's own emotions,
- Ability to discern and understand other's emotions,
- Ability to use the vocabulary of emotion and expression,
- Capacity for empathic involvement,
- Ability to differentiate subjective emotional experience from external emotion expression,
- Adaptive coping with aversive emotions and distressing circumstances,
- Awareness of emotional communication within relationships, and
- Capacity for emotional self-efficacy.

Skills one through six are based on developmental research on emotions but the final two skills are based on her experience as a clinical developmental psychologist. Each chapter contained organizing subtitles and ended with culture, developmental stage and gender information. In keeping with her leanings to Lewis and Michaelson, her most basic skill, 'awareness of one's own emotions,' is one that requires cognitive ability. She stipulated that, to accomplish the first skill, (Lewis' argument) the child must know how the body feels to have an emotion. A child needs to be age four or five to demonstrate this skill reliably. Of all the skills, skill four, the capacity for empathic involvement appears to be an outlier. While the material she presented was interesting to read, the role of empathy as a skill of emotional competence wasn't argued convincingly. On the other hand, skill 7 had a great deal of face validity. It suggested that there is a skill of emotional meta-communication.

A strength of the book is its comprehensive examination of the skills she proposed. She covered many practical issues in emotional competence. The book conveyed a strong sense of children in their world and thus it was easy and enjoyable to read. A limitation of the book related to Dr. Saarni's description of the differences between the theoretical models and how she applied them. There is a distinct difference between the social constructivists and functionalists. If child psychiatrists or residents are not familiar with the difference, this book will confuse their understanding. The former see emotions as arising from the development of cognition and the latter see emotion as not developmentally dependent upon cognition, rather, an organizing principle in development in its own right. Despite this, the effort and breadth of the treatment of emotional competence as illustrated in this book makes it well worth the read.

Esther Cherland MD

Behavior Problems in Preschool Children, Second Edition: Clinical and Developmental Issues.

Susan B. Campbell. The Guilord Press, NYC, 2002. 300 pp. $38.00 USA.

I had the pleasure of reviewing the second edition of " Behavior Problems in Preschool Children." As I was already very familiar with the first edition, I thought reviewing the second edition would be comparatively easy.

It was enjoyable reading but not necessarily that easy for two reasons. First, I went to and fro from the first edition (1990) to the current one to find out how the author incorporated new information on the models and behavior of preschool development. Theoretical and conceptual issues of preschool behavior problems were modified in the new edition but not to the degree I expected. The second reason for my difficulty was my expectation that the newer edition would incorporate research findings on brain development, for example, regarding links with the self-regulation capacities and right orbitofrontal development. That aspect was not elaborated in this book.

My next move was to read the chapter on family factors and young children's development, chapter 4, in which I expected new information and was well rewarded. This chapter is substantially modified and expanded to include the complexities facing modern families.

Overall, the book is divided into 9 chapters. The first chapter addresses theoretical and conceptual issues.

The second chapter entitled "Developmental Issues" contains pearls of wisdom that are hard to ignore. Consider for example, "ability to engage in pretend play implies some degree of stable self image that permits the child to switch roles." Also, "preschoolers are much less egocentric than was believed twenty years ago."

The next chapter, "Clinical Issues" was well written with simple language and demonstrative clinical examples. These examples may have been taken from the author's longitudinal studies but they could easily represent the patient population of any early child development team. Many studies were reported that addressed the nature of children's problems at different ages. Clinically prototypical vignettes emphasized 'how children's symptoms become salient at different ages.'

The ensuing chapters addressed family factors and sibling relationships.

Chapter 6 on peer relationships included a clinically relevant discussion on the developmental importance of peers in preschoolers. This chapter will be very useful for clinicians introducing strategies for social skills training in preschoolers. The discussion on the role of peers in augmenting social difficulties for aggressive and shy peers was particularly important.

Preventive and intervention strategies were well covered in the next chapter. The author concluded that there was a need for more integrated treatment approaches that should be offered to families during earlier stages of child development. Longitudinal studies of cohorts of preschoolers followed until elementary age and from age 3 to age 13 were described and illustrated the complexities in extrapolating to future development of the child.

In the last chapter, the author made an impressive case, using already available evidence, to create improved social policies within a developmental framework. The policies discussed ranged from preventive programs for preschoolers and their families to parental leave and adequate child care.

For me, there were some important topics that were underemphasized or missing such as: cultural issues, aggressive neighborhoods and aggressive toys in perpetuating externalizing behavior. Moreover, there was hardly any discussion about those unfortunate preschoolers who exhibit behavioral disturbance due to emotional, physical or sexual trauma, or children born to substance /alcohol using mothers.

In overall summary, this book provided a comprehensive developmental and clinical framework to understand the preschooler's behavior and as such is an essential addition to the reference library.

My rating is 7/10.

Dr Pratibha Reebye, MD

Social Processes in Children's Learning.

Paul Light, Karen Littleton. Cambridge University Press, New York, NY. 1999. 117 pp. $49.95 USA.

This book is part of a series of the Cambridge Studies in Cognitive and Perceptual Development, which aims "to provide a scholarly forum for current theoretical and empirical issues in cognition and perceptual development." This particular book is about the effect of social interaction on learning and problem solving behaviour in children of late primary and early secondary school age.

For the last thirty years the question of the significance of social interaction on learning was at the heart of the debate about the mixing of children of different genders, classes, and intellectual levels in the same learning environments. It underlies such controversial issues as bussing and mainstreaming in order to integrate children previously schooled apart. In seven compact chapters the authors present their research showing how various structured situations, defining the interaction among participants, affect the problem solving approach and, in turn, the learning process in individuals and pairs.

The book comprises seven chapters whose titles reflect a logical progression from the introductory "Peer Interaction and Learning: Perspectives and Starting Points" through chapters that review "Peers and Puzzles: A First Series of Studies", "Computer and Learning Gender Issues"; "Social Comparison and Learning" to "Interaction and Learning: Rethinking the Issues."

The authors draw mainly on their own research done in collaboration with others to look at how "social interactions between learners influences the learning experience." They indicate that the work draws both from education and psychology. In the preface, several important points are made, which form an introduction and a foundation for appreciation of these studies: Humans are distinctive cultural beingswith the capacity for socially grounded learning. This involves understanding the purposes and intentions of others in learning situations as well as the capacity to appropriate their point of view in shared activities. A progression from imitation through instruction to collaborative learning in early childhood is seen as vital to cultural learning. Social processes mediate learning in several ways. In the educational field there has been interest in the potential of group work for fostering learning for several decades. Group situations are commonly used in today's classrooms. The computer has helped to reverse a relative decline in group work, since students often work at computers in pairs or small groups.

In a series of studies they examine the various ingredients of learning situations such as: gender, the nature of the task, the necessity to discuss or interact, the initial competencies of participants, the competency differential between participants and the use of a computer and learning pairs or small group situations. The researchers follow improvements in the learning of individuals as well as the performance of the pair

or group. "Productive conflict" is believed to be a necessary ingredient. Based on observations of participants in a computer based problem adventure solving task, the authors conclude that "it is not so much a case of facilitation of performance due to the presence of peers working on the same task as a matter of degradation of performance through anxiety when children work alone." About mixed gender peers the authors write, "It is our interpretation that it is not gender so much as self confidence that is at issue."

The studies presented and discussed have a gentle progression from the simple to the more complex, thus taking along the average reader. The material is compact and scholarly with helpful illustrations. It is well referenced and it is itself a very valuable reference on the impact of social interaction on learning in school age children. It would be of particular interest to those in the field of educational psychology, and school psychiatry.

Llewellyn W. Joseph, MD.

Even From a Broken Web: Brief, Respectful Solution-Oriented Therapy for Sexual Abuse and Trauma.

Bill O'Hanlon and Bob Bertolino. W.W. Norton and Co., NYC, 1998. 127 pp. $24.99 Cdn.

In recent years sexual abuse and trauma as a focus of therapy has become mainstream and many books have been written on assessment and treatment, not only for the clinician, but also for the client/victim. These books have been written from a variety of theoretical perspectives. This book is written by two well known experts in solution focussed therapy. The authors take issue with the idea that therapy needs to be long term and dwell on the past. Instead, they encourage a focus on the present and future rarely encouraging regression, or the need to re-experience the trauma.

The authors suggest that the essential difficulty in trauma involves the tendency for people to be disconnected from their inner selves separating various aspects of their experience through what they call the 3 D's of the after effects of sexual abuse - dissociation, disowning and devaluing. Their therapy is directed at achieving coherence and a different valuation of what has happened, opening up the possibility of alternative behaviour. In many ways, this theory is compatible with cognitive approaches that work with beliefs, assumptions and meaning attributions to achieve change. They also borrow heavily from M. Erickson and V. Frankyl, separating symptomatic from healing trances.

Chapters 2 to 4 outline how they work with clients illustrating various theoretical points with clinical examples or stories. "People's statements are not the way things are, but the way they have perceived or experienced a particular thing. By reflecting back their statements as perceptions, they introduce the notion of possibility," (p49). Problematic patterns are recognized and then changes suggested that involve changing the sequence, antecedents, consequences, invariant actions, repetitive interactions and bodily behaviour. They coach people to talk in "video talk" (action terms) rather than in vague or interpretive words or phrases.

The authors make clear that possibilities should not be confused with positives. The thrust of therapy is to attack the 'stuckness' so that new ways of behaving can be seen and tried. They say clients often don't have a sense of future other than a repetition of the past. The therapist aims to open up the possibility of a preferred future. They encourage the ability to speak about one's abuse but not to relive, re-experience or wallow in it.

Chapter five describes short term group exercises. They find groups very useful to reduce shame and normalize what is felt without regression and reliving and as a positive way of introducing alternative perspectives of meaning and action. Only briefly do they discuss how to manage cutting, self harm, flash backs or dissociation.

I'm not sure how I feel about the book and was left somewhat dissatisfied, even though there are many helpful suggestions. Many of the people I work with would find the approach difficult as their internal schemas are so negative that they are unable to visualize how things might be different. The very defences that enabled them to survive interfere with their behaving in alternative ways. There is little discussion of resistance or the mechanisms that interfere with change or how to surmount them. Such a discussion would have made the book more useful.

A discussion of the work on the biology of trauma might have strengthened their theoretical base. In the book they talk of lack of coherence in the parts of the person which current research suggests is mirrored in changes in brain with the proposition that much of the work of therapy is to get memories and emotions (right brain activity) into the open so it an be re-evaluated and given a different meaning (by the left brain).

The many stories that are used to illustrate points make the book an easy read. The summaries at the end of each chapter are excellent. The style is free of jargon and flows nicely.

In summary, there is much that is useful in the book, but it is not a 'must have' book on the topic and much of what they suggest is also found within other theoretical models.

Elsa Broder, MD

The Treatment of Obsessions.

S. Rachman, Oxford University Press Inc., New York, 2003, pp. 162. $59.95 Cdn.

This book is an excellent manual that describes a focused, specific treatment for obsessions. The book is well written, succinct and has a number of very practical strategies to manage obsessions. The book is most appropriate for the treatment of older adolescents and adults.

The book is divided into ten chapters. The first few chapters discuss the nature of obsessions, the background and the rationale for this treatment. The following three chapters focus on assessment procedures and stages one and two of treatment which are considered essential for therapists. The subsequent chapters, that address techniques and tactics for coping with self-defeating safety behaviour and different forms of obsessions, are non-essential and are utilized when appropriate. Therapists are provided information on how to assess progress and manage problems. The ninth chapter is entitled "Therapist's toolkit" and is a summary of all the key instruments described in the manual that the therapist can utilize in treatment. The final chapter has a series of case illustrations, demonstrating the types of cases that can benefit from treatment. The author does describe one case that did not improve with treatment.

Rachman emphasizes that this treatment is to be used for classical obsessions that have three main themes: aggression, sex, or blasphemy. This treatment may be beneficial in a proportion of children and adolescents as a recent study found that the most common obsessions in a sample of children with OCD were contamination and worries about harm and in adolescents, more religious worries.[1]

Rachman's theory of obsessions draws on the work of Salkovski and Clark. Salkovski believed that it was not the content of the intrusions but rather the meaning that the person attached to such intrusions that was important. Salkovski identified that individuals with obsessions have a sense of inflated responsibility. Clark argued that panic is caused by a catastrophic misinterpretation of certain bodily sensations. Rachman's cognitive theory states that obsessions are caused by catastrophic misinterpretations of the significance of one's unwanted intrusive thoughts. In the case of obsessions, inflated responsibility is particularly noticeable when people are prone to the cognitive biases of thought-action fusion (TAF), a concept coined by Rachman. TAF refers to the phenomenon in which people tend to regard their thoughts as being psychologically equivalent to the corresponding action and/or believe that their thoughts of possible misfortunes actually increase the likelihood that the misfortune will occur. This concept has been well studied in adults. There is only one study examining the cognitive processes proposed to be etiologically important in the conceptualization of OCD in a sample of children between age 7 and 13 years. Children with OCD were found to have significantly higher ratings of responsibility, severity, TAF, and less cognitive control than non-OCD children. There have been no such studies in adolescents.[2]

With respect to assessment, the Yale Brown Obsessive Compulsive Scale (Y-BOCS), the Obsessive-Compulsive Inventory (OCI) and the Beck Depression Inventory (BDI) are recommended as part of the preliminary assessment. For the specific assessment of obsessions, a semi-structured interview that is designed to collect information about the content and frequency of the obsessions, the triggers, safety behaviour, and maintaining conditions, as well as the personal significance that the patient attributes to the obsessions, is conducted. The Personal Significance Scale helps in the assessment and guides the course of therapy. The scale consists of 26 questions, all of which are rated on a 10 cm visual analogue scale, which would be useful for adolescents. The scale is administered at the beginning of each session to measure the personal significance of the obsessions, the amount of obsessional activity per week and the degree of distress it causes. A therapist version is completed at the end of each session. Patients can also keep a simple daily record of their unwanted intrusive thoughts. As a guide to treatment, the 19-item self-report Thought Action Fusion (TAF) scale, which provides a total score indicating the proneness to this cognitive bias, is utilized.

The treatment consists of 8-12 weekly sessions, starting with twice a week and gradually tapering to once every three weeks. A session-by-session progress chart sets out the structure for each session. Rachman suggests that the sessions be taped and the patients review the tape before the next session. The patient is given homework exercises and it is emphasized that the work between sessions is crucial. Booster sessions are planned as necessary, and review and follow-up meetings are always arranged.

The primary aim of treatment is to assist the patient to make more realistic and accurate interpretations of the significance of their unwanted, intrusive thoughts. The techniques are essentially cognitive and can be used to supplement the standard Obsessive Compulsive Disorder (OCD) treatments. It is important for the therapists to use flexibility in administration of the treatment.

As the focus is on changing the patients' misinterpretations of the significance of the intrusive thoughts, the first step in treatment is education. Patients are informed that unwanted intrusive thoughts are nearly universal and they are given a printed list of common examples. The second part of the educational component consists of a description of the treatment model, the rationale of the treatment plus references. The patient is asked to explain the treatment model and their response is recorded.

The second treatment stage involves collecting a full account of the content of the obsessions. Encouraging the patient to describe and then record the occurrence of the obsession, in a mechanical manner, changes their significance. The collection of this information is then used, in the usual way of cognitive therapy as a basis for assessing the patient's interpretation of the obsession. The patient is encouraged to construct alternative interpretations of the intrusive thoughts and to match the available evidence for and against the original catastrophic significance and the alternatives. This step may include behavioural experiments. The avoidance behaviour that results from the obsessions is tackled by encouraging the patients to gradually and steadily expose themselves to the anxiety-evoking situations.

Other techniques to work with self-defeating safety behavior such as avoidance, concealment, thought suppression, neutralization, reassurance seeking, and obsessions are outlined. For example, mini-experiments, in which the patient tests the validity of specific expectations, are outlined. The purpose of the mini-experiments is to allow the patient to collect direct, personal information, pertaining to important OCD beliefs. These behavioural experiments are in contrast to exposure exercises in which the primary aim is to reduce fear.

To monitor changes, the therapist can observe changes on the Personal Significance Scale at each session. At the end of treatment the pretreatment measures, OCI, Y-BOCS, BDI, and the full structured interview are re-administered. Rachman stresses that an important index of change is the patient's behaviour.

Overall, this book is a very useful, practical manual for older adolescents and adults. It will be important to follow this treatment over time to determine if it can be applied to children and younger adolescents.

Margaret Steele MD

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Announcement

Evaluation of the effects of a golf challenge on friendliness, enthusiasm and water-fondness among Canadian Child Psychiatrists. A Pilot Study

The Canadian Academy Golf Consortium (CAG Consortium)

BACKGROUND

Rumour is that in early November, 2003 several members of the Canadian Academy of Child and Adolescent Psychiatry (CACAP) skipped part of the important proceedings of the Annual Meeting in Halifax, NS, arriving late to the poster session and behaving in a somewhat elated, yet disruptive fashion. To address this problem, the Scientific Committee of the Academy commissioned the Canadian Academy Golf Consortium to conduct a pilot study to assess the effects of golf on the mood and eagerness of Academy members. The proposed study was conducted at Le Challenger Golf Course, 2525 rue des Nations, Saint-Laurent, Quebec, on October 2, 2004.

METHODS

All participants N= 8 (6 male, 2 female) were randomly assigned to two groups. Age of the participants is not disclosed for reasons of personal pride. Individuals within each group took turns – in an orderly manner- to hit a small spherical object, not less than 42.67 mm (1.680 inches) in diameter and not greater than 45.93 g (1.620 ounces avoirdupois) in weight – or about the size of a golf ball- with either wood or iron sticks ("clubs"). The first group initiated the experiment at 13:20 hr. and the second group at 13:28 hr. After several attempts, participant individuals managed to sink the spherical object into a cylindrical cavity carved out in the ground ("hole") and located somewhere between 340 and 385 yards from the starting point. The dimensions of the hole were exactly 108 mm (4 1/4 inches) in diameter and at least 101.6 mm (4 inches) deep. Each time a ball was sank into the hole, the self-esteem of the individual sinking the ball was expanded; instantly intra-group members expressed words of praise for the person sinking the ball. Once all four intra-group members sank their balls, the whole procedure was repeated in a compulsive fashion for seventeen additional times. The experiment lasted approximately 4 hours and 45 minutes in total.

Groups were compared on three dimensions: enthusiasm, friendliness and moisture fondness. As a proxy for enthusiasm noise volume -measured in decibels (db) - made by intra group members when balls were sank into the hole was used. Friendliness scores reflected a composite count of gestures of support consisting of the number of hand-shakes, pats in the back and words of encouragement expressed every time an intra-group member did something really good or terribly awful. Finally, moisture fondness was defined as the inverse to the ability to stay dry and measured as the amount of rain afflicting participants measured in cubic mm (mm3) of rain per square cm (cm2) of body surface. Due to the fact that participants are humble individuals-who do not see themselves as real professionals- a student t-test for independent groups was chosen for the analytical design.

TABLE 1

Group comparisons on measures of enthusiasm, friendliness, and moisture fondness.

	Group 1	Group 2	t	df	Sig (2-tailed)
Starting time (hr)	13:20	13:28			
Enthusiasm (db) Mean (sd)	185.7 (17.9)	187.7 (13.4)	0.179	6*	0.864
Friendliness (gestures of encouragement) Mean, (sd)	147.2 (5.9)	144.0 (7.1)	-0.703	6*	0.509
Moisture fondness (mm^3/cm^2	0.17	4.78	-24.355	6*	<0.001

*Note: hr= hours, db=decibels, sd= standard deviation, df= degrees of freedom, *equal variances assumed*

RESULTS

Participants managed to stay calm, focused and fervently completed all required tasks. Table 1 presents a summary of the performance of both groups on the three primary outcome measures. Both groups received extremely high ratings on the enthusiasm and friendliness dimensions which are not statistically different from each other. However the 13:28 group demonstrated an exaggerated fondness for moisture, clearly reaching statistically significant P values. This second group also showed extreme recklessness as they persisted in their attempts to complete the 18th hole, using metal objects, during a severe thunderstorm.

DISCUSSION

Golf represented an opportunity for members of the Academy to demonstrate sportsmanship, tenacity, face adversity and ability to manage unforeseen complications and/or impediments. In spite of facing buckets of rain, menacing winds, threat of lightening and serious distractions by former local politicians all participants demonstrated high levels of enthusiasm and camaraderie. This collaborative research strengthened interpersonal bonds as a consequence a powerful desire to repeat this scientific endeavour at the next Academy Meeting has emerged. Given the fact that this was a pilot study and results are limited by the sample size a larger study including more participants is strongly recommended. Members of the CAG Consortium have volunteered to conduct a larger scale randomized study as well as a prospective longitudinal follow-up program. Members of the Academy are cordially invited to participate in these future scientific quests.

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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, and pharmacology 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 and Adolescent 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)
Letters to the Editor (maximum 300 words including references if any)

Format of Submissions
Submissions can be made by e-mail using *MS Word compatible format* or by mail to the editorial assistant. 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. Abstracts of maximum 200 words are required for the original articles and reviews following the format; introduction, method, results, conclusion. References should be as follows in the text of the article: Gorman et al (1998) or …….(Gorman et al, 1998). All maunscripts should have three to five relevant keywords placed below the abstract. 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).

References should follow the style eg. **Carrey, N. & Virani, A. (2003). Commentary: Suicidal ideation reports from pediatric trials for paroxetine and venlafaxine. Canadian Child and Adolescent Psychiatry Review, 12(4), 101-102**. For further questions on style please consult the 5th edition of the APA Publication Manual.

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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FOR ADVERTISEMENT RATES PLEASE CONTACT EDITORIAL ASSISTANT

All submissions should be sent to Vicki Simmons
Editorial Assistant
CACAP Review
4731 Carloss Place
Victoria, BC
V8Y 1C9
E-mail: vsimmons@shaw.ca

INSTRUCTIONS POUR LES AUTEURS ET LES COLLABORATEURS

Académie canadienne de psychiatrie de l'enfant et de l'adolescent

Les textes et manuscrits peuvent porter sur n'importe quels sujets traitant de la santé et de la maladie mentale chez l'enfant et de l'adolescent, en pédopsychiatrie, en psychologie de l'enfant, en pédiatrie, en psychopharmacologie, en psychiatrie générale et géronto-psychiatrie, en médecine interne ou dans d'autres spécialités médicales, de même qu'en psychologie générale, en sociologie et/ou en santé au travail, textes et manuscrits susceptibles d'intéresser les professionnels de la santé de l'enfant et de l'adolescent.

Articles originaux et revues de littérature (maximum de 3000 mots, incluant les tableaux et les références)

Nous cherchons des articles de fond, des articles descriptifs, des études quantitatives ou des articles de recherche, des revues de littérature, des présentations de cas cliniques ainsi que des lettres à l'éditeur. Les soumissions seront étudiées par un comité de pairs. L'auteur principal sera informé des résultats du comité en deçà de six semaines de sa soumission. De façon générale, seuls les articles originaux seront acceptés. Il peut arriver cependant et exceptionnellement qu'un texte déjà publié puisse l'être de nouveau s'il est d'un intérêt primordial, unique, pour les membres de l'Académie canadienne de psychiatrie de l'enfant et de l'adolescent. La reproduction d'un tel texte nécessitera l'obtention d'une permission explicite de la part de l'auteur principal et du responsable de la publication.

Les présentations de cas (maximum de 1000 mots, incluant les références) les lettres à l'éditeur (maximum de 300 mots, incluant les références)

Le format des soumissions

Toute soumission peut être envoyée à la secrétaire de rédaction par courriel ou par la poste. Utiliser le format MS Word compatible, la police de caractère Arial ou Times New Roman, des caractères d'au moins 11 points de grandeur, et écrire à double interligne. Titres et sous-titres ne doivent pas être en caractère gras. Les noms de tous les auteurs, leurs compétences pertinentes et affiliations, doivent être clairement indiqués sous le titre principal ainsi que l'adresse postale, le numéro de téléphone et de télécopieur de même que l'adresse courriel du premier auteur ou de l'auteur principal. Pour les articles originaux et les revues, nous exigeons des résumés au maximum de 200 mots, selon le format suivant: introduction, méthodologie, résultats, conclusion. Tous manuscripts doivent avoir 3-5 mots clés pertinents placés au dessous du résumé. Les références doivent être présentées comme suit: Gorman et al (1998) ou …… (Gorman et al, 1998). Lorsqu'il y a plus d'une référence pour le même auteur, les références à la fin de l'article doivent suivre un ordre chronologique. S'il y a plus d'un article dans la même année, utiliser la présentation suivante: Gorman et al (1998a, et 1998b).

Les références, en somme, se font dans le style suivant: **Carrey, N. & Virani, A. (2003). Note: Rapports sur les idéations suicidaires provenant d'essais pédiatriques de la paroxétine et de la venlafaxine. Revue canadienne de psychiatrie de l'enfant et de l'adolescent, 12(4), 101-102.** Pour de plus amples informations concernant le format, consulter la 5e édition du APA Publication Manual.

Il revient aux auteurs d'assurer que leur travail ait reçu l'approbation éthique là où nécessaire. Si un auteur désire soumettre un ou plusieurs articles déjà publiés, il doit obtenir une permission écrite de l'éditeur qui détient les droits d'auteur.

LA PROMOTION DE CONFÉRENCES ET D'ATELIERS SERA INCLUSE SANS FRAIS.

POUR PLUS D'INFORMATION SUR LES TARIFS PUBLICITAIRES, VEUILLEZ ENTRER EN CONTACT AVEC LA SECRÉTAIRE DE RÉDACTION.

Envoyer les soumissions à Vicki Simmons
Secrétaire de rédaction
Revue de l'Académie canadienne de psychiatrie de l'enfant et de l'adolescent
4731 Carloss Place
Victoria, BC
V8Y 1C9
Courriel-: vsimmons@shaw.ca

St. John's Health Care Corporation
Children and Women's Health Program

Locum
Child Psychiatrists

Two locum positions are available for child psychiatrists beginning immediately for one year at the Janeway Children's Health and Rehabilitation Centre, St. John's, Newfoundland. The candidate will join a group of three other child psychiatrists at a fully accredited teaching pediatric hospital. The hospital is affiliated with the Faculty of Medicine, Memorial University of Newfoundland.

The candidates must possess FRCPC or equivalent, including at least two years of training in Child Psychiatry and be eligible to practice medicine in Newfoundland and Labrador. In accordance with Canadian immigration regulations, preference will be given to Canadian citizens and permanent residents.

St. John's is a city that boasts of its beauty and low crime rate as well as offering many cultural and recreational activities. Interested applicants should sent their curriculum vitae with names of three references to:

Dr. R. Williams
Vice President, Medical Services
Room 1352, Administration
Health Sciences Centre
300 Prince Philip Drive
St. John's, NL, A1B 3V6

Telephone: (709) 777 - 1308
Fax: (709) 777 – 6307
Email: Robert.Williams@hccsj.nl.ca

TORONTO EAST
GENERAL HOSPITAL

CHILD AND ADOLESCENT MENTAL HEALTH PROGRAM

PSYCHIATRISTS - Full and Part time

Child and Adolescent Psychiatrists are needed to play a key role in the development, implementation and ongoing clinical leadership of our new Child and Adolescent Mental Health Program that includes a: 6 bed inpatient unit, transitional day program and emergency services. Responsibilities will include direct clinical services, consultation and collaboration with the multidisciplinary team in partnership with the program coordinator and consultation with community resources. Sessional support is provided.

The program sits within a comprehensive adult Mental Health Service and has the support and involvement of our regional in hospital paediatrics unit. Successful candidates will have related experience and qualification in Child Psychiatry.

Please submit your resume to:

Dr. A. Meschino
Chief of Staff
825 Coxwell Avenue
Toronto, Ontario M4C 3E7
Fax (416) 469-6554

Childhood Onset Schizophrenia Study

Child Psychiatry Branch

National Institute of Mental Health, National Institutes of Health, Department of Health and Human Services

Bethesda, Maryland USA

The Child Psychiatry Branch is interested in seeing children who are responders as well as non-responders to current treatments. Children and their families are brought to the National Institutes of Health, Clinical Center at our expense for an intensive research diagnostic evaluation and, when appropriate, clinical trials. Criteria: boys and girls 6-18 years old with onset of psychotic symptoms before the age of 13, with an IQ above 70 (pre-psychotic) and family involvement. Families of children with schizophrenia who are interested in participating in research are encouraged to fill out the NIMH Childhood Onset Schizophrenia Survey at http://chpwebsurvey.nimh.nih.gov. Any questions you can call Ms. Lenane at 1-888-254-3823.

A child's stage of development must be taken into account when considering a diagnosis of mental illness. Behaviors that are normal at one age may not be at another. Rarely, a healthy young child may report strange experiences – such as hearing voices – that would be considered abnormal at a later age. Clinicians look for a more persistent pattern of such behaviors. Parents may have reason for concern if a child of 7 years or older often hears voices saying derogatory things about him or her, or voices conversing with one another, talks to himself for herself, stares at scary things – snakes, spiders, shadows – that are not really there, and shows no interest in friendships. Such behaviors could be signs of schizophrenia, a chronic and disabling form of mental illness. Schizophrenia is very rare in children, affecting only about 1 in 30,000, compared to 1 in 100 in adults. Children with schizophrenia experience difficulty in managing everyday life. They share with their adult counterparts psychotic symptoms (hallucinations, delusions), social withdrawal, flattened emotions, increased risk of suicide and loss of social and personal care skills.

Additional information can be obtained at the following NIMH websites:

http://www.nimh.nih.gov/publicat/schizkids.cfm

http://intramural.nimh.nih.gov/chp/cos/index.html

Source: NIMH.

NIMH
National Institute of Mental Health

NOTES