Introduction
Personality Disorders in Childhood and Adolescence

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This theme issue considers paediatric narcissistic and borderline personality disorders from the perspectives of either diagnosis or treatment. Patients with borderline pathology, in particular, present with considerable frequency to paediatric emergency rooms for the assessment of suicidal ideation and attempts, and challenge the clinician to find innovative treatment interventions to address their distress and interpersonal difficulties. Not by any means an exhaustive overview of paediatric personality disorders in general, this issue is intended to stimulate questions concerning the validity of such constructs and their detection and management.

Many clinicians are reluctant to diagnose personality disorders (PDs) during youth, viewing paediatric personality deviations instead as reflective of given developmental stages. This is so despite evidence that certain youth are indeed at risk for the eventual development of PDs as adults. Unfortunately, late identification of these disorders prevents timely treatment and potentially increases morbidity.

This theme issue deals with three predominant questions. First, is there a paediatric construct analogous to BPD of adulthood? If a paediatric form of such a disorder exists, then according to the validity criteria of Robins (1985) it should be characterised by a specific course and treatment response as well as correlates (psychosocial and neurocognitive) serving as external validators. Second, can empathy serve as an endophenotypic marker which could further delineate certain PDs and thus promote evidence-based research? Third, can we as yet reliably identify narcissistic behaviours in youth and characterise their treatment responses and interactions with caregivers?

The first article by Bondurant et al offers an overview of the literature concerning the BPD construct during adolescence. Cross-sectional studies tend to support both the convergent and discriminant validity of this construct, but when using the adult criteria and threshold to diagnose the adolescent form of the disorder, it lacks predictive validity. This is in contradistinction to other studies (Crawford et al, 2001) which have shown an overall greater stability among Cluster B personality disorders from early adolescence to adulthood than externalizing and internalizing disorders. Nonetheless, it leads one to question whether the adult symptom criteria and threshold should be used to make the adolescent diagnosis. Prospective studies may indicate which BPD traits are most enduring.

The paper by Zelkowitz et al gives an overview of their research program into paediatric borderline pathology. Addressing a debate in child psychiatric circles concerning a potential overlap between ADHD and the borderline construct, they compared two groups of children, one suffering from borderline pathology and the other not, both attending a day hospital program. No inter-group differences were found with respect to the occurrence of ADHD. They then describe a second study wherein they demonstrated that neurocognitive deficits and a history of abuse made significant and independent contributions to the variance in borderline pathology. Their work thus provides empirical data to support the concurrent validity of this construct in children. Furthermore it stimulates paediatric research on neurobiological correlates which have been already tested in the adult BPD population (Siever et al, 2002)

Nixon et al discuss the development and initial pilot of a combined Dialectical Behavioural Therapy and Therapeutic Support Group for the treatment of self-injuring adolescents, many of whom present with borderline pathology. They provide a detailed description of their therapeutic groups and the process by which they were implemented within their therapeutic milieu. Their treatment approach, including concurrent parent and adolescent groups, were thus consistent with current treatment trends with this population and could lend themselves to implementation in other settings.

The fourth paper by Morrison explores the neurobiology of empathy which is clinically impaired or underdeveloped in several PDs, especially the narcissistic, antisocial and schizoid types. Morrison refers to a neurocognitive model, the forward model, wherein motor and emotional aspects of an experience are imprinted in our neural networks. This neural template is then automatically and non-consciously activated when the person is feeling empathetic towards another person's experience. This theory has been consistently verified during the past decade (Singer et al, 2004), and corresponds to other neurobiological research on consciousness (Edelman, 2003). This is based on the premise that a multitude of potential synaptic connections can be formed in the brain in response to any stimulus. However, only those that are adaptive (as determined by feedback from the environment) are consolidated, and can be accessed subsequently in similar situations. This applies to the motor, emotional and cognitive components. Applied to psychopathology of personality disorders, this model suggests that such disorders are marked by either defective environmental feedback or defective integration of that feedback, leading to distorted perceptions of reality and corresponding distorted self-perceptions. These findings, which give biological and empirical credence to the construct of personality disorders, resonate with psychodynamic models of PDs as elaborated by Kernberg and Bergeret (Posner et al, 2003). Morrison considers the implications of this model for such therapeutic interventions as the cognitive-behavioural technique of role modelling, play therapy and psychodrama where the body of the therapist plays an important role.

The next two papers deal with the measurement and treat-

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ment of paediatric narcissistic conditions. Accordingly, Guile et al describe the reliability of one of several paediatric measures of those conditions which they have been studying. This measure, which was developed and tested in their psychometric research program, corresponds to the DSM-IV and was adapted from the Diagnostic Interview for Narcissism developed by Gunderson and his team (Gunderson et al., 1990) for NPD in adults. This set of instruments should allow for longitudinal studies on this disorder.

The last paper, emanating from the same research team, deals with two principle findings with respect to treatment consisting of both parent counselling and psychodynamic therapy. First, it suggests that parents of youth suffering from narcissistic disorders tend to sabotage access to treatment, perhaps concerned that such treatment would disturb an idealised dyadic relationship. Second, such youth manifest a constellation of responses to treatment, both as forms of resistance to treatment and as essential components of the treatment process, such as mirroring. Interestingly, children with underdeveloped empathic abilities resort readily to mirroring of the therapist' attitude, reminiscent of the aforementioned findings on the neurobiology of empathy.

In conclusion, research in the area of paediatric personality disorders is moving us closer to discerning the validity of these constructs in youth, their identification, treatment implications and the ultimate outcome of affected individuals.

REFERENCES

Crawford, T.N., Cohen, P., Brook, J.S. (2001). Dramatic-erratic personality disorder symptoms: II. Developemntal pathways from early adolescence to adulthood. *Journal of Personality Disorders*, 15(4),336-350.

Edelman, G.M. (2003). Naturalizing consciousness: a theoretical framework. *Proceedings of the National Academy of Sciences*.100(9), 5520-5524.

Gunderson, J.G., Ronningstam E, Bodkin A. (1990). The Diagnostic Interview for Narcissitic patients. *Archives of General Psychiatry*. 47, 676-680.

Posner, M.I., Rothbart, M.K., Vizueta, N., Thomas, K.M., Levy, K.N., Fossella, J., Silbersweig, D., Stern, E., Clarkin, J., Kernberg, O. (2003). An approach to the psychobiology of personality disorders. *Development and Psychopathology*,15, 1093-1106.

Robins, L.E. (1985). Epidemiology: reflections on testing the validity of psychiatric interviews. *Archives of General Psychiatry*, 42, 918-924.

Siever, L.J., Torgersen, S., Gunderson, J.G., Livesley, W.J., Kendler, K.S. (2002). The borderline diagnosis III: identifying endophenotypes for genetic studies. *Biological Psychiatry*, 51(12),964-968.

Singer, T., Seymour, B., O'Doherty, J., Kaube, H. (2004). Empathy for pain involves the affective but not sensory components of pain. Science,303 (5661), 1157-63.

Construct Validity of the Adolescent Borderline Personality Disorder: A Review

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ABSTRACT

Introduction: Although the term borderline personality disorder (BPD) is used to describe adolescents in clinical settings, there is confusion as to what it comprises. To further elucidate that diagnosis, this article reviews its construct validity. **Method:** Relevant publications appearing in PsychInfo (1872 to present) were reviewed for the purposes of this article. **Results:** Thirty-six of the approximately sixty-five publications selected for consideration were included in this review. **Conclusion:** The construct validity of adolescent BPD is supported by internal consistency (comparable to that of adults), group differences (ie this diagnosis segregates BPD from non-BPD adolescents), convergent validity (ie multiple measures of this disorder measure the same pathology) and concurrent validity, whereby these youth manifest functional impairment and distress. By contrast, the adolescent BPD criteria manifest less construct validity than the adult diagnosis in that its criteria did not uniformly predict the overall diagnosis, and showed more criterion overlap with other personality disorders and a broader pattern of axis II comorbidity. Further diminishing its construct validity, factor analysis suggested that adolescent BPD was not a single entity, and its low predictive validity was demonstrated by little diagnostic stability through adolescence into adulthood.

Key Words: adolescent, review, borderline personality disorder, validity, construct.

RÉSUMÉ

Introduction: Même si le terme de personnalité *borderline* est utilisé en pratique dans la description de certains adolescents, celui-ci porte à confusion. Pour mieux préciser ce qu'il veut dire, nous allons revoir la validité du construit de celui-ci. **Méthodologie:** Nous avons utilisé la moitié des 65 publications retrouvées lors de la recherche de la littérature sur le sujet. **Conclusions:**La validité du construit du diagnostic de personnalité *borderline* à l'adolescence est basée sur la consistance interne (comparable à celle que l'on trouve chez l'adulte), les différences entre groupes (i.e. que ce diagnostic permet de séparer les adolescents *borderline* des non-*borderline*), la validité convergente (i.e. qu'il existe plusieurs façons de mesurer cette pathologie) et la validité concourante qui démontre que ces adolescents présentent une certaine détresse et un handicap fonctionnel. Par contre, les critères diagnostiques de personnalité *borderline* à l'adolescente on une validité de construit moins fiable que chez l'adulte en ce sens qu'ils sont *moins* en mesure de prédire de façon uniforme l'existence de cette pathologie et que les critères s'imbriquent avec ceux des autres troubles de la personnalité et autres troubles comorbides en axe II. L'analyse factorielle réduit encore la validité du construit de la personnalité *borderline* à l'adolescence en démontrant que ce type de personnalité ne représente pas une entité unique; le fait que la stabilité du diagnostic durant cette période allant du début de l'adolescence au début de la période adulte soit faible démontre que la validité critérielle du diagnostic est incertaine.

Mots-clefs: Adolescent, revu, personnalité borderline, validité, construit

INTRODUCTION

Adolescent psychopathology in general can involve affective lability, impulsivity, identity confusion, and a tendency to idealize peers while devaluing others (Block et al, 1991). Those same features also characterise patients specifically suffering from borderline personality disorder (BPD) (Kernberg, 1975). Despite these similarities, research has shown borderline adolescents to be distinct from their peers (Ludolph et al, 1990; Faulkner et al, 1999; Westen et al, 2003). Block et al (1991) concluded that while all adolescents may struggle with similar developmental crises, the BPD adolescent "has neither the ego strengths nor the facilitated environment to launch her successfully into adulthood".

Criteria for the diagnosis of BPD in adolescence reflect those of the adult disorder, for which several sets of criteria will be described. According to the DSM IV (American Psychiatric Association, 1994), the diagnosis of BPD in adulthood requires that the individual demonstrate "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts." Such individuals are further characterised by identity disturbance, concerns about abandonment, recurrent suicidal behaviour, chronic feelings of emptiness and transient, stress-related paranoid ideation or severe dissociative symptoms.

Kernberg (1975) further defined borderline personality organization patients as occupying a borderline area between psychosis and neurosis, in a stable not fluctuating pattern. They are characterised by identity disturbance, primitive defense mechanisms (ie splitting, idealisation, devaluation and projective identification) and predominantly intact reality testing, despite regression and micro-psychotic episodes.

Finally, Gunderson & Singer (1975) identified six features that characterized borderline patients, including the presence of intense affect, a history of impulsive behaviour, a certain level of social adaptiveness, brief psychotic experiences, loose think-

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ing in unstructured situations, and relationships that vacillate between transient superficiality and intense dependency. Despite these well-established criteria for the BPD construct in the adult population, there is uncertainty as to whether there is a corresponding construct for the adolescent population.

Initial conceptualisations of *adolescent* BPD emphasised its developmental history. Masterson (1978) viewed BPD as a culmination of childhood events initiated by intense feelings of abandonment, a resulting clinging to the maternal figure, and a failure to progress through normal developmental stages of separation-individuation to autonomy. Clinical and empirical findings suggest that BPD derives from traumatic childhood experiences including abuse, maternal neglect and rejection, grossly inappropriate parental behaviour, disrupted attachments, multiple parent surrogates and familial psychopathology in general (Grilo et al., 1999; Ludolph et al, 1990; Goldman et al, 1993).

Although these patient characteristics would appear to apply to adolescent patients we currently diagnose as suffering from BPD, many aspects of this diagnostic construct in adolescents need to be clarified. For example, there has been relatively little investigation of the prevalence, manifestations and long-term ramifications of this diagnosis (Meijer & Treffers, 1991). The following review will consider the empirical findings concerning the construct validity of adolescent BPD, using predominantly the DSM and Gunderson criteria for the adult diagnosis as a reference point.

METHOD

A search of PsycInfo 1872 to present was carried out, with the use of the following keywords "personality disorder", "borderline personality disorder", "borderline", as well as the terms "adolescent" and "adolescence". Non-English publications were excluded, as were publications concerning children and young adult populations. Inclusion criteria consisted of an adolescent study population, and the use of validated borderline personality disorder measures. These measures include the Diagnostic Interview for Borderline patients (DIB, Gunderson et al, 1981), and its revised version (DIB-R, Zanarini et al, 1989), the Personality Disorder Examination (PDE, Loranger et al, 1988), the Personality Diagnostic Questionnaire (PDQ, Hyler et al, 1988), and the Millon Adolescent Clinical Inventory (MACI, Millon et al, 1993). Publications assessing BPD using DSM criteria (DSM III, III-R, and IV) were also included. Based on the above exclusion and inclusion criteria, thirty-six publications of the original sixty-five articles selected were ultimately included in the review.

RESULTS

The first consideration with respect to construct validity concerns group differences, and more specifically, whether or not adult BPD criteria differentiate BPD from non-BPD adolescents. Bernstein et al. (1993) found that in a community sample of adolescents, 15% of males and 17.2% of females (aged 11-17 years), met the criteria for BPD, and Chabrol et al. (2001) estimated its overall frequency to be 14% in a random sample of French high school students. It was also determined that adolescent inpatients with BPD are clinically distinct from their peers and that adult BPD criteria are applicable to adolescents (Block et al, 1991; Ludolph et al, 1990; Faulkner et al, 1999; Westen et al, 2003).

Becker et al (2002) found no significant difference in the baseline rate of BPD when comparing hospitalised adolescents (53 %) with adults (47 %). However, when the diagnostic efficiency of the BPD criteria was examined in these two groups, the positive predictive power of the adult criteria (ie the ability of each criterion to predict the presence of the disorder) was more uniform in the adult than the adolescent group. By contrast, the negative predictive power (ie absence of the criterion renders the diagnosis less likely) of the criteria was comparable between the two groups. Hence, while it is possible to apply the adult criteria to the diagnosis of adolescent BPD, some diagnostic criteria are more predictive of the adolescent disorder than others.

Becker et al (1999) examined the homogeneity, another indicator of construct validity, of the BPD diagnostic construct in adolescent and adult inpatients. To do so, they explored the cohesiveness (internal consistency and mean inter-criterion correlations) *within* the BPD construct, as well as inter-category associations between BPD and *other* personality disorder criteria. They found the cohesiveness within the BPD category to be only moderate, but comparable, for both the adolescent and adult groups.

Criterion overlap (ie the extent to which criteria of different personality disorders overlap) was then assessed. In adolescents and adults, the borderline criteria were found to be consistently more related to one another than to other personality disorders criteria. However, the degree of correlation between criteria of BPD and those of other personality disorders was almost always greater in the adolescent group, suggesting a lesser degree of discriminant validity of the adolescent BPD diagnosis.

Convergent validity, a third element of construct validity, was assessed in two ways. First, correlations were sought between the BPD diagnosis and other measures and variables with which it shares an overlap of constructs. Westen et al (2003) examined the relationship between diagnoses derived from each of two measures (ie the DSM-IV axis II criteria and the Shedler-Westen Assessment Procedure-200 for Adolescents (SWAP-200A)) and instruments of adaptive functioning and childhood behaviour profiles. Strong positive associations were found between both diagnostic measures and suicide attempts, psychiatric hospitalizations, and aggressive and externalizing behaviours. These similar findings from two separate measures further support the integrity of the BPD adolescent construct.

A second approach to the determination of convergent validity is to evaluate if the adolescent BPD construct overlaps with other theoretically-related constructs, such as cluster B personality disorders. Becker et al (2000) found that the BPD group of patients (adolescents and adults) showed an overrepresentation of all kinds of personality disorders, in contradistinction to a non-borderline group with personality disorders, thus showing mild support for the adolescent construct.

Further, the adolescent BPD group had a relatively broad distribution of clusters A, B and C axis II co-morbidities, whereas the pattern of adult BPD comorbidity was more restricted to cluster B. The authors suggest that the broad pattern of comorbid overlap found in the adolescent sample suggests a more diffuse range of psychopathology in adolescents, and thus chal-

lenges the notion of such a construct in that population.

A fourth means by which construct validity can be measured is through factor analysis. Westen et al (2003) used factor analysis to develop an empirically- and clinically-based classification of adolescent personality disorders. Using the SWAP-200A, and allowing for both dimensional and categorical diagnoses of personality disorders, they discerned five statistically independent, non-overlapping personality disorders: antisocial-psychopathic, emotionally-dysregulated, avoidant-constricted, narcissistic and histrionic. They further examined correlations between these factors and other variables, including axis II diagnoses and measures of adaptive functioning. The axis II-defined diagnosis of adolescent BPD was strongly correlated with two separate factors (ie the emotionally-dysregulated and histrionic factors), suggesting that the unitary adult-based axis II BPD criteria may not be applicable to the adolescent population.

The emotionally-dysregulated factor then positively correlated with suicide attempts, and psychiatric hospitalizations, to name a few, while the histrionic factor positively correlated with suicide attempts, amongst other variables. The authors suggested that while those two personality configurations share many of the features of the current borderline diagnosis, maintaining them as two separate entities may be a more accurate reflection of personality pathology in adolescence. The combination of these two factors into one diagnosis may represent an "artifact of overlapping diagnostic categories". Their findings support the diagnosis of personality disorders in adolescence, but raises questions specifically as to the validity of a BPD construct during that developmental stage.

To examine the concurrent validity of adolescent BPD, and thus its clinical relevance, investigators have sought correlations between it and various measures of distress and dysfunction. Bernstein et al (1993) originally validated BPD diagnoses against indicators of functional impairment and distress, measures of problems at school and work and measures of psychopathology, and found BPD to be associated (ie increased odd ratio) with eleven out of twelve measures. Levy et al (1999) found adolescent personality disorders in general to be associated with significantly greater levels of impairment and distress. Finally, Westen et al (2003) correlated BPD diagnoses (derived using three different diagnostic measures) with conceptually relevant measures of impairment and distress, finding similar patterns of dysfunction and distress in association with the BPD construct, irrespective of the diagnostic tool employed. The above findings demonstrate that the concurrent validity of adolescent BPD has been consistently supported when assessed in terms of associated distress and dysfunction.

Again in the realm of concurrent validity, female adolescent inpatients with BPD, in contrast to those without, were found to have more frequent time-outs, behave more aggressively, have been subjected to more drug and/or alcohol screens and have poorer self-concepts (Faulkner et al, 1999; Pinto et al, 1996). In a similar fashion, Westen et al (2003) found that BPD was the personality disorder most highly correlated with suicide attempts in a sample of adolescent patients.

Conversely, adolescent inpatients who had attempted suicide, compared to "never-suicidal" inpatients, were more likely to have a personality disorder, and a greater prevalence and severity of borderline traits and disorder (Wade, 1987; Brent et al, 1993). Although not directly relevant to concurrent validity, increased suicidality (defined on a spectrum ranging from suicide ideation to completion) in BPD adolescents has been associated with the number of stressful life situations, familial alienation, impaired functioning, and co-existing major depressive disorder (Runeson & Beskow, 1991; Young & Gunderson, 1995; Friedman et al, 1983).

As further markers of concurrent validity, and in this context of stress, adolescent BPD has also been associated with concurrent axis I disorders, such as depression (McManus et al, 1984), bipolar disorder (Kutcher et al, 1990) and substance abuse (Grilo et al, 1996), and Marton et al (1989) found that BPD was the most common personality disorder (ie a rate of 30%) diagnosed in their sample of depressed adolescents.

Another key concern of any construct is its predictive validity: its stability, and how it evolves over time. Korenblum et al (1990) assessed personality disorder clusters A, B (including BPD), and C longitudinally in children at the ages of 13, 16 and 18. Although no subjects were diagnosed within cluster B at the age of 13, 40 % of the sample showed personality dysfunction compatible with cluster B personality disorders by the age of 18. When the two year stability of BPD was examined in adolescents, persistence rates were relatively low (ie ranging from 23% to 33%), and even within these 'stable' BPD patients, symptoms varied over time (Bernstein et al, 1993; Garnet et al, 1994; Mattanah et al, 1995).

Others assessed adolescent BPD predictive validity by evaluating impairment and distress at future time periods. Levy et al (1999) found adolescents with overall personality disorders showed increased levels of drug use and greater frequencies of inpatient treatment during the ensuing two years. However, they found no differences between those with and without personality disorders in terms of current employment, alcohol abuse, legal difficulties, psychiatric symptoms, or social and family relationships.

Several authors have also investigated the diagnostic trajectory of personality-disordered adolescents. Johnson et al (1999) found cluster B personality disorder diagnoses to be associated with increased risk in early adulthood of disruptive, mood, substance use and personality disorders, but not anxiety disorders or suicidality. Further, for those with cluster B disorders in adolescence, each additional co-morbidity almost doubled the odds of having a personality disorder as an adult (Kasen et al 1999). Lastly, Lewinsohn et al (2000) found that, for those adults prone to a mood disorder, BPD symptoms in adolescence predicted a more complex form of that mood disorder in adulthood.

Conversely, adolescent axis I pathology has been retrospectively noted among young adults later diagnosed with personality disorders, and Kasen et al (1999) found disruptive and depressive disorders in adolescence to be associated with cluster B personality disorders as adults. Similarly, the presence and number of axis I diagnoses (Lewinsohn et al, 1997) in adolescence were found to be associated with the general category of personality disorders in adulthood, and specifically adolescent anxiety disorders and attention deficit hyperactivity disorder (Rey et al, 1995)

with the development of BPD later on (Lewinsohn et al, 1997). No association was found between adolescent BPD and violence and criminal behaviours in adulthood (Johnson et al. 2000).

CONCLUSION

From the perspective that adult criteria for the BPD construct have traditionally been used as an anchor from which to diagnose BPD in adolescence, two conclusions can be drawn from the above review. First, a number of factors contribute to the notion that adolescent BPD is a valid construct. For example, it has a comparable degree of internal consistency and group differences to the adult construct, and it shows a high degree of concurrent validity, as adolescents diagnosed with BPD also show functional impairment and distress. As well, on a test of its convergent validity, there was a high correlation between two separate BPD diagnostic measures.

Second, and by contrast, several factors detract from the notion that it is a valid construct. For example, BPD criteria among adolescents, when compared to adults, were less uniform with respect to diagnostic efficiency, showed a broader pattern of axis II co-morbidity and more criterion overlap with other personality disorders, suggesting that BPD is more diffuse in nature in adolescents. Additionally, factor analysis suggested that BPD was not a single entity in adolescence. Lastly, the construct showed a low degree of predictive validity, with little diagnostic stability, including associations with both axis I and axis II disorders, but not necessarily BPD, in adulthood.

This mixed picture concerning the validity of the adolescent BPD construct raises some questions. First, could these inconsistencies suggest non-homogeneity among adolescents currently diagnosed with BPD? Second, could the current diagnostic construct comprise both a state and/or a trait? Finally, do these discrepancies in measures of validity, particularly predictive, reflect multiple adolescent developmental pathways, normal and abnormal, following three potential suggested trajectories: diagnostically stable, diagnostically transient, and diagnostically variable (Mattanah et al, 1995)? Further research is warranted to elucidate the answers to these questions, and to thus clarify the nature of adolescent BPD.

REFERENCES

Becker, D.F., Grilo, C.M., Morey, L.C. et al. (1999). Applicability of personality disorder criteria to hospitalized adolescents: evaluation of internal consistency and criterion overlap. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 200-205.

Becker, D.F., Grilo, C.M., Edell, W.S. & McGlashan, T.H. (2000). Comorbidity of borderline personality disorder with other personality disorders in hospitalized adolescents and adults. *American Journal of Psychiatry*, 157, 2011-2016.

Becker, D.F., Grilo, C.M., Edell, W.S. & McGlashan, T.H. (2002). Diagnostic efficiency of borderline personality disorder criteria in hospitalized adolescents: comparison with hospitalized adults. *American Journal of Psychiatry*, 159, 2042-2047.

Berstein, D.P., Cohen, P. Velez, C.N., Schwab-Stone, M., Siever, L., & Shinsato, L. (1993). Prevalence and stability of the DSM-III-R personality disorders in a community-based survey of adolescents. *American Journal of Psychiatry*, 150, 1237-1243.

Block, M.J., Westen, D., Ludolph, P., Wixom, J., & Jackson, A. (1991). Distinguishing female borderline adolescents from normal and other disturbed female adolescents. *Psychiatry*, 54, 89-103.

Brent, D.A., Johnson, B., Bartle, S., Bridge, J., Rather, C., Matta, J., Connolly, J., & Constantine, D. (1993). Personality disorder, tendency to impulsive violence and suicidal behavior in adolescents. *Journal of American Academy of Child & Adolescent Psychiatry*, 32(1), 69-75.

Chabrol, H., Montovany, A., Chouicha, K., et al. (2001). Frequency of borderline personality disorder in a sample of French high school students. *Canadian Journal of Psychiatry*, 46, 847-849.

Diagnostic & Statistical Manual of Mental Disorders, 4th Ed. American Psychiatric Association, 1994.

Faulkner, C.J., Grapentine, W.L., & Francis, G. (1999). A behavioral comparison of female adolescent inpatients with and without borderline personality disorder. *Comprehensive Psychiatry*, 40(6), 429-433.

Friedman, R.C., Aronoff, M.S., Clarkin, J.F., Corn, R., & Hurt, S.W. (1983). History of suicidal behaviour in depressed borderline inpatients. *American Journal of Psychiatry*, 140, 1023-1026.

Garnet, K.E., Levy, K.N., Mattanah, J.J.F., Edell, W.S., & McGlashan, T.H. (1994). Borderline personality disorder in adolescents: ubiquitous or specific? *American Journal of Psychiatry*, 151, 1380-1382.

Goldman, S.J., D'Angelo, E.J., & DeMaso, D.R. (1993). Psychopathology in the families of children and adolescents with borderline personality disorder. *American Journal of Psychiatry*, 150, 1832-1835.

Grilo, C.M., Becker, D.F., Fehon, D.C.,Edell, W.S., & McGlashan, T.H. (1996). Conduct disorder, substance abuse disorders, and coexisting conduct and substance use disorders in adolescent inpatients. *American Journal of Psychiatry*, 153, 914-920.

Grilo, C.M., Sanislow, C., Fehon, D.D., Martino, S., & McGlashan, T.H. (1999). Psychological and behavioral functioning in adolescent psychiatric patients who report histories of childhood abuse. *American Journal of Psychiatry*, 156, 538-543.

Gunderson, J.G., & Singer, M.T. (1975). Defining borderline patients: an overview. *American Journal of Psychiatry*, 132, 1-10.

Gunderson, J.G., Kolb, J.E., Austin, V. (1981). The diagnostic interview for borderline patients. *American Journal of Psychiatry*, 138, 896-903.

Hyler, S.E., Reider, R., Williams, J.B.W., Spitzer, R.L., Hendler, J.,& Lyons, M. (1988). The Personality Diagnostic Questionnaire: development and preliminary results. *Journal of Personality Disorders*, 2, 229-237.

Johnson, J.G., Cohen, P., Skodol, A.E., Oldham, J.M., Kasen, S., & Brook, J.S. (1999). Personality disorders in adolescence and risk of major mental disorders and suicidality during adulthood. *Archives of General Psychiatry*, 56, 805-811.

Johnson, J.G, Cohen, P, Smailes, E., Kasen, S., Oldham, J.M., Skodol, A.E., & Brook, J.S. (2000). Adolescent personality disorders associated with violence and criminal behavior during adolescence and early adulthood. *American Journal of Psychiatry*, 157, 1406-1412.

Kasen, S., Cohen, P., Skodol, A.E., Johnson, J.G., & Brook, J.S. (1999). Influence of child and adolescent psychiatric disorders on young adult personality disorder. *American Journal of Psychiatry*, 156, 1529-1535.

Kernberg, O. (1975). Borderline conditions and pathological narcissism. New York: Jason Aronson.

Korenblum, M., Marton, P., Golombek, H., & Stein, B. (1990). Personality status: Changes through adolescence. *Psychiatry Clinics of North America*, 13(3), 389-399.

Kutcher, S.P., Marton, P. & Korenblum, M. (1990). Adolescent bipolar illness and personality disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 29(3), 355-358.

Levy, K.N., Becker, D.F., Grilo, C.M., Mattanah, J.J. F., Garnet, K.E., Quinlan, D.M., Edell, W.S., & McGlashan, T.H. (1999). Concurrent and predictive validity of the personality disorder diagnosis in adolescent inpatients. *American Journal of Psychiatry*, 156, 1522-1528.

Lewinsohn, P.M, Rohde, P., Seeley, J.R., & Klein, D.N. (1997). Axis II psychopathology as a function of axis I disorders in childhood and adolescence. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36(12), 1752-1759.

Lewinsohn, P.M., Rohde, P., Seeley, J.R, Klein, D.N., & Gotlib, I.H. (2000). Natural course of adolescent major depressive disorder in a community sample: predictors of recurrence in young adults. *American Journal of Psychiatry*, 157, 1584-1591.

Loranger, S.W., Susman, V.L., Oldham, J.M. Russakoff, M. (1988). The personality disorder examination (PDE) manual. Yonkers, NY: DV Communications.

Ludolph, P.S., Westen, D., Misle, B. et al. (1990). The borderline diagnosis in adolescents: symptoms and developmental history. *American Journal of Psychiatry*, 147, 470-476.

Marton, P., Korenblum, M., Kutcher, S., Stein, B., Kennedy, B. & Pakes, J. (1989). Personality dysfunction in depressed adolescents. *Canadian Journal of Psychiatry*, 34(8), 810-813.

Masterson, J.F. (1978). The borderline adolescent: An object relations view. *Adolescent Psychiatry*, 6, 344-359.

Mattanah, J.J.F., Becker, D.F., Levy, K.N., Edell, W.S., & McGlashan, T.H. (1995). Diagnostic stability in adolescents followed up 2 years after hospitalization. *American Journal of Psychiatry*, 152, 889-894.

Meijer, M., & Treffers, P.D. (1991). Borderline and schizotypal disorders in children and adolescents. *British Journal of Psychiatry*, 158, 205-212.

Millon, T., Millon, C., & Davis, R. (1993). *Manual for the Millon Adolescent Clinical Inventory*. Minneapolis, MN: National Computer Systems.

Pinto, A., Grapentine, W.L., Francis, G., & Picariello, C.M. (1996). Borderline personality disorder in adolescents: Affective and cognitive features. *Journal of American Academy of Child & Adolescent Psychiatry*, 35(10), 1338-1343.

Rey, J.M., Morris-Yates, A., Singh, M., Andrews, G., & Stewart, G.W. (1995). Continuities between psychiatric disorders in adolescents and personality disorders in young adults. *American Journal of Psychiatry*, 152, 895-900.

Runeson, G., & Beskow, J. (1991). Borderline personality disorder in young Swedish suicides. *Journal of Nervous & Mental Disease*, 179, 153-156.

Wade, N. (1987). Suicide as a resolution of separation-anxiety among adolescent girls. *Adolescence*, 22, 169-177.

Westen, D., Shedler, J., Durrett, C., Glass, S. & Martens, A. (2003). Personality diagnoses in adolescence: DSM-IV Axis II diagnoses and an empirically derived alternative. *American Journal of Psychiatry*, 160, 952-966.

Young, D.W., & Gunderson, J.G. (1995). Family images of borderline adolescents. *Psychiatry*, 58, 164-172.

Zanarini, M.C., Gunderson, J.G., Frankenburg, F.R., & Chauncey, D.L. (1989). The Revised Diagnostic Interview for Borderlines: discriminating BPD from other Axis II disorders. *Journal of Personality Disorders*, 3, 10-18.

Borderline Pathology of Childhood: Implications of Early Axis II Diagnoses

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ABSTRACT

Introduction: A personality pathology framework may be useful in the diagnosis and treatment of children with chronic psychopathology and impairment in many domains of functioning. This paper presents the utility of such an approach through a description of research investigating borderline pathology of childhood (BPC). **Methods:** Literature regarding the phenomenology, risk factors, and outcomes of BPC and similar disorders is reviewed. **Results:** Research conducted at the SMBD-Jewish General Hospital in Montreal has shown that children with BPC can be reliably identified via chart review, and that they exhibit a pattern of risk factors similar to that of adults with borderline personality disorder, such as psychological trauma and deficits in executive function. Preliminary results of a follow-up study in adolescence suggests that these children remain more functionally impaired than a comparison group. Our current research investigates neuropsychological deficits and their relationship to trauma in children with BPC. We are also exploring whether a similar pattern can be observed in their parents. **Conclusion:** We conclude that BPC symptom patterns may diagnostically define a group of high risk children and may eventually guide our approach to early intervention.

Key words: Borderline pathology of childhood, personality development, risk factors

RÉSUMÉ

Introduction: La référence à un schéma de troubles caractériels peut être utile chez l'enfant au niveau du diagnostic et du traitement dans les pathologies chroniques mais également dans d'autres vices de fonctionnement. Cet article illustre l'utilité d'une telle approche via une description des recherches sur les pathologies *borderline* de l'enfance. **Méthodologie:** Nous avons effectué une revue de littérature en ce qui a trait aux symptômes, aux facteurs de risque et à l'évolution de ce type de pathologie. **Résultats:** Les recherches effectuées à l'Hôpital Général Juif de Montréal ont montré que : 1) les pathologies *borderline* de l'enfance peuvent être identifiées d'une manière fiable par l'étude de dossiers et 2) les facteurs de risques incluant les traumatismes psychologiques et les déficits des fonctions d'exécution sont en bonne partie assez semblables à ceux qui l'on retrouve chez l'adulte présentant un trouble de personnalité *borderline*. Nous menons actuellement une étude approfondie sur les déficits neuropsychologiques et les liens entre ces déficits et les traumatismes vécus par ces enfants. Nous étudions également les parents de ces enfants afin de déterminer s'il existe aussi chez eux les mêmes relations entre les déficits neuropsychologiques et les traumas. Les résultats préliminaires d'enfants devenus adolescents nous indiquent que ceux-ci demeurent plus dysfonctionnels que le groupe contrôle. **Conclusions:** Nous croyons que l'identification de certains symptômes ou catégories de symptômes suggestifs d'une pathologie borderline pourrait avoir une certaine pertinence tant au niveau du diagnostic que de l'orientation du traitement chez l'enfant.

Mots-clefs: Pathologie(s) *borderline* de l'enfance, développement de la personnalité, facteurs de risques.

INTRODUCTION: Continuity of psychopathology from childhood to adulthood

A diagnosis of personality pathology in children implies the presence of pervasive and chronic symptoms associated with impaired functioning that are not attributable to an episodic disorder (Hill & Rutter, 1994). Research findings regarding the long-term outcome of child psychopathology suggest that children do not necessarily outgrow their difficulties (Hechtman, 1996). Instead, early onset of illness and severity of symptoms tend to predict a chronic course of psychopathology (Tremblay et al., 2004; Zoccolillo, Quinton, Pickles, & Rutter, 1992), with a continuation of symptoms into adolescence and adulthood.

Research indicates that the precursors to some types of adult psychopathology can be observed in early childhood. Caspi and colleagues (1996) reported that observable symptomatology in children as young as three years of age can be predictive of major psychiatric diagnoses, such as antisocial personality disorder and depression, by 21 years of age. Similarly, research involving community samples of children has shown that behavioral disturbances in kindergarten are strongly predictive of both substance abuse (Masse & Tremblay, 1997) and delinquency (Tremblay, Pihl, Vitaro, & Dobkin, 1994) during adolescence. Impulsive symptoms in children are precursors of personality disorders in adolescence (Bernstein, Cohen, Skodol, Bezirganian, & Brook, 1996), while impulsive personality disorders in adolescents are strong predictors of adult personality pathology (Rey, Morris-Yates, Singh, Andrews, & Stewart, 1995).

Accordingly, an exploration of personality constructs may contribute to our understanding of the continuity of early pathological traits and symptoms. Recent research investigat-

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ing personality in children indicates that personality structure in children is similar to that of adults (Shiner & Caspi, 2003). Studies have identified a small number of distinct personality types in early childhood that are predictive of later functioning (Hart, Atkins, & Fegley, 2003; Robins, John, Caspi, Moffitt, & Stouthamer-Loeber, 1996). By extension, utilization of personality pathology constructs may permit us to account for a broad range of symptomatology and a more chronic course, thereby affording clinicians a more useful diagnostic approach for children with multiple dysfunctions than the current practice of assigning several Axis I diagnoses.

BORDERLINE PATHOLOGY OF CHILDHOOD: Clinical and Research Challenges

In keeping with this formulation, the construct of borderline pathology of childhood (BPC) may provide us with a means to identify a group of severely disturbed children who exhibit impairment in many domains of functioning (Ad-Dab'bagh & Greenfield, 2001). The earliest descriptions of borderline pathology of childhood (Kernberg, 1983; Kestenbaum, 1983) were based on clinical observation using diverse or unsystematic criteria with small samples. They described a heterogeneous population (Petti & Vella, 1990) characterized by impaired thought processes, unstable mood, impulsive behavior, difficulty in social relationships, and neurological soft signs. Lofgren and colleagues (Lofgren, Bemporad, King, Lindem, & O'Driscoll, 1991) found that children with borderline pathology met diagnostic criteria for various axis II diagnoses by 18 years of age, but not bipolar or schizophreniform psychosis, which further supports the utility of using BPC as a diagnostic category.

Our research team has used the label "borderline" to describe a clinical picture resembling borderline personality disorder (BPD) in adults, which is characterized by impulsivity, emotional instability, transient psychotic episodes, unstable relationships, and cognitive impairment (American Psychiatric Association, 1994). We have demonstrated that these children can be reliably identified using a structured chart review measure (Guzder, Paris, Zelkowitz, & Marchessault, 1996; Guzder, Paris, Zelkowitz, & Feldman, 1999). The work of our research team and others have also identified risk factors associated with BPC, including psychological trauma, parental psychopathology, and neuropsychological deficits (Paris, 2003). Furthermore, preliminary data from an ongoing follow-up study indicates that the presence of BPC may be associated with a poorer prognostic presentation in adolescence (Zelkowitz et al., 2004). These results suggest that this diagnostic approach has clinical utility.

Other research groups have employed different terminology to refer to children with very similar symptom patterns. Some researchers have used the term "multiple complex developmental disorder" (MCDD) to distinguish these children from patients with autism or other pervasive developmental disorders (Lincoln et al., 1998;Towbin et al., 1993; van der Gaag, Buitelaar, van den Ban, Bezemer, & van Engeland, 1995). Proposed diagnostic criteria for MCDD include anxiety, impaired regulation of affective states, poor social relationships, deficits in cognitive processing, and the presence of thought disorder (e.g., magical thinking, bizarre ideas, and paranoid preoccupations) (Buitelaar & van der Gaag, 1998; Towbin et al., 1993). The prognosis for children with MCDD is poor, with longer hospital stays and less satisfactory outcomes following discharge, as compared to children with mood or conduct disorder alone (Towbin et al., 1993).

Kumra and colleagues (1998) used the term "multidimensionally impaired syndrome" (MDI) to describe a group of young patients who exhibit brief hallucinations and delusions particularly when stressed, emotional lability, impaired interpersonal skills, and marked aggression. These children differed from patients with early-onset schizophrenia in terms of cognitive development, attentional deficits, autonomic reactivity, and severity of behavior problems (Kumra et al., 1998). Moreover, children with MDI were distinguished from children with autistic spectrum disorders in that the former group did not exhibit significant impairment in social interaction, stereotyped behavior, and poor language development typical of children in the latter group. Follow-up studies involving children with multidimensionally impaired syndrome indicated that very few had psychotic disorders in adolescence, but many exhibited mood disorders and disruptive behavior disorders (Nicolson et al., 2001).

To summarize, several research teams have identified a distinct group of children with widespread psychopathology affecting multiple spheres of functioning. Although the diagnostic labels applied to the children are different, the diagnostic criteria are very similar. We have chosen to retain the label "borderline pathology of childhood" because of the similarities of both the symptom patterns and the risk factors to those of adults with borderline personality disorder. Since BPC is distinguishable from diagnostic categories such as autistic spectrum disorders or childhood schizophrenia (Ad-Dab'bagh & Greenfield, 2001), it may be more useful to conceptualize it as a personality construct or personality disorder prodrome, affecting a child's thoughts, emotions, and behaviors. The use of traits and personality dimensions such as impulsivity might be a new direction for diagnosis in childhood.

SIR MORTIMER B. DAVIS-JEWISH GENERAL HOSPITAL RESEARCH PROGRAM

Our research group has investigated the associated risk factors and long-term outcomes of BPC. We are beginning to explore possible neuropsychological risk factors for borderline pathology in children and their parents. Following is a brief description of this research.

Pilot Project

The first step in our program was to determine the prevalence of BPC and identify associated risk factors through a chart review investigation of a cohort of 98 children (79 males, 19 females) in a day hospital treatment program (Guzder et al., 1996). We employed the Child Version of the Retrospective Diagnostic Interview for Borderlines (CDIB-R; Greenman, Gunderson, Cane, & Saltzman, 1986), a structured instrument designed to identify borderline pathology of childhood via chart review. The instrument yields ratings on 5 subscales measuring social adaptation, impulsivity, affect, psychosis, and interpersonal relations. We were able to establish good inter-rater reliability for this measure (K = .72). A group of 41 children met the CDIB-R criteria for BPC. There was no difference in the mean age of the children (10.0 for borderlines, 9.6 for non-borderlines), and the gender distribution in the two groups was similar (73% of the borderline

group was male, as was 86% of the non-borderline group). Both the borderline and non-borderline groups showed poor global functioning, and our findings were independent of the severity of impairment. The groups did not differ in comorbidity, except for a higher frequency of post-traumatic stress disorder in the BPC group. This finding suggests that borderline pathology is distinguishable from other common behavioral disturbances in childhood, such as conduct disorder.

The most striking differences between our groups were that sexual abuse, physical abuse, and extreme neglect were all significantly more frequent in the borderline group. This may account for the higher rate of PTSD diagnoses in the borderline group. In addition, the borderline group was significantly more likely to have parents with histories of substance abuse and criminality. In a logistic regression on diagnosis, sexual abuse and extreme neglect had independent effects, while physical abuse, parental substance abuse and parental criminality did not. In a multiple regression on a scale measuring borderline pathology, a measure of cumulative abuse (the sum of all categorically measured occurrences of physical, sexual, and verbal abuse, and severe neglect) had an effect independent of non-abuse factors, such as the child's age and gender, and indices of parental dysfunction (criminality and substance abuse). It is noteworthy that the findings from this chart review study indicated that the risk factors for BPC in school-aged children are similar to those in adolescent and adult borderline personality disorder patients (Paris, 1994; Zanarini 2000,).

Cross-sectional study

The next step was to carry out a more detailed cross-sectional study investigating child diagnosis, parental factors and neuropsychological vulnerability in a separate cohort of 94 children (81 males and 13 females, with a mean age of 9.8 years) attending a child psychiatry day treatment center. We found that the prevalence of BPC in this new sample was virtually the same (43%) as in the chart review study sample (42%). Parent and teacher ratings of behavior problems indicated that children with BPC were more likely than the comparison group of children to exhibit the mixture of impulsive, affective, and cognitive symptoms that define the borderline construct, with higher scores on scales measuring thought problems, anxiety and depression, social problems and aggressive behavior. These findings support the construct validity of BPC, even though BPC overlaps with a number of known DSM-defined disorders that are themselves heterogeneous, including conduct disorder, oppositional-defiant disorder and attention deficit disorder. The results of the cross-sectional study also supported our earlier findings that parental neglect and childhood sexual abuse were more prevalent among children with BPC (Guzder et al., 1999).

There were significant differences between the two groups on scales drawn from standard neuropsychological measures (Paris et al., 1999). Results from the Continuous Performance Test and the Wisconsin Card Sorting Test demonstrated that children with borderline pathology show deficits in executive function, particularly their ability to sustain attention, plan, and think flexibly. These difficulties parallel the clinical phenomena often seen in adolescents and adults diagnosed with borderline personality disorder, such as impulsive and rigidly categorical thinking. Based on our research findings, we concluded that both psychological trauma and deficits in executive functioning make significant and independent contributions to the variance in borderline pathology of childhood (Zelkowitz, Paris, Guzder, & Feldman, 2001).

Adolescent Follow-up

Our ongoing research involves a re-assessment of the cross-sectional sample of 94 children in adolescence. Preliminary analyses indicate that parents of the adolescents with a history of BPC rate their adolescents as more functionally impaired, with more internalizing and externalizing problems, such as thought problems and delinquent behavior (Zelkowitz et al., 2004). These results support our proposition that the diagnostic construct BPC may be of prognostic importance.

Neuropsychological risk factors

In general, our research is informed by a stress-diathesis model (Monroe & Simons 1991; Paris, 1999). We hypothesize that children with BPC suffer from a combination of temperamental vulnerability and environmental adversities such as trauma. While it is possible that life events cause neuropsychological deficits, children with BPC may also have abnormalities in brain "wiring," due to pre- or perinatal insult or to genetic predisposition. Psychosocial risk factors could then act as environmental stressors, which, when combined with neurobiological vulnerabilities, would shape the clinical syndrome of borderline pathology. Clarification regarding how neuropsychological vulnerabilities and trauma interact in development, or whether a kindling effect is part of the course of the BPC, is needed.

To address this question, we have undertaken a pilot study to extend our understanding of risk factors for BPC by making a more precise determination of neuropsychological impairment in these children, and assessing their parents for similar vulnerabilities. We will further explore how the pattern of neuropsychological deficits associated with BPC might be related to early psychological trauma. While we cannot ascertain if these neuropsychological findings originate in genetics, pre- or perinatal factors, or trauma sequelae, we can further understand the interaction of several environment and constitutional influences, in an effort to define treatment needs and develop early intervention programs.

CONCLUSION

Children who are characterized by the construct BPC are highly symptomatic and difficult to treat. Research suggests that these children engage in high-risk behaviors, and they appear to have a poor long-term prognosis. The assessment of borderline pathology in children is seldom undertaken systematically by child psychiatrists, even though this syndrome may be a precursor to various DSM-IV Axis II disorders in adolescents and adulthood. Since impulsive symptoms and negative affective states are a prominent feature of BPC, it is possible that future longitudinal research will document that these children may be at particular risk for developing Cluster B Personality disorders. From a clinical standpoint, a focus on BPC symptom patterns may diagnostically define a group of high-risk children, as well as direct our approach to their treatment. Although adult patients with BPD are often treated with SSRI's or other medication, current concerns regarding the possible dangers of psychophar-

macological interventions with children may further motivate researchers to identify alternative therapeutic strategies for children with BPC.

REFERENCES

Ad-Dab'bagh, Y., Greenfield, B. (2001). Multiple complex developmental disorder: The "multiple and complex" evolution of the "Childhood Borderline Syndrome" construct. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40, 954-964.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition. Washington, DC: American Psychiatric Press.

Bernstein, D.P., Cohen, P., Skodol, A., Bezirganian, S., Brooks, J.S. (1996). Childhood antecedents of adolescent personality disorders. *American Journal of Psychiatry*, 153, 907-913.

Buitelaar, J.K., van der Gaag, R.J. (1998). Diagnostic rules for children with PDD-NOS and Multiple Complex Developmental Disorder. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 39, 911-919.

Caspi, A., Moffitt, T.E., Newman, D.L., Silva, P.A. (1996). Behavioral observations at age three predict adult psychiatric disorders: Longitudinal evidence from a birth cohort. *Archives of General Psychiatry*, 53, 1033-1039.

Greenman, D.A., Gunderson, J.G., Cane, M., Saltzman, P.R. (1986). An examination of the borderline diagnosis in children. *American Journal of Psychiatry*, 149, 1723-1726.

Guzder J, Paris J, Zelkowitz P, Marchessault K. (1996). Risk factors for borderline pathology in children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 26-33.

Guzder, J., Paris, J., Zelkowitz, P., Feldman, R. (1999). Psychological risk factors for borderline pathology in school-age children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 206-212.

Hart, D., Atkins, R., Fegley, S. (2003). Personality and development in childhood: A person-centered approach. *Monographs of the Society for Research in Child Development*, 68(1):Serial number 272.

Hechtman, L. (Ed). (1996). Do they grow out of it? Washington, DC: American Psychiatric Press.

Hill, J., & Rutter, M. (1994). Personality disorders. IN: Rutter M, Taylor, E, Hersov L (Eds), *Child and Adolescent Psychiatry: Modern Approaches*, pp. 688-696, London: Blackwell Scientific Publications.

Kernberg, P.F. (1983). Borderline conditions: Childhood and adolescent aspects. IN: Robson KS (Ed), *The Borderline Child*, pp 101-119, New York: McGraw Hill.

Kestenbaum, C.J. (1983). The borderline child at risk for major psychiatric disorder in adult life: Seven case reports. IN: Robson KS (Ed), *The Borderline Child*, pp 49-81, New York: McGraw Hill.

Kumra, S., Jacobsen, L.K., Lenane, M., Zahn, T.P., Wiggs, E., Alaghaband-Rad, J., et al. (1998). "Multidimensionally impaired disorder": Is it a variant of very early onset schizophrenia? *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 91-99.

Lincoln, A.J., Bloom, D., Katz, M., Boksenbaym, N. (1998). Neuropsychological and neurophysiological indices of auditory processing impairment in children with multiple complex developmental disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 100-112.

Lofgren, D.P., Bemporad, J., King, J., Lindem, K., O'Driscoll, G. (1991). A prospective follow-up study of so-called borderline children. *American Journal of Psychiatry*, 148, 1541-1545.

Masse, L.C, Tremblay, R.E. (1997). Behavior of boys in kindergarten and the onset of substance use during adolescence. *Archives of General Psychiatry*, 54, 62-68.

Monroe, S.M, Simons, A.D. (1991). Diathesis-stress theories in the context of life stress research. *Psychological Bulletin*, 110, 406-425.

Nicolson, R., Lenane, M., Brookner, F., Gochman, P., Kumra, S., Spechler, L., et al. (2001). Children and adolescents with psychotic disorder not otherwise specified: A 2 to 8-year follow-up study. *Comprehensive Psychiatry*, 42, 319-325.

O'Leary, K.M., Cowdry, R.W. (1994). Neuropsychological testing results with patients with borderline personality disorder. IN: Silk KR (Ed), *Biological and neurobehavioral studies of borderline personality disorder*, pp 127-158), Washington, DC:American Psychiatric Press.

Paris, J. (1994). Borderline Personality Disorder: A Multidimensional Approach, Washington, DC:American Psychiatric Press.

Paris, J. (1999). Nature and Nurture in Psychiatry: A Predisposition-Stress Model of Mental Disorders, Washington, DC:American Psychiatric Press.

Paris, J. (2003). Personality Disorders Over Time: Precursors, Course and Outcome. Washington, DC:American Psychiatric Press.

Paris, J., Zelkowitz, P., Guzder, J., Joseph, S., Feldman, R. (1999). Neuropsychological factors associated with borderline pathology in children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 770-774.

Petit, T.A., Vella, R.M. (1990). Borderline disorders of childhood: An overview. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29, 327-337.

Rey, J.M., Morris-Yates, A., Singh, M., Andrews, G., Stewart, G.W. (1995). Continuities between psychiatric disorders in adolescents and personality disorders in young adults. *American Journal of Psychiatry,* 152, 895-900.

Robins, R.W., John, O.P., Caspi, A., Moffitt, T.E., Stouthamer-Loeber, M. (1996). Resilient, overcontrolled, and undercontrolled boys: Three personality types in early adolescence. *Journal of Personality and Social Psychology*, 70,157-171.

Shiner, R., Caspi, A. (2003). Personality differences in childhood and adolescence: Measurement, development, and consequences. *Journal of Child Psychology and Psychiatry*, 44, 2-32.

Towbin, K.E., Dykens, E.M., Pearson, G.S., Cohen, D.J. (1993). Conceptualizing "borderline syndrome of childhood" and "childhood schizophrenia" as a developmental disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32, 775-782.

Tremblay, R.E., Nagin, D.S., Seguin, J.R., Zoccolillo, M., Zelazo, P.D., Boivin, M., Perusse, D., Japel, C. (2004). Physical aggression during early childhood: Trajectories and predictors. *Pediatrics*, 114, e43-e50.

Tremblay, R.E., Pihl, R.O., Vitaro, F., Dobkin, P.L. (1994). Predicting early onset of antisocial behavior from school behavior. *Archives of General Psychiatry*, 51, 732-739.

van der Gaag, R.J., Buitelaar, J.K., van den Ban, E., Bezemer, M., van Engeland, H. (1995). A controlled multivariate chart review of multiple complex developmental disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34, 1096-1106.

Zanarini, M.C. (2000). Childhood experiences associated with the development of borderline personality disorder. *Psychiatric Clinics of North America*, 23, 89-101.

Zelkowitz, P., Guzder, J., Paris, J., Feldman, R., Roy, C. (2004, October). Adolescent follow-up of children with and without borderline pathology. Paper to be presented at the Meetings of the Canadian Academy of Child and Adolescent Psychiatry, Montreal, QC.

Zelkowitz, P., Paris, J., Guzder, J., Feldman, R. (2001). Diatheses and stressors in borderline pathology of childhood: The role of neuropsychological risk and trauma. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40, 100-105.

Zoccolillo, M, Quinton, D., Pickles, A., Rutter, M. (1992). The outcome of conduct disorder: Implications for defining conduct disorder and adult personality disorder. *Psychological Medicine*, 22, 971-986.

Developing and Piloting Community-Based Self-Injury Treatment Groups for Adolescents and Their Parents

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ABSTRACT

Introduction: Self injurious behaviour is not uncommon in depressed adolescents while little is known about effective treatments for this behaviour in this age group. The objective of this article is to illustrate the development and initial pilot of groups for adolescents who self injure and their parents. **Method:** Articles and texts derived from a literature search of group treatments for self injuring adolescents were used to develop a pilot group for self injuring adolescents and a separate group for parents. The groups were piloted over the spring of 2004, at a community child and youth mental health clinic. **Results:** Eight weekly sessions for adolescents and 4 biweekly sessions for parents occurred. The adolescent group was a back to back dialectical behaviour therapy (DBT) skills group followed by a therapeutic support group. Two thirds of both the adolescents and parents completed their groups. Overall, adolescents found both theirs and the parent group helpful. Parents reported that their group enabled more balanced and less reactive communication as well as benefit in meeting and talking with other parents facing similar difficulties. **Conclusion:** Further refinement and formal evaluation of such group therapy approaches to the treatment of self injurious behaviour in adolescents is warranted.

Key Words: Adolescents, parents, self-injury, dialectical behaviour therapy, therapeutic support groups

RÉSUMÉ

Introduction: L'automutilation est relativement fréquente chez l'adolescent déprimé. Il existe peu d'études cependant sur le traitement de cette automutilation à l'adolescence. Cet article a pour objectif d'illustrer comment nous avons développé une intervention pour adolescents qui s'automutilent et leurs parents. **Méthodologie:** Nous avons étudié plusieurs articles de la littérature, chapitres de livres, traitant des interventions de groupe pour contrer l'automutilation chez les adolescents et, à partir de là, nous avons formé, au printemps 2004, deux groupes : le premier, composé d'adolescents qui présentaient de l'automutilation et, le second, des parents de ces adolescents. **Résultats:** Il y a eu huit rencontres hebdomadaires pour le groupe des adolescents et quatre rencontres bimensuelles pour les parents. Les interventions dans le groupe des adolescents furent de deux ordres : le développement d'habilités en thérapie béhaviorale dialectique (TBD) suivi immédiatement d'intervention de support. Les deux tiers des adolescents et des parents se sont rendus jusqu'à la fin des traitements. En bref, les adolescents firent mention d'amélioration du comportement d'automutilation et conclurent que leur groupe et celui des parents avaient tous deux été utiles. Les parents quant à eux firent état que leur groupe de traitement leur avait permis d'être plus nuancés et moins défensifs dans leurs rapports avec leurs enfants; ils ajoutèrent que le fait de se rencontrer et de partager ensemble les difficultés avait eu un effet salutaire. **Conclusions:** Il y a lieu de poursuivre l'évaluation de ces interventions de groupe pour contrer les comportements d'automutilation chez l'adolescent.

Mots-clefs: Adolescents, parents, automutilation, thérapie béhaviorale dialectique, thérapie de support en groupe.

INTRODUCTION

Self injurious behaviour (SIB) has been reported to be as high as 61 % in terms of lifetime prevalence in psychiatric adolescent inpatients. (DiClemente et al., 1991) with an incidence of repetitive SIB of 30 to 38% over a 4 month sampling period in adolescent inpatient and partial hospitalization programs respectively (Nixon et al, 2002). SIB in this population is typically described as superficial to moderate, episodic or repetitive, compulsive or impulsive, and nonstereotypic in nature. Comorbidity with mood disorders in adolescent inpatients is noted with depression acting as a key factor in the risk of repetition. (Ghaziuddin et al., 1992, Hawton et al.,1999). SIB is also a commonly known symptom in the presentation of borderline personality disorder (BPD) (American Psychiatric Association, 1994). Functional models of SIB include environmental and interpersonal models, antisuicide or sexual drive models and affect regulation models (Suyemoto, 1998). Affect regulation is the most frequently reported role of SIB, with the behaviour functioning to express, validate, and/or regulate such emotions as depression, tension, and anger. Nixon et al., 2002 noted in their sample of hospitalized adolescents with repetitive SIB that in addition to affect regulation being the primary function of SIB, this behaviour was often or always associated with stress (100%, n=42) and many reported addictive features (81%).

Family factors have also been associated with adolescents who self injure. These include family life that is rigid in values, inconsistent, with reversed or a breakdown of family roles (Selekman and King, 2001). These authors propose that solution oriented brief family therapy, which accentuates family strengths and resources, offers another approach with adolescents who self harm while is not necessarily considered the sole method of treatment. Woodberry et al, 2002, in a theoretical review of family therapy and dialectical behaviour therapy with adolescents, work with the thesis that emotional dysregulation is a result of

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the interaction between biology, individual characteristics and their social environment. Although multifamily skills group format has been one modification to traditional DBT for the adolescent population, the authors acknowledge that integration of family therapy per se has been a challenge both theoretically and structurally.

Group therapies for adolescents, in general, enable a number of therapeutic goals by virtue of peer to peer interaction including catharsis, learning to share with others, learning interpersonal and social skills and learning from each other (Kymissis, P, 1994). Group therapies have been shown to be effective in the treatment of adolescent depression including cognitive behavioural treatment, with or without a parent component (Clarke et al., 1999) and therapeutic support groups (Fine et al., 1991). In regards to group treatments for self harming adolescents, Wood et al., 2001 studied group therapy for repeat self harmers versus routine care. There was some evidence to suggest that those who participated in group therapy were less likely to repeat the behaviour in follow up. The use of group therapies is considered both feasible and promising in the treatment of adolescents with depression and or self harm.

Fine et al., 1991, in their comparison of a therapeutic support group for depressed adolescents versus a social skills group, showed greater reduction in clinical depression and significant increases in self concept in the former approach. Principles of a therapeutic support group (TSG) for adolescents include: 1. providing a process oriented group based on interpersonal, experiential and insight oriented approach, 2. providing a milieu where adolescents utilize their peers to facilitate separation from their families, and 3. that the group milieu provides a supportive environment for them to interact in a context free of preconceived demands. The primary aim is to improve self concept by identifying and reinforcing individual strengths while at the same time group processes such as identification, cohesion, and interpersonal learning occur. A feature of this type of group is that it combines readily with other forms of treatment such as individual and family work (Baron, P., 1994).

Dialectical behaviour therapy was initially developed for borderline personality disordered female adults with chronic self injuring behaviour (Linehan et al., 1991). This treatment focuses on skills development and balancing change with validation. Four modules comprise the focus of treatment; mindfulness, distress tolerance, emotional regulation and interpersonal effectiveness. A. Miller et al., 1997, adapted this treatment to suicidal adolescents and in a study of a 12 week DBT program for adolescents outpatients (weekly individual therapy, weekly multifamily skills training group, and telephone based skills coaching with the individual therapist) found one distress tolerance and three mindfulness skills as the most highly rated by the participants. The authors proposed that adolescents tolerated skills which involved uncomfortable thoughts and feelings without requiring active attempts to change whereas the emotional regulation and interpersonal effectiveness skills are more change oriented.

Reduced psychiatric admissions and improved rates of retention to outpatient treatment were noted to be higher in a study of parasuicidal adolescent outpatients participating in DBT versus those in treatment as usual. (Rathus and Miller, 2002) A recent study of the feasibility of DBT modified for suicidal adolescent inpatients (Katz et al, 2004) concluded that DBT could be effectively implemented on an acute care adolescent inpatient unit. This program ran for two weeks one DBT session daily over 10 days, twice weekly individual DBT psychotherapy including a review of diary cards, and a DBT milieu treatment to facilitate skills generalization.

Impediments to implementing non modified DBT in community care settings include cost of training and cost of providing intensive treatment including telephone support and availability of resources. For this reason we chose to develop and pilot a combined DBT and TSG group based intervention for adolescents referred to community mental health centres in an urban setting and develop a separate parent group. The objective of this article is to 1) illustrate the development and initial pilot of groups for adolescents who self injure and their parents, 2) report on feasibility of applying such an approach with this population in a community setting and participant feedback.

METHOD

A literature search of articles and texts on treatment of self injurious behaviours in the last 15 years was completed. Work sessions with several therapists of a community child and youth mental health team to review the literature and develop a group based treatment for parents and adolescents occurred over a four month period prior to commencing recruitment. Two designated therapists for the adolescents group and two for the parent group further refined group content. The adolescent group was a combined skills group, based on the principles of DBT and supportive psychotherapy group based on the manualized therapeutic support group for adolescents (Baron, 1994). All therapists had previous experience with group therapies for adolescents and/or parents although none had undergone formal training for TSG or DBT. One page evaluation sheets were completed at the end of each group by the adolescents and separately by their parents. This basic questionnaire asked the respondent to identify 1) the three main things they had learnt in their session, 2) to identify what was most helpful and least helpful in the session and 3) additional comments. A general evaluation was conducted at the final wrap up group by the adolescents. A pilot of eight weekly adolescent groups and four biweekly parent groups was conducted over the spring of 2004 at a community mental health center for children and youth in Victoria, BC.

RESULTS: Adolescent Group

Key materials used to develop the skills based portion of the adolescent group included Marsha Linehan's manual on DBT (Linehan, 1993) and articles on DBT for adolescents (Rathus and Miller, 2002, Miller et al, 1997). DBT handouts, modified for depressed, suicidal adolescents were obtained with the author's permission (A. Miller). Only minor changes were made in these handouts for pilot purposes. We chose to remove the term "patient" in the DBT assumptions handout and used a general "we" for statements, such as "We are doing the best we can". In the list of pleasurable activities (emotional regulation module), several items including "losing weight" were removed and others were slightly modified.

We chose also not to ask participants to complete a self in-

jury diary as it was felt that adolescents were likely to not be accurate or compliant in reporting. Adolescents were asked to complete either at home between sessions or at the beginning of the next group a "self assessment sheet" (SAS) (see figure 1.). This handout asks to identify a situation in which they either self injured, had the urge to do so, or did neither but identify a stressful event or trigger which they might have acted on in the past. The SAS breaks down the event to identify, in addition to triggers, levels of distress, resulting actions and consequences, and a self rating of outcome. In addition, they are asked to identify which skills they used or what they might have done differently.

Due to the start of the group occurring at the end of April and believing that it would be difficult to keep participants in the group past mid June due to end of school we chose to run only an 8 week (versus 10-12 week) pilot utilizing three of the four DBT skill components: mindfulness, distress tolerance, and emotional regulation. This was based on distress tolerance and mindfulness being the highest rated skills in a study of the behavioral analysis of DBT in suicidal adolescents (Miller, 2000). The emotional regulation module was chosen over interpersonal effectiveness as we felt interpersonal issues were more likely to be discussed in general in the supportive psychotherapy portion of the group.

In regards to the DBT skills portion of the group, session 1 was an orientation to the group, introducing members, reviewing basic group rules and attendance expectations, outlining the group program and reviewing the basis of DBT and DBT assumptions. The use of SAS was also reviewed and given as homework.

Session 2 welcomed and oriented new members, reviewed what was discussed at session 1 and taught mindfulness including a feelings exercise. All sessions thereafter commenced with reviewing the SAS with an example to be given from the previous week. The group became closed to new members. Session 3 reviewed skills related to mindfulness and gave related homework handouts. After the break and prior to the start of the therapeutic support group a mindfulness exercise was led by one of the therapists. Session 4 reviewed the homework and commenced the distress tolerance module with a further 2 homework handouts given. Session 5 was used to recap and review both the mindfulness and distress tolerance modules and included a review of homework.

Sessions 6 and 7 addressed the emotional regulation module. At the end of session 7 participants were asked to bring special treats to mark the last "wrap up" group. Session 8 included reviewing the SAS sheets and focused on obtaining overall feedback on handouts and the group format.

In addition, the manual on group based therapeutic support, developed by Dr. P. Baron in consultation with Dr. S. Fine (Baron, 1994) was used as the basis for the second half of the group session. Session 1 was a general orientation, session 2 worked on building cohesion and identifying therapeutic issues, further sessions were used to resolve these issues with the final session to support individual change and termination. The manual reviews a total of twelve sessions although in our group this was reduced to eight. The four sessions that were removed were the "resolving issues" sessions due to the limit of 8 sessions for this pilot. Self harming behaviour was not the focus of this group although DBT skills that were utilized and reported by participants could be reinforced.

In offering a community based group program, we chose to have a format where referrals could come from any of the four community based child and youth mental health programs in the region. Adolescents referred had key criteria to meet: 1. be between the age of 12 and 18, male or female, 2. have a history of self injuring behaviour two to three times in the past month, 3.not actively psychotic or suicidal, 4. normal intelligence, 5. motivated to attend group sessions, 6. not in hospital at the start of group. The requirement was also included that their primary therapist who referred them would remain available to individuals and families, at minimum, for crisis intervention. Adolescents and families could remain in individual and/or family based therapies although the primary focus of the program was to provide group based therapies as the main treatment. Adolescents whose parents declined group participation would not be excluded.

Approximately 15 individuals were asked by their primary therapist if they were interested in participating in the group. One was hospitalized so was excluded. The two main reasons given for those not accepting the group was that they were not available to attend on that day or they were not interested in further therapy. Six accepted, 3 of whom were permitted to join at the second session. Their ages ranged from 14 to 18, all female. Four individuals completed the group with the 2 drop outs occurring at week 4. The format was once a week, 3:30-4:15 pm: DBT skills group, 10 minute break with snack and drink provided, 4:25-5:00: therapeutic support group. We used a large room with a table and chairs and blackboard for the skills group, moving the chairs to the other side of the room, in circle formation for the TSG. Lights were dimmed for the mindfulness exercises.

Self assessment sheets helped to identify group members who were invested in change and using new skills as well as to identify specific patterns of behaviour. Adolescents were specifically instructed not to elaborate on other self harm incidents outside of the one they were reporting. This was intentional in order to contain the discussion. Many in the group were noted to have significant problems with alcohol and drugs despite ongoing treatment for that. Post group evaluation sheets for the adolescent group initially had limited comment with a principle theme being helpful to identify with those with similar issues. Session 2 feedback demonstrated a difficulty in committing to the group as several considered quitting having been encouraged to reconsider. In session three, group cohesion was improving as feedback indicated that the second half of the group was helpful and that they could continue to identify and support others. Further evaluation sheets were mixed in terms of feedback but overall participants found listing pleasurable activity and self disclosure in the TSG as helpful.

Parent Group

Due to the family issues related to SIB, we felt it was important to have a separate parent component. Parent groups were

developed de novo from two key adolescent DBT and family therapy articles by Woodberry et al., 2002 ,and Miller et al., 2002 and Matthew Selekman's text: "The Razor's Edge: Solution Oriented Brief Family Therapy with Self Harming Adolescents",2002. Woodberry et al, summarize key family factors in working with families with depressed and suicidal/self injuring adolescents: 1. decreasing family risk factors eg. abuse or psychopathology, 2. reducing skills deficits and increasing certain skills among family members such as affect identification and management, 3. enhancing potential protective factors eg warmth and adaptability, 4. improving interpersonal interactions eg. parents to decrease reactivity. Key elements from Selekman's text in regards to family issues include improving communication, reviewing myths around self harming behaviours eg. not every adolescent who self injures is borderline personality disorder, aggravating factors such as family breakdown, contagion, teen pressure, and building on strengths. Overlap between solution oriented and DBT associated family factors included the need to connect emotionally and, validate as opposed to invalidate emotional states as well as identify and fortify protective factors.

Based on this information the following sessions were developed:

Session 1:

a) Introduction and review of parent group goals

b) Guidelines for confidentiality

c) Self injurious behaviour in adolescents discussed from the perspective of how the behaviour is understood to be multi-determined, what the functions of SIB can be including tension reduction and providing "relief" from intense emotions

d) Myths of self harm reviewed, based on Selekman's text, including the myth that all self harming adolescents are borderline personality disordered

e) Crisis management principles reviewed including parental reaction when their adolescent self injures and preventing repetition.

f) Major family challenges and strengths also identified.

Session 2:

a) Welcomed some new parents

b) Reviewed and expanded on topics of session 1

c) Family interactions discussed, particularly parents tendency to regress in terms of their own behaviour and their need to reduce their reactivity and avoid "traps".

d) Principle of validation introduced

Session 3:

a) Check in to review the previous two weeks

b) Review of the last session

c) Focus on defining and creating a safe and balanced environment, eg. parents having a separate life from teens, creating norms within the family despite the "chaos", and understanding the relationships between adolescent peers

d) Communication skills including active listening and reflective feedback discussed

e) Homework task was given whereby parents were instructed to ask their teen to teach them something that they did not know. The objective of this task was to recognize that their teen had mastery over certain tasks and to promote reciprocal validation.

Session 4:

a) Reviewed the previous session and homework task

b) Importance of adolescent separation/individuation discussed

c) Family goals

d) Family secrets including abuse, neglect, marital difficulties and parental psychopathology.

Parent reports in their post group evaluations indicated that in session one, reviewing the myths of SIB was helpful as well as the need to develop skills to manage crises. Parental validation and identification were also found beneficial as part of the group process. Session 2 in fact went on a further 30 minutes indicating parent's desire for contact and discussion. Feedback from session 2 indicated that parents had understood the need to decrease reactivity and balance communication. What appeared most helpful was listening to other parents with similar experiences. Session 3 feedback consistently reported that parents understood the importance of "letting go" and fostering independence in their adolescent. One parent identified the difficulty in incorporating different opinions from different counseling sources. Session 4 feedback commented that parents had understood the need to remove feelings of shame associated with their problems, the value of setting goals and creating hope. The ongoing need to foster independence and not "smother" their teens was again acknowledged. Additional comments highlighted once again the benefit of discussion amongst parents and the need for more parent groups in order to permit more process work.

Overall Impressions

At the final general evaluation, mindfulness was the most consistently reported skill in being most helpful, with the therapeutic support group rated very to extremely helpful. Two rated their SIB as 100% better, two 50% better. All four would recommend the group to others. Verbal feedback was consistent in the report that certain handouts were found to be too complex and that the skills learning component would be more effective if it was more interactive, eg. like a TV game show. Comments regarding the parent group indicated that parents showed a better understanding of their adolescents and that their relationship had improved in terms of better communication, and parents being able to "back off".

Therapists' impressions of group type and format were generally favorable. The groups were relatively well structured and readily reproducible. In the adolescent DBT group it was felt that there were a significant number of handouts, a few of which the therapists themselves found less than straight forward. Recognizing the limit that was set in terms of length of groups and number of sessions, a balance is required in terms of amount of homework handouts and skill based handouts. Completed homework remained inconsistent throughout the group while all participants were able to fill out an SAS at minimum at the beginning of each group. The parent group was felt to be readily accepted by parents with the sense from therapists as well that more parent groups were required to cover the material and permit parents to connect with each other.

CONCLUSION

Development of combined groups for adolescents who self injure and their parents was formulated from the literature using several models: 1. modified dialectical behavior therapy and therapeutic support groups for adolescents 2.solution oriented brief family therapy and family therapy based on DBT principles including reciprocal validation and skill enhancement for parents. Overall participants rated the groups as helpful.

Limitations to the interpretation of preliminary feedback from participants include:

- reduced number of sessions (from 12 to 8) in the TSG limits the amount group cohesiveness and therapeutic work.
- modified DBT pilot was incomplete in that the interpersonal effectiveness skills portion of the DBT group was piloted with the other three skills modules.
- therapists did not have formal training in either DBT or TSG.
- evaluations were interpreted by the group therapists themselves.

In general, these groups were readily reproducible in a community setting with adolescents and their parents. Further refinement and evaluation of such programs for the treatment of SIB is warranted.

FIGURE 1

SELF ASSESSMENT SHEET

Name: _____ Date: _____

What happened?_____

Where were you? _____

Was there a trigger?_____

What were you thinking?_____

What did you do?

_____

_____

_____

_____

Did you use any techniques to cope differently with your distress? _____

_____

_____

_____

What were the consequences? What happened after? _____

_____

_____

_____

How did you handle yourself?

1	2	3	4	5
Poorly	Not so well	Okay	Good	Great

How upset were you?

1	2	3	4	5
Very Upset	Really	Moderately	Mildly but still okay	Not at all

What would you do differently? _____

_____

_____

_____

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REFERENCES

American Psychiatric Association (1994). *Diagnositic and Statistical Manual of Mental Disorders*, 4th edition (DSM IV). Washington, DC: American Psychiatric Association

Baron, P., & Fine, S. (1994). Therapeutic Support: A Manual, unpublished.

Clarke, G.N., Rohde, P., Lewinsohn, P.M., Hops, H. & Seeley, J.R. (1999). Cognitive-behavioral treatment of adolescent depression: efficacy of acute group treatment and booster sessions. *J Am Acad Child Adolesc Psychiatry*. 38(3), 272-279.

DiClemenre, R.J., Ponton, L.E., & Hartley, D. (1991). Prevalence and correlates of cutting behaviour: risk for HIV transmission. *J Am Acad Child Adolesc Psychiatry* 30, 735-739.

Fine, S., Forth, A., Gilbert, M. & Haley, G. (1991). Group therapy for adolescent depressive disorder: a comparison of social skills and therapeutic support. *J Am Acad Child Adolesc Psychiatry* 30(1), 79-85.

Ghaziuddin, M., Tsai, L., Naylor, M. & Ghaziuddin, N. (1992). Mood disorder in a group of self-cutting adolescents. *Acta Paedopsychiatr* 55, 103-105.

Hawton, K., Kingsbury, S., Steinhardt, K., James, Anthony & Fagg, J. (1999). Repetition of deliberate self-harm by adolescents the role of psychological factors. *J. of Adolesc* 22, 369-378.

Katz, Laurence Y., Cox, Brian J., Gunasekara, Shiny & Miller, Alex L., (2004). Feasibility of Dialectical Behavior Therapy for Suicidal Adolescent Inpatients. *J.Am. Acad. Child Adolesc*. Psychiatry, 43(3), 276 –282.

Kymissis, P. (1994). Group Psychotherapy with Adolescents. In: Comprehensive Group Psychotherapy. Kaplan, H., Sadock, B., eds. Baltimore: Williams and Wilkins, pp 577-584.

Linehan, M., Armstrong, H.E., Suarez, A., Allmon, D. & Heard, H.L. et al.(1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Arch Gen Psychiatry* 48, 1060-1064.

Linehan, M. (1993). *Skills Training Manual for Treating Borderline Personality Disorder*, Guilford University Press, New York.

Miller, A.L., Rathus, J.H., Lineham, M.M., Wetzler, S. & Leigh, E. (1997). Dialectical behaviour therapy adapted for suicidal adolescents. *J Pract Psychiatry Behav Health* 3, 78-86.

Miller, A.L., Wyman, S.E., Huppert, J.D., Glassman, S.L. & Rathus, J.H. (2000). *Analysis of Behavioural Skills Utilized by Suicidal Adolescents Receiving Dialectical Behavior Therapy Cognitive and Behavior Practice* 7, 183-187.

Nixon, M.K., M.D., Cloutier, P.E., M.A., Aggarwal, S., M.D. (2002) Affect Regulation and Addictive Aspects of Repetitive Self-Injury in Hospitalized Adolescents. *J.Am. Acad. Child Adolesc. Psychiatry* 41(11), 1333–1340.

Rathus, J.H. & Miller, A.L. (2002). Dialectical behaviour therapy adapted for suicidal adolescents. *Suicide Life Threat Behav* 32, 146-157.

Selekman, M. & King, S. (2001). "It's My Drug": Solution-Oriented Brief Family Therapy with Self-Harming Adolescents. *J. of Systemic Therapies*, Vol. 28, 88-104.

Selekman, M.D. (2002). Living on the Razor's Edge: Solution-Oriented Brief Family Therapy with Self-Harming Adolescents, W.W. Norton and Co., New York.

Suyemoto, K.L. (1998). The functions of self-mutilation, *Clin Psychol Rev*, 18, 531-554.

Wood, A., Trainor, G., Rothwell, J., Moore, A. & Harrington, R. (2001). Randomized trial of group therapy for repeated deliberate self-harm in adolescents *J Am Acad Child Adolesc Psychiatry* 40(11), 1246-1253.

Woodberry, K.A., Miller, A.L., Glinski, J., Indik, J. & Mitchell, A. (2002). Family therapy and dialectical behaviour therapy with adolescents: Part II: a theoretical review. *Am J of Psychotherapy* 56(4), 585-602.

Understanding Others by Understanding the Self: Neurobiological Models of Empathy and their Relevance to Personality Disorders

Jason Morrison, MD[1]

ABSTRACT

Introduction: The ability to accurately infer the thoughts, intentions and emotional states of others has often been associated with the concept of empathy. Deficits in this ability are common in those with personality disorders. **Method:** Current neurocognitive models of empathy-related abilities and the biological research to support them are discussed. **Results:** There is evidence that observing the actions of others activates regions of the observer's brain involved in executing the analogous action. It is proposed this motor resonance is used to cortically simulate observed movements. Simulation may permit access to the thoughts and emotions of the observer when they make a similar action. This information could then be used to infer the intentions of the observed person. **Conclusion:** The relevance of these models to clinical aspects of personality disorders is discussed.

Key Words: Empathy, personality disorders, mirror neurons

RÉSUMÉ

Introduction: Le fait de pouvoir déchiffrer correctement les pensées, les intentions et les émotions d'une autre personne a souvent été associé au concept d'empathie. L'incapacité de faire ainsi se retrouve fréquemment chez les personnes présentant des troubles caractériels. **Méthodologie:** Nous discuterons des modèles neurocognitifs traitant du développement des habiletés d'empathie et des recherches biologiques sous-jacentes. **Résultats:** À l'évidence, l'observation des agissements des autres stimule les régions du cerveau de l'observateur qui alors tend à agir de la même façon. Nous formons l'hypothèse qu'une telle 'résonance' stimule le cortex de l'observateur – ce qui lui permet d'avoir accès aux mêmes pensées et aux mêmes émotions que celles de la personne observée. **Conclusions:** Nous discuterons de la pertinence de ces modèles dans l'intervention clinique auprès de personnes présentant des troubles caractériels.

Mots-clefs: Empathie, troubles de la personnalité, les cellules 'miroir'.

INTRODUCTION

Everyday we make judgments about the emotions, thoughts and intentions of the people around us. Often without conscious deliberation, we quickly and accurately note things such as the subtext of a conversation, or subtle signs of distress in another person. Often these observations lead to elaborate inferences about their thoughts and desires that some authors have said is akin to mind-reading (Frith & Frith, 1999). In many ways this ability is the grease that facilitates social life, as these quick inferences allow us to modify our interactions with others and to respond appropriately to their desires, even when there has been little directly communicated.

This ability is often associated with the concept of empathy. Over the last century "empathy" has been used to describe a variety of related phenomena such as the ability to discriminate the emotional states of others, the capacity to take the perspective of another, and the evocation of a shared affective response, among others (reviewed by Wispé, 1987). In the clinical setting a therapist is considered very empathic when she can accurately infer and anticipate the thoughts and feelings of her patient. In this paper, the term empathy will be used in its broadest sense, referring to the full range of psychological and interpersonal skills that are involved in identifying and understanding the perspective of another person.

Empathy and Psychopathology

The importance of empathy-related skills to everyday functioning is obvious to those treating people with psychiatric disorders. From the boy with Asperger's syndrome who cannot decipher reciprocal social interactions and has no friends, to the girl with social phobia who believes others are constantly scrutinizing her, to the psychotic teenager who misinterprets other's actions as malevolent, problems with empathy-related abilities are an important cause of dysfunction in psychopathology.

This is especially true in those with personality disorders. In Axis I disorders poor interpersonal functioning is often a consequence of the prominent cognitive, perceptual, and physical symptoms and often improves when these symptoms remit. However, in Axis II disorders, problems with interpersonal functioning tend to be more severe than with Axis I disorders (Skodol et al., 2003), and are a core symptom rather than a consequence of the disorder. This is reflected in the DSM-IV general criteria for a personality disorder (see Figure 1, American Psychiatric Association, 1994). Difficulties in "perceiving and interpreting self, other people, and events" and in "interpersonal relationships" are two of the four core areas of dysfunction cited in criterion A. These two interrelated dimensions nicely describe the main function of empathic skills.

It is interesting to note that perception of self and perception of others is linked in these diagnostic criteria. This implies that for people with personality disorders, deficits in empathy-related skills may be related to a more general perceptual problem involving the self as well.

New research into the brain mechanisms of empathy offers some intriguing hypotheses about why perception of self and

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others may be linked. An emerging neurocognitive model suggests that inferences about the emotions of others are made by first stimulating their actions cortically. This simulation may allow the observer to access his own associated emotions during similar movements, and to then use this information to infer the emotions of the other person. In this way, we see the world as a mirror of our self; a provocative idea that resonates with both phenomenology in psychiatric disorders, and with concepts in psychodynamic theory.

This paper will focus on neurocognitive mechanisms thought to underlie the phenomenon of empathy, and finish by considering insights these models bring to the phenomenology and treatment of personality disorders.

Neurobiological Models of Empathy

Most people have had the experience of unconsciously mimicking the actions of someone they were watching. For example, seeing someone yawn usually elicits a reflexive yawn in the observer, or a football fan absorbed in a game might find himself leaning to dodge an opponent along with the player on television. Early 20th century psychologists called this phenomenon "motor mimicry" and felt it might be a primitive form of empathy (Bavelas et al, 1987). Variations of motor mimicry are particularly evident early in development. Infants begin to imitate movements and facial expressions from birth, and it is thought that imitation is a key source of a child's learning, especially in the pre-linguistic years (Meltzoff & Moore, 1997). Nonetheless, as the early investigators felt, this reflexive imitation is a long way from the more subtle and cognitive empathy abilities in adults.

A number of discoveries in the past 10 years have allowed researchers to connect imitation and empathy in a much more plausible way. Proceeding from the theoretical to the biological, a cognitive model for understanding self-generated movements will be presented, and then built upon to show how a brain network representing self-generated actions could be used to predict the actions of others. Lastly, exciting new discoveries in neurobiology that link theory to biology will be discussed.

Understanding our own intentions: the "forward model"

Many of the theories pertaining to mechanisms of empathy have emerged from investigations of how biological motion is perceived and analysed. It is perhaps not immediately obvious, but perception of movement plays an important role in our understanding of the world. At a basic level, movement helps people identify other people. For example, from 3 months of age, babies can distinguish biological movement from non-biological movement (Fox & McDaniel, 1982). As well, Johansson (1973) attached small lights to the joints of people walking in a dark room, and showed that subjects could readily identify human movement from moving light arrays showing non-human movement.

Movement also plays an important role in self-awareness. For example, our movements are a major contributor to our sense of agency: we get constant feedback that we are a conscious being via the translation of our intentions into movement. One of the more important areas of work for models of empathy has taken a closer look at this translation: how are our movements recognized as being self-generated?

At first, imagining a movement as being anything other than self-generated may be difficult. In everyday life, the impression that our movements are self-initiated is a seamless perception that does not require conscious deliberation. However, disruption of this perception occurs with the delusions of passivity seen in psychosis, where the person feels an external force controls their movements, speech or thoughts. In addition, with the use of a mechanical hand to delay the time between initiating a movement and feeling the returning sensory information, it is also possible to disrupt this perception experimentally (Wolpert et al., 1995).

There is growing body of work examining the question of how the brain distinguishes whether incoming sensory information, such as a moving finger, is the result of a self or non-self generated movement. A "forward" model has been elaborated to explain how this might be achieved (Wolpert et al, 1995; Wolpert et al., 2003). It is theorized that throughout development, the cerebellum builds up a "database" of the sensory feedback received for every action undertaken – everything from simple actions like waving the hand, to more complex actions like hitting a baseball. For example the precise muscle force, acceleration, and direction required to swing a bat would be stored, as well as physical characteristics of the bat and ball. With repetition and experience, this database grows, and the cerebellum becomes able to predict the sensory feedback that would result upon completing a given action. When a movement is initiated, it is proposed that a copy of the motor command is sent to the cerebellum allowing anticipation of the sensory feedback. If the actual sensory feedback matches the predicted feedback, the signal passing to the rest of the brain is attenuated and the movement is perceived as self-generated. If it does not match, the signal is not attenuated and the movement is perceived as externally generated. This type of model is called a "forward" model because information is sent ahead at the time of movement initiation.

In the case of a moving finger, signals initiating movement are sent from the premotor cortex to both the muscles of the finger, and to the cerebellum. The returning sensory information is compared to the predicted sensory feedback and if they match, the signal will be attenuated and perceived as self-driven.

Empirical research with humans is just beginning, but there is preliminary neuroimaging data to support this theory. Blakemore et al (1998) found in an fMRI study that the somatosensory cortex was less activated in self-generated than externally generated touch. This supports the idea that sensory afferent attenuation is involved in distinguishing self-generated movements. Imamizu et al. (2000) found a distinctive cerebellar activation that was present after subjects learned to use a new tool. They concluded this was an image of the internal representation of a motor sequence, although this requires further investigation.

Understanding the forward model is important because it posits a neural structure that is a surrogate for an internal representation of self. The proposed action database in the cerebellum represents an accumulation of an individual's motor experience and is used to interpret and predict incoming sensory

information to help create a coherent and consistent response to external and internal stimuli. In addition, via its central role in distinguishing self from non-self movements, it would play a critical role in establishing and maintaining the self/non-self boundary that characterizes normal mental life. The cognitive models of empathy explored in the next section often imply the existence of a similar database or internal model for information on emotions and intentions. The forward model thus provides a starting point for imagining these structures.

Understanding others: a projection of ourselves

As discussed earlier, everyday human interactions rely upon the ability to make quick and accurate inferences about the thoughts, emotions and future actions of others. Blakemore and Decety (2001) have proposed this is achieved via a mechanism similar to that proposed in the forward model, albeit in reverse order.

They propose that when we observe another person initiate a movement, we map the sensory information about their movements onto the internal database of actions proposed in the forward model. By comparing the observed action with the repertoire of self-generated actions stored in the cerebellum, the brain can predict what action will likely be undertaken. For example, upon seeing someone's hand begin to move toward an apple, this visual information is sent to the cerebellum. In the cerebellum, cross-referencing this information with the possible self-generated motor actions that begin in this way, a short list of probable actions (e.g. "the person will grasp the apple and bring it to the mouth", "they will place it elsewhere"), and less probable actions ("they will pick it up and throw it") is generated. Additional information could refine the list even further, such as the subject's direction of gaze, another person pointing at the apple, or the environmental context.

Of course in everyday life inference are made not only about a subject's next action, but also about the associated thoughts, intentions and emotions. Decety and Blakemore (2001) suggest this is achieved by working back from the cerebellar representation of a given action to the intention that most often leads to that action. Whichever cognitions or emotions most often trigger the action in the observer would be used to infer the emotional state or thoughts of the observed subject. For example, for someone who likes to eat apples, a common precipitant to grasping an apple might be hunger, and so the most salient inference might be that the observed person is hungry. For someone who is more preoccupied with cleanliness and order, the most salient thought might be to tidy up, and so they might infer the person would put the apple in the cupboard.

This mechanism may also account for how we detect the emotional state from a facial expression. For example, when one sees someone smiling, this would activate the sensory cortical areas for the corresponding mouth, face and eye movements, map them onto the cerebellar database, which from there could map back to the common thoughts or emotions that lead to this motor activity (e.g. happiness or "he's thinking something funny").

Despite some preliminary biological research, this model remains very theoretical. However, a class of neurons has recently been discovered whose function provides a biological substrate for this type of cognitive model.

Mirror neurons and a simulation theory of empathy

The premotor cortex is involved in the planning and execution of movements, and is arranged in a homuncular fashion similar to the primary motor cortex sitting just behind it. In the macaque monkey, an area of the ventral premotor cortex called F5 is involved in the control of hand and mouth movements (Rizzolatti et al., 1988). In the mid-nineties, a class of neurons was discovered in F5 that fired not just during self-generated movements, but also when observing that same movement in another monkey (Gallese et al., 1996; Rizzolatti et al., 1996). Due to this quality, the authors called these "mirror" neurons. Neurons with similar properties have also been found in the superior temporal sulcus (STS), and the inferior parietal lobule, and are thought to form an integrated "mirroring system" in the brain (Rizzolatti et al, 2001).

Of particular importance is that these neurons fire only during the initiation or observation of actions, not just movement. For example, they fire in response to observing another monkey grasp an object, but not to observing simple opening and closing of the hand. They also do not fire to grasping by non-living objects such as a mechanical hand (Rizzolatti et al., 2001). This suggests they code for a particular relationship in motor terms between subject and object. In other words, they are coding for intention, and not just for movement (Gallese & Goldman, 1998).

Mirror neurons represent a plausible organic substrate that begins to bridge the gap between the cognitive models of empathy and actual biology. First, they provide evidence that there are cells that respond specifically to observed movements. The fact that they are found in brain areas that also plan movements is intriguing. In addition, since their firing is linked to particular actions and intentions, there is no need to link with a separate structure (such as the putative action database in the cerebellum) in order to decode the intention from the motor action.

Gallese (2003a,b) has proposed that action observation leads to activation of the mirror neurons that also plan and initiate this action in the observer. He suggests that this resonant firing leads to a cortical simulation of the movement without actual motor imitation. That is, seeing someone reach for an apple triggers the same cortical neurons involved when the observer reaches for an apple, only the motor component is not initiated. However, the simulation permits direct connections to the limbic and frontal structures thought to contain information about the emotions and thoughts associated with this movement.

Subsequent studies have moved beyond vision to investigate possible mirror links with other sensory modalities. Kohler et al. (2002) found neurons in macaque premotor cortex that fire upon initiating, seeing, or hearing a particular action.

Although much of this work so far has been with non-human primates, there are a growing number of studies supporting a mirror system in humans. A variety of studies using electroencephalography (EEG), magnetoencephalography (MEG), and transcranial magnetic stimulation (TMS) have shown that activation of the prefrontal cortex during action observation is similar to during action execution (reviewed in Rizzolatti et al, 2001). One study reported a finding in humans analogous to mirror neurons. Hutchison et al. (1999) recorded from individual neurons in the anterior cingulate cortex in conscious patients

during neurosurgery, and found that among a group of neurons that responded to the experience of pain, one responded both to feeling pinprick, and also to observing the surgeon receive a pinprick.

Neuroimaging studies using fMRI have added further support to the idea of a mirror system in humans. Iacobini et al. (1999) found that during both observation and imitation of a motor action, analogous structures to the mirroring system in macaques (i.e. the ventral premotor cortex, posterior parietal cortex and posterior STS) were activated in humans. Subsequent studies have also found mirroring effects with seeing and feeling touch (Keysers et al., 2004).

As the simulation model predicts, these imaging studies support the notion that observing a given movement causes a resonant firing of neurons in the same areas responsible for the corresponding movement in the observer. The next step would be to provide evidence of a connection between the action representation and the associated emotions or thoughts. This is difficult to demonstrate in monkeys, but there is now preliminary data from human imaging studies to support this connection.

Carr et al. (2003) found that both observing and imitating a variety of facial expressions activated very similar brain regions, including the fronto-temporal areas activated in previous studies on the putative mirroring system in humans. They also found that these areas, as well as the insula and amygdala, were more activated during imitation. They hypothesized that actions are represented in fronto-temporal mirror areas, and then link up to their associated emotion via projections through the insula to limbic structures such as the amygdala. Wicker et al. (2003) found observing faces and feeling disgust activated similar structures in the anterior amygdala and the ACC. This study also found insula activation, but only in the disgust condition and not the pleasant condition.

Clearly, research investigating this hypothesis in humans is just beginning. Not surprisingly the precise brain areas and the order in which they are activated remains hotly debated (Carr et al., 2003; Blakemore & Decety, 2001; Preston & de Wall, 2002; Gallese, 2003a,b). Nonetheless, there is remarkable consistency in the human work so far to suggest that as with monkeys, there is a mirroring system involving the ventral premotor cortex and inferior parietal areas that responds to action observation much as it does to action execution. Furthermore, that connections between this system and the limbic area (perhaps via the insula) may be involved in connecting a represented action to its associated emotion.

Implications for Personality Disorders

The simulation model of empathy predicts that people make inferences about the intentions and actions of others based on their own internal repertoire of intentions and actions. Our default is to suspect that others will act as we have acted in the past. By extending the model to human emotions and thoughts, it suggests that we believe others will feel as we ourselves would feel or think in the same situation. This theory has relevant implications for work with personality disorders.

As discussed earlier, a core dimension of personality pathology is a problem in perceiving and interpreting both self and others. This fits very well with the simulation models: if it is true that we perceive the world based on our internal model of ourselves, it would necessarily be the case that disordered perceptions of self and others would go together. In fact the model implies that distorted perceptions of others are really the consequence of a dysfunctional internal model of self. This could be useful in planning a treatment strategy.

Following from the model, there are two approaches that could be used to decrease this perceptual distortion. The first would be to try and teach the patient that their perceptions of other's intentions are incorrect. By teaching them to question their interpretations, and use more reliable methods to derive their inferences, these distortions might be overcome, leading to better interpersonal functioning. A second approach would be to focus on the distorted or negative sense of self directly. Based on the mirroring theory, treatments that focused on modifying maladaptive thoughts and perceptions about self should at the same time improve the way that others are perceived. In theory, this second approach would be more efficacious as it addresses distortions of both self and other simultaneously. It is unclear to what extent distorted perceptions of self change in step with distorted perceptions of others during the course of treatment for personality disorders. It is however an interesting and testable hypothesis.

The simulation theory of empathy also provides a number of provocative links with concepts in psychodynamic theory germane to personality disorders. For example, the defense mechanisms projection and projective identification have traditionally been considered immature defense mechanisms (Valliant, 1993). However, in the simulation theory, a process akin to projection is proposed as the mechanism underlying all empathic understanding. This view parallels Kleinian and Object Relations theory where projection and projective identification are considered universal mechanisms involved in normal psychic development as the infant traverses the paranoid position (Klein, 1975).

This raises the question of whether it is the content of the projection or the psychic mechanism itself that is maladaptive. It could be that the mechanism of projection is a universal and neutral psychic function, and in people with a healthy self-image and a functioning mirroring system, it is adaptive and thus largely invisible. However, in those with a troubled or immature perception of self, the projections are distorted and inaccurate, and thus stand out as a maladaptive defense. The more frequent use of projection and projective identification by those with personality disorders may simply reflect the higher rates of disordered self-perception in this population.

Another possibility is that the direct mirroring and projection implied by the simulation theories is important early on in development, but that their persistence in the mature adult may be a type of neurodevelopmental problem associated with psychopathology. This would parallel Klein's view that many forms of character pathology result from fixation in the paranoid position (Klein, 1975).

Kohut is the psychoanalyst who most famously emphasized the importance of empathy in therapy, and discussing a "mirroring system" in the brain underlying empathy

brings to mind his concept of the "mirroring transference". He felt that consistent failure by a parent to empathically attend to a child's needs could lead to a damaged "self" and various types of personality pathology (Kohut & Wolf, 1978). He felt that empathically recognizing and mirroring the patient's needs in therapy could bridge this developmental lacune, and lead to a repaired self. This requires a highly developed sense of empathic acuity where the therapist can feel what the patient feels from moment to moment; a process where there is vicarious experiencing of an emotional perspective and a shared affective response. Mirror neurons may be the biological substrate via which Kohut was able to make this empathic connection.

The simulation theory also meshes well with general psychodynamic treatments in child psychiatry. For example, play therapy has been an important modality of treatment for young children with mood and behaviour problems. The rationale for play therapy is that young children do not have the cognitive and linguistic capacity to articulate thoughts and feelings like adults in traditional therapy, and so play is used as a window to their internal world (Coppolillo, 1996). The idea is that insight into how they understand themselves and the world can be gained by observing how they attribute thoughts and intentions to the toys and therapist. Certainly the simulation model would suggest that this is indeed a very prudent way to understand the child's internal representations, as toys represent an excellent, developmentally appropriate screen upon which to project their developing internal model of self.

Limitations and Future Directions

Although the findings related to the mirror system are exciting, the theories remain quite speculative, and several issues remain to be addressed.

First of all, several years of replication and further study are needed to better establish the validity of these ideas in actual biology. A compelling piece of evidence would be demonstrated impairment in empathic ability following injury to the brain areas implicated in the mirroring system in humans. In addition, discovery of mirror neurons in other animals might allow evolutionary insights as to whether this is a phenomenon of primates, or a more generalized mechanism of perception, conserved in evolution across many species.

There are important conceptual problems as well. For example, the simulation theory does not account for how we attribute thoughts and intentions to people that are not directly observed, such as those we read about, or hear described. There is a large literature on "theory of mind"- the processes via which we attribute mental states to self and others - that has been reviewed extensively elsewhere (Frith & Frith, 1999; Baron-Cohen et al., 2000; Frith & Frith, 2003). Although theory of mind accounts and simulation accounts of empathy are not completely incompatible, there is disagreement about how beliefs and desires are represented in the brain, and attempts to reconcile the two are underway (see Gallese, 2003a).

Another difficulty is that most people are able to articulate an understanding of other people that is objectively quite different from how they see themselves. As some in the self-psychology literature have written, the empathic therapist can "comprehend the experience of others from their own unique perspective, which is often very different from 'what I would feel if I were actually in their place'" (Baker & Baker, 1987, p.2). Although the simulation theory explains well how it is possible to vicariously experience the emotional state of another person, it does not explain how a therapist could know the idiosyncratic cognitions that a given patient associates with these emotions. Rather than simply using their own associated cognitions, the therapist must make guesses based on earlier information from the patient, their experience from other patients, etc. Thus, simulation cannot be the only way in which we make inferences about others. There must be a more nuanced mechanism that allows other information to be used besides simply an automatic mirroring leading to an inference. Simulation theories need to propose mechanisms that explain when and why the inferences they derive are ignored or overruled.

Lastly, an elegant theory would integrate the intuitive connections between motor mimicry phenomena, early childhood social learning via imitation, and the findings with mirror neurons.

One possibility is that the fast, automatic initial interpretation of others uses the mirroring system, but that this information is then modified or suppressed by more explicitly conscious reasoning. Perhaps in infants the mirror neuron simulations lead to overt imitation, but that during development the motor component is increasingly inhibited by cortical (and possibly conscious) mechanisms, leaving only brain simulations in mature adults.

This type of developmental hypothesis could be investigated with neuroimaging and EMG studies in children to see if there is a more robust connection between action observation and actual motor imitation compared to adults. Unfortunately, there are no studies explicitly testing the mirroring system hypothesis in children or even immature non-human primates. Certainly there are many practical problems with trying to functionally image children, especially if interaction is required. These difficulties would increase with even younger children, and might limit the feasibility of this sort of work.

People with psychiatric disorders are another important population that has not been studied thus far. Given that psychiatry is the main area in medicine in which problems with empathy-related skills arise, they might be an ideal group to investigate the mirror system hypothesis. There are numerous questions that could be investigated. Does poor empathy imply a defect in the mirroring system? For example, do people with autism spectrum disorders have deficits in mirroring systems? If so, to what extent is this modifiable? Can improvements in self-other distinction and empathy during therapy be correlated with activation of different brain regions in imaging studies? This is potentially a very rich area of investigation for psychiatry.

For now, clinicians will have to be satisfied with the less tangible but equally intriguing conceptual possibilities that this research provokes, bringing us a little closer to integrating clinical observations with neurophysiology.

FIGURE 1

DSM-IV General Diagnostic Criteria for a Personality Disorder

An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following ways:

- cognition (i.e. ways of perceiving and interpreting self, other people, and events)
- affectivity (i.e. the range, intensity, lability, and appropriateness of emotional response)
- interpersonal functioning
- impulse control

The enduring pattern of behaviour is inflexible and pervasive across a broad range of personal and social situations.

The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

The enduring pattern is not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. head trauma).

REFERENCES

American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders, 4th Ed.

Baker, H.S. & Baker, M.N. (1987). Heinz Kohut's self psychology: an overview. *American Journal of Psychiatry*, 144:1-9.

Baron-Cohen, S., Tager-Flusberg, H., & Cohen, D.J. (2000). *Understanding other minds: perspectives from developmental cognitive neuroscience, 2nd edition*. Oxford University Press.

Bavelas, J.B., Black, A., Lemery, C.R., & Mullett, J. (1987). Motor mimicry as primitive empathy. In Empathy and its development, N Eisenberg & J Strayer (Eds.), Cambridge University Press.

Blakemor,e S.J. & Decety, J. (2001). From the perception of action to the understanding of intention. *Nature Reviews Neuroscience*, 2, 561-567.

Blakemore, S.J, Wolpert, D.M. & Frith, C.D. (1998). Central cancellation of self-produced tickle sensation. *Nature Neuroscience*, 1, 635-40.

Carr, L., Iacoboni, M., Dubeau, M.C., Mazziota, J.C. & Lenzi, G.L. (2003). Neural mechanisms of empathy in humans: a relay from neural systems for imitation to limbic areas. Proceedings of the National Academy of Sciences, 100, 5497-5502.

Coppolillo, H.P. (1996). Use of play in psychodynamic psychotherapy. In Child and Adolescent Psychiatry: *A Comprehensive Textbook, 2nd editon* , M Lewis (Ed.),Williams & Wilkins.

Frith, C.D. & Frith, U. (1999). Interacting minds – a biological basis. *Science*, 286, 1692-1695.

Frith, U., & Frith, C.D. (2003). Development and neurophysiology of mentalizing. Philosophical Transactions of the Royal Society of London B Series, 358, 459-473.

Fox, R., & McDaniel, C. (1982). The perception of biological motion by human infants. *Science*, 218, 486-487.

Gallese, V. (2003a). The manifold nature of interpersonal relations: the quest for a common mechanism. Philosophical Transactions of the Royal Society of London B Series, 358, 517-528.

Gallese, V. (2003b).The roots of empathy: the shared manifold hypothesis and the neural basis of intersubjectivity. *Psychopathology*, 36, 171-180.

Gallese, V., & Goldman, A. (1998). Mirron neurons and the simulation theory of mind-reading. *Trends in Cognitive Science*, 2, 493-501.

Gallese, V., Fadiga, L., Fogassi, L. & Rizzolatti, G. (1996). Action recognition in the premotor cortex. Brain, 119, 593-609.

Hutchison, W.D., Davis, K.D., Lozano, A.M., Tasker, R.R. & Dostrovsky, J.O. (1999). Pain-related neurons in the human cingulated cortex. *Nature Neuroscience*, 2, 403-405.

Iacoboni, M., Woods, R.P., Brass, M., Bekkering, H., Mazziotta, J.C. & Rizzolatti, G. (1999). Cortical mechanisms of human imitation. *Science*, 286, 2526-2528.

Imamizu, H., Miyauchi, S., Tamada, T, Sasaki, Y., Takino, R., Putz, B., Yoshioka, T., Kawato, M. (2000). Human cerebellar activity reflecting an acquired internal model of a new tool. *Nature*, 403, 192-195.

Johansson, G. (1973). Visual perception of biological motion and a model for its analysis. Perception and Psychophysics, 14, 201-211.

Keysers, C., Wicker, B., Gazzola, V., Anton, J.L., Fogassi, L., Gallese, V. (2004). A touching sight: SII/PV activation during the observation and experience of touch. *Neuron*, 42, 335-346.

Klein, M. (1975). Love, guilt and reparation: and other works 1921-1945. Hogarth Press.

Kohler, E., Keysers, C., Umilta, M.A., Fogassi, L., Gallese, V., Rizzolatti, G. (2002). Hearing sounds, understanding actions: action representation in mirror neurons. *Science*, 297, 846-848.

Kohut, H. & Wolf, E.S. (1978). The disorders of the self and their treatment: an outline. *International Journal of Psychoanalysis*, 59, 413-425.

Meltzoff, A.N. & Moore, M.K. (1997). Explaining facial imitation: a theoretical model. *Early Development and Parenting*, 6, 179-192.

Preston, S.D. & de Waal, F.B.M. (2002). Empathy: its ultimate and proximate bases. Behavioural and Brain Sciences, 25, 1-72.

Rizzolatti, G., Camarda, R., Fogassi, L., Gentilucci, M., Luppino, G., & Matelli, M. (1988). Functional-organization of inferior area-6 in the macaque monkey; II. Area F5 and the control of distal movements. *Experimental Brain Research*, 73, 491-507.

Rizzolatti, G., Fadiga, L., Gallese, V. & Fogassi, L ,(1996). Premotor cortex and the recognition of motor actions. *Cognitive Brain Research*, 3, 131-141.

Rizzolatti, G., Fogassi, L, &Gallese, V, (2001). Neurophysiological mechanisms underlying the understanding and imitation of action. *Nature Reviews Neuroscience*, 2, 661- 670.

Skodol, A.E., Gunderson, J.G., McGlashan, T.H., Dyck, I.R, Stout, R.L., Bender, D.S., Grilo, C.M., Shea, M.T., Zanarini, M.C., Morey, .LC., Sanislow, C.A. & Oldham, J.M. (2002). Functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder. *American Journal of Psychiatry*, 159(2):276-83.

Vallian,t J., (1993). The wisdom of the ego. Howard University Press.

Wicker, B., Keysers, C., Plailly, J., Royet, J-P., Gallese, V., Rizzolatti, G. (2003). Both of us disgusted in my insula: the common neural basis of seeing and feeling disgust. *Neuron*, 40, 655-64.

Wispé, L. (1987). History of the concept of empathy. In Empathy and its development, N Eisenberg & J Strayer (Eds.), Cambridge University Press.

Wolpert, D.M., Doya, K. Kawato, M. (2003). A unified computational framework for motor control and social interaction. *Philosophical Transactions of the Royal Society of London B Series*, 358, 593-602.

Wolpert, D.M., Ghahramani, Z., & Jordan, M.I (1995). An internal model for sensorimotor integration. *Science*, 269, 1880-1882.

Initial Reliability of the Diagnostic Interview for Narcissism Adapted for Preadolescents: Parent Version (P-DIN)

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ABSTRACT

Introduction: the Diagnostic Interview for Narcissism, an instrument developed by Gunderson and associates to assess pathological narcissistic traits in adults, has been adapted for use with parents of preadolescents as a semi-structured interview. A sixth section has been added to assess the parental narcissistic investment of the child. **Methods:** the sample consists of 21 parents of children (aged 8-13 years) at risk for narcissistic personality disorder. An interviewer-observer design, with independent interview evaluation, was used to assess inter-rater reliabilities. Both raters were blind to diagnostic information. **Results:** Very good inter-rater reliabilities (ranging from .85 to 1.00) were obtained for all 35 statements of this Parent version of the DIN (P-DIN). Good internal consistencies a=0.82, a=0.88, a=0.69, respectively) were obtained for the first three Sections of the P-DIN, which include all the DSM-IV criteria for Narcissistic Personality Disorder. Section V, Social/Moral Adaptation (a=0.54), and Section VI, Parental Narcissistic Investment of the Child (a=0.62), had weaker internal consistencies. Section IV, Mood States, had the lowest internal consistency (a=0.50). Finally, a high reliability coefficient was obtained for the total scale (a=0.92, 32 statements for Sections I to V). **Conclusion:** present results of this pilot study justify further research into the P-DIN psychometric properties.

Key words: narcissism, narcissistic personality disorder, scale, personality assessment, child

RÉSUMÉ

Introduction: L'Inventaire diagnostique du narcissisme chez l'adolescent, développé par Gunderson et son groupe pour évaluer les pathologies narcissiques chez l'adulte, a été adapté sous forme d'entretien semi-structuré auprès de parents de préadolescents. **Methodologie:** L'échantillon regroupe 21 parents de jeunes à risque (âgés de 8 à 13 ans) pour une pathologie narcissique. La fiabilité test-retest fut effectuée indépendamment par deux personnes ignorant tout des données diagnostiques. **Résultats:** Pour les 35 énoncés de la section de l'Inventaire qui touche aux parents (P-DIN), nous avons obtenu une très bonne fiabilité entre les deux évaluateurs (de 0,85 à 1,00). Pour les trois premières parties du P-DIN, lesquelles incluent tous les critères diagnostiques du DSM-IV pour un diagnostic du trouble de personnalité narcissique, la cote de consistance interne a été de 0,82, 0,88 et 0,69 respectivement. Pour la partie V de l'Inventaire (l'adaptation sociale/morale), la consistance interne a été de 0,54 et, pour la partie VI (l'investissement parental de nature narcissique auprès de l'enfant), de 0,62. La partie IV (les affects) a montré un plus fiable niveau de consistance interne, soit 0,5. Dans l'ensemble, nous avons obtenu une cote de fiabilité élevée, soit 0,92. **Conclusion:** Les résultats de cette étude-pilote sont encourageant et justifie la poursuite de la recherche sur les propriétés psychométriques du P-DIN.

Mots-clefs: narcissisme, trouble de personalité narcissique, échelle d'évaluation, évaluation de la personalité, enfant

INTRODUCTION

The construct of narcissistic pathology in children and adolescents remains a controversial topic. Both the psychodynamically-oriented literature (Bleiberg, 1994, 2001; Kernberg, 1989; Kernberg et al., 2000; McDavid and Pilkonis, 1996) and our clinical observations (Guilé, 1996), however, support the clinical need for delineating a core set of pathological narcissistic behaviors in children.

Narcissistic children experience interpersonal difficulties with peers as well as relatives. They appear haughty and self absorbed, as well as exploitative and demanding of others but giving little in return. They behave as if they are entitled to do what they want, avoid making any effort to realize their academic potential and tend to control others through dramatic tantrums. Their grandiose self-experience is organized around over-evaluation of their achievements, fantasies of invulnerability, success or beauty, and a feeling of uniqueness. Their need for admiration is impossible to fulfill (Guilé, 1996).

Lack of empathy and hypersensitivity to criticism and defeat are associated with longstanding problems of adjustment in school and at play as well as treatment resistance and failure (Kernberg, 1989; Guilé et al., 2002). Self-centeredness and lack of empathy, which are central to narcissistic conditions impede the development of peer relations in children (Kernberg et al., 2000; Rinsley, 1990). Consequently, they constitute risk factors for the development of disturbances in identity and autonomy during adolescence (Weise et al., 2004; Guilé, 1999; Kernberg et al., 1997; Kernberg, 1991, 1989) and may increase the risk of presenting a personality disorder in adulthood (Crawford et al, 2001; Korenblum et al., 1997; Rey et al., 1995; Bleiberg, 1990). Accordingly, it may be useful to properly identify narcissistic pathology in children so that earlier detection and more effective intervention programs can be provided to these children.

Identifying narcissistic traits in children

Identifying narcissistic traits in children and adolescents remains a challenge (Guilé, 1999; Hill and Rutter, 1995). More broadly, evaluation of children requires special considerations

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(AACAP, 1997). Psychiatric diagnosis «is rooted in the clinician's understanding of the vicissitudes of normal and abnormal child development» (p. 5S). Narcissism, as part of a developmental process, is described by Paulina Kernberg (Kernberg, 1989,1991; Kernberg and al., 2000), who clearly distinguishes between normal and pathological narcissism among children. Paulina Kernberg states that in normal infantile narcissism, fantasies of great power and self-centered activities reflect age-appropriate developmental needs. However, in children with pathological narcissism, «the demands are excessive and can never be fulfilled; in fact, they are secondary to an ongoing denigration and even destruction out of envy of whatever supplies are received» (Kernberg, 1991, p. 675). In order to identify narcissistic characteristics, the clinician must tap beyond the child's actual clinical presentation, the long-standing symptom pattern which is characteristic of personality pathology.

According to Otto Kernberg (1984), objective criteria can be used to identify traits of pathological narcissism outside of the therapeutic context. The DSM-IV (APA, 1994) specifies that to be applied «in children and adolescents, the nine adult criteria must have been present for at least one year» (p. 631). In a comparative analysis, Guilé (1996) found a high concordance between three sets of clinical criteria (APA, 1994; Bleiberg, 1990; Kernberg, 1989). Frequently cited limitations to assessing childhood personality disorders include the lack of standardized measurements, high comorbidity and poor diagnostic stability (Mercier, 1991; Eppright et al., 1993).

Recent longitudinal research performed by Crawford and associates (2001), however, reported high stabilities of pathological narcissistic behaviors in boys and girls from early adolescence into adulthood. One can argue that diagnostic stability will likely improve with the development of reliable instruments. The review of BPD studies conducted by McDavid and Pilkonis (1996) suggested an overall increase in the stability of diagnosis, which paralleled the improvement of standardized diagnostic procedures. The development of a standardized instrument that reliably identifies narcissistic pathology in children may facilitate solid and consistent empirical research.

Objective of this Study

The assessment of psychopathology in children requires information from at least two sources: the child and the parents (AACAP, 1997). In addition, it is recommended that the assessment of personality pathology is based on a semi-structured interview in combination with a self-report measure (Zimmerman, 1994). As a first step in the process of developing a set of instruments, this pilot study investigates the Parent version of the Diagnostic Interview for Narcissism (P-DIN), a newly developed semi-structured interview administered to parents, in order to identify pathological narcissistic behaviors in children. The P-DIN is based on the Diagnostic Interview for Narcissism (Gunderson, Ronningstam, & Bodkin, 1990), an instrument designed to investigate Narcissistic Personality Disorders in adults using DSM-III-R criteria. The specific objective of this study is to evaluate the interrater reliability and internal consistency of the P-DIN in a sample of parents with preadolescents exhibiting pathological narcissistic behaviors.

METHOD

Sample

Participants were parents of children attending a university-based psychiatric OPD for youths at risk of developing personality disorder. Children were referred for pathological narcissistic behaviors such as the following traits: 1) overestimation of talents or achievements; 2) fantasies of being all powerful; 3) feeling of being special or unique; 4) intense need of admiration 5) sense of entitlement; 6) tyrannical behaviors with peers or with adults; 7) lack of empathy; 8) feelings of envy leading to excessive and repeated demands; 9) arrogant or contemptuous behaviors; 10) hypersensitivity to criticism or defeat; 11) egocentric behaviors. Those traits are congruent with a previous review of the literature (Guilé, 1996). Out of a pool of 44 subjects in treatment at the time of the study and presenting with those narcissistic traits, 21 agreed to participate.

This final sample included 17 boys and 4 girls, ranging in age from 8 to 13 years [age distribution: 8 years (n=1), 9 years (n=4), 10 years (n=5), 11 years (n=4), 12 years (n=3), 13 years (n=4)]. Eight children came from a one-parent household, and 12 were living with the biological mother and a father figure. One child was living with the paternal aunt and her family, with frequent visits from the biological father. Since the presence of depressive or manic symptoms could modify the course of grandiosity and, therefore, distort the clinical assessment (Ronningstam et al., 1995), children with Major Depressive, Manic or Bipolar Disorders were excluded from the study. Children with Mental Retardation, Psychotic or Pervasive Developmental Disorders were also excluded. This was done so that cognitive impairment pertaining to those disorders was not confused with distortions in self-perception or perception of others observed in narcissistic children. Diagnoses in the final sample included ADHD (n=7), ODD (n=3), ADHD+ODD (n=2), ADHD+AnxD (n=1), which were regrouped into a group of externalizing disorders (N=13). The internalizing disorders group (N=8) included Anxiety Disorder (n=4), Mood Disorder (n=1), Mood+AnxD (n=1) and Adjustment Disorder (n=2). No significant difference between these two groups was found with regard to narcissistic traits.

Instrument

The Parent Diagnostic Interview for Narcissism (P-DIN) is a semi-structured interview (copy available from the first author upon request) of 153 probes covering all DSM-IV criteria for NPD, as well as narcissistic components found in the literature (Guilé, 1996). It has a structure that parallels the adult version of the DIN (see Appendix 1). It groups 32 descriptive characteristics in five sections: grandiosity, interpersonal relationships, reactiveness, mood states, social/moral adaptation. An additional section grouping three other characteristics targeting the parental narcissistic investment of the child has been added. Each of these characteristics is written in the form of a statement (n=35) and is evaluated separately by the means of discrete probes (n=153). The interview lasts about 45 minutes.

A time frame of one year was chosen to assure that the scoring is based on usual patterns of the youth's life. All probes and statements are scored by the interviewer as 2 (often), 1 (sometimes), or 0 (never). With respect to the procedure described

by Cohen and associates (1987), scaled statement and section scores were predetermined according to clinical judgment and then applied to all subjects. Scaled scores for sections 1-5 were summed up to get a total score for the child's pathological narcissistic behavior whereas the sixth section remained as a separate section probing the parental narcissism.

The Parent Diagnostic Interview for Narcissism (P-DIN) is an adaptation of the Diagnostic Interview for Narcissism (DIN; Gunderson et al., 1990), a research-based semi-structured interview for identifying narcissistic traits in adults, that can be used with parents for identifying narcissism in children. Five sections of the Diagnostic Interview for Narcissism (DIN) describe the narcissistic patients' distinctive characteristics, including I) grandiosity, II) interpersonal relations, III) reactiveness, IV) affects and mood states, and V) social and moral adaptation (see Appendix 1). A total of 33 statements describe the characteristics of narcissistic patients comprised in the five sections of the DIN. Satisfactory interrater reliability was obtained for 31 of the 33 statements. Very high interrater reliabilities were obtained for the five section scores. The internal consistency for the total scale was also high (a=0.81). The correlation coefficient for each statement with its corresponding section total also provided an acceptable measure of internal consistency: a=0.60 for sections I, II, and IV. Lower correlations were obtained for section III (a=0.44) and section V (a=0.49). Comparison of clinical versus DIN diagnostic assignment yielded concordance rate of 80%. Using a cut-off score of 9, sensitivity and specificity were respectively 0.63 and 0.88 (Gunderson et al., 1990).

The primary changes made in the adapted DIN (see Appendix 1), from the adult version were as follows: 1) In the Grandiosity section, the statement on invulnerability was divided into belief in invulnerability and avoidance of vulnerability; 2) Self-centered behavior (statement 15), originally found in the Grandiosity section in the adult DIN, was moved to the Interpersonal Relations section. Self-centeredness in children, is more clearly expressed within interpersonal relationships; 3) Statement 17, «Lack of commitment to anyone» (formulation in the adult DIN) was adapted to correspond to the development of peer relations in preadolescents, and was renamed «Lack of reciprocity»; 4) Section IV on Mood States underwent the most extensive changes. Preadolescents with narcissistic personality disorder primarily manifest anhedonia, boredom or irritability (Guilé, 1996); 5) The additional section intends to assess the parents' narcissistic investment of the child. Including three criteria identified in the literature and from clinical experience, this section consists of three statements which assess: a) whether one of the parents feels that his/her child has unique and superior talents and abilities, b) whether this parent is reluctant to acknowledge his/her child's vulnerabilities and difficulties, and c) whether this parent is able to acknowledge his/her child's specific needs. This sixth section may indicate to clinicians the degree of reliability of the parent's responses. A narcissistic injury to the parent may result from the realization that his/her child has the profile of behavioral disturbances portrayed by the DIN. Clinicians find that a narcissistic parent often tends to report less problems with their child in order to minimize their own narcissistic injury.

Procedure

All parents signed a consent form which explained the purpose of the study and any risks and benefits incurred. The Parent-DIN was then administered to the parents. An interviewer-observer design, with independent interview evaluation, was used to assess interrater reliability. Each rater served almost equally as interviewer and observer. Subject assignment to interviewer-observer pair was randomized by consecutive entry in the study. Both raters were blind to diagnostic information and to the other rater's scoring. Both raters had received the same training (i.e., they became familiar with the literature, and they attended four trial interviews). Information collected on the sample included: sex, age, family structure at time of interview, and diagnosis on Axis I. Clinical diagnoses according to DSM-IV criteria (APA, 1994) were made at intake by an experienced psychiatrist (JMG).

Statistical analyses

Norman and Streiner's (1994) recommendations were followed to establish the sample size for Kappa's confidence interval. A minimum of 18 subjects is required when the agreement must focus on three categories (often, sometimes, never). For the calculation of the correlations, a power analysis revealed that approximately 20 subjects are needed for an expected coefficient of 0.7, in a one-tailed 2% test and 95% power (Borenstein & Cohen, 1990).

RESULTS

Child's pathological narcissistic behavior

Scaled sections scores and total score for the child's narcissism are presented in Table 1.

Interrater Reliability

Kappa coefficients and confidence intervals for all 35 statements are presented in table 2. Very good interrater reliability was obtained for all statements (ranging from 0.85 to 1.00).

Internal Consistency

The reliability coefficients (Cronbach's alpha) for the 35 statements (Table 3) range from 0.51 to 0.94 with a median coefficient of 0.71. Sections I, Grandiosity, and II, Interpersonal Relations, have very good internal consistency (a=0.82 and a=0.88, respectively, Table 4). A somewhat weaker internal consistency was obtained for section III (Reactiveness a=0.69), and the additional section, Parental Narcissistic Investment of the Child (a=0.62). Section V, Social/Moral Adaptation and section IV, Mood States, had the lowest internal consistencies (a=0.54 and a=0.50 respectively), suggesting that the probes in these sections need to be reformulated or redistributed. Finally, a very good reliability coefficient was obtained for all 32 statements within sections I to V (a=0.92).

The correlations (Table 4) between the five sections and the total score indicate that the first three sections are very significantly ($p < .001$) correlated with each other and with the total score. Social/Moral Adaptation is highly correlated ($p < .001$) with the total score and significantly correlated with sections I, II and III (respectively $p < .05$, $p < .01$ and $p < .01$). Although significantly correlated with the total score ($p < .05$), section IV (mood states) appears to be poorly or not correlated with other sections.

DISCUSSION

The adapted version of the Diagnostic Interview for Narcissism, which regrouped 35 statements into six sections (see Appendix 1), was designed to be administered to parents. Summing up the first five sections scores yields a continuous score (0-13), which can serve as a quantitative index of pathological narcissistic behavior of the child. The sixth section tackles aspects of the parental narcissism. The purpose of the current study was to evaluate the instrument's interrater reliability. In addition, the study examined the internal consistency of the questionnaire in order to identify probes that needed further revisions.

The results revealed high interrater reliability coefficients for all 35 statements. This suggests that the adapted DIN can be administered by appropriately trained raters who are not experts in assessing personality disorders. Reliability coefficients (alpha) for sections I, II, and III were satisfactory (respectively 0.82, 0.88, 0.69). Moreover, these three sections are significantly correlated with each other and that many statements within these sections are correlated with each other. Interestingly, all DSM-IV criteria for Narcissistic Personality Disorder are found within the first three sections of the DIN (Grandiosity, Interpersonal Relations and Reactiveness). These results are quite similar to those reported by Gunderson and his associates (Gunderson et al., 1990; Ronningstam & Gunderson, 1991; Ronningstam et al., 1995), who found that in a larger sample of adult participants, the first three sections of the DIN appeared to contain criteria that were more specific to narcissistic personality disorder.

Sections IV (Mood States) and V (Social/Moral Adaptation) required the greatest amount of adaptation from the original DIN for adults, and our results indicate they will need further modifications. The heterogeneity, and more likely the low number of probes within sections IV and V, explains why a lower reliability coefficient was obtained for both sections. Apart from its positive correlation with the total score, there were very poor correlations between section IV and any of the other sections, confirming Gunderson's findings on the adult version that section IV «does not contribute greatly to the overall content of the interview» (Gunderson et al., 1990, p. 679). Moreover, items in section IV were more difficult for parents to report on reliably due to varying perceptions of mood states. This is congruent with the common finding in child epidemiological studies that the parent tends to under report internalized disturbances (Valla et al., 1993).

Although grouping heterogeneous statements, Section V (Moral/Social Adaptation) is significantly correlated with the total score on narcissism and the three sections depicting the core features of narcissistic disorders: grandiosity, interpersonal difficulties and reactiveness. The additional section presents some interesting preliminary findings. The statements in this section did not correlate with the overall score, but did correlate with several statements within the DIN. Parents who tended to exaggerate their child's talents (S33) reported more reactions on the part of their child to others' envy of him/her. However, these parents also tended to be unable to acknowledge their child's needs (S35). Parents who were unable to acknowledge their child's needs also had a strong tendency to report that their child does not express a need for admiration, is not sensitive to criticism and does not take pleasure in activities that he/she usually enjoys (anhedonia). These findings support clinical observations that narcissistic parents tend to report fewer problems in their children.

Major limitations of this study included the small sample size and the limited generalizability of the findings. No information was available on the parents who refused to participate. Given that it was a sample of youths presenting with narcissistic traits, generalization to other populations cannot be assumed. Furthermore, the study sample consists mainly of boys, which call into questions the generalizability of the findings to female subjects. For those reasons, results should not be interpreted as estimates of the prevalence of narcissistic psychopathology in psychiatric settings. Another limitation came from the gender ratio of the respondents who were mainly mothers. Generalizability to fathers has to be assessed. Finally, given the cross-sectional nature of the design, no information is available for short term or mid-long term stability of the measurement. This adapted version of the DIN needs further research into its psychometric properties, including test-retest reliability, specificity and sensitivity, with larger samples of preadolescent.

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TABLE 1

Scores for the Five Sections and Total Score for the Child's Narcissism

Sections	Mean	Standard Deviation	Range of scores
Grandiosity	7.3	3.8	0-16
Interpersonal Relations	10.5	5.5	0-20
Reactiveness	4.6	2.7	0-10
Mood States	2.9	1.7	0-6
Social/Moral Adaptation	5.1	1.8	0-10
Total scaled score	8.1	4.0	0-13

TABLE 2

Kappa Coefficients for the Interrater Reliability of Statements of the P-DIN

Statement	Kappa	CI[a]	Statement	Kappa	CI[a]
1	.92	.77 - 1.00	19	1.00	NA
2	1.00	NA	20	.92	.77 - 1.00
3	1.00	NA	21	1.00	NA
4	1.00	NA	22	1.00	NA
5	.92	.77 - 1.00	23	1.00	NA
6	.93	.78 - 1.00	24	1.00	NA
7	1.00	NA	25	1.00	NA
8	1.00	NA	26	1.00	NA
9	.85	.60 - 1.00	27	1.00	NA
10	.91	.74 - 1.00	28	.92	.76 - 1.00
11	1.00	NA	29	1.00	NA
12	.92	.77 - 1.00	30	.89	.67 - 1.00
13	1.00	NA	31	1.00	NA
14	1.00	NA	32	.87	.62 - 1.00
15	1.00	NA	33	1.00	NA
16	.91	.74 - 1.00	34	.88	.66 - 1.00
17	.93	.79 - 1.00	35	1.00	NA
18	1.00	NA			

Note : [a] = 95% Confidence Interval

TABLE 3

Alpha Reliability Coefficients for Statements and Number of Probes in Each Statement of the P-DIN

Statement	*a*	Statement	*a*	Statement	*a*
S1 – 4 probes	.68	**S16** – 7 probes	.67	**S31** – 3 probes	.63
S2 – 6 probes	.75	**S17** – 5 probes	.63	**S32** – combined probes	N.A.
S3 – 4 probes	.71	**S18** – 5 probes	.72	**S33** – 2 probes	0.94
S4 – 5 probes	.74	**S19** – 8 probes	.83	**S34** – 2 probes	.66
S5 – 2 probes	.70	**S20** – 3 probes	.52	**S35** – 2 probes	.53
S6 – 3 probes	.59	**S21** – 3 probes	.78		
S7 – 5 probes	.68	**S22** – 8 probes	.76		
S8 – 7 probes	.75	**S23** – 4 probes	.80		
S9 – 10 probes	.79	**S24** – 3 probes	.58		
S10 – 6 probes	.72	**S25** – 2 probes	.82		
S11 – 3 probes	.59	**S26** – 1 probe	N.A.		
S12 – 6 probes	.78	**S27** – 1 probe	N.A.		
S13 – 9 probes	.80	**S28** – combined probes	N.A.		
S14 – 2 probes	.76	**S29** – 2 probes	.85		

TABLE 4

Alpha Coefficients and Correlations Between the Five Sections and Total Score of the P-DIN

	a	I	II	III	IV	V
I - Grandiosity	.82					
II - Interpersonal Relationships	.88	.87***				
III - Reactiveness	.69	.66***	.71***			
IV - Mood States	.50	.04	.43*	.35		
V - Social/Moral Adaptation	.54	.49*	.59**	.61**	.09	
Total scale	.92	.91***	.97***	.83***	.46*	.67***

* $p < .05$ ** $p < .01$ *** $p < .001$

REFERENCES

American Academy of Child and Adolescent Psychiatry (1997). Practice parameters for the psychiatric assessment of children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, October 36(10), Supplement: 4S-20S.

American Psychiatric Association (1994). *The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Washington DC.

Bleiberg, E (2001). Treating Personality Disorders in children and adolescents. New York: Guilford Press.

Bleiberg, E. (1990). The clinical challenge of children and adolescents with severe personality disorders. *Bulletin of the Menninger Clinic*, 54, 107-210

Bleiberg, E. (1994). Normal and pathological narcissism in adolescence. *American Journal of Psychotherapy*, 48(1), 30-51.

Borenstein, M., Cohen, T. (1990). *Statistical Power Analysis*. Lawrence Erlbaum Associates. Hillsdale.

Cohen, P., Velez, N., Kohn, M., et al. (1987). Child psychiatric diagnosis by computer algorithm: Theoretical issues and empirical tests. *Journal of the American Academy of Child and Adolescent Psychiatry*, 26(5), 631-638.

Crawford, T.N., Cohen, P., Broo,k J.S. (2001) Dramatic-erratic Personality Disorder symptoms: II. Developmental pathways from early adolescence to adulthood. *J Person Disorders* 15(4),336-350.

Eppright, T.D., Kashani, .JH., Robison, B.D. et al. (1993). Comorbidity of conduct disorder and personality disorders in an incarcerated juvenile population. *American Journal of Psychiatry*, 150, 1233-1236.

Guilé, J.M. (1999). États limites et troubles de personnalité chez l'enfant et l'adolescent. In Psychopathologie de l'enfant et de l'adolescent. E Habimana, M. Tousignant(Eds). Gaetan Morin, Montréal; 257-278.

Guilé, J.M. (1996). Identifying narcissistic personality disorders in preadolescents. *Cananadian Journal of Psychiatry*, 41, 343-349.

Guilé, J.M., Mbékou, V., Fortier, H., Cornez, C., Bergeron, L., Sayegh, L. (2002) Variables associées au trouble de personnalité narcissique chez l'enfant et l'adolescent. *Annales Médico-Psychologiques*, 160, 550-558.

Gunderson, J.G., Ronningstam, E., Bodkin, A. (1990). The diagnostic interview for narcissistic patients. *Archives of General Psychiatry*, 47, 676-680.

Kernberg, P. (1989). Narcissistic disorder in childhood. *Psychiatric Clinics of North America*, 12(3), 671-694.

Kernberg, P. F., Weiner A.S., Bardenstein, K.K. (2000). Personality disorders in Children and adolescents, New York, Basic Books.

Kernberg, P. F., Hajal, F., Normandin, L. (1997) Narcissistic Personality Disorder in Adolescent Inpatients: a Retrospective Record Review. In Disorders of Narcissism, E.F. Ronningstam (Ed.), Washington, D.C., *American Psychiatric Press*, 437-456.

Korenblum, M., Marton, P., Golombek, H. et al. (1987). Disturbed personality functioning: Patterns of change from early to middle adolescence. *Adolescent Psychiatry: Developmental and Clinical Studies*, 14, 407-416.

McDavid, J., Pilkonis, P.A. (1996). The stability of personality disorder diagnoses. *Journal of Personality Disorders*, 10(1), 1-15.

Mercier, H. (1991). La psychopathie et sa relation avec le narcissisme pathologique. *Comportement Humain*, 5, 131-143.

Rey, J.M., Morris-Yates, A., Singh, M, et al. (1995). Continuities between psychiatric disorders in adolescents and personality disorders in young adults. *American Journal of Psychiatry, 152(6)*, 895-900.

Rinsley, DB. (1990). The severely disturbed adolescent: Indications for hospital and residential treatment. *Bulletin of the Menninger Clinic*, 54, 3-12.

Ronningstam, E., Gunderson, J.G., Lyons, M. (1995). Changes in pathological narcissism. *American Journal of Psychiatry, 152(2)*: 253-257.

Ronningstam, E., Gunderson, J.G. (1991). Differentiating borderline personality disorder from narcissistic personality disorder. *Journal of Personality Disorders, 5(3)*, 225-232.

Valla, J.P., Bergeron, L., Breton, J.J., Gaudet, N., Berthiaume, C., (1993). Informants, correlates and child disorders in a clinical population, *Canadian Journal of Psychiatry*, 38(6): 406-11.

Weise, K.L, Tuber, S. (2004). The self and object representations of narcissistically disturbed children: en empirical investigation. *Psychoanalytic psychology*. 21(2), 244-258.

Zimmerman, M. (1994). Diagnosing personality disorders. A review of issues and research methods. *Archives of General Psychiatry*, March, 51, 225-245.

APPENDIX 1

PARENT VERSION OF THE DIN ADAPTED FOR PREADOLESCENTS

Section I: Grandiosity

1- Exageration of talents[a]
2- Belief in invulnerability
3- Avoidance of vulnerability
4- Grandiose fantasies[a]
5- Denial of dependency needs
6- Uniqueness[a]
7- Superiority
8- Boastful behaviour

Section II: Interpersonal Relationships

9- Need for admiration[a]
10- Idealization
11- Devaluation/contempt
12- Envy[a]
13- Entitlement[a]
14- Arrogant/haughty behaviour[a]
15- Self-centered behavior
16- Lack of empathy[a]
17- Lack of reciprocity
18- Exploitiveness[a]

Section III: Reactiveness

19- Hypersensitivity to criticism
20- Hypersensitivity to defeat
21- Suicidal/self-destructive reactions
22- Aggressive reactions
23- Reactions to others' envy

Section IV: Mood States

24- Anhedonia
25- Boredom
26- Irritability

Section V: Social/Moral Adaptation

27- Academic and athletic achievements
28- Superficial values and interests
29- Disregard for values/rules
30- Antisocial reactions
31- Recurrent antisocial behaviors[b]
32- Psychosexual development

Additional Section: Parental Narcissistic Investment of Child

33- Parental exageration of child's talents
34- Parental reluctance to acknowledge child's difficulties
35- Parental inability to acknowledge child's needs

ADULT VERSION OF THE DIN

Section I: Grandiosity

1- Exageration of talents[a]
2- Invulnerability
3- Grandiose fantasies[a]
4- Not needing others
5- Uniqueness[a]
6- Superiority
7- Self-centered/referential behaviour
8- Boastful/pretentious behaviour

Section II: Interpersonal Relations

9- Need for admiration[a]/
10- Idealization
11- Devaluation/contempt
12- Envy[a]
13- Entitlement[a]
14- Arrogant/haughty behaviour[a]
15- Exploitiveness[a]
16- Lack of empathy[a]
17- Lack of of commitment to anyone

Section III: Reactiveness

18- Hypersensitivity
19- Reactions to criticism/defeat
20- Suicidal/self-destructive reactions
21- Aggressive reactions
22- Reactions to others' envy

Section IV: Mood States

23- Emptiness
24- Boredom
25- Meaninglessness
26- Futility
27- Badness[b]

Section V: Social/Moral Adaptation

28- High achievement
29- Superficial values
30- Disregard for values/rules
31- One or a few crimes
32- Antisocial pattern[b]
33- Perversions/promiscuity

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[a] Criterion used in DSM-IV for narcissistic personality disorder.

[b] Presence of this characteristic weighs against a diagnosis of narcissistic personality disorder.

Child and Parent Variables Associated with Treatment Response in Narcissistic Youths: The Role of Self-Blame and Shame

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ABSTRACT

Introduction: this retrospective study aimed at exploring the impact of parental and youth narcissism on service utilization and response to psychotherapy. **Method:** thirty-six 9-13 years-old narcissistic youths receiving a combined treatment (psychodynamic psychotherapy + parental counselling) were independently assessed for child pathological narcissism, parental narcissism, child's treatment attitude and psychiatric/psychosocial services utilization. **Results:** Parent and child narcissistic characteristics were negatively correlated with the use of OPD services. Child self-blame and lack of empathy predicted a lesser OPD utilization. Child pathological narcissism was significantly correlated with the specific treatment response pattern composed of the set of attitudes consistently observed in psychotherapy with narcissistic youths. Sixty percent of the variance in treatment response was accounted for by four narcissistic characteristics of the child: devaluation of others, avoidance of vulnerability, boredom, and self-blame. Post hoc analyses highlighted the role of the child's self-blame, which mediated the relation between parental narcissism and service use while acting as a moderator in reversing the relation between parent narcissism and treatment response. Relationships between self-blame, shame-proneness and guilt, and limitations of the study are discussed. **Conclusion:** Prospective studies with a larger sample are needed to confirm the association between self-blame and response to treatment in narcissistic youths.

Key words: narcissism, shame, self-blame, personality disorder, psychotherapy outcome, parent-child relationship

RÉSUMÉ

Introduction: Cette étude rétrospective vise à explorer l'impact des variables narcissiques parentales et infantiles sur l'utilisation des services et la réponse au traitement **Méthode:** Dans un échantillon de 36 jeunes de 9-13 ans présentant un trouble narcissique et bénéficiant d'un traitement combiné (psychothérapie psychodynamique et guidance parentale), nous avons évalué indépendamment les traits de narcissisme pathologique de l'enfant et du parent, l'attitude en thérapie de l'enfant et l'utilisation des services de soins. **Résultats:** Les caractéristiques narcissiques de l'enfant et du parent étaient négativement corrélées à l'utilisation des services. Les auto-reproches et le manque d'empathie chez l'enfant prédisaient une utilisation moindre des services de clinique externe. Le narcissisme pathologique de l'enfant était significativement corrélé avec le patron de réponse spécifique comprenant les attitudes couramment manifestées en psychothérapie par les jeunes narcissiques. Quatre traits narcissiques rendaient compte de soixante % de la variance de la réponse au traitement: dévaluation des autres, évitement de la vulnérabilité, ennui et auto-reproches. Des analyses post-hoc ont éclairé le rôle des auto-reproches chez l'enfant: cette caractéristique médiatise la relation entre le narcissisme parental et l'utilisation des services tandis qu'elle modère celle que le narcissisme parental entretient avec la réponse au traitement. Les limitations de l'étude ainsi que les relations entre les auto-reproches, la honte et la culpabilité sont ensuite discutées. **Conclusion:** Des études prospectives sur de plus grands échantillons permettront de confirmer l'association entre les auto-reproches et la réponse au traitement chez les jeunes présentant un trouble narcissique.

Mots clés: narcissisme, honte, auto-dévaluation, troubles de personnalité, résultats de psychothérapie, relation parent-enfant

INTRODUCTION

Clinical studies have consistently stressed how challenging is the treatment of narcissistic disorders in children and adolescents (Bleiberg, 2001; Kernberg et al., 2000). Narcissistic youths seem prone to drop out from treatment or act out if their behaviour is inappropriately managed within the therapeutic frame (Kernberg et al., 2000). They elicit in their therapists "the helplessness and vulnerability they cannot tolerate in themselves" (Bleiberg, 2001). Clinically, they appear oppositional and self absorbed, demanding of others but giving little in return. They behave as if they are entitled to do what they want, avoid making any effort to realize their academic potential and tend to control others through dramatic tantrums. Their grandiose self-experience is organized around over-evaluation of their achievements, fantasies of invulnerability and a feeling of uniqueness. Dealing with a frail self-esteem, they remain hypersensitive to criticism and defeat. They blame others for their longstanding problems of adjustment in school and at home which are in fact related to their lack of empathy, their feelings of envy and their unrelieved need for admiration (Guilé, 1996).

Recent research reported high stabilities of pathological narcissistic behaviours in boys and girls from early adolescence into adulthood (Crawford et al., 2001). However, the role treatment can play in preventing those youths from structuring their psy-

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chopathology into a Personality Disorder in adulthood is still unknown. Research on factors influencing the treatment outcome of these disturbances in children and adolescents is mostly confined to case-report studies underscoring their flickering compliance (Bleiberg, 2001; Kernberg et al., 2000; Guilé, 1996). Extensive research on paediatric Axis I disorders has already demonstrated that both the child psychopathology and the parental characteristics predict treatment response (Weisz et al., 2002; Verhulst et al., 1997). In keeping with these findings, this retrospective study aimed at exploring the impact of parental and youth narcissism on service utilization and response to psychotherapy.

METHODS

Sample

Participants were pre-adolescents referred to an outpatient specialized clinic for youths at risk of developing Personality Disorder and attending the first step of the OPD multiphasic treatment plan. Attendees participated in a one school-year individual psychodynamic psychotherapy whereas parents were given parental counselling. Only subjects who received one yearlong treatment at the time of the study were included in the study. The sample included 36 Caucasian subjects ranging in age from 9 to 13 years (mean: 10.92 +1.34 years). The Gender proportion was 75% boys and 25% girls. Two thirds of the children lived with their 2 parents. DSM-IV Axis I diagnosis composition was 52.8% disruptive disorders equally composed of ADHD and ODD, 27.8% anxiety disorders (mainly separation anxiety disorder), and 5.6% adjustment disorders. A remaining 13.9% presented a combined type with disruptive and anxiety disorders. ADHD children were receiving 20 to 35 mg Methylphenidate daily. No subject had been hospitalized.

Measures

Based on a review of the clinical literature (Guilé, 1996), four variables have been described which have a relationship with the treatment of narcissistic youths: child and parent narcissism; and two variables which correspond to the response to treatment: treatment attitude and service use.

1. Child pathological narcissistic behaviour. The Retro-Diagnostic Interview for Narcissism (Retro-DIN) is an adaptation, for reviewing children's medical charts, of a largely-used research semi-structured interview (Gunderson et al., 1990). This adaption has been shown to be a specific and sensitive instrument for identifying narcissistic behaviour in adults. The Retro-DIN regroups 34 narcissistic traits into 5 sections (grandiosity, interpersonal relationships, reactiveness, mood states and adaptation) paralleling the adult version (see Appendix 1). By summing up the section scores one can derive a continuous score (0-13) as a quantitative index of pathological narcissistic behaviour of the child. The total score is then defined as a dimensional personality trait and not as a categorical diagnosis. Interrater-reliabilities were calculated for this study and ranged from .62 to 1.0. Only the interrator reliability coefficient for denial of dependency needs and idealization scored below .70 (k = .62, CI=0-1.00). Sections' alpha coefficients were respectively: grandiosity (I): .73, relationships (II): .71, reactiveness (III): .70, mood states (IV): .58, adaptation (V): .52 and Total items score: .79.

2. Parental Narcissism. Parental narcissism (PN) includes a set of traits reported in the clinical literature: presence of narcissistic traits in one of the parents, overidealization, and over-investment of partial characteristics of the child's performance and behaviour instead of an integrated investment of the child (Kernberg et al., 2000; Guilé, 1996; Segal, 1996).

3. Treatment attitude: This variable encompasses a set of behaviours consistently observed in psychodynamic psychotherapy with narcissistic youths (Kernberg et al., 2000; Guilé, 1996) including frequent use of sadistic themes in play, mirroring play, hypersensitivity to the therapist's interventions, reluctance to engage in pretend play.

4. Service use: The third variable regroups psychosocial and health services received at school, in Community Services(CS) and in Child Psychiatry Out-patients Departments (OPD).

Interrater-reliabilities (using interclass correlation coefficients (ICC) calculated for the last three variables were good: parental narcissism (ICC=.97, CI=.92-.99), child's treatment attitude (ICC=.94, CI=.84-.98), psychosocial and health services received at school (ICC=.90, CI=.72-.96), CS (ICC= .77, CI=.39-.92) and OPD (ICC =.76, CI=.36-.91).

Procedure

Axis I diagnoses were assigned by an experienced psychiatrist (JMG) according to DSM-IV criteria. Mental retardation, psychotic and major affective disorders were excluded. Two independent raters, blind to the child's identity and diagnosis, scored narcissistic pathology through a chart review process using the Retro-DIN. Interrater reliability was then calculated. As a second step, two other independent raters, blind to the child's diagnosis and Retro-DIN score, assessed the three other variables mentioned in the measures section. Interrater reliability was also established for each of the measurements.

Data analysis

Preliminary analyses including chi-square and t tests were conducted to determine whether demographic variables were related to the tested variables. Correlation analyses and multiple regression techniques were then used to examine the relationships between child and parent narcissistic variables and the two variables targeting treatment response as criterion variables. With respect to the model proposed by Baron and Kenny (1986), post hoc analyses were performed to determine whether the independent variables play a moderator or mediator role within the interaction. Based on a model including one co-variate which yields a R^2 of .50, an alpha set at .05 and power at .80, an increment of .10 would be obtained with a sample size of 35 subjects.

RESULTS

Characteristics of the sample and preliminary analyses

Scores obtained with the Retro-DIN on the pathological narcissistic behaviour of the child confirmed that the sample was mainly composed of narcissistic subjects (mean total score = 11.03 ± 2.16). Skewness and Kurtosis coefficients were not significant. Preliminary analyses revealed no effect of age, gender, family structure, Axis I diagnoses or medication (methylphenidate) on the tested variables.

Parental and child narcissism

Parental narcissism (PN) was positively correlated with the child's anhedonia (r=.44, p<.01), denial of dependency (r=.40,

p<.05), devaluation (r=.49, p<.01) and with the entire DIN Mood section (r=.34, p<.05). PN was inversely correlated with the child self-destructiveness (r=-.38, p<.05).

PN was inversely correlated with OPD services utilization (r=-.38, p<.05). Child narcissistic behaviour was inversely correlated with OPD use (see Table 1). Child self-destructiveness was the only characteristic to be positively correlated with OPD use (r=.36, p< .05). In addition, the suicidal reactions section (III, 21), composed of suicidal threats when the child is facing criticism or defeat, was correlated with support at school (r=.36; p<.05) whereas avoidance of vulnerability was inversely correlated (r=-.51, p<.01). No correlation was found between child and parent narcissism, and community services.

Multiple regression analyses were then performed with the child narcissistic characteristics as predictors and OPD use as the criterion variable. Stepwise analyses revealed that only lack of empathy (β=-.34, t=-2.58; p<.05) and self-blame (β=-.52, t=-3.99; p<.001) contributed to the variance in OPD use (R^2 =.44, R^2adj=.41, F (2,33) =13.17, p<.001). Parental narcissism (PN) emerged also as a predictor of service use (R^2adj=.12, F(1,34)=5.68, p<.05). Post hoc probing for mediating/moderating role of the different variables was performed. Self-blame (SB) remained significant whereas the predictive power of PN was no longer found (PN: β=-.15, t=-.81; NS; PN x SB: β=-.18, t=.71; NS). Thus, child self-blame appeared to mediate the interaction between parental narcissism and services use.

Regression analyses conducted with parent and child narcissism as predictors and treatment-attitude as criterion confirmed that child narcissism was a potent predictor of treatment attitude contributing to 30% of the variance (R^2=.34, R^2adj=.29, F(2,26)=7.26, p<.005). Stepwise regression performed on the child narcissism correlated variables yielded a 4 variables equation (R^2=.67, R^2adj=.62, F(4,26)=13.11, p< .001) including boredom (β=.38, t=2.76; p<.05), self-blame (SB) (β=-.39, t=3.30; p<.001), devaluation (β=.28, t=2.19; p<.05) and avoidance of vulnerability (β=.28, t=2.16; p<05). More than 60% of the variance in treatment attitude was accounted for by a combination of these four narcissistic characteristics of the child. Interestingly the two affect variables (boredom and self-blame) accounted for about 50% (R^2adj=49, F 2,28)=5.76, p<001). Post hoc analyses revealed a significant interaction between self-blame (SB) and parental narcissism (PN) (SB: β=1.05, t=3.55; p<001; PN: β=60, t=2.89; p=007; SB x PN: β=. t=.40; p=002) which pleaded for a moderating role of the child self-blame on the interaction between PN and treatment attitude.

DISCUSSION

Parent and child narcissism and the child's response to treatment

This study highlights the impact of parent and child narcissistic traits on the child's response to treatment in several ways. The services utilization and interpersonal relationships profile of the children seemed to mirror those of their parents. First, although only gleaned from the child's chart, the parental narcissism correlated both with the child's anhedonia and with two defense mechanisms observed in the child's interactions with others: denial of dependency and devaluation. Second, both the child's and the parent's narcissism showed an inverse correlation with outpatient service utilization.

Third, as one would predict intuitively, those youth who expressed suicidal reactions were able to garner services from the school, whereas those who were vulnerable and avoidant did not access such services. From a clinical perspective, this might suggest that the fear of being vulnerable prevents the child from seeking services that might threaten his precarious sense of self-esteem, and thus presents a challenge to the school preventive care system intent on identifying and helping such youth. Fourth, two clinical features on the child's part, lack of empathy and self blame, accounted for 40% of the variance in OPD service use, and parental narcissism for another 12% of that variance. The above suggests that a significant inherent trait of such youth, an underdeveloped sense of empathy, might prevent them from perceiving a potential treatment benefit on their interpersonal relationships, and thus lead to treatment avoidance.

Fifth, this study has confirmed the association between the child narcissistic psychopathology and the previously reported set of attitudes which is observed in psychodynamic psychotherapy with narcissistic youths i.e., mirroring and sadistic themes in play, hypersensitivity to the therapist's interventions, and reluctance to engage in pretend play (Kernberg et al., 2000; Guilé, 1996). Furthermore, the results suggest that four characteristics of the child's narcissism are of particular predictive value. They include: the avoidance of vulnerability; the devaluation of others; the presence of boredom, and self-blame. Therapists working with youth manifesting those characteristics can anticipate the eventual therapeutic appearance of such issues as the development of sadistic play themes, hypersensitivity to the therapist's interventions and reluctance to engage in pretend play.

Our results are thus consistent with previous studies stressing the impact of parental characteristics on the treatment of childhood disorders (Weisz et al. 2002; Brent et al., 1998). The co-occurrence of a mental disorder of the same kind in the parent and in the adolescent has been identified in depression as a predictor of adverse outcome (Brent et al., 1998). In our study, the parental narcissism (PN), including a specific pattern of parent-child interaction (Kernberg et al., 2000; Guilé, 1996, Segal, 1996), emerged as a predictor of psychiatric services utilization and treatment attitude. The more narcissistically woven the parent-child relationship is, the less the psychiatric services are used, and the stronger is the child's reluctance to engage in psychotherapy. It suggests that the members of the narcissistic parent/child dyad specifically do not want to disrupt the idealized parent/child relationship, and will thus not risk a psychotherapy process.

Self-blame, shame and self-esteem in psychotherapy

Self-blame implies the capacity to attribute the source of a problem to the self rather than to others. As the results showed, self-blame moderated the impact of parental narcissism on the child's treatment attitude for those youth who were already engaged in the treatment process, but curtailed the treatment for those who were not yet engaged.

From a research perspective on narcissism, self-blame might be a more promising construct than seemed to be self-esteem in

the area of narcissistic psychopathology. In narcissistic disordered youths, self-esteem appears to be an ambiguous construct which does not necessarily co-vary with narcissism. Watson and colleagues (1996) showed that in a community sample of 459 young adults, the relation between narcissism and self-esteem depends on the level of social adjustment. Moreover it seems that the correlation between self-esteem and narcissism depends largely on the instruments used to measure self-esteem (Watson et al., 1996; Hibbard, 1993). Other constructs related to pathological narcissism, as shame or self-blame mentioned earlier, might be more relevant and specific. Self-blaming transactions have been reported as a key feature in psychodynamic psychotherapy of narcissistic patients (Zaslav, 1998). They denote "transactions that in psychotherapy mobilize shame". Zaslav underlined shame-proneness as a patient's particular vulnerability requiring ,when present, specific adaptation of the psychotherapy technique. In a university sample of 701 youths (mean age=21), Hibbard (1993) showed that shame was significantly correlated with pathological narcissism. Gaze aversion which might been related to shame-proneness, has been also pinpointed as a component of the child narcissistic picture (Kernberg et al., 2000). Building on this association between narcissism and shame, it could be hypothesized that shame-proneness plays a significant role in treatment participation. It could be stated that the proposal of treatment elicits shame in the patient and then prevents him/her from assenting to treatment. This perception that the treatment is shame-provoking constitutes a barrier to treatment participation in the sense of Kazdin and Wassell (1999). These authors stressed the importance of such factors in demonstrating that barriers to treatment participation were significantly correlated with therapeutic change.

While applying these notions to childhood and adolescence, one should take a developmental stance as Kagan posited (2001). Within the context of the emotional development of the child, shame refers to the recognition of the violation of a standard of conduct. Guilt which appears later, is related to the recognition that the violation of a personal standard could have been inhibited and its cause should be attributed to self rather than to others. In keeping with our results, it could be also hypothesized that once in treatment, the youth who is able to blame himself, experiences guilt to some extent and achieves a better collaboration in psychotherapy if the therapist provides a warm and empathetic support. The set of treatment attitudes observed in psychotherapy with narcissistic youths and reported above, could correspond to this process. From a clinical and psychodynamic perspective, these attitudes represent both a form of resistance to treatment, and thus negative attributes, and by contrast, essential characteristics of a treatment process which need to be manifest, addressed and resolved, and thus positive. Their absence could result in unresolved conflict and thus an unsuccessful treatment.

Our findings are not conclusive due to several limitations of this study. First, chart review, rather than direct clinical observation, guided characterization of parent/child interaction and determination of parental narcissism. As well, the study was retrospective and the sample size was small and restricted to narcissistic children enrolled in an OPD treatment setting. Future studies should consider a prospective design using measures of parental and child narcissism, and include information concerning the child's mood, the therapeutic alliance and behavioural outcomes.

TABLE 1

	Child Retro-DIN's	
sections & traits	**Use of psychiatric services**	**Treatment attitude**
I Grandiosity	-.33*	
I.1exaggeration of talents	-.34*	
I.3 avoidance of vulnerability		.49**
I.4 grandiose fantasies	-.35*	
II Interpersonal relationships		.36*
II.6 lack of empathy	-.42*	
II.11 devaluation		.50**
III Reactiveness		.42*
IV Mood states		.70***
IV.25 boredom		.67**
IV.26 irritability		.61**
IV.27 self-destructiveness	.36*	
IV.28 self-blame	-.58**	-.37*
Total score		.58**

Pair-wise Correlations Between Child Narcissism and Response to Treatment

*p < .05, ** p < .01, *** p < .001

Only the significant correlations are reported

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REFERENCES

Baron, R.M., Kenny, D.A. (1986). The moderator-mediator variable distinction in social psychological research: conceptual, strategic and statistical considerations. *Journal of Personality and Social Psychology*, 51(6), 1173-1182.

Bleiberg, E. (2001). Treating Personality Disorders in children and adolescents. New York: Guilford Press.

Brent, D.A., Kolko, D.J., Birmaher, B. (1998). Predictors of treatment efficacy in a clinical trial of three psychosocial treatments for adolescent depression. *J Am Acad child Ado Psychiatry.* 37(9):906-914.

Crawford, T.N., Cohen, P., Brook, J.S. (2001). Dramatic-erratic Personality Disorder symptoms: II. Developmental pathways from early adolescence to adulthood. *J Person Disorders* 15(4):336-350.

Guilé, J.M. (1996). Identifying Narcissistic Personality Disorder in preadolescents. *Can J Psychiatry*. 41:343-349.

Gunderson, J., Ronningstam, E., Bodkin, A. (1990). The Diagnostic Interview for Narcissistic patients. *Arch Gen Psychiatry* 47:676-680.

Hibbard, S.(1993). Adult children of alcoholics: narcissism, shame and the differential effects of paternal and maternal alcoholism. *Psychiatry*. 56:153-162.

Kagan, J. (2001).Emotional development and psychiatry. *Biol Psychiatry*. 49:973-979.

Kazdin, A.E., Wassell, G. (1999). Barriers to treatment participation and therapeutic change among children referred for conduct disorder. *J Clin Child Psychology.* 28(2):160-172.

Kernberg, P., Weiner, A.S., Bardenstein, K.K. (2000). Personality Disorders in children and adolescents. New York: Basic Books.

Segal, B.M.(1996). The role of pathological self-objects in the development of a form of defensive self. *Psychoanalytic Quarterly* 65(4):747-60.

Verhulst, F.C., Van der Ende, M.S. (1997). Factors associated with child mental health service use in the community. *J Am Acad child Ado Psychiatry*, 36(7):901-909.

Watson, P.J., Hickman, S.E., Morris, R.J. (1996). Self-reported narcissism and shame: testing the defensive self-esteem and continuum hypotheses. *Person. Individ. Diff.* 21(2):253-259.

Weisz, J.R., Hawley, K.M. (2002). Developmental factors in the treatment of adolescents 70(1):21-43.

Zaslav, MR. (1998). Shame-related states of mind in psychotherapy. *Jnal Psychotherapy Practice Research*, 7:154-166

APPENDIX 1

RETRO-DIN ADAPTED FOR CHART REVIEW

Section I: Grandiosity

1- Exaggeration of talents[a]
2- Belief in invulnerability
3- Avoidance of vulnerability
4- Grandiose fantasies[a]
5- Denial of dependency needs
6- Uniqueness[a]
7- Superiority
8- Boastful behaviour

Section II: Interpersonal Relationships

9- Need for admiration[a]
10- Idealization
11- Devaluation/contempt
12- Envy[a]
13- Entitlementa
14- Arrogant/haughty behaviour[a]
15- Self-centered behaviour
16- Lack of empathy[a]
17- Lack of reciprocity
18- Exploitiveness[a]

Section III: Reactiveness

19- Hypersensitivity to criticism
20- Hypersensitivity to defeat
21- Suicidal reactions
22- Aggressive reactions
23- Reactions to others' envy

Section IV: Mood States

24- Anhedonia
25- Boredom
26- Irritability
27- Self-destructiveness
28- Self-blame

Section V: Social/Moral Adaptation

29- Academic and athletic achievements
30- Superficial values and interests
31- Disregard for values/rules
32- Antisocial reactions
33- Recurrent antisocial behaviours[b]
34- Psychosexual development

[a] Criterion used in DSM-IV for narcissistic personality disorder.

[b] Presence of this characteristic weighs against a diagnosis of narcissistic personality disorder.

A tribute to Dan Offord, Canada's "gentle giant" of child psychiatry

Peter Szatmari, MD[1]

Great sadness and deep affection marked the recent passing of Dr. David "Dan" Offord, the renowned and much-loved child psychiatrist who devoted his life and career to bettering the lives of children around the world. He died on April 10 at age 70, following a courageous battle with cancer.

Regarded as one of the world's leading experts in child development, Dr. Offord was Professor Emeritus in the Department of Psychiatry and Behavioural Neurosciences at McMaster University in Hamilton, Ontario. It was here in the early '80s that he launched the landmark study that first identified the scope of mental health problems in children by reporting the disturbing statistic that one in five children has a serious emotional or behavioural problem. The Ontario Child Health Study remains one of the most important population-based studies on children's mental health conducted anywhere in the last 30 years and continues to fuel groundbreaking research into the factors that cause children to be "at risk".

For the past 20 years, as founding director of the Offord Centre for Child Studies (formerly the Canadian Centre for Studies of Children at Risk), Dr. Offord led a team of scientists, clinicians, and staff dedicated to finding solutions to the emotional, social, and cognitive problems faced by disadvantaged children. The Centre has grown to become one of the world's leading centres for the scientific study of child emotional and behavioural problems, highly regarded in Canada and throughout the world for the strength of its research and its commitment to train future generations of scientists to tackle the important issues that have an impact on children's mental health and development.

Dr. Offord was widely recognized for his world-class research achievements, his leadership in the field of child psychiatric epidemiology, his educational contribution to generations of medical students, physicians, and other health care professionals and his devotion to the cause of disadvantaged children.

For 47 years, he was the director of Christie Lake Camp near Perth, Ontario, where close to 400 disadvantaged boys and girls enjoyed a camp experience each summer. It was this real-life experience that grounded his research and clinical practice and reinforced his belief that the right supports delivered early in a child's development can enrich the life quality and life chances of our most vulnerable children.

Dr. Offord received his MD in 1957 from Queen's University and his fellowship in psychiatry in 1965. He held positions at the University of Florida, Pennsylvania State University and the University of Ottawa before joining the faculty at McMaster in 1978 as associate professor, clinical epidemiology and biostatistics. He served as Research Director of the Chedoke Child and Family Centre (1978-1999) and as Head of the Division of Child Psychiatry at McMaster (1987-2002).

Dr. Offord's expertise in the area of disadvantaged children and youth earned him international acclaim and deep admiration from colleagues in Canada and around the world. He was President of the Canadian Academy of Child and Adolescent Psychiatry from 1982 to 1984, served 10 years as a National Health Scientist, and was an Atkinson Fellow at the Canadian Institute for Advanced Research. He was the recipient of many awards from the American Public Health Association, the Psychology Foundation of Canada, the American Psychiatric Association, the American Orthopsychiatric Association, and the Canadian Paediatric Society. He was awarded the Golden Jubilee Medal and was recently recognized by the Ontario Legislative Assembly.

He chaired many national and international committees including the Ontario Mental Health Foundation, the Ontario Ministry of Community and Social Services, the Institute of Medicine, the National Academy of Sciences, and the Premier's Council on Health, Well-being, and Social Justice. He was involved with the children's mental health programs of the National Institutes of Health in Washington, and was a member of the MacArthur Foundation Research Network on Psychopathology and Development. He authored over 200 peer-reviewed publications on children's mental health, disadvantaged children, mental health policy for children, antisocial behaviour, child psychiatric epidemiology, community programs for children, and the Early Years. In 2001, he received the Order of Canada in recognition of his work as a psychiatrist and his commitment to improving the lives of children.

With Dr. Offord's death, the world has lost an outstanding scientist, a devoted clinician and a passionate advocate of children and youth, an extraordinary leader whose work has had a profound influence on the practice of child psychiatry and on mental health research and policy across many continents. Jean Pigott, founding chair of the Offord Centre, has described Dr. Offord as "a giant of a man who understood that our future lies in the hands of our children – the leaders of tomorrow." He was indeed a giant in the field of child psychiatry, but a gentle giant to all who knew and worked with him, particularly the children whose lives he touched so deeply.

Dan Offord devoted his life to understanding the factors that make children vulnerable and that put them at risk of a poorer quality of life. He thought deeply about the interventions that communities need to put in place to reduce the burden of suffering associated with psychosocial disadvantage and with emotional and behavioural problems in children and youth. His life and career stand as a shining example of what can be achieved through the combination of first-class scholarship and a practical clinical concern for the wellbeing of all children.

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Book Reviews

Adolescents, Alcohol and Substance Abuse: Reaching Teens Through Brief Interventions.

Peter M. Monti, Suzanne M. Corby and Tracy A. O'Leary (Editors). Guilford Press, NYC, 2001, 350 pp. $37.00 USA.

Alcohol and substance abuse in adolescents is an increasingly complex problem and this book attempts to provide a place for the use of brief psychotherapeutic interventions in addressing the problem in adolescents. As a prelude to discussing brief interventions for teenagers with substance abuse problems, the authors provide an excellent overview of relevant issues in adolescent development and the challenges that they present in relation to the risk of substance abuse.

The 11-chapter book focuses largely on alcohol abuse with little information on other substances of abuse. The second chapter focuses on the central idea of, "harm reduction" as a goal for treatment and secondary prevention of alcohol and substance abuse problems in adolescents. The chapter offers a sound defense for the notion that abstinence is not the only treatment goal in adolescents and that reduction in frequency and intensity of substance use can eventually lead to the prevention of addiction and substance dependence in young people. The authors emphasize the value of taking advantage of, "teachable moments," when adolescents are facing problems related to their drinking such as: car accidents, relationship difficulties and the risk of sexually transmitted diseases including HIV.

The third chapter provides an exhaustive compendium of substance abuse assessment tools. The authors report accurately that these instruments differ in the applicability to the different stages of adolescent development; however, the published instruments are not organized in a manner, which addresses this. The role of personality and learning factors in alcohol and substance abuse is well discussed in chapter 4, with a good literature review.

The second section of the book, chapters 5 to 10; are devoted to "motivational enhancement" for alcohol abusing youth. The possible applications of "motivational enhancement" to younger teens are discussed speculatively with insufficient empirical support.

Chapter 9 discusses co-morbid psychiatric problems. This chapter is well researched, however, the authors present co-morbid psychiatric diagnoses as mere, "labels" which can interfere with treatment of substance abuse. The need for accurate psychiatric diagnoses and therefore treatment in adolescents with substance abuse is neglected and minimized in favor of brief interventions as if they are mutually exclusive.

Chapter 10, which examines the role of the Internet and modern technology, is quite up to date and is a good resource for practitioners treating adolescents in this modern age. The caveat, however, is that websites and links frequently change and need to be monitored closely. The chapter includes a comprehensive framework for understanding brief interventions, which address coexisting larger systemic issues better than some of the previous chapters, which examine brief interventions almost in isolation from other real problems which may exist for substance abusing adolescents.

In summary, the book points out that most research on brief interventions involves alcohol abuse and older college age adolescents. Information on early adolescents and on substances other than alcohol is generally lacking. The last chapter on Transdisciplinary Research redeems the book by integrating the complex coexisting issues in substance abuse treatment and enhances some of the earlier chapters. The use of actual interview dialogue to demonstrate some of the models of brief interventions is useful to the reader. The risk of presenting brief interventions as a panacea for the complex problems inherent in alcohol and substance abuse in adolescents is one of the core problems of this book. It is unfortunate that a book focusing on substance abuse in this depth has no physician as a contributing author to the chapter on psychiatric co morbid disorders. Though this book could be a useful resource to therapists treating adolescents with substance abuse problems, it is not eclectic enough in its presentation of the complexity of the problem of alcohol and substance abuse in adolescents.

Thad Ulzen, MD

Serious Emotional Disturbance in Children and Adolescents: Multisystemic Therapy.

Scott W Henggeler, Sonja K Schoenwald, Melissa D Rowland , Phillippe B Cunningham.. The Guilford Press, NYC, 2002. 260 pp Hardcover $35.00 USA.

I began this book with a lot of anticipation as I was hoping to learn concepts that would be helpful for the care of adolescents with Fetal Alcohol Spectrum Disorder (a particular clinical interest). Although Multisystemic therapy (MST) is the official subtitle, this is in fact the book's main theme and narrative. This form of 'wrap-around' therapy comes from the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina. All four authors are from this university.

The book sets the template for MST:

1. MST therapists are full time master's level, or highly competent, clinically skilled, bachelor's level, professionals assigned to the MST program solely.
2. MST therapists operate in teams of no fewer than two and no more than four therapists, plus a supervisor.
3. MST caseloads do not exceed six families per therapist, with the normal range being three or four "active" cases.
4. Expected duration of treatment is 3-5 months.
5. MST therapists are accessible at times that are convenient for their clients and, in times of crisis, very quickly.
6. The MST program will have a 24-hour-per-day, 7-day-per-week on-call system to provide coverage when MST therapists are on vacation or taking personal time.

Oh, that the Canadian Mental Health Care System could afford such luxury! At a time when many special needs case managers have a 100 to 150 client caseload, the thought of a maximum of 6 cases sounds a bit utopian. Nevertheless the MST program works and has performed well-funded outcome studies to evaluate the veracity and length of its effect.

The main clinical construct, as hypothesized source of the adolescent's serious emotional disturbance, was a deficit in their interactions. Unfortunately little clinical analysis appeared to be given to the additional mix of co-morbid issues, such as developmental and medical. The main emphasis was on psychiatric and substance use disorders.

The book appeared to be a bit too MST-centric and dismissed the history of family therapy interventions such as instrumental, strategic, systemic and narrative, with little ceremony. At the same time, family types were recognized in their method of dividing families into authoritative (high control, high warmth), authoritarian (high control, low warmth), permissive (high warmth, low control) and neglectful (low control,

low warmth). The high control, high warmth family functioning was the apparent but unstated clinical goal.

The section on Crisis intervention and psychiatric emergencies was the most informative and practical, but one of the core elements was a child/adolescent psychiatrist available 24 hours a day, 7 days a week. This seemed only possible in large urban teaching hospital centres in Canada.

Overall the book is a good example of a labour-intensive community psychiatric intervention using well-developed protocols and training for a notoriously difficult patient population. It has been well evaluated and, as implemented and researched by the authors, shows positive effects on family relations and functioning, increased school attendance and less disability from adolescent psychiatric disorder and decreased substance abuse. As such, it is essential reading for administrators and clinicians working with this population in the community. Given the intensity and costs of the service, on going evaluations of the economics of service provision will remain an important component of evaluation and implementation of this program in community settings.

Kieran O'Malley, MD

Clinical Practice of Cognitive Therapy with Children and Adolescents: The Nuts and Bolts.

Robert D. Friedberg and Jessica M McClure. Guilford Press, NYC, 2002. 354 pp. $35.00 USA.

Friedberg is a psychologist in the middle stages of his career and McClure is his former graduate student in the beginning of her professional career but with her own developing role as a professor and researcher. This combination of experience with the practice of cognitive therapy refined in the crucible of therapy with hundreds of children and the challenging graduate student who makes us learn even more, produces a lively book that brings practical examples based on sound theory that will be of interest to a wide audience.

The introduction describes the significant similarities and differences in applying cognitive therapy developed for adults to the growing and developing work with children and adolescents. Whether with children or adults, cognitive therapy remains problem-focused, active and goal-oriented. Agenda setting, eliciting feedback and homework are still central tenets and core constructs.

The differences are familiar to those of us who work with children. Children are not usually attending on their own volition and are frequently creating a problem for a contextual system as opposed to identifying their own psychological problem. The developmental differences and language abilities play a stronger role in determining how the strategies of cognitive therapy are simplified and applied. It is in these differences that the book shows its strengths with creative strategies and applications. The authors emphasize the importance of having fun with children while doing therapy. This keeps the children engaged and motivated. They maintain this by ensuring that reward for change is built into the therapy.

From this, they build the basics and importance of a solid history (in particular, the five components of the presenting problem: behavior, cognition, mood, physiological and interpersonal), adding the key elements important for the cognitive approach, the need for a case conceptualization and the nature of the collaborative relationship with the child and youth.

These are fundamentals for any work with children but the authors add the perspective and information that will be needed for their approach. This allows them to move on to the six components of the treatment sessions (mood check-in, homework review, agenda setting, session content, homework assignment and eliciting client feedback) and the gradual introduction of the teaching to the patient that sets the stage for work in the child. Finally, the authors can introduce and provide examples of the commonly used techniques, now in a context established by the earlier chapters.

These preparatory chapters set the stage for more specific work. A chapter is devoted to each of the commonly managed disorders, depression, anxiety and disruptive behavioral disorders. Since children and adolescents do not live in isolation, the last chapter reviews the use of cognitive techniques and working with parents.

It's difficult to convey the enjoyable parts of the book without naming some of the techniques such as: Treasure Chest, Responsibility Pie, Taking Command or Blaming Yourself Worksheet, Thought Feeling Watch, Ms. Stakes Sweep, Tracks of My Fears Worksheet, Badge of Courage Worksheet. At the same time, the names may convey the sense that this is only for children of trivializes some of the challenges of working with disruptive teenagers, which the author's do not do. Here is one sample of a simple technique, the Butterfly Thoughts:

"Do you know what a butterfly is? You see, a butterfly starts out as a caterpillar. Then is changes into a butterfly. Isn't that cool? A caterpillar turns into a butterfly. It is really important to know that the way you explain what happens to you can change. The things that you say to yourself when you are feeling badly like 'I'm no good,' 'No one likes me,' or 'I will make a fool of myself' are your caterpillar thoughts. They haven't yet changed into butterfly thoughts. I want you to try to turn these caterpillar thoughts into butterfly thoughts."

Event: "I forget to do my chores and mom and dad get mad at me."

Feeling: "Sad"

Caterpillar Thought: "They hate me because they think I'm lazy and spoiled."

Can it be changed to Butterfly Thought: "Yes"

Butterfly Thought: "I did forget to do the chores. I need to do better at reminding myself. They are disappointed in me but they still love me."

In 14 chapters, Friedberg and McClure have included enough of the basics of Cognitive Therapy that beginners will understand the basic concepts and techniques well enough to use it as a framework to understand how to work with children and adolescents. Practitioners with experience will find the overview of concepts, practical applications and examples, with many case and technique illustrations, brings refreshing new ideas to their therapy tool box. It is the kind of book that lends itself to use with students in psychotherapy supervision or with team members for educational workshops.

Wade Junek, MD

Specific Learning Disabilities and Difficulties in Children and Adolescents: Psychological Assessment and Evaluation.

Alan and Nadeen Kaufman (Editors). Cambridge University Press, Cambridge, U.K., 2001, 467 pp. $59.95 USA.

This book, a compilation of chapters from a collection of international experts, was a pleasure to read and review.

The book is a valuable reference that benefited my clinical practice long before I was asked to provide this review. It is strongly grounded in current theory-driven research. Further, it provides practical information relevant to assessing children with specific learning disabilities. Of great importance, a number of the authors also detail how the results of assessment can be used effectively to formulate intervention strategies. The target audience of this book is broad, including practicing clinicians, educators, academic researchers, and individuals training for these professions. Overall, the structure and content of this book make it one that is pertinent to and potentially useful for this large audience. While the book doesn't necessarily bring new concepts to light, it provides a comprehensive overview of key issues in psychometric assessment of children and adolescents with specific learning disabilities.

The chapters in this text range in their content from detailed descriptions of specific psychometric instruments to chapters that address important historical, theoretical, philosophical, and empirical issues. Many of the authors discuss key issues and controversies that exist regarding learning disability assessment and intervention. Along with these discussions, pertinent research is presented in the context of how it can be used in the assessment and treatment of children with learning disabilities.

A number of the chapters in this book discuss specific psychometric instruments. They provide thorough descriptions of the theoretical models upon which these tests are based, their empirical properties, and detailed descriptions of the tests' features. Of considerable value, these chapters also provide practical applications for these tests, implications of the results obtained from them, and case studies to illustrate how they can be used effectively. These "test oriented" chapters are excellent resources for individuals who wish to learn how to apply the tests appropriately and effectively.

Some ideas and arguments presented by authors in the more theoretical and philosophical chapters are, at present, hotly debated. While I disagree with some of their views, the authors' points are thoughtful and well constructed. Generally, both sides of controversial topics are presented and discussed. It is very important to read some of these arguments in a broader context, taking the available literature into account. For example, in what is possibly the most controversial chapter in this book, Feuerstein and Feuerstein make an admirable effort to reconcile two very different models of assessment in order to glean the valuable attributes of each. Whether or not one agrees with their ideas, these authors make their point clearly and with fairness.

There are a few chapters in this book that should be highlighted. Wiig contributes a thorough discussion of language assessment that provides an excellent overview of historical and theoretical issues. She also provides a comprehensive outline of recommendations for empirically based practice methods of assessment, case formulation, and diagnosis of language disorders. Spreen's chapter on the neurological foundations, theories, and subtypes of learning disabilities provides a glimpse of the historical progress in our understanding of the biological underpinnings of learning disabilities. This chapter also provides a brief but useful discussion of the important implications of neurological abnormality in the field of specific learning disabilities. Reitan and Wolfson provide an excellent review of the research programs of four important neuropsychological research laboratories. They discuss some of the key principles of pediatric neuropsychological assessment and provide a valuable review of research that compares typically developing children to children with congenital and/or acquired learning disabilities.

The final chapter, written by the editors, provides an excellent integration of the contents of the whole text. This chapter is worth reading before the others and then again after one has read the entire book. Kaufman and Kaufman openly discuss controversial issues and persuasively present their views on these issues. They take a very pragmatic approach in discussing some of the theoretical arguments made in earlier chapters and by other experts who did not author chapters in their book. It is commendable that they were able to do this in the context of current realities of practice in educational and health care settings. I applaud their efforts in their chapter and more broadly, in pulling together the knowledge of the experts who contributed to this valuable book and highly recommend the book to clinicians, especially those working with children with learning disorders.

Bruce D. Dick, Ph.D.

The First Session With Children And Adolescents: Conducting A Comprehensive Mental Health.

Alvin E. House, Ph.D. The Guilford Press, NYC, 2000, 250 pp. $32.00 USA.

This book successfully reflects House's rich experience in assessing the mental health of a young person, with a focus on the initial session. It is comprehensive, practical and appealing to both novice and experienced professionals involved in the mental health care of children and adolescents.

Dr. House is a clinical psychologist with more than 25 years of clinical experience in conducting assessments for medical, vocational, educational and forensic consultations. As an Associate Professor at the Illinois State University, he teaches psychopathology, psychological assessments and mental health diagnosis at the graduate level. He has co-authored a manual on observational assessments of children, published articles, and written book chapters on intellectual, personality and neuropsychological testing. He is the author of DSM IV Diagnosis in the Schools. (New York, Guilford Press, 1999).

In this book's first chapter, the author states his personal philosophy about the process of assessment and offers an overview of the rest of the book. In the second chapter, he deals with the developmental aspects, including special populations such as children with sensory and motor limitations, and the different types of nonverbal clients. Included in this chapter is a discussion of diversity and cultural issues.

House devotes a whole chapter to collateral sources of data covering the following: interview of significant others, behaviour rating scales, questionnaires, psychological testing, previous records including academic, medical, social service, juvenile court and mental health. Several chapters are done in the format of presenting problems such as cognitive, emotional, behavioural, and relationship troubles. The differential diagnosis that could be entertained on cognitive problems is discussed extensively. Included in this section is the evaluation of exceptional talent and gifted children.

The chapter on evaluating emotional problems includes discussion of the various types of anxiety disorders, somatization disorders, depression and the bipolar spectrum. Special attention was given to the effect of the environment, trauma and suicide assessment.

The chapter on evaluating behaviour disorders is invaluable. It includes a well-formulated discussion on differentiation of the diagnostic categories, interview segments, co-morbidity, temperaments, and evaluation of the youth in the juvenile justice system.

The chapter on evaluating relationship problems has valuable references to those interested in the diagnosis of borderline personal-

The chapter on evaluating behaviour disorders is invaluable. It includes a well-formulated discussion on differentiation of the diagnostic categories, interview segments, co-morbidity, temperaments, and evaluation of the youth in the juvenile justice system.

The chapter on evaluating relationship problems has valuable references to those interested in the diagnosis of borderline personality traits in the youth. Temperament, deficits in social skills, behaviour control, emotional regulation and sensitive issues of parenting are discussed.

Mental retardation, pervasive developmental disorders and psychotic disorders are covered under evaluation of pervasive disorders. In the remaining chapters, substance use, tics, gender, impulse and eating disorders, child sexual abuse, sleep, identity and elimination problems are discussed.

In the second last chapter, House openly shares his personal assessment routine from start to finish. His routine contains an outline of a general protocol for the mental health evaluation of a minor. The book is generous with practice gems, which would take years to develop on your own. A few examples of these practice gems are the following: notes on disruptive and intolerable behaviour, position on child/adolescent privacy, variables associated with high risk of suicide, and sample questions for interviewing teenagers with symptoms associated with ADHD. He shares an interview protocol for reviewing chemical use in youth. He shares interview segments on a brief cognitive evaluation of a young child, on alcohol use, on checking visual hallucinations and fears. In addition he includes a couple of summarized outlines covering observation during interview and behaviour report.

The final, 12th chapter, offers the author's personal concluding thoughts on his practice. While he saves his commentary for the last chapter, his passion and rich experience is evident throughout the book. The reference list is impressive, current and valuable. The book touches on wide range of issues with references for further reading.

Lastly, the author closes with wise advice on record keeping, namely, to stay within the guidelines of one's professional group. He recommends devising a personal system to review annually one's clinical practice through the records. He recommends a self-assessment practice to ensure that one is consistent with current guidelines and standards.

This is an excellent reference textbook for all practicing disciplines involved in mental health assessments of children and adolescents at any level of expertise. It should be available at both health and social service agencies, clinics and offices dedicated to children and adolescents, as well as to students in both fields. It is well written in a teaching mode, giving one the feeling of being in a classroom. Throughout the book the author conveys the point that understanding and respect for the individual is key.

Mary Lou M. Dancel, MD

What Works for Whom? A Critical Review of Treatments for Children and Adolescents.

Peter Fonagy, Mary Target, David Cottrell, Jeanette Phillips, and Zarrina Kurtz. The Guilford Press, NYC, 2002. 525 pp. $48.00 USA.

This scholarly book is the timeliest addition to our understanding of evidence-based therapies for childhood mental disorders.

The use of the term "evidence based therapies" (EBT) has become quite common. However, after reading this book I was struck how most clinicians (myself included) may be using this term in an overly simplistic manner.

The book contains 13 methodically constructed chapters that introduce the reader to the aspects of outcomes methodology, epidemiology and terminology thus grounding the knowledge of the reader who will then better appreciate discussion about individual disorders.

Interestingly, the appendices were also quite informative. For example, in Appendix 2, the authors clarified which search items were used to match up with related clinical terms. Some were surprising but educative. For example: 'Bullying' as a search term picked up conduct disorder and ODD! I tried out these search items and they worked as stated!

Our knowledge of therapeutic modalities for children has been taking a quantum leap and that makes one wonder if the discussion regarding current EBT will hold even two to three years from now. Even then, the first two chapters were so powerfully written that they will always be the guideposts for further discussion on the EBT in children. Those chapters are the heart and soul of this book and I will spend some time describing them for the benefit of busy clinicians.

The first chapter addressed the importance of outcome measurements in practicing EBT and the emphasis on EBT itself. Quality of care is not the only driving force behind the movement towards EBT. Behind quality of care is the accountability of professionals to the funders and purchasers of health care. "Governments and health funders are attracted to the notion of allocating health resources on the basis of evidence."

Using a classification system proposed by Hoagwood and Jensen five levels of outcome were described:

The symptomatic or diagnostic level,
Adaptation to the psychosocial environment,
The mechanisms (such as the cognitive and emotional capacities),
The transactional aspects of development,
The level of service utilization and satisfaction with services.

The authors then gave a rich appraisal of the limitations of treatment outcomes in psychosocial treatment research. I found the use of RCT (randomized controlled trials) especially relevant. Can RCTs be considered as a gold standard of evaluation research when applied to childhood treatment outcomes? The authors concluded that at present, the results from RCTs should be considered as the best option for clinicians who wish to base their practice on scientific data.

The second chapter described epidemiological aspects of childhood disorders including prevalence, natural history, risk factors and the stability of disorders. The latter topic was very important since the evidence they presented suggested that child psychiatric disorders are not likely to remit spontaneously. Indeed, since they can become resistant to treatment with time, the use of the earliest possible intervention was emphasized.

The rest of the book reviewed different childhood disorders, current EBT and the implications of EBT. These disorders included: anxiety disorders, depressive disorders, disturbance of conduct, attention deficit hyperactivity disorder, Tourette's disorder, psychotic disorders, pervasive developmental disorders, self harming disorders, children with physical disorders and children with specific developmental disorders. There was a comprehensive review of the evidence for the effectiveness of psychopharmacologic, cognitive behavioural (problem solving, skills training and social skills training), psychodynamic and multi-modal treatments.

There were definite variations in the level of discussion for these disorders. For example, the chapter on conduct disorders was the most comprehensive and could have stood on its own. The chapter on specific developmental disorders, on the other hand, covered mostly speech language and cognitive disorder treatments and was designed for a North American audience.

In their conclusions, the authors stated 11 points that characterized treatment research in the field of child and adolescent mental health.

Many of these included much common sense such as the use of a framework incorporating the transactional, family and societal influences on the child's disorder.

This book has to be read in the order that it is written and in that hierarchical manner, I found it enjoyable. The concluding chapter made the best sense after following the logic of accepting or refuting the evidence for successful treatments in earlier chapters. There was no subjective bias in the book to lead the reader in a particular direction and full acknowledgement was given to clinicians and to their clinical judgment.

This book should be in the department library. It is not a clinician's handbook, but it is a good tool for clinician teachers who want to teach good evidence based medicine. My rating: 7/10

Prat Reebye, MD

When Parents Disagree and What You Can Do About It.

Dr. Ron Taffel with Roberta Israeloff. The Guilford Press, NYC, 2003. 256 pp. $16.95 USA.

I signed up to review this book thinking it was written for adolescents who get caught up in their parents' fights and want to stop being trapped in the role of go-betweens. After all, if this was meant for parents, wouldn't you expect a title such as "How to Stop Fighting Manual for Parents" or "Ending the Parental Divide"? Unfortunately, one quick look at the back cover revealed that Dr. Taffel is a long-time contributing editor at Parents Magazine and that this last book of his is meant for parents, not children or teens.

Setting aside my initial disappointment, I noted the crisp layout, with lots of bullets, tables and sub-headings, and the reasonable $16.95 (US) price for 256 pages and looked forward to an innovative approach to parental discord and perhaps a good book to recommend to some of the families I work with.

Unfortunately, the content proved to be anything but original and rather narrow in its focus on the stereotypical white, middle-class North American family of the Baby-Boom generation, with absolutely no reference to extended families, parents of different cultural backgrounds, gay parents, or even joint custody arrangements.

The book is organized in three sections:

Part I: "The Endless List" is based on the author's experience listening to what American parents complain about during the workshops he conducts from coast-to-coast, as well as the (now dated) 1993' "National Study of the Changing Workforce." From both of these he concluded that, although a majority of women are now in the workplace, 75% of dads are still not consistently involved in the daily hands-on care of children and their wives don't trust them to do a good job without a list of detailed instructions. Dr. Taffler's advice to mothers is "Let go, shorten your list and you'll enjoy your family more and maybe even improve your sex life." The message to fathers is that quality time doesn't happen on a schedule: conversations happen on the way to baseball or dance class or during bedtime rituals, so it's important to share those day-to-day routines to develop a close relationship with your children, not just to share your wives' load of parental responsibilities.

The second section of this book, which contains the author's main message, is entitled "Hot Spots for Women and Men" and, once again, it is based on the 50's stereotype of the "tough dad and lenient mom" and the related cultural assumptions that women find it easier to express and understand emotions and men tend to hold their feelings inside and take out their frustrations on the remote control or the golf course. In the Chapter entitled "Father Knows Best," we are introduced to such a typical couple of parents who fight non-stop over discipline, with the father being the distant critic of a more lenient and over-accommodating mom who has little control over her kids who fight non-stop over dinner, which she always prepares. Again, a somewhat simplistic solution: get dad to cook one evening and let the kids microwave quick dinners twice a week. This seems to work miracles in alleviating everyone's stress and almost eliminates all fights. To give the authors credit, there is a chapter devoted to the reverse family dynamics, 'A strict mom and lenient dad,' but once again, getting the father to share responsibilities around the house changed everybody's attitude and reduced the fighting.

Perhaps the best chapter in this entire book is the one, entitled "Everything you need to know about discipline" which takes the reader through different developmental stages and disciplinary measures which work for each one, with an emphasis on enforceable limits and consequences. Regardless of family types, the content here is important for all.

Part III: "Beyond Gender...Almost!" talks about when parents "loose it" and how they can use "time-outs" to avoid slinging mud at each other and irretrievably damaging their relationship. Then there's a chapter on children's temperaments and the fact that some kids are much more challenging than others, followed by a chapter on sibling rivalry in which parents are advised to resist taking sides, not to over identify with one particular child, to spend extra time with each child in different one-on-one combinations and "stop trying to control everything." In other words, only get involved in sibling fights when you absolutely must. Finally, the last chapter talks about the need for parents to "nourish each other" and take time off from their parenting duties.

In summary, this book is rather superficial in its approach to parental disagreements. Rather than looking at the values each parent brings to the relationship and the socio-cultural, ethnic, religious and personal principles which shape these values and beliefs, rather than offering parents a framework for working out together what their parenting goals and objectives are, the authors focus on stereotypical communication patterns in what amounts to the 'Men are from Mars, Women from Venus Guide To Parental Disputes:' easy summer reading and definitely a few good tips here and there, but very narrow in its portrayal of typical family fights.

Arlette Lefebvre, MD

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)
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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.

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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.

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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).

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CONFERENCE WATCH 2004

Canadian Academy of Child & Adolescent Psychiatry, 24th Annual Conference, October 3, 4 & 5th, 2004, Montreal, Quebec, Fairmont Queen Hotel.

Canadian Psychiatric Association, 54th Annual Meeting, October 14-17th, 2004, Fairmont Hotel, Montreal, Quebec.

American Academy of Child & Adolescent Psychiatry, 51st Annual Meeting, October 19-24th, 2004, Washington Hilton, Washington, D.C.

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