An Epidemiological Perspective of Obsessive-Compulsive Disorder in Children and Adolescents

*Joshua Fogel, Ph.D.
Affiliations:Johns Hopkins University, Bloomberg School of Public Health, Department of Mental Health[1]; Department of Biostatistics[2]; School of Medicine, Department of Psychiatry and Behavioral Sciences[3]

Abstract

Obsessive-compulsive disorder (OCD) is reviewed from an epidemiological perspective. OCD is defined according to the DSM-IV and ICD-10, with differences noted between these two classification systems. The epidemiological rubrics of quantity (prevalence), location (genetic methods and gender differences), cause (genetic etiology), and causal mechanisms (natural history and clinical course) are reviewed. The review concludes that more research is needed to further understand the epidemiology of OCD in children and adolescents, both from a Canadian and worldwide perspective.

Introduction

Obsessions are defined as "persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress" (American Psychiatric Association, 1994). Compulsions are defined as "repetitive behaviors or mental acts the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification" (American Psychiatric Association, 1994). Associated features of OCD include avoiding situations that relate to the obsessional content, hypochondriacal worries, guilt, a strong sense of responsibility for the symptoms, and sleep difficulties. Compulsion performance can become all consuming and result in serious marital, occupational, and/or social disability (American Psychiatric Association, 1994).

The Diagnostic and Statistical Manual of Mental Disorders - 4th edition (DSM-IV; American Psychiatric Association, 1994) and International Statistical Classification of Diseases and Related Health Problems - 10th Revision (ICD-10; World Health Organization, 1992) are the two most commonly used manuals for conceptualizing psychiatric disorders. The DSM-IV is the manual typically used in the United States/Canada while the ICD-10 is more commonly used in Europe. Table 1 describes classification of OCD according to both manuals.

A DSM-IV diagnosis of OCD is made when all five criteria above are met. Note that category "A" can be either obsessions or compulsions. Also category "B" is not required for a diagnosis of OCD in children. Category "C" differentiates between one having delusions where one does not realize the obsessions and/or compulsions are unreasonable. If an individual for most of the time does not recognize that the obsessions and/or compulsions are excessive or unreasonable, one specifies "with poor insight". This specification can be used for an individual on the boundary between delusions and OCD. Even with this specification, the individual qualifies for a diagnosis of OCD. Also, DSM-IV classifies OCD as an anxiety disorder while ICD-10 does not.

One Austrian study comparing a clinical sample of children and adolescents with OCD showed poor agreement between the two classification symptoms. These authors concluded that DSM-IV criteria are preferred over the ICD-10 as they allow for a more detailed and age-independent description of the symptoms of OCD (Steinberger & Schuch, 2002). A recommendation for clinicians is to be aware of the diagnostic criteria used in the studies that they read as different classification systems may show different results.

Epidemiological Rubrics

Quantity

Different studies from different countries and populations are reviewed below. In a study in the southeastern US (Valleni-Basile et al., 1996) of students from grade 7 to 9, 0.7% one-year incidence of OCD and 8.4% one-year incidence of subclinical OCD is reported. They also quote studies of OCD in adolescents with community prevalence of 0.2-1.2%.

Apter et al. (1996) studying 16-17 year old Israeli army inductees determine with DSM-IV criteria a lifetime prevalence of 2.3% for OCD and 3.9% for subclinical OCD. They quote prevalence studies showing for high school students 0.35% with OCD and 2% with subclinical OCD. They quote another Israeli army inductee study showing 3.6% point prevalence and a non-Israeli study showing 3.0% point prevalence of OCD in adolescents. A New Zealand study of 18 year olds found 4.0% prevalence (Zohar, 1999).

Also, to the author's knowledge, only one epidemiological study reports the prevalence of obsessive-compulsive symptoms in children where 2.8-4.5% ranges are reported for a German sample of 8-year olds (Thomsen, 2000). No Canadian epidemiological studies exist that study the prevalence of OCD in children and adolescents. Weissman et al. (1994) pooled the data from 7 nations/regions worldwide and reports data from an adult Canadian epidemiological study done in Edmonton that show 1.4% annual prevalence and 2.3% lifetime prevalence of OCD. The DSM-IV quotes lifetime prevalence of 2.5% and one-year prevalence of 1.5-2.1% for OCD but does not categorize these prevalence rates

*Correspondence: Joshua Fogel, Ph.D.
Johns Hopkins University, Bloomberg School of Public Health, 624 North Broadway, Suite 861, Baltimore, MD 21205
e-mail: jfogel@jhsph.edu

for children, adolescents, and adults. Overall these studies can be summarized to show that OCD ranges for adolescents from 0.35-4.0%.

Location

Genetic studies do not report separate categories for children and adolescents and the genetic studies are reviewed below. Family studies using the family history method (indirect interview) show a rate of 32% for obsessive traits in first-degree relatives of OCD patients. Another study showed that 15.9% of parents are affected with OCD traits. Using the family study method (direct interview) of probands and families, 13% of all first-degree relatives had OCD. In a Mexican study, 4.9% first-degree relatives had OCD (Wolff, Alsobrook, & Pauls, 2000).

Also, the rate of OCD among first-degree relatives of Tourette's syndrome probands was significantly higher than rates of those from the general population (interview method unknown). Also, some forms of OCD are related to Tourette's syndrome, some are familial, and the inheritance of OCD is consistent with the transmission of an autosomal dominant genetic locus (Horwath & Weissman, 2000).

Genetic research shows no difference between male and female probands or between affected male and female parents for age of onset (Cavallini, Albertazzi, Bianchi, & Bellodi, 2002). These results are interesting in that the patients sampled were from a clinical sample and other clinical non-genetic studies show no gender differences. However, population based approaches show gender differences as shown from the ECA study (e.g., see Horwath & Weissman, 2000; Karno et al., 1988).

With regard to gender differences, there again is limited research with regard to children and adolescents. One US study showed higher prevalence of 3.3% for adolescent males as compared to 2.6% for females (Zohar, 1999) while an Israeli study of army inductees showed no gender differences between males and females in lifetime prevalence and also endorsement of a variety of OCD symptoms (Apter et al., 1996). The one reported Canadian study done in Edmonton shows lifetime prevalence of 2.7% for females and 2.0% for males (Weissman et al., 1994). In general, among adult studies, epidemiological samples show gender differences, while clinical patient samples do not (Horwath & Weissman, 2000; Weissman et al., 1994).

Cause

It is difficult to find a true cause, as there are many criteria involved before one can infer causation. Almost all of the research quoted below is from adult populations, which can be helpful for understanding the child and adolescent populations. Suspected causal influences for OCD include cocaine use, female gender, not working for pay, a prior history of alcohol dependence, affective disorder, and phobic disorder (Crum & Anthony, 1993). Other possible suspected causal influences reported for OCD include birth abnormalities, heritability, temper tantrums, intelligence, neuropsychological status, parental mental health, socioeconomic status, language impairment, Tourette's syndrome, and eating disorders (Douglass et al., 1995). Douglass et al. in a New Zealand sample conclude that perinatal problems/complications, parental educational status, maternal IQ, parental SES, a variety of habits/behaviors, IQ, neuropsychological tests, eating disorders, and Tourette's syndrome are not causal influences for OCD while depression in early adolescence and possibly substance dependence are suspected causal influences for OCD (Douglass et al., 1995). Religion and birth order are not causal influences for OCD (Nestadt et al. 1998). Black race, increasing age, more baseline undesirable life events and fewer desirable life events, and medium to high SES are suspected causal influences for OCD (Valleni-Basile et al., 1996). Also, there are higher odds ratios for those with OCD than those without OCD for lifetime major depression and also other anxiety disorders (Weissman et al. 1994). In a New Zealand sample, OCD was comorbid with major depression, social phobia, and substance dependence (Douglass et al., 1995). Overall, these suspected causal influences are numerous, yet they have not been shown/replicated in many studies. Replications and further studies are necessary in order to determine the suspected causal influences for OCD. At present, it is difficult to conclude the specific suspected causal influences for OCD.

As stated above, the pursuit of causation is challenging. Genetic approaches are a way to suggest causation. They include twin studies, segregation analysis, linkage analysis, and association studies.

Twin studies show that 63% of monozygotic twins are concordant for OCD. Also, in a Japanese study there was 20% concordance in 4 pairs of dizygotic twins and 80% concordance in 10 pairs of monozygotic twins (Wolff et al., 2000). In a sample of 1,054 twins, using principal components analysis of the Padua Inventory of Obsessions and Compulsions the authors conclude that obsessions have 33% heritability and compulsions, a 26% heritability (Micallef & Blin, 2001). These studies show that there is a large genetic influence to OCD. However, there are environmental factors for OCD as there was not 100% concordance for the monozygotic twins.

Segregation analysis studies of OCD are not as conclusive as the other methods. One study of OCD probands determined that one could not reject autosomal dominant or recessive models. Another study of families with OCD probands showed contribution of a major gene, but they could not determine a specific genetic model of dominant, recessive, or additive. Overall we can conclude that genes (and/or multiple genes) contribute to OCD but it is difficult to exactly model it (Wolff et al., 2000).

Linkage analysis studies show negative results for genetic causes. One study performing linkage analysis using a three-generation family having OCD and tics, did not have a statistically significant log odds ratio for the 4p13 region (Wolff et al., 2000). Another study had negative results on a battery of genes for receptors and enzymes involved in both dopamine (O4 receptor; dopamine transporter) and serotonin (5-HT, 1Dbeta; serotonin 2A receptor) neurotransmitters of OCD (Micallef & Blin, 2001; Wolff et al., 2000).

Association studies show no association between DRD3 and OCD, DRD4 and OCD, and no alteration in coding region for SLC6A4 and OCD. However, there is an association between the long form of the promoter SLC6A4 and OCD, for the COMT gene, there is a L/L genotype significance with OCD, and there is a sexually dimorphic association between OCD and the allele of the MAOA gene (Wolff et al., 2000).

Causal Mechanisms

Epidemiological mechanisms are based on natural history studies and clinical course studies. Natural history studies show that OCD has clinical manifestations that change as time progresses; the number of OCD symptoms gradually increases during childhood and then decreases during late adolescence and early adulthood. OCD is more severe in males where OCD developed before age 10 and in females where OCD developed after age 10. It is controversial if those with subclinical symptoms of OCD progress to OCD. The debated issue is if subclinical OCD is a stage of development or a level of severity. Also, children and adolescents can change from one category of OCD to another (Mataix-Cole et al., 2002). However, there is a pattern of moving from more severe to less severe OCD categories (Valleni-Basile et al., 1996).

Clinical course studies show that in children there is a positive association of OCD with increased IQ throughout adolescence. As they aged, adolescents with OCD and tics were more likely to have tics in adult years. Also, childhood conduct disturbance predicted early adolescent OCD. Childhood tics and early adolescent separation anxiety predicted the development of OCD symptoms in late adolescence. Tics and ADHD in late adolescence predicted more OCD symptoms in adult years (Peterson, Pine, Cohen & Brook, 2001).

Genetic studies of symptoms show that the median age at onset in the offspring generation was lower than the parent generation. This suggests an "anticipation effect" where there is a reduced age at onset for a specific disease (i.e., OCD) in offspring generations (Cavallini et al., 2002). Family aggregation exists in OCD but the evidence is not as strong as that shown for a genetic anticipation effect and family aggregation is helpful but only a link in the chain to suggest true causation.

Future Epidemiological Research

Many areas exist for future research. Studies are needed to determine the incidence and prevalence of OCD in children. Canadian studies are needed to determine the possibly unique characteristics of a Canadian sample of children and adolescents. Also ethnic Canadian groups should be studied to see if there are different rates for the Anglophone, Francophone, and First Nation populations.

Suspected causal influences for OCD are often a hodgepodge of studies with conflicting results and more research is needed to refine them. Another area relates to the differences observed between clinical and epidemiological studies and future research should try to resolve some of these conflicting results. In conclusion, OCD has a number of future research questions that may be asked to help further understand it. With further studies we may be able to understand these currently unanswered questions, which will help expand our knowledge of OCD.

References

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

Apter A, Fallon TJ Jr, King RA, Ratzoni G, Zohar AH, Binder M, Weizman A, Leckman JF, Pauls DL, Kron S, & Cohen DJ. (1996). Obsessive-compulsive characteristics: from symptoms to syndrome. Journal of the American Academy of Child & Adolescent Psychiatry, 35(7), 907-912.

Cavallini MC, Albertazzi M, Bianchi L, & Bellodi L. (2002). Anticipation of age at onset of obsessive-compulsive spectrum disorders in patients with obsessive-compulsive disorder. Psychiatry Research, 111(1), 1-9.

Crum RM, & Anthony JC. (1993). Cocaine use and other suspected risk factors for obsessive-compulsive disorder: a prospective study with data from the Epidemiologic Catchment Area surveys. Drug and Alcohol Dependence, 31(3), 281-295.

Douglass HM, Moffitt TE, Dar R, McGee R, & Silva P. (1995). Obsessive-compulsive disorder in a birth cohort of 18-year-olds: prevalence and predictors. Journal of the American Academy of Child & Adolescent Psychiatry, 34(11), 1424-1431.

Horwath E, & Weissman MM. (2000). The epidemiology and cross-national presentation of obsessive- compulsive disorder. Psychiatric Clinics of North America, 23(3), 493-507.

Karno M, Golding JM, Sorenson SB, & Burnam MA. (1988). The epidemiology of obsessive-compulsive disorder in five US communities. Archives of General Psychiatry, 45(12), 1094-1099.

Mataix-Cols D, Rauch SL, Baer L, Eisen JL, Shera DM, Goodman WK, Rasmussen SA, & Jenike MA. (2002). Symptom stability in adult obsessive-compulsive disorder: data from a naturalistic two-year follow-up study. American Journal of Psychiatry, 159(2), 263-268.

Micallef J, & Blin O. (2001). Neurobiology and clinical pharmacology of obsessive-compulsive disorder. Clinical Neuropharmacology, 24(4), 191-207.

Nestadt G, Bienvenu OJ, Cai G, Samuels J, & Eaton WW. (1998). Incidence of obsessive-compulsive disorder in adults. Journal of Nervous and Mental Disease, 186(7), 401-406.

Peterson BS, Pine DS, Cohen P, & Brook JS. (2001). Prospective, longitudinal study of tic, obsessive-compulsive, and attention-deficit/hyperactivity disorders in an epidemiological sample. Journal of the American Academy of Child & Adolescent Psychiatry, 40(6), 685-695.

Steinberger K, & Schuch B. (2002). Classification of obsessive-compulsive disorder in childhood and adolescence. Acta Psychiatrica Scandinavica, 106, 97-102.

Thomsen PH. (2000). Obsessions: The impact and treatment of obsessive-compulsive disorder in children and adolescents. Journal of Psychopharmacology, 14(2), S31-S37.

Valleni-Basile LA, Garrison CZ, Waller JL, Addy CL, McKeown RE, Jackson KL, & Cuffe SP. (1996). Incidence of obsessive-compulsive disorder in a community sample of young adolescents. Journal of the American Academy of Child & Adolescent Psychiatry, 35(7), 898-906.

Weissman MM, Bland RC, Canino GJ, Greenwald S, Hwu HG, Lee CK, Newman SC, Oakley-Browne MA, Rubio-Stipec M, Wickramaratne PJ, & et al. (1994). The cross national epidemiology of obsessive compulsive disorder. The Cross National Collaborative Group. Journal of Clinical Psychiatry, 55, S5-S10.

Wolff M, Alsobrook JP 2nd, & Pauls DL. (2000). Genetic aspects of obsessive-compulsive disorder. Psychiatric Clinics of North America, 23(3), 535-544.

World Health Organization (1992). International Statistical Classification of Diseases and Related Health Problems - 10th Revision. Geneva: Author.

Zohar AH. (1999). The epidemiology of obsessive-compulsive disorder in children and adolescents. Child and Adolescent Psychiatric Clinics of North America, 8(3), 445-460.

Table 1

Classification of Obsessive-Compulsive Disorder

Categories	DSM-IV	ICD-10
A. Presence of recurrent obsessions and/or compulsions	yes	yes
B. Patient realizes they are excessive and unreasonable (not required for children)	yes	yes, but no mention of the children exclusion
C. Severe enough to be time consuming or cause marked distress or significant impairment	yes	yes, but no mention of time consuming
D. If other axis I disorder present, obsessional or compulsive content not restricted to it	yes	mentions comorbidity of depression and OCD – OCD diagnosis preferred only in absence of depressive episode
E. Disturbance not due to direct physiological effects of substance or general medical condition	yes	not mentioned

Food for thought: Will adolescent girls with eating disorders self-monitor in a CBT group?

Shana Nichols, B.Sc., *Joanne Gusella, Ph.D.

Abstract

This study of a Cognitive Behavior Therapy group examined the process of self-monitoring by adolescent females with eating disorders in group treatment. Five females, aged 17-18 with Anorexia Nervosa (n = 2) and Bulimia Nervosa (n = 3), participated in an 8-week treatment group. Self-monitoring occurred on 50% of the days and was highest during the first 3 weeks of treatment. Commitment to monitoring was related to the girls' self-reported readiness to change. Girls with Anorexia self-monitored as frequently as those with Bulimia. The clinical usefulness of self-monitoring with adolescents is discussed.

Introduction

Cognitive Behavior Therapy (CBT) is the most extensively researched and empirically supported treatment for Bulimia Nervosa (Fairburn, 2002), and shows promise with Anorexia Nervosa (Vitousek, 2002). Self-monitoring is considered to be the cornerstone of CBT. Daily food diaries provide a detailed record of eating patterns and weight control practices. Reviewing the diaries reveals the triggers for binge eating and purging, and can increase overall awareness of food consumed. Self-monitoring also has reactive effects (i.e., it can produce a desirable change in the frequency of a target behaviour; Korotitsch & Nelson-Gray, 1999), making it an effective intervention.

Compliance with self-monitoring in adolescents has not been systematically addressed; yet it is crucial to CBT treatment. Failure to comply will increase resistance, and possibly lead to dropping out of therapy. Motivation may play a key role in the willingness to complete food records (Korotitsch & Nelson-Gray, 1999).

The transtheoretical model of change (e.g., Prochaska, 1979) offers a framework for conceptualizing how people make behavioral change. The Stages of Change are: Precontemplation, in which individuals may be unaware of the problem, and unwilling to change; Contemplation, in which they are thinking about change but are not yet ready to make a commitment; Preparation, in which they are intending to change in the near future; Action, in which they are actively involved in making changes; Maintenance, in which they are maintaining the changes made; and Termination, in which the behaviors are no longer a problem. There is evidence that stage of change is related to improvement in therapy in adults (e.g., Franko, 1997) and in adolescent girls (Gusella, Butler, Nichols & Bird, 2003) with eating disorders.

Outcome studies have typically not reported estimates of compliance with self-monitoring, nor has the optimal length for recording been established (Cone, 1999). Given the paucity of data, we do not know how long individuals will self-monitor, and if it loses its effectiveness after a period of time. It is also unclear whether self-monitoring is effective with individuals with Anorexia Nervosa who may become anxious about food consumed (Wilson & Vitousek, 1999). The present study addressed the process of self-monitoring in adolescent girls attending a CBT group.

Method

Participants

All adolescent girls presenting for treatment at the IWK Health Centre undergo a comprehensive diagnostic assessment of an eating disorder using DSM-IV criteria. Group participation is a voluntary option, offered as part of a comprehensive treatment plan. After completion of an initial psychoeducational group, the 9 group members were asked individually if they would like to participate in an Action(CBT) group geared at changing eating disordered behaviors. Five girls, ages 17 and 18, consented to being involved. All girls in the Action stage agreed (n=3), one girl in Preparation, and one girl in Contemplation. The 4 who declined were in Precontemplation (n=1), Contemplation (n=1) and Preparation (n=2). Diagnoses of participants were as follows: Anorexia Nervosa (n = 2), Bulimia Nervosa (n = 3).

Measures

Food and Thought Diary. The diaries were adapted from Fairburn (1985). Girls were asked to record time of eating, food and amount eaten, place, binge/purge episodes, and thoughts and feelings associated with eating. Examples of serving sizes were provided, as well as extra room for journaling, goals, and questions.

Motivational Stages of Change for Adolescents Recovering from an Eating Disorder (MSCARED). As part of the pre-assessment for group participation, girls identified what stage of change they were at based on defining statements corresponding to each stage. For information on reliability and validity of the MSCARED, refer to (Gusella et al., 2003).

Procedure

Our group was a modified version of Fairburn's (1985) CBT model and included psycho-education, behavioral approaches, and cognitive restructuring of distorted thoughts and beliefs. Group sessions were centered around completion of self-monitoring, group feedback on each girl's progress, and weekly goal setting. As the girls reviewed their food

*Joanne L. Gusella, Ph.D.
Eating Disorders Clinic,4th Floor Link, IWK Health Centre, 5850 University Avenue, Halifax, NS, Canada, B3J 3G9 e-mail: joanne.gusella@dal.ca

diaries aloud, the group provided praise and constructive advice. The eight group sessions were each one hour long. To increase motivation to complete the diaries they were designed to blend in with their notebooks, and a signed commitment to self-monitor was obtained.

Results

Length of Self-monitoring:

Out of the 56 possible days for self-monitoring, the girls monitored for 46% of the days (n = 5; M = 20.81 days, SD = 17.31). Each of the girls monitored for a minimum of 18 days (18-53 days), with the exception of one group participant who monitored for only 6 days. A closer look at her pre-group assessment revealed that she was in the Contemplation stage.

Figure 1 illustrates that most of the girls' self-monitoring occurred during the first 3 weeks. Planned paired t-tests revealed that rate of self-monitoring started off high, but dropped off after week 2. In session 4, the importance of self-monitoring was discussed. There was an increase in week 5, followed by a drop to lower than previous levels (see Figure 1).

Differences Across Diagnosis

Monitoring was generally detailed enough regarding the type of food or beverage consumed to allow the dietician to calculate a caloric amount. The girls with Anorexia used more accurate portion size descriptions (e.g., grams, tsps) and their diaries were neat and well organized. In comparison, girls with Bulimia tended to provide more vague descriptors of portion sizes (e.g., a "handful", a "piece"of), and their diaries were often messy and hard to follow.

Clinical Uses of Food Diaries

(1) Plotting frequency of eating disordered behaviors. For the purposes of illustration, data are presented for L.J. (Anorexia), who self-monitored on all but 5 days. Figure 2 illustrates her calories consumed, binges, and purges for each day of group. L.J. attended group while participating in the inpatient program. Calories consumed were adequate (i.e., not restrictive) throughout the course of the group, and it was clear in her diary that her pattern of eating was healthy, generally including 3 meals and 3 snacks per day. However, the frequency of purging remained fairly constant. Binge eating did not occur while she attended the group.

(2) Examining thoughts and feelings. The girls reported both positive and negative thoughts and feelings before and after eating. These descriptions tended to be brief, one to three word phrases. Negative thoughts tended to precipitate and follow binges, while positive thoughts were commonly seen when the girls were experiencing success with their eating goals. Examples of positive and negative thoughts and feelings included: this is yummy, I feel proud, I feel relaxed, I want to get it over with, I'm feeling guilty, and I feel fat.

Discussion

Despite the small sample size and the need to replicate these results, this study provided evidence that adolescent girls with eating disorders are able to self-monitor during a CBT group. However, readiness to change was an important factor. Girls who chose to participate were in Preparation or Action, and ready to make the commitment to self-monitor. One girl in Contemplation made a commitment but was unable to follow through with monitoring, and was ill-prepared to make changes in her eating disordered behavior. Those who declined to be involved in the Action (CBT) group, were all in Pre-Action stages. A question worthy of further research is whether individuals who volunteer to self-monitor as part of a CBT group are self-selecting on the basis of their more advanced stage of readiness to change. The assessment of stage of change may help to explain treatment compliance. Clinically, the results suggest that self-monitoring may be best introduced when the youth is in the Action stage.

Even though the participants committed to self-monitor and every effort was made to support their efforts, girls monitored most consistently for only a three week period. Self-monitoring might be considered a tool that helps youth begin to take action, by learning more about their patterns of eating, their triggers for disordered eating, and their associated thoughts and feelings. However, it appears that once it has served its purpose, adolescents lose interest in completing it. It is not known whether compliance with self-monitoring also drops off for adults over the course of a CBT group. This study found that regardless of diagnosis, girls in the group were willing to self-monitor. We suspect that this reflects their mutual readiness to change. The two girls with Anorexia, were both engaged in normalizing their eating patterns under the direction of their dietitians. One expressed relief when she learned that the other was also eating 3 meals and 3 snacks a day. If one of the girls had not been in Action, and significantly restricting, she may have had a negative influence on the other girl's eating pattern. Youth indicated that the benefits of self-monitoring outweighed the drawbacks. While some found it hard to remember to complete the food diaries, and to face the amounts eaten, girls generally reported that it made them more aware of their patterns, and able to learn from mistakes. As suggested by Korotitsch and Nelson-Gray (1999), the reactive effects of monitoring were evident. One girl reported that just knowing that she would have to complete her food diary pre-empted binge eating. Results of this study demonstrate the clinical usefulness of self-monitoring, and the need to further investigate its applicability and limitations.

References

Cone JD. (1999). Introduction to the special section on self-monitoring. A major assessment method in clinical psychology. Psychological Assessment,11, 411-414.

Fairburn CG. (1985). Cognitive-behavioral treatment for bulimia. In D.M. Garner and P.E. Garfinkel (Eds.), Handbook of psychotherapy for anorexia nervosa and bulimia. (pp. 160-192). New York: Guilford Press.

Fairburn CG. (2002). Cognitive-behavioral therapy for Bulimia Nervosa. In C.G. Fairburn and K.D. Brownell (Eds.), Eating Disorders and Obesity (2nd Edition) A Comprehensive Handbook. (pp. 302-307). New York: Guilford Press.

Franko D. (1997). Ready or Not? Stages of change as predictors of brief group therapy outcome in bulimia nervosa. *Group,21*, 39-46.

Gusella J, Butler G, Nichols L, Bird D. (2003). A brief questionnaire to assess readiness to change in adolescents with eating disorders: Its applications to group therapy. European Eating Disorders Review, 11, 58-71.

Korotitsch WJ, & Nelson-Gray RO. (1999). An overview of self-monitoring research in assessment and treatment. Psychological Assessment,*11*, 415-425.

Prochaska J. (1979). Systems of Psychotherapy: A Transtheoretical Analysis. Illinois: Dorsey Press.

Prochaska J, DiClimente C, & Norcross J. (1992). In search of how people change: Applications to the addictive behaviors. American Psychologist,47, 1102.1114.

Vitousek KM. (2002). Cognitive-behavioral therapy for Anorexia Nervosa. In C.G. Fairburn and K.D. Brownell (Eds.), Eating Disorders and Obesity (2nd Edition) A Comprehensive Handbook. (pp. 308-313). New York: Guilford Press.

Wilson GT, & Vitousek KM. (1999). Self-monitoring in the assessment of eating disorders. Psychological Assessment,11, 480-489.

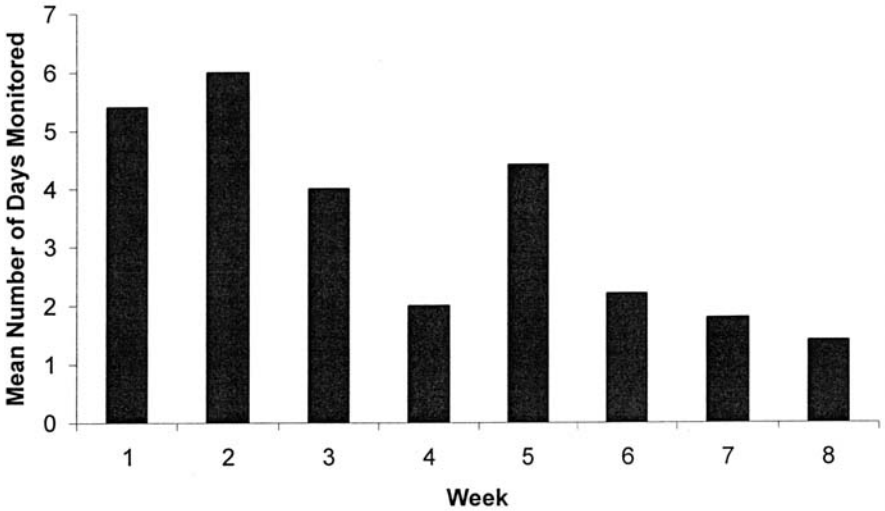


Figure 1. Mean number of days monitored per week of CBT group therapy (N=5 girls).

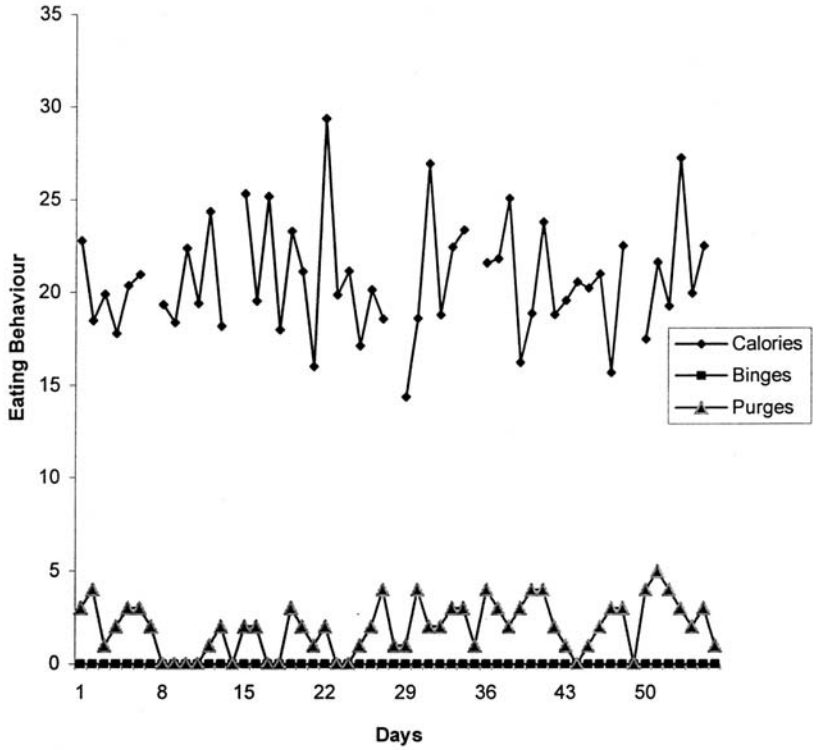


Figure 2. Number of calories (in hundreds) and numbers of binges and purges per day during the 8-week (56 day) group for L.J. No Binges occurred during this period.

The Effects of Massage Therapy & Exercise Therapy on Children/Adolescents with Attention Deficit Hyperactivity Disorder

*Barbara Maddigan, M.D.; FRCPC; Pamela Hodgson, Registered massage therapist; Sylvia Heath, RN; Barbara Dick, yoga therapist; Kimberly St. John, MD, FRCPC; Tina McWilliam-Burton, MD, FRCPC; Christine Snelgrove, MD,FRCPC; Hubert White, MD, FRCPC

Attention Deficit-Hyperactivity Disorder (ADHD) is both a common and disabling disorder. As many as 3-5% of school age children have this disorder, characterized by inattentiveness, impulsivity, and hyperactivity which significantly impairs social, academic, or occupational functioning (Kaplan & Sadock). These patients present frequently to psychiatry for assessment and treatment, and while medications and behaviour modification management help control this disorder, they are not curative. Many parents are seeking alternative therapies for their children, and massage therapy is one such possibility. Massage therapy has been studied in a number of medical and psychiatric illnesses with positive results (American Psychologist, Dec.,1998). A recent study by Field et al 1998, showed massage therapy to decrease fidgeting and improve scores on the Conners Scale (Conners, 1995) in adolescents with ADHD. Massage therapy has also been shown to increase serotonin levels (Field et al 1996, Ironson et al 1996) which might help modulate elevated dopamine levels thought to occur in children with ADHD.

This pilot project had three main objectives: (1) to examine whether massage or exercise therapy would be effective in reducing symptoms or medication dose in attention deficit hyperactivity disorder in school age patients already stabilized on medication and/or behavioural modification; (2) to examine patient and parental compliance with a weekly outpatient clinical session and educational component of daily home-based intervention; (3) to examine the feasibility of using massage and/or exercise therapy with children with ADHD on a larger scale and for a longer period of time.

Methods

Patients previously diagnosed with ADHD, combined type, according to DSM IV criteria who were stabilized on current treatments for the past two months, were randomly assigned to one of three groups: (1) massage therapy, (2) exercise therapy, or (3) control group. All other treatments as prescribed, including outpatient appointments with a primary psychiatrist, social worker and/or psychologist, and medications were continued. All patients were assessed at weeks 0, 6 and 12, by a clinical assessment with the outpatient nurse and a Conners Rating Scale filled out both by the parent and teacher. There was also a questionnaire for patients and families at week 12, and a follow-up phone call to families at week 15. Patients assigned to the control group continued with their regular treatment and follow-up. Patients assigned to the massage or exercise therapy group were assigned 6 - 20 minute sessions given once weekly for 6 weeks, at the psychiatry outpatient department.

Both the massage and exercise therapy interventions took place with parents attending and with patients attired in the normal school clothes. For the massage therapy interventions, the patients lay prone and supine on a massage therapy table. Massage therapy techniques were adapted to each individual and included Swedish, Craniosacral and Manual Lymph Drainage techniques. The exercise interventions were also tailored to each individual and were classical yoga poses chosen to stretch and relax the whole body. Both groups received a handout describing the interventions, instructions for home care, and a home care calendar to mark each day when they spent five minutes or more doing the intervention with their child. Parents watched the interventions and were instructed on how to perform the massage or help with the exercises at home. Parents in both the massage therapy group and exercise group were given an opportunity each week to practice the techniques before leaving and to ask any questions about what they were doing and how the child was responding.

A follow-up telephone call was made by the outpatient nurse to each family 3 weeks after this study's completion. Three questions were asked: (1) Do you have a particular comment on how we can improve this study? (2) Would you take part in another study such as this? and (3) Was this a positive or negative experience for you and your child?

Unfortunately, due to recruitment issues and 3 drop outs, the sample sizes were small, with 3 in the massage therapy group, 3 in the exercise group, and 4 in the control group.

The Conners Scale used was the short version (Connors), and the clinical assessment done by the outpatient nurse on each patient covered areas such as social functioning, self-control, academic functioning, mood, affect, neurovegetative features, family functioning with respect to child, and medications and other treatments were recorded. Parents were instructed during the last 5 minutes of the exercise and massage therapy groups how to perform either an exercise or a massage therapy technique with their children at home every night for the following week.

*Correspondence to: B. Maddigan, Dept. of Psychiatry, Janeway Child Health Centre, 300 Prince Philip Drive, St. John's, NL A1B 3V6 bmaddiga@mun.ca

Results

All parents involved in this study indicated that this was a positive experience for them and their children. The Parent Conners Scale also indicates an improvement in the Conners Rating Scale for children in the massage therapy group. (See graph 1-4) These results were not evident however, in the Teacher's questionnaire. We would have liked to have done the 12 week Teacher's Conners Scale, but due to the timing of the study, this was unable to be obtained.

The clinical assessment done by the outpatient nurse illustrated a positive response with both the massage and exercise group. Positive comments reported after 6 weeks in the massage group were better anger control, improvement in mood, more restful sleep and an improvement in social functioning in 2 of the 3 participants, and improvement in focusing at school. All found it relaxing and felt comfortable with the technique. One parent reported a sense of closeness between her and her child. In the exercise group it was reported that there was improvement in the ability to do homework and to cope in stressful situations. Balancing and flexibility had also been noted to be improved.

The overall response from the home record was positive. In the massage group, comments included a sense of closeness between mother and child, more periods of relaxation, and settling better at night. The home record from the exercise group was also positive with reports of improved concentration, balance and flexibility.

The satisfaction questionnaire from the massage therapy group revealed that the experience was an enjoyable one with moderate improvement in behaviour and concentration. The exercise group gave a similar report with findings of improvement in relaxation, flexibility and concentration. Both groups scored an average of 4 out of 5 on their satisfaction questionnaires. The score for the control group was 3.5/5 with moderate enjoyment of the study with an indication that they would have preferred to be in the massage therapy or exercise group. All, however, indicated they would be interested in participating in another similar study.

The follow-up phone call was also very positive in that all families indicated that they would participate in another study such as this and all said that it had positive effects on them and their children.

Overall negative comments were few and included: Massage Group; at home the child was not always compliant and only wanted it done certain times. Exercise Group: the patients didn't like participating with the parents at home and had difficulty holding poses. Also, most parents would like to have had longer teaching sessions.

The percentage of children on Ritalin was 70%. The percentage of children receiving other multidisciplinary interventions such as psychology and social work was 30%.

Discussion

Although the objectives of this project are difficult to comment on due to the small sample size, and thus clinically significant data is lacking, the experience of both the patients and the families was positive. There was also a trend of improved symptomatology evident within the massage therapy group, coupled with an enthusiasm by the families with regard to this treatment.

The increased scores between the 0 and 6 week Teacher's Conners Scale for the massage and exercise group may indicate an increase in awareness of the teacher on these issues in that particular student. Also a letter from one teacher pointed out that most children tend to be more excited, active and inattentive at the end of the school year. The lack of criticism by patients and families must be tempered with the possibility of participants' reluctance to offend the research team. None of the parents commented on difficulties attending the sessions and there were particularly positive comments for the children in the massage and exercise group stating that the children enjoyed this activity and the parents found this to be of benefit for them. The home record compliance was variable among the participants.

There were a number of difficulties associated with this project. The sample size was small. Initially we thought that it would be relatively easy to recruit a larger number of patients for this study. However, parents' ability to attend regularly became a factor as transportation for families was an issue, which led to the drop out of at least 2 families. Most children who are stabilized on their medication are referred back to their family doctor and thus patients in our practice are usually not yet stabilized. The actual hospital location also changed during the study and may have been disruptive. The 12 week Teacher's Conners Questionnaire could not be done because the school year had ended, as recruitment difficulties led to delay in starting the study. Parents were asked to come to six sessions of either massage or exercise therapy, and most families missed at least 1 to 3 sessions. Although no one commented on this in the follow-up telephone call, 6 sessions may be too many given other commitments that families have.

The massage therapist noticed that the parents in her group expressed a sense of satisfaction in being able to be an active, helpful participant in the treatment of their children. They felt that doing the massage therapy at home gave them a positive physical contact with their children. It was an opportunity to connect with their children in a non-authoritarian, care giving manner.

The exercise therapist noted that the completion of the exercise at home for the parent and child was more challenging for the parent in that they needed to act in a more authoritative role with this intervention. She did note that all children involved in her group were very enthusiastic about the exercise, and said that they enjoyed doing it. Taking into consideration the parent/child interactions observed by the exercise therapist during this intervention, it may be beneficial for the parent to be either actively involved with the exercise, or not present in the room. The exercise therapist went on to suggest that perhaps an exercise group for the children within a hospital setting would be an effective way to help teach the children the yoga exercises with parental involvement. She also noted that one of the children who was also

involved in Tae Kwan Do found the yoga exercises very enjoyable and continued his practice at home.

These encouraging results lead us to feel that there is some promise in this area for further research. We would redesign a future study to focus on an inpatient group where patients do not have to travel to obtain treatment. An alternate option would be to decrease the sessions possibly from 6 massage/exercise sessions to 3 and increase the parental instruction, to address comments made by parents that they would like more time with the hands on instruction.

With mounting parental dissatisfaction being expressed in our clinics, with stimulant medication for children with ADHD, alternative therapies deserve further research.

References:

American Psychiatric Association, 1994 Diagnostic and statistical manual of mental disorders. 4th ed. Washington (DC): APA.

Conner Keith C, Ph.D., 1989, 1990. Conners Rating Scales Manual.

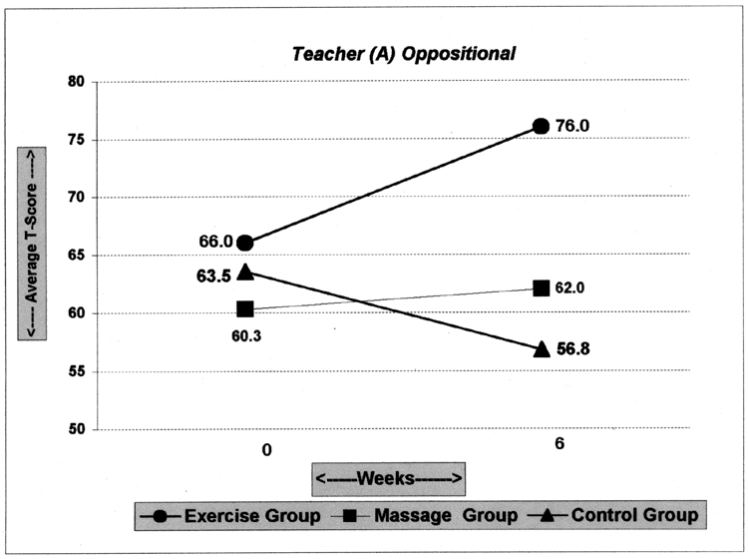
Field TM. et al, (1998) Adolescents with attention deficit hyperactivity disorder benefit from massage therapy. Adolescent, 33, 103-108.

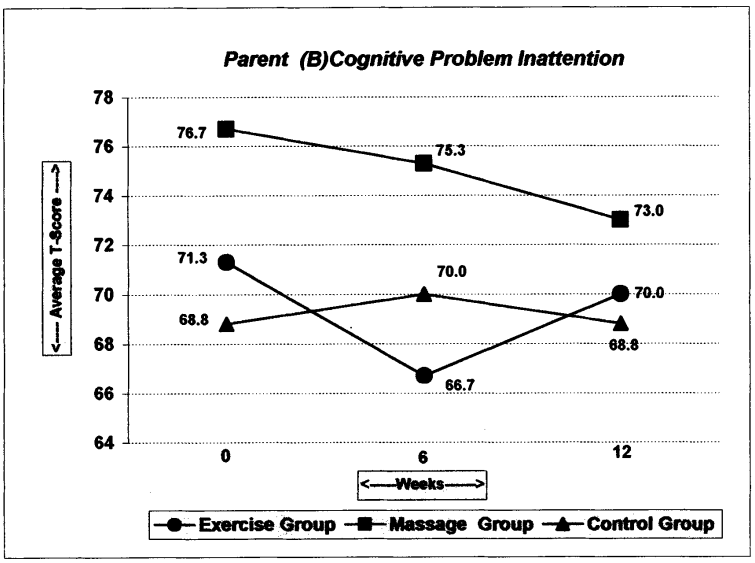
Field TM. (1998) Massage therapy effects. American Psychologist 1270-1281, Dec. 1998.

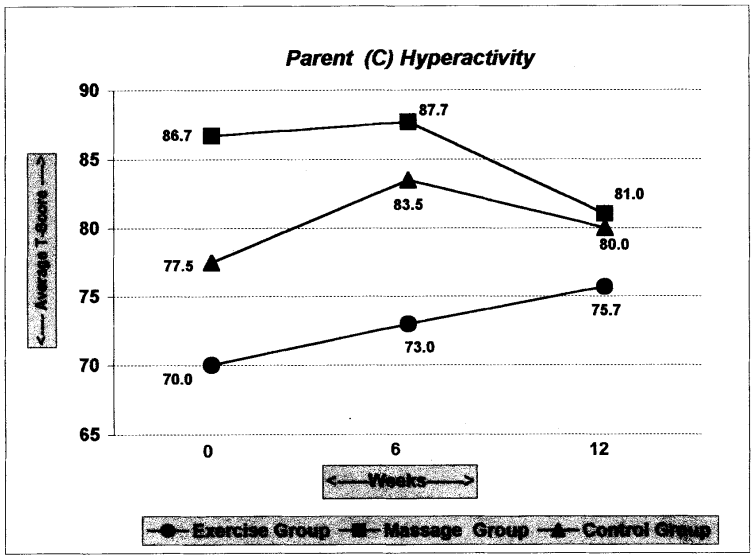
Field TM., (1996) Massage therapy for infants of depressed mothers. Infant Behaviour and Development. 19. 109-114.

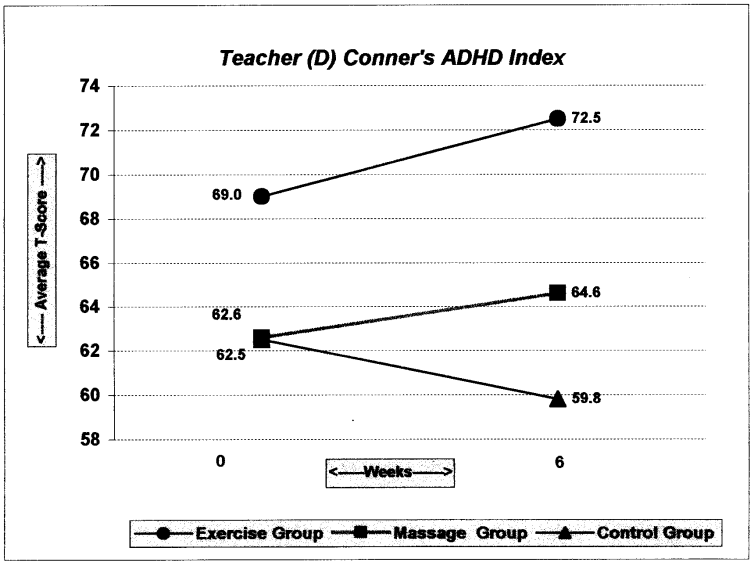
Ironson G. (1996) et al. Massage therapy is associated with enhancement of the immune system cytotoxic capacity. International Journal of Neuroscience. 84. 205-218.

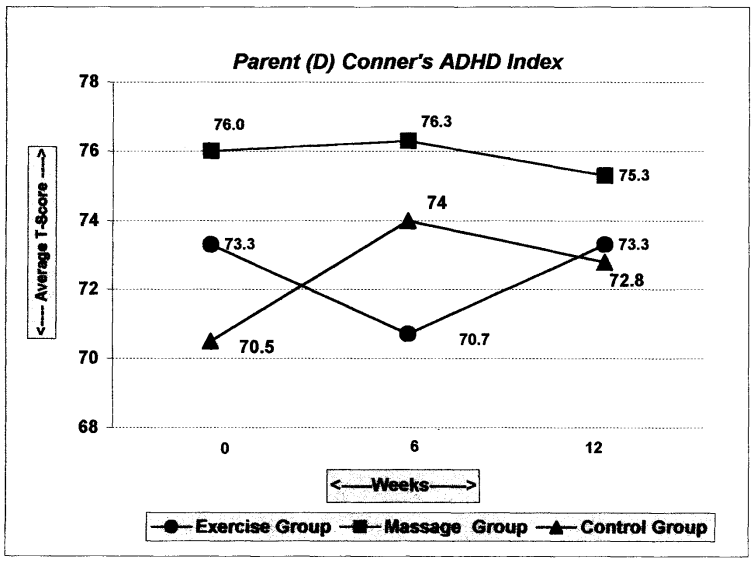
Kaplan H, Sadock B, Grebb. (1994), Kaplan and Sadock's Synopsis of Psychiatry, 7th ed, Baltimore, Williams & Wilkins.






Parent (C) Hyperactivity
90
85
80
75
70
65
86.7
87.7
81.0
83.5
80.0
77.5
75.7
73.0
70.0
0
6
12
<---Weeks--->
<--- Average T-Score --->
Exercise Group
Massage Group
Control Group


Teacher (D) Conner's ADHD Index
74
72
70
68
66
64
62
60
58
72.5
69.0
64.6
62.6
62.5
59.8
0
6
<---Weeks--->
<--- Average T-Score --->
Exercise Group
Massage Group
Control Group


Parent (D) Conner's ADHD Index
78
76
74
72
70
68
76.0
76.3
75.3
74
73.3
73.3
72.8
70.5
70.7
0
6
12
<---Weeks--->
<--- Average T-Score --->
Exercise Group
Massage Group
Control Group

Letter to the Editor

Case Report: Body Piercing and Reduction of Repetitive Self-Injury

Dr. Laurence Jerome
M.B.Ch.B.,M.Sc.,M.R.C.PSYCH., F.R.C.P. (C)

To the editor:

I would like to report a clinical observation in support of the recent article by Nixon et al (1), "An Open Trial of Auricular Acupuncture for the Treatment of Repetitive Self-Injury in Depressed Adolescents".

The case involves a sixteen-year-old girl with a three to four year history of cutting behaviour at times of stress. The initial assessment revealed that she had reported being sexually abused a number of years earlier when the family was living in England. She had not disclosed this to the family until recent times. The family was in a state of flux and the mother was emotionally unavailable to the child because of her work. The patient was experiencing difficulties academically and socially and was engaged in a number of impulsive sexual relationships with boyfriends.

Therapy involved a combination of individual cognitive behavioural and family therapy. Medication management trials of antidepressants and stimulants as well as mood stabilizers produced relatively little benefit.

The patient reported that she experienced significant reduction in stress when she cut her forearms. The effect was short-lived and appeared to have a repetitive addictive quality subjectively.

Throughout the therapy she had a number of body piercings mainly in her ears as well as her tongue. She reported that every time she had a new body piercing she experienced significant reduction in the urge to cut that could last up to 6 weeks at a time. The most beneficial body piercing was in her tongue. She described being able to play with the tongue ring by rolling it around inside her mouth at times of stress and self-induce a state of relaxation. This could be done without it being visible to other people.

This seemed to enhance a degree of self-control. Her mother was quite opposed to the frequency with which she had new body piercings and seemed unaware of the potential benefit in terms of stress management that this seemed to confer. However, she independently observed that the frequency of the cuttings reduced for a period of up to 6 weeks after her new piercing.

One may conceptualize cutting behaviour as an attempt at self-calming and self-soothing that becomes maladaptive and repetitive with addictive qualities. Explanatory models of harm reduction utilized in management of substance abuse may offer a possible understanding of the benefit of this phenomenon in both this case and the article by Nixon et al.

Utilizing an addiction model, body piercing may be seen as reducing addictive behaviors by enhancing self-control. This could be seen as a form of harm reduction of impulsive and addictive behaviors analogous to attempts to reduce the frequency of substance use and related negative psychosocial consequences. This case is offered as a further example of a practical management technique similar in form to auricular acupuncture that may enhance self-soothing and reduce the frequency of more overt and socially disapproved self-harmful behaviors in individuals with poor impulse control.

One important caveat would be that this procedure should be done under sterile conditions to avoid the risk of infection.

REFERENCES

Nixon MK, Cheng M, Cloutier P. (2003). An Open Trial of Auricular Acupuncture for the Treatment of Repetitive Self-Injury in Depressed Adolescents. CCAP Review, 12:1 10-11.

Notice...

The February 2003 edition of Canadian Child & Adolescent Psychiatry Review published an article titled "A Report from the Advocacy Committee, POLICY STATEMENT: CORPORAL PUNISHMENT". Inadvertently a preamble was omitted that contained the authors' names and indicated that the article was a DRAFT statement only and that it was submitted to invite commentary from the CACP membership. We apologize for this error.

The authors of the draft statement, Dr. Ellen Lipman, Dr. Harriet MacMillan and Dr. Wade Junek invite comments. Your replies can be forwarded to Dr. Herb Orlik, Chair, Advocacy Committee, c/o Maritime Psychiatry, IWK Health Centre, 5850 University Avenue, Halifax, NS B3J 3G9 or e-mailed to horlik@dal.ca

Book Reviews

Anxiety Disorders in Children and Adolescents: Research, Assessment and Intervention.

Wendy K. Silverman and Philip D.A. Treffers (Editors). Cambridge: Cambridge University Press. 2001. 402pp. $64.95 U.S.

This book arose from an international research conference on anxiety disorders in children and adolescents, held in Leiden, The Netherlands, in May 1997. While 12 of its 16 chapters started as papers presented at the conference, they were "extensively revised or fully rewritten" for this volume. The other four chapters were written specifically for this book. Fifteen of the book's 25 authors are from Europe, the remainder being from North America, Israel and New Zealand.

Anxiety disorders are examined from many perspectives. An unusual and interesting contribution, written by the editors, is the opening chapter on "Anxiety and its disorders in children and adolescents before the twentieth century." It emerges that Hippocrates (460-370 BC) referred to anxiety in children in his *Aphorisms*. After that little attention seems to have been paid to the subject until the Middle Ages, but from the sixteenth century onwards there was much discussion of sleep disorders, nightmares, enuresis, hysteria and melancholia. Sadly, it seems that psychiatrically disturbed children were among the victims of the witch burning of the sixteenth century. Gradually, however, the care of those suffering from mental illness was brought into the domain of doctors and away from the clergy. By the latter part of the nineteenth century anxiety played a prominent place in the literature on child and adolescent psychiatry.

The remaining chapters range widely, examining the possible contribution of genetic, developmental, cognitive, social, attachment and neuropsychiatric causes. Other chapters deal with post-traumatic stress disorder, epidemiology, treatment and prevention. The two chapters on treatment are the weakest. The one on "psychosocial interventions" is confined mainly to a review of the efficacy of various forms of cognitive-behaviour therapy. Virtually, no mention is made of the possible value of family therapy, nor is there discussion of individual, non-cognitive, psychotherapeutic approaches.

The chapter on "pharmacological treatment" is better. It concludes, appropriately, that, "for most anxiety problems, non-pharmacological interventions, such as cognitive-behavioural therapies, family interventions or behavioural programmes are the primary treatment." It's a shame that family interventions are not given more attention, though behavioural programming is dealt with elsewhere in the book.

Throughout this book the emphasis is on examining the scientific evidence for what is presented. This is, no doubt, because most of the chapters had their origin in an "international research conference." Thus, each chapter is followed by an extensive list of references and the book will be a valuable source of additional information.

Most of the chapters are well written and make for easy reading. This does not, however, apply to Chapter 5, on the "Neuropsychiatry of Paediatric Anxiety Disorders," in which long, tortuous sentences with redundant words, abound. For example: "Our understanding of the neurobiology of anxiety has been propelled by new pharmacological therapeutic tools specific in their impact on certain central nervous system (CNS) receptors within the 'stress-response system'." Surely that could be said more simply!

There is much of value in this book, which should certainly be in the libraries of centres in which children or adolescents with anxiety disorders are treated or assessed. There will be few professionals who work with anxious children who will not learn something new from it.

Philip Barker,

Professor Emeritus of Psychiatry, University of Calgary

Defiant Teens: A Clinician's Manual for Assessment and Family Intervention.

Russell A. Barkley, Gwenyth H. Edwards, Arthur L. Robin. Guilford Press, NY. 1999. 198pp $35.00 U.S.

The management of disruptive behavior disorders is the "bread and butter" of child and adolescent clinical practice. This updated approach by Barkley et al is a welcome addition to his previous work in this area.

This multi-authored book is a sequel to Barkley's early books on Defiant Children and provides an updated approach placing disruptive behaviors within a developmental context. Whilst growing out of previous clinical work in the manuals on defiant children, the authors set a clear developmental frame for working with adolescents who need to "buy-in" to any treatment approach that is going to have a chance of success. They describe a behavioral contracting approach that is enhanced by its emphasis on developing an understanding for both the parent and the adolescent of the underlying cognitive distortions and techniques to manage and reframe these maladaptive attitudes within the family. The book is based on extensive clinical experience as well as the findings from on-going research funded by the NIMH.

In Part 1, the rationale for the program and the clinical assessment of defiant adolescents and their families is outlined. The differential diagnosis with severe conduct disorder and co-morbidity issues with ADHD, mood and anxiety disorders and substance abuse are clearly spelled out along with clear expectations and contraindications for using this approach. The program calls for orientating the parents to the approach (Chapters 1 through 9) before moving on to Problem Solving Communication Training (PSCT) with the family and the adolescent. PSCT therapy appears to be a "user-friendly" family based approach to cognitive behavior therapy for families complete with handouts to provide structure to "homework" tasks so essential in this approach.

Part 3 provides well-written assessment materials generating behavioral profiles from the adolescent, the parent and the school as well as the usual child, family, developmental and medical history.

In Part 4, the parent handouts cover general principals of behavior change, antecedent, behavior and consequence analysis, behavioral contracting, and recommendations for schools for ADHD management. Legal school issues are written from an American perspective and are not directly relevant to Canadian legislation. The handouts outlining the Cognitive Behavioral Therapy framework are practical and well done. These include steps to better problem solving, problem-solving worksheets, problem solving exercises (Homework), communication habits and

two charts on unreasonable beliefs, one for parents and one for adolescents.

The handouts, which can be photocopied for individual families, are excellent. The applicability to outpatient work has been well demonstrated empirically. The authors emphasize the factors that predict success and those that militate against the use of this approach at least until the adolescent or the marriage or the parental psychopathology has been addressed. The value of treating concurrent parental psychopathology such as adult ADHD is particularly relevant given the high prevalence in families with adolescents with disruptive behavior disorders and ADHD.

The authors point outthe need for further research on early treatments addressing co-morbidities in the adolescents and their parents in order to open the door for this approach to be more successful in those families that we are commonly asked to help.

This book is well written and a worthy text for one of the "bread and butter" disorders of our work.

Laurence Jerome MD, FRCPC

Early Experience and the Life Path.

Ann Clarke and Alan Clarke, Jessica Kingsley, London and Philadelphia. 2000. 126 pp., $28.00 (Canadian), $19.95 (U.S.) Paperback

This book should be required reading for all mental health professionals. Drawing on their 40 years of work and reviewing a wide body of research, British psychologists and researchers Ann and Alan Clarke argue that the presumed permanent adverse effects of experience as an infant can have unwarranted negative influences on mental health practices and policy. This belief in the special or even overwhelming long-term effects of early adversity is deeply embedded in our culture and reflected in popular literature and journalism as well as some professional schools of thought. Interestingly, the Clarkes refer to a similar publication in 1976, Early Experience: Myth and Evidence with contributions from Bronfenbrenner, Kadushin, Kagan, Rutter and Tizard, which, they believed, contained overwhelming evidence for their conclusion that children could recover from earlier deprivation. Continuing to monitor the research and literature in this field, however, they concluded that another review of the evidence was necessary.

The Clarkes state that early experience is a first step on a long and complex path through life. By itself, this first step does not determine a child's future and may in fact, have little long-term influence. Biological, psychosocial, transactional and chance factors all play a part and have an impact throughout a person's lifetime. There is no known adversity from which at least some children have recovered if moved to a more positive environment. Early experiences, either negative or positive, may be reinforced and perpetuated by transactional experiences leading to a chain of good or bad events.

After discussing the difficulties of extrapolating from longitudinal studies, the authors accent the continuities and changes in long-term development and note that early characteristics, such as IQ and personality traits, are poorly correlated with adult equivalents. They point out that many highly competent and mature adults have survived an extremely troubled and confusing childhood, and that many bright and successful children fail to fulfil their earlier promise. The chapter on children rescued from very severe adversity documents considerable improvement in young children from concentration camps and orphanages who were placed in adoption or foster homes and some intriguing case examples illustrate their arguments. One is of identical twin boys whose mother died shortly after birth. They were cared for by a social agency for a year, fostered by an aunt for 6 months, and then returned to their father. His new wife kept the twins locked in the cellar for the next five and a half years. Discovered at age seven, they were very small, lacked speech and suffered from rickets. Doctors confidently predicted permanent physical and mental handicap. But after special schooling and adoption by exceptionally dedicated women they became adults who appear normal, stable and enjoy warm relationships. One is a technical training instructor, the other a computer technician.

The chapter on outcomes in children who were removed from situations of less severe adversity or received interventions such as the Headstart Program summarises much interesting research. For instance, studies of children placed in foster care indicate, "The outcome is generally much better than professional prejudice suggests." In a final chapter, where possible contrary evidence is sought, Rutter's recent research on a large cohort of children who were adopted from Romanian orphanages is examined. These infants were in appalling conditions. There was no personalised caregiving, little or no stimulation, few if any playthings, and most were confined to their cribs. They were fed with gruel from propped up bottles. It comes as no surprise that children who were subjected to these conditions for more than six months were less likely to make the very substantial gains documented in younger adoptees.

The authors maintain a scholarly and dispassionate approach throughout, carefully examining the evidence for various theories and propositions. While they provide some historical background about the belief in the monumental importance of infant experiences, they offer no suggestions about its current persistence. This reviewer wonders whether the current state of the world will further this belief. It appears to reflect an understandable wish to simplify an otherwise scary and unpredictable world and provide an infant with a permanent protective amulet against the slings and arrows of later misfortune.

Sue Penfold MD, FRCPC

Empathy and Moral Development: Implications for caring and Justice.

Martin L. Hoffman. Cambridge University Press. Cambridge, UK. 2000. 331 pp. $39.95 UK.

Empathy and Moral Development represents the life's work of Professor Hoffman, integrating over 30 years of research with information and ideas gleaned from the psychological and social development theories of the last century. Starting with biblical concepts of sin and guilt and drawing on the germinal theories of historical figures such as Rousseau, Freud and Piaget, the author also discusses Kohlberg's theory and modifications by later followers.

The first chapter begins with a brief overview of the previous and current theories and the historical sources for the book, giving clear definitions and outlining the theory to follow. Each of the seven sections of the book expands on important key concepts introduced earlier. There are frequent references to and review of the previously discussed material. The first section of the book explains the "innocent bystander" model that has been used

for decades to explore human moral development. Concepts from animal arousal and behavior models are linked with human infant research on early affective and cognitive development. The research quoted is illustrative and extensive. The section ends with a discussion of the differences between empathy, guilt, sympathy and injustice. Parts Two and Three introduce the concept of guilt and how parental discipline interacts with a child's cognitive skills to guide moral development. This first half of the book could have been expanded further through the use of more examples and further exploration of how genetics and innate brain processes contribute to the development of empathy. Hoffman also seemed to emphasize the psychosocial aspects over the behavioral cognitive and genetic aspects, but it is a good review of the field to date.

The second half of the book is very interesting. The examples given are more current, complete and involved. The author shines as he discusses his integration of existing theory and research into a comprehensive model. He sketches a brief picture of different types of guilt, and a theoretical hierarchy. He expands on his assertion that both parental discipline and peer interaction are necessary for the development of guilt and morality. His collected statistics on parental discipline and its effects on children's moral development are impressive. He explains why empathy can operate in some situations and can be overwhelmed in others, even when the individuals involved are highly empathic (i.e. therapist burnout). Numerous examples are given of how guilt and empathy are motivators for human action, especially prosocial and "altruistic" actions. In light of the events of September 11, 2001, Hoffman's concepts explain much of the individual and social group actions which followed.

Section Four of the book asks the question "Is Empathy Enough" to explain moral action. Types of bias which may affect empathy and moral action are examined. Empathy's self-destructive and self-limiting qualities are explored and integrated in Darwinian fashion. Hoffman states that a morality based on empathy alone would not be fair in large mixed or larger human groups and would lead to bias and conflict. To live together peaceably, Hoffman insists that empathy must be embedded in moral principles, the subject of the fifth part of the book. Hoffman shows how empathy (affect) becomes linked or bonded to moral principles (of cognitive and social origin) as the person develops. The synthesis is used powerfully to explain the perpetuation of social attributes of caring and justice in western society. Useful definitions of key concepts in justice research are included.

Parts six and seven of the book are the slimmest and cover culture, wherein issues of the universal applicability of the key concepts are examined, and intervention, which hopefully can someday be expanded into its own volume. A few directions in designing empathic training for use in young offenders and other children at risk are given, but not in the kind of depth currently desperately needed in the field.

The book is well organized in its scant 300 pages and set up as a graduate course. It is an easy book from which to learn. It would make an ideal text and makes for a brilliant discussion overall, as it presents the author's theory that will, no doubt, form the basis for future research and intervention in this area.

Lori Ann Vogt

Genograms: Assessment and Intervention. 2nd Edition.

Monica McGoldrick, Randy Gerson and Sylvia Shellenberger. WW. Norton and Co., N.Y. 1999. 243pp. $17.00 U.S.

This book, now in its 2nd edition, provides a useful review of the theory and clinical application of the Genogram. Through the vehicle of illustrative examples of famous families from the world of entertainment, politics and therapy, the reader is taken through the process of working with a family and producing a functional model of a family over time. The purpose of the genogram can be as diverse as conventional recording of a family medical history to mapping out the complex interrelationship of families to their biopsychosocial environment. As the authors point out, not all systems theorists have paid homage to detailing a family's history, preferring in some cases, such as Minuchen, to focus on immediate family relationships or, as Haley would have, to avoid a "family ghost." The genogram approach involves a process of "mapping out" multigenerational transmission of family patterns on the assumption that this knowledge will allow families to make more informed alternative choices for their future.

The book contains 90 genograms, illustrating the development of family genograms, by utilizing the famous families mentioned earlier. There are 8 chapters which cover developing a genogram, interpreting family structure, relationship patterns and triangular relationship patterns, assessing family roles, function, balance, resilience and resources. There are specific chapters on tracking families over time, on clinical use and on research applications.

The chapter on clinical application has the ring of clinical truth and would be a helpful read for the novice therapist as well as the more experienced clinician. The authors argue that the method of engaging the family in a common task of constructing their own family tree is "empowering " and creates a focus on the family process away from diversion towards or "scapegoating " the individual. Through the story of clinical case material the reader is taken through the clarification of family patterns, reframing and detoxifying family issues and using the genogram to design interventions. The application of rituals as a way "transforming" loss is discussed.

The chapter on research application gives some fascinating information on high levels of inter-rater reliability in a short 16-minute interview, which captures key elements for constructing the genogram. Computer soft ware is now available to automate the process, allowing family members to interact with the computer and generate their own genogram in response to standardized prompts. Different versions of the family over time, key family events and individual histories can be generated by the programme and printed of for the family to take home and work on between sessions.

Despite this being a multi-authored book, the writing is clear and speaks to the reader with one voice. There are good references to each chapter. Whilst not being a manualized approach to family therapy, this theoretical exposition of an important approach to families is worthy of a place in the child psychiatry departmental library, if not on the residents' bookshelf.

Laurence Jerome MD, FRCPC

Helping At-Risk Students: A Group Counseling Approach for Grades 6-9.

Jill Waterman, Elizabeth Walker. Guilford Press, New York, N.Y. 2001. 221 pp. $30.00 Paperback.

This book is a manual for a curriculum entitled SPARK which is administered to students in grades 6 to 9 at-risk for mental health problems. The curriculum is intended to 'spark' greater student achievement, social-emotional growth, and nonviolent responding. A group process model aimed at developing

interpersonal skills is combined with a psycho-educational model focused on building competency by development of specific skills such as anger management, interpersonal conflict resolution, effective study skills, communication tools, and peer pressure resistance.

The book is divided into three chapters. In the first chapter, the authors provide useful guidelines for setting up and leading groups. In selecting group members they consider factors such as gender, ethnic composition, grade level and group size. SPARK groups are based on a 15-session model with seven modules. The modules address issues salient for at-risk youth: Trust Building and Communication Skills; Anger Management and Problem-Solving Skills; Ethnic Identity and Anti-Prejudice; Educational Aspirations; Peer Pressure and Gangs; Exposure to Violence and Post-traumatic Stress Reactions; and Family Relationships. There is flexibility in the number and order of the modules but the authors stipulate that all groups should begin with the Trust Building and Communication Skills module. The groups are activity-based, engaging, and interactive.

Each session begins with a check-in, which allows each student to share experiences or feelings that have occurred in the last week. The leader introduces the module, the goal and the activity for the week. At the end of each session, students participate in 'checkout' where they discuss what they learned and share their feelings about the session.

The authors describe six characteristics of the most successful group leaders. They do a pre-group interview in order to obtain student assent and gather information about the student. Tips on how to present the group to prospective members are provided. The authors describe group counseling techniques such as developing trust, understanding confidentiality, building group cohesion, empathic responding and reflections. Issues pertaining to group process such as pointing out verbal versus nonverbal communication and processing interpersonal issues between group members are addressed. The challenges for group leaders such as child abuse, suicidal ideation and members who do not participate are acknowledged and strategies to manage them are outlined. Parameters of the group leader role including participation in activities; self-disclosure by leaders; and respecting one's own feelings are described. At the end of the group the participant is involved in a post-group interview in order to assess whether the group has been helpful.

The second chapter describes the SPARK Curriculum in detail. The choice of the curriculum content after Module One is based on a psycho-educational model aimed at developing skills to alleviate common problems for high-risk youth. It begins with a module on Anger Management and Problem solving Skills. The anger management and problem-solving techniques advocated in this module are taught, emphasized, and reinforced throughout the rest of the curriculum to continue and expand skill building. The other modules were selected because they represent areas of significant concern for at-risk youth. For each module the goal, an overview of the sessions, the activities and materials are described in detail. The authors discuss the content of each module and provide specific questions that could be utilized.

The third chapter, which discusses the effectiveness of the SPARK groups, is brief. The authors describe the demographics of the students who participated. The groups appeared to be effective in academic achievement, psychological adjustment, self-esteem, peer connectedness and attachment. However, the authors believe that their measure of physical aggression was of questionable validity, explaining why no significant decrease in physical aggression was reported.

The last section of the book is the Appendices which provide samples of the referral form; a sample script for presenting SPARK groups to potential group members; parent consent form; student assent form; and pre-group and post-group interviews. These examples are very helpful, especially for the novice group leader. Some of the questions asked of group participants such as community violence exposure and gang involvement would seem to pertain to youth living in large American cities. The authors give scoring instructions and information about the interviews that is confusing. In addition to the written instructions, a sample questionnaire with scoring might have been more helpful. They provide curriculum materials and handouts in English and Spanish.

Overall, this is very practical, useful book that outlines a school curriculum for students in grades 6 to 9 who are at-risk for mental health problems. Mental health professionals in individual or group counseling could also use the activities.

Margaret Steele MD, FRCPC
London, Ontario

Imaging the Impossible: Magical, Scientific, and Religious Thinking in Children.

Karl S. Rosengren, Carl N. Johnson, and Paul L. Harris. Editors. Cambridge University Press, Cambridge, UK. 2000. 418 pp. Hardback $64.95 US; Paperback $24.95 US

This book has a very enticing title. "This volume is about the development of human thinking that stretches beyond the ordinary boundaries of reality" (page xiii). The book presents research and academic analyses of the thinking processes of children about magic, science, and religion. The three Editors have selected a collection of 13 chapters from 22 authors from the United States, France and United Kingdom. The authors are from University Departments of Psychology, Educational Psychology, Experimental Psychology, Speech Communication, and Education; and most of the references are from these disciplines. I decided to write this review without looking at the recent review of this book in the December 2001 issue of the Journal of the American Academy of Child and Adolescent Psychiatry.

Although adhering to the main theme of human thinking beyond reality, the 13 chapters provide a wide range of exploration. My four favourite chapters are 1, 8, 9 and 10. Chapter 1: "The Makings of the Magical Mind" introduces a definition of magic and research on a subset of magic, called sympathetic magical thinking. The authors of this chapter propose that magical thinking is useful in thinking about situations that current knowledge cannot explain, and observes that people tend to blend both scientific and magical thinking into everyday life situations. Chapter 8: "Versions of Personal Storytelling/Versions of Experience" analyzes the use of speech genres, such as fairy tales, myths, parables, and personal storytelling from a communication perspective. Speech genres communicate a personal aspect of reality or imagined reality, but it is also strongly influenced by larger systemic family or societal genres.

Chapter 9: "The influence of Religious Beliefs on Parental Attitudes about Children's Fantasy Behaviour" is my favorite chapter with an interesting discussion on imaginary companions in three different family contexts: Hinduism, Fundamentalist Christian; and Mennonite faith. It is an interesting fact that 28% of North American children have imaginary companions (page 251). Fundamentalist Christians view fantasy as a form of deceit and discourage their children in believing in Santa Claus, because in discovering that Santa Claus is a myth will lead them to question also the existence of God.

A humorous jewel was that the words 'Santa' and 'Satan' have the same letters (page 254). Chapter 10: "Religion, Culture and Beliefs about Reality in Moral Reasoning" discusses how children and adults would use moral judgment if God had condoned stealing as one of the commandments. This chapter also includes a discussion on the balance between individualistic and collectivistic thinking in India.

There are two chapters presenting experimental data on the cognitive processes of children. Chapter 2:"Phenomenalistic Perception and Rational Understanding in the Mind of an Individual" presents research findings on a group of six- and nine-year old children in an experiment, which uses a wooden box to create a magical impression of sudden spontaneous transformation of a postage stamp into different objects. Chapter 4:"The Development of Beliefs about Direct Mental-Physical Causality in Imagination, Magic and Religion" presents research data on a group of fifty preschoolers on their concept of 'wishing'.

The other seven chapters are also discussions of high academic caliber on various aspects, such as magical thinking (Chapter 3), how children's religious beliefs differ from adults (Chapter 5), empirical and metaphysical questions used by children (Chapter 6), how metaphysical thinking challenges Piaget's work on children's cognition (Chapter 7), the distribution and development of creationist and evolutionist thinking in children (Chapter 11), 8 categories of responses to anomalous data (Chapter 12), and the historical interaction between theology and scientific thought (Chapter 13).

As a child psychiatrist looking for further clinical insight, reading this book was not easy because of its distance from clinical literature. As a person trained in science and working with children, there were many informative chapters. This topic of thinking beyond reality is neither easy to research nor easy to quantify. The editors have done well in putting together such an extraordinary collection. As a clinician, this book is too academic, but filled with nice-to-know information. For the researcher of children's cognitive processes, this is an important book on that which is usually left out or forgotten: the magical or religious thoughts of children.

David Shih, MD, FRCPC
January 2002

Psychological and Developmental Assessment: Children with Disabilities and Chronic Conditions.

Rune J. Simeonsson and Susan L. Rosenthal, Editors. Guilford Press. N.Y. 2001. 386 pp. $60.00 U.S.

This book is a 'must read' for child psychiatrists, developmental pediatricians and clinicians who work with children with disabilities.

The editors Rune J. Simeonsson and Susan L. Rosenthal have proven that scholarly books can offer practical dimensions. This book has contributions from the fields of school psychology, pediatrics, human development, neuropsychology, rehabilitation counseling, pediatric psychology and psychiatry.

One can confidently say that the majority of contributors are from various fields of psychology as the format of chapters is quite uniform and the whole book is laid out in an orderly categorical fashion. The book is divided into four main parts.

The first part addresses dimensions and issues in clinical assessment of children with disabilities. I was extremely impressed with the stepladder approach in planning an evaluation. The authors teach, through a clinical vignette, how to construct an intervention model. The steps they ask you to consider are precisely what we do in our clinical practice; however, these interventions are aimed at a chronically disabled child (medical or neurological/psychological). For example, consider these simple steps in an intervention plan for a 4-year-old with fragile X syndrome, an example cited by the authors: • Specify goals/objectives for the child • Prioritize goals by weighting scales • Project a scale of worst to best outcomes for each goal. • Define child's present status on each side. • Carry out program for specified duration. • Identify follow up status on each side. • Calculate initial and follow up GAS scores (Goal Attainment Scaling)

We could use this approach to planning whether working with children who require educational interventions or who are being assessed self-injurious behavior.

The second part is as informative as it addresses the general assessment issues of children suffering from chronic disabilities. The chapters on qualitative and quantitative developmental assessments are absolutely invaluable. I never thought I would enjoy reading Piaget's theory so much. The authors included a well-defined and well-formulated description of different psychometric measures of cognition used in early childhood. The measures are described according to the age of the child and whether they are useful with developmentally delayed children. For example, Miller Assessment for Preschoolers (Miller, 1982) is said to be more appropriate for preschoolers with perceptual or language problems and coloured Progressive Matrices (Raven, 1991b) are more applicable for children with a hearing impairment.

This chapter also offers an eco-behavioural approach in clinical assessment that accounts for the child's experiences within the environment ranging from the molecular (interactional or instrumental variables) to the molar (broad variables such as gender, disability, socioeconomic status) dimensions. The family assessment includes important indices such as family culture, family interactions and the role of significant others.

Part three describes specialized measures and strategies for unique clinical situations and specialized populations such as maltreated young children, infants, children with motor impairments, deaf, visually impaired and children with autism.

The outstanding contribution in this section is the chapter on assessment of children with chronic illness, my favorite, as it covers common scenarios child psychiatrists face during the consultation-liaison process. While reviewing various assessment strategies for children with chronic respiratory illnesses (asthma), genetic diseases, and juvenile rheumatoid arthritis, particular emphasis is placed on the study of two dimensions of cognitive domain in these children: the child's understanding of concepts related to illness and health and the child's knowledge of his own condition.

It is important to note that the chapter on developmental measures for children with neurological dysfunction emphasized that clinicians could still accomplish a reasonable assessment in his/her office that would be as valuable as several batteries of neuropsychological tests.

The last chapter describes ethical and legal issues involved in assessment of children with special needs. Although legal issues described are not very applicable to Canadian practitioners, the guidelines for making ethical assessment decisions are.

This is a book one would like to refer to from time to time when working with children with disabilities. The book has contributed richly to fields of psychology and developmental processes of young children. In my opinion, it has the potential of becoming an authoritative text.

Dr Pratibha Reebye, Infant Psychiatry Clinic
Children's & Women's Health Centre of BC

The Depressed Child and Adolescent 2nd Edition

Ian Goodyer, Editor. Cambridge University Press, New York, NY. 388 pp $64.95 US Paperback.

This book was most enthusiastically received for review. The first edition, made substantial contributions to our understanding of this huge and burgeoning area of child and adolescent psychiatry. The information contained in this edition is comprehensive, and, almost certainly, to the point of overload for individual consumption although it represents a most useful single source for reference and development of ideas.

As a multi-authored book, it is inclusive, incisive and informed and succeeds in broadening the base of knowledge to equip the specialist well for current and future practice. The "offshore" perspectives contained in the book add to the North American perspective, and the inclusion of chapters on Emotional Intelligence, the Impact of Life Events, and Historical Aspects of Mood and its Disorders in young people must be seen as very considerable assets.

The chapters almost warrant reviews on their own, in particular, Terwogt and Stegge's review of the construct of emotional intelligence, which has been brought out of the "pop psychology" arena. The chapter describes the wide range of vulnerabilities thought to underpin the AXIS I disorders in children and youth including even the sense that they are "just not getting it." Many useful constructs that relate to empathic skill development are considered.

The chapter on developmental precursors is exemplary and McCauley et al is skillful in pulling disparate ideas together.

Physiological precursors, of course, are a source of much interest at this time. They are reviewed well, if not as fully, perhaps, as might have been expected. The chapter does, however, leave us with an interesting construct that biological deregulation may act as a key vulnerability and may determine which young persons follow the route of an affective disorder.

Kolvin and Sadowski write a comprehensive review of the literature on clinical phenomenology and classification of childhood depression and shed light on contemporary algorithms, and co-morbid disorders. They draw the reader's attention to the observation that school age children are capable of reporting feelings and thoughts, even when parents are not fully aware of their child's symptoms. The best practice calls for direct interviewing of the child along with complementary interviewing of parents. They note that features of depression are similar in school-aged children and adolescents through to adults but with major developmental variations. Although less is known than would be expected, the natural history of childhood depression and the complex interplay between major depression and dysthymic disorder is well described. Depression may not only be followed by suicidal behaviour but may indeed be secondary to it. I believe it would have been helpful if Kovacs' construct of a gateway to major depression also included anxiety disorders.

The sections on epidemiology are informative and inclusive if a little indigestible. Strober's review of the family-genetic aspects of juvenile affective disorder similarly is full and summarizes the contemporary literature.

The review on neuro-endocrine aspects of adolescent depression is perhaps better known to readers of this journal and serves as a useful reference. This, of course, is key knowledge still in search of its place in our overall understanding.

Ian Goodyear's contribution on the nature and salience of life events reminds clinicians of the need for a thorough temporal history, even when the trigger and response is not obvious.

The chapter on suicide covers much contemporary thought but was somewhat confusing and may be worth a more critical review by members of our Academy. Two reviews on psychopharmacology and psychotherapy were disappointing and would not be seen as strengths.

The book concludes with a chapter called Natural History of Mood Disorders in Children and Adolescents by Harrington and Dubicka and serves as a fine summary of much that has been written regarding course, timelines, links with suicide and vulnerabilities, both biological and genetic. This chapter also touches on recovery and reminds us that failure to achieve full remission has a negative prognostic message for the future.

This book is commended to the readership and should be seen as an important component of a departmental library. For those interested in subspeciality areas it will serve as a useful vehicle to direct further inquiry in study. The cost is almost at the limit of what is reasonable for a paperback; perhaps the cost of doing business has gone up! At a time when the value of the textbook is open to question Goodyer's work represents an exception.

The book is clearly written and a sound editorial hand is in play.

D.F. MARR, M.B., Ch.B., M.R.C. Psych., FRCPC, Sudbury, Ontario

Treatment Manual For Anorexia Nervosa - A Family- Based Approach.

James Lock, Daniel le Grange, W. Stewart Agras, Christopher Dare. Guildford Press, New York, London. 2000. 276 pp. Hardcover - $65.00 Cdn.

As a family therapist, I found this book presented interesting theoretical and practical approaches to the dilemma of working with adolescents and their families around the issue of anorexia nervosa. The book offers a structured approach to working with these families, which could be followed as prescribed, but only if one works as part of a team who could and wanted to work in concert with this theoretical model. The model clearly advocates putting parents in charge of the adolescent's eating behaviours and giving them the responsibility of the re-feeding process. For those family therapists working alone or with a team who may not share these authors' approach to anorexia, there are both theoretical and practical examples that are worthy of implementing into one's own practice with anorexic families.

The authors clearly present three phases of the family treatment of anorexia, moving from the initial phase of re-invigorating the parents to be able to take on the task of re-feeding their adolescent, to the second phase of the adolescent and parents negotiating a new pattern of relationships, to the last phase in which adolescent issues are examined in the context of the absence of anorexic symptomatology. The authors explain the theoretical model behind this approach clearly and outline the steps one would take to follow this path with actual process interviews, in order that the therapist can get a feel as to how this model is put into practice. A cornerstone of this model is the observation of a family meal, which is provided by the parents and brought to the therapist's office. Care is given to the discussion about what foods the parents thought were appropriate to re-nourish their daughter and examples of how the parents were coached to persuade their daughter to eat more than she had planned. Examples of how families may

collude with the anorexic symptoms and the therapeutic response to this collusion are given.

The authors give excellent examples of the use of circular questioning in bringing about the participation of siblings in the family sessions. They present transcribed interviews showing how they involve the siblings with the goal being their empathic support to the patient as she struggles with the need to gain weight. Sibs are instructed not to assist the parents in their role of not letting their sister starve herself. Examples are also given to encourage parents in separating the eating disorder from the patient so that a co-operative alliance can be established between parent and adolescent regarding weight gain. The authors help the therapist to see the importance of focusing on the anorexic symptomatology and need for vigilance in insisting upon continued weight gain, which is particularly difficult for parents once the immediate medical crisis is over as the adolescent regains some weight. The authors site research around the poor prognostic implications of negative parental criticism toward their anorexic adolescent. They recommend choosing parental counselling rather than conjoint family therapy if it appears that conjoint sessions will exacerbate these negative qualities.

The emphasis on parental control over the eating disorder illustrates one side of the dimension between those who advocate this approach and others whose theoretical model leans more toward the motivational approach, relying more heavily upon the adolescent's own decision to work towards recovery. For me this book provides a valuable tool to help the clinician working with adolescents and their families in programs whose theoretical framework follows either of those models. I highly recommend it for any therapist who has struggled with the difficult task of trying to keep a family focused on the arduous task of re-nourishing their adolescent to health. It gives a step by step approach to the therapist which will help her keep the focus on the initial presenting problem, and not become side-tracked with secondary albeit compelling problems, as the illness of anorexia will invariably do to both therapist and family alike.

Nancy Oberdorf, MSW, RSW,
Eating Disorders Program
B.C.'s Children's Hospital, Vancouver, B.C.

OBITUARY FOR

Dr. Hira Panikkar

February 2nd, 1928 to September 6th, 2002

We would like to express our appreciation of an endearing and respected colleague, Hira Panikkar who passed away on September 6th 2002.

Hira was a woman with tremendous "style" in both her social relationships and professional life. Most people who had contact with her remarked on how she made one feel special and indeed she always noticed the good qualities of colleagues and patients. She was Clinical Head of the Infant Psychiatry Clinic at the Women's and Children's Health Centre of BC. She taught community health nurses and other health professionals about the mental health of infants and young children. She was the founder of the Western Canadian Association for Infant Mental Health a branch of the World Infant Mental Association and she made close friends with many colleagues in mental health throughout the World.

She came to Vancouver from Winnipeg where she was the Director of Child and Adolescent Psychiatry at the Children's' Hospital and a full time member of the University staff. Hira had many other interests. She painted and had shown some of her work at the Vancouver Academy of Art. She read widely and had an amazing facility to remember details of her readings.

Hira studied medicine in India and was one of the top graduates at her medical school. She married Mohan, a specialist in public health. Unfortunately when they moved to Vancouver he was starting to become ill and he predeceased her. She was intensively loyal to her family of two daughters, a son and four grandchildren.

Hira enhanced the general "esprit de corps" of the large outpatient clinic and was always encouraging about clinical and research ventures. She was always very enthusiastic and she enjoyed life with great verve and superb social skills. We miss her tremendously and we still expect her friendly greeting in the corridors.

Dr. S. Fine
Dr. G. Weiss
Dr. P. Reebye
Department of Psychiatry, Division of Child Psychiatry
Children's & Women's Health Centre of British Columbia

C4, 4480 Oak Street, Vancouver, BC V6H 3V4

PARENT INFORMATION SHEET

Severe Acute Respiratory System (SARS)

A tip sheet for parents on how to answer children's questions about SARS

What does the word SARS mean?

SARS is the name of a new "flu-like sickness" which first showed up in people living in China and Hong Kong and is now showing up in people in other parts of the world, such as Canada.

SARS = Severe acute respiratory syndrome

What is a "flu-like sickness"?

A "flu-like sickness" is one that causes fever, chills, cough, body aches and sometimes headaches. There are many, many different types of viruses that cause "flu-like sickness". The SARS virus is only one of them.

Where did SARS come from?

Doctors and scientists have found out that SARS is caused by a virus which first showed up in people living in Hong Kong and China and now has shown up in some parts of Canada too.

What is a virus?

Viruses are tiny living things too small to be seen without a microscope.

How do people get SARS?

Viruses can be spread through different ways. Some viruses are spread through blood, but other viruses, like the ones that cause colds, are easy to catch from being with people. Doctors believe the SARS virus spreads much like the cold virus, in tiny little drops that spray out of an infected person's mouth when he or she sneezes, coughs, laughs or even talks. If someone else breathes in these drops or gets them on their hands and then touches their mouth or nose, the virus can get in their body and he or she can get SARS too.

I had a cough and a fever before Christmas. Does that mean I have SARS?

No. There are many, many different kinds of reasons why kids get coughs and fevers. SARS is only one of them and it only started being a problem in Toronto recently, when a lady who visited Hong Kong, where there are a lot of people who have SARS, brought back this flu virus with her.

What can I do to stay safe and not catch the SARS virus?

Making sure you wash your hands before meals is the best way to avoid catching any flus, not just the one caused by the SARS virus.

Talking to Your Child about SARS

It may be helpful to talk to your child to see if he/she is worried about SARS. All of the news about SARS can lead children to feel anxious. Children will look to parents for guidance and help.

Here are some general suggestions.

Listen to your Child

* In the face of a threat such as SARS, feelings of fear are healthy and natural for adults and children.
* It is important that children of all ages have a chance to talk about what is worrying them.
* Children need to feel that parents are taking them seriously.
* Children's fears may be exaggerated due to their imagination, but it is important for adults to listen.
* False reassurance ("Don't worry") is generally not helpful.

Facilitate a Discussion

* Do not minimize the danger of SARS, but put the problem into a realistic perspective.
* Give factual information about SARS.
* Discuss concerns in terms that your child can understand.
* It is okay for parents to talk about their own concerns and anxiety in an honest way.
* It is scary for children if they feel that adults are too afraid to talk or are hiding something.
* Feel free to say when you don't know the answer, and be willing to find out information.

Offer Reassurance

* Youngsters need to look to you for reassuring information.
* Only a very small number of children in Ontario are even suspected of having SARS.
* Explain to your child that there are practical steps he/she can take such as handwashing to minimize the threat.
* Make sure they understand that they should not share snacks or drinks with friends.
* Engage in normal family routines. This is comforting because it is familiar and predictable.
* Be prepared to spend a little more time with your child to convey that you are available to them.

Take Care of Yourself

* As adults, we may find our own emotions in turmoil too.
* But it is important not to let these get in the way of our listening to children or to 'take over' the home or classroom.
* We need to connect with other adults to fulfill our own emotional needs.
* Informal discussions with our spouse/partner, close friends, or extended family members can help to fill this need.

The information provided here was taken from the Hospital for Sick Kids Website and provides information to parents on how to talk to their children about SARS. The Review would like to thank those responsible for the website for permitting its publication in this edition. **(www.sickkids.ca/familyinformation)**

CONFERENCE WATCH

"The Future of Health Care: Valuing Children, Youth and Families" 2003 Annual Meeting, Canadian Association of Pediatric Health Centres, **June 15-18, 2003** Hyatt Regency Hotel, Calgary, Alberta www.caphc.org (613) 738-4164

Canadian Psychiatric Association, *53rd Annual Conference,* October 23-November 2, 2003 Halifax, Nova Scotia, World Trade & Convention Centre.

The American Academy of Child & Adolescent Psychiatry, *50th Anniversary Meeting,* October 14-19th, 2003 Miami Beach, Florida, Fontainebleau Hilton.

Canadian Academy of Child & Adolescent Psychiatry, *23rd Annual Meeting*, November 2- 5th, Halifax, Nova Scotia, Delta Barrington, Delta Halifax, World Trade &

The Editorial staff wish to invite its members and readers to forward listings for upcoming conferences and meetings to be advertised in the Canadian Child & Adolescent Psychiatry Review "Conference Watch".
Please submit listings to:

Tena Roebuck, *Editorial Assistant*
tena.roebuck@iwk.nshealth.ca or
IWK Health Centre, Maritime Psychiatry, 5850 University Ave, Halifax, NS B3J 3G9
Tel: (902) 470-8377 Fax: (902) 470-8937

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

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

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

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

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

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

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

Child and Adolescent Psychiatrists

Regional Child/Adolescent Mental Health Program

Southlake Regional Health Centre is a full-service, 300-bed Hospital located 45 minutes north of Toronto in the town of Newmarket. Serving an immediate catchment area made up of both urban and rural communities, Southlake serves approximately 200,000 residents in northern York and southern Simcoe Regions.

Supported by a medical staff of over 115 specialists and 110 family physicians, Southlake is the Regional Centre for Child and Adolescent mental health beds, Child and Adolescent Eating Disorders, Level II Perinatal and Paediatric Care, and Cardiac Care. A full range of diagnostic and consultative services are on-site and include,CT, MRI and Nuclear Medicine. A massive $149 million expansion and redevelopment project has commenced that will result in the construction of a new six-storey tower, modernization to existing buildings and the addition of approximately 120 new beds.

Southlake Regional Health Centre's Regional Child and Adolescent Mental Health Program has immediate openings for at least two full-time and/or part-time child and adolescent psychiatrists to join its multidisciplinary team. The opportunity also exists for one of the successful candidates to play a greater leadership role in the program as physician leader.

Currently including six child and adolescent psychiatrists, the team provides clinical consultation and follow-up to the following programs:

Outpatient:
- Child and Family Clinic
- Eating Disorder Program
- Child and Adolescent Crisis Program
- Emergency Department

Inpatient:
- Five recently-opened child and adolescent mental health beds
- Paediatrics

All of the programs enjoy a close, collaborative relationship with nearby academic teaching centres.

Billing is fee for service with additional support through sessional fees.

Interested specialists should send their curriculum vitae to:

Dr. Louis Balogh, Chief of Staff
Southlake Regional Health Centre
596 Davis Drive
Newmarket, Ontario L3Y 2P9
T: (905) 895-4521 ext. 2625
F: (905) 853-2217
Email: lbalogh@southlakeregional.org

We thank all applicants for their interest, but only those selected for an interview will be contacted.

INSTRUCTIONS TO AUTHORS AND CONTRIBUTORS

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

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

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

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

CONFERENCE AND WORKSHOP ANNOUNCEMENTS WILL BE INSERTED FREE OF CHARGE
FOR ADVERTISEMENT RATES PLEASE CONTACT EDITORIAL ASSISTANT

All submissions should be sent to

Ms. Tena Roebuck
Editorial Assistant
CCAP Review
Maritime Psychiatry
IWK Health Centre
5850 University Avenue
Halifax. Nova Scotia. Canada. B3J 3G9
E-mail: tena.roebuck@iwk.nshealth.ca

NOTES