Book Reviews

Developmental Disabilities and Dual Diagnosis: A Guide for Canadian Psychiatrists
McCreary, B. Queen's University Press: Kingston, Ontario, 2005.132 pp. CA $25.00.

Dr. McCreary provides a clear and concise review of the knowledge, skills and attitudes that are useful for all physicians who have patients with mental retardation in their practice. Since two per cent of the population has mental retardation, all physicians can expect to treat a patient with mental retardation in their career.

Part 1 provides a clear description of the abilities that persons with the varying degree of impairment have, as well as the common comorbidities, and common problems for referral to psychiatry or other specialties. There is a section devoted to genetic and environmental causes of mental retardation. Dr. McCreary also provides an outline of the developmental, educational and social services that are needed to maximize the adaptive capacities of the person with a developmental disability.

In Part 2, skills for conducting a psychiatric assessment that leads to the formulation of a management plan are addressed. These include engaging the help of other medical specialties. He addresses informing and educating the family and other caregivers so that they can carry out the management plan. Another section discusses the ambulatory and inpatient treatments that a psychiatrist would usually provide.

Part 3 addresses attitudes that greatly enhance the outcome for people with mental retardation. The challenges that the family and other caregivers face are identified, as well as information about enlisting the services of other medical and paramedical disciplines. Dr McCreary addresses the need for vigilance regarding the risk of neglect or abuse of persons with a developmental disability since they are at increased risk to be targeted. In addition, the information regarding assessment of capacity to consent to treatment is useful. Finally, a number of other activities such as parenting and situations involving conflict with the law are discussed.

The book is clearly written, well referenced, and has a self-assessment quiz. I would recommend the book to psychiatrists as well as physicians of any speciality.

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Imitation and the Social Mind: Autism and Typical Development
Rogers, S .J. & Williams, J. H. G. (Editors.) Guilford Press: New York, 2006, 466 pp. US $65.00.

This is a very powerful academic work edited by two well known scientists in the field of autism. Sally Rogers from the M.I.N.D. Institue at the University of California and Justin H G Williams from the University of Aberdeen offer an impressive editorial expertise. Together they have bound twenty eight viewpoints, including their own, in mere four hundred and sixty six pages.

There are three themes that are embedded in eighteen chapters: namely; imitation in typical development; evolutionary and neural bases of imitation; and imitation in autism and other clinical groups. As the reading under this theme is technical, readers are slowly directed to atypical forms of imitation.

The first chapter on studies of imitation in early infancy is written by Sally Rogers, who introduces the novice reader to the early development of imitation studies such as by Meltzoff and Moore. These are now considered classic experiments of study of infants ages 12-17 days who could imitate tongue protrusion and mouth opening. Many replication studies followed with completely opposite findings. These results reflected the methodological differences across labs and how the interpretation of imitation phenomenon was made. Daniel Stern integrated imitation findings to suggest interpersonal development such as shared affect at a dyadic level. The other set of studies reviewed in this chapter focus on longitudinal studies examining neonatal imitation. Dr. Rogers then analyzes how mimicry and imitation correspond. The term imitation is reserved for behaviors that involve understanding of both goals and means of the model. Mimicry on the other hand is explained as a powerful social phenomenon as a contributor to interpersonal

transmission of emotional states. (page 15) This chapter also raised one important question regarding the possible role of mirror neurons in the development of gestural imitation, mimicry, emulation and emulation related phenomena in humans.

The following chapter authored by Elise Masur is an important one for child psychiatrists. It offers us in a simple language how imitation in the first year of life occurs and functions of naturally occurring dyadic imitation. I was impressed with the fact that it is the second year that is extremely important for focusing on the children's imitation as it changes dramatically. Imitative skills that infants practice with their mothers might be useful later on when socially relating to peers. These imitations skills might be instrumental in learning about language and the meanings of their cultural practices.

I definitely will recommend reading of chapter three for all clinicians involved in the field of autism. I agree with the author (Malinda Carpenter) that comparing typically developing children with children having the diagnosis of autism, relative weaknesses and strengths of the two groups can be more meaningful. Typical infants will understand others' goals and intentions toward objects by end of one year. Typical growing infants also have the ability to collaborate with others by sharing goals. Children with autism show a different pattern. They might show relative strengths in goal directed, meaningful instrumental tasks but deficits appear in the imitation of action, style, and body and facial movements especially if they are non meaningful. They show imitative difficulties in declarative (social) reasons.

Chapter four is a difficult read. The authors Eric Moody and Daniel McIntosh explore the controversial premise of mimicry in autism. The definitions of mimicry, imitation and emulation are clarified for us. Mimicry is rapid, automatic and is expected to be less influenced by learning, social motivation and socialization. If mimicry deficits are said to arise from motor deficits, then the cerebellum hypothesis in the genesis of autism spectrum disorder seems relevant.

Tony Charman, in the next chapter, takes readers to reflect upon intriguing questions. Whilst discussing the process of imitation in different clinical groups, he makes us wonder about how children with autism who have relatively preserved language skills differ from other children? The evidence for a role of mirror neuron systems in language, imitation and motor abilities is another suggested area for investigation.

Jacqueline Nadel asks another crucial question: Does imitation matter to children with autism? Her elegant description of the golden age for imitation was interesting. She states that this golden age for imitation starts around eighteen months and ends around forty-two months, using learning (focused on motor strategies) and nonverbal communication through imitation as an instrument. She gives a very interesting description of the use of still face paradigm revised to explore the question when do children form a concept of others as interactive partners. Here, the experiment starts with a still partner that becomes animated and then becomes inanimated through second still face. Nonverbal children with autism did not show any discomfort during the first still face, reacted positively through the animated episode and reacted with negative behaviors to the second still face. Here, imitation was found to be a powerful motivator for emotional reactions displayed during the second still face. These children then understood that a stranger is an interactive agent. Infants and nonverbal children with autism are able to take turns, alternately imitating simple actions.

In chapter seven authors Nielsen, Suddendorf and Dissanayake explore the ability for synchronized imitation in the children diagnosed as having autism. This chapter presents one fundamental argument that imitation deficits seen in children with autism cannot entirely be attributed to either social dysfunction or disruptions in their ability to identify a match between their own behavior and that of another (page 150).

The next chapter is very difficult reading, but re-reading it a few times makes a lot of sense regarding the different viewpoints of the theory of mind, including contributions from cultural psychology. The authors ask if people with autism have deficits in cultural knowledge. This brave question opened a new way of looking at persons with autism for me. Their answer is eloquently expressed, "In the end what is

affected, to a greater or lesser extent, in one way or another, is the ability to acquire culture, which modulates virtually every aspect of human cognition and behavior."(page 188).

Chapter 9 made one important but controversial point. The authors agree that in individuals with autism, imitation disturbance must be understood, specifically an aspect of imitation (i.e., identification) which they consider a *core deficit* in autism.

The two chapters in Part II named evolutionary and neural bases of imitation took me an entire month to grasp. For clinicians working with individuals with autism, there is an important diagram that could provide a direction for treatment strategies, although the authors may not have implied this use. This diagram is called "social learning" dissection.

Part III has seven important chapters. This part deals with biobehavioral findings and clinical implications. Of interest is the chapter by Sally Rogers and Justin H.G. Williams in which they discuss controversies regarding imitation phenomenon in autism, and the last chapter where Bruce Pennington and the editors provide an authoritative and influential summary of the work in this book. This chapter provides for necessary readings to understand where we stand in the field of autism as regards to considering imitation as a core deficit, providing substrate to understand or use it as a comparative approach. The authors then revisit five hypotheses made in their earlier papers and examine with the evidence to see if they are still valid.

It is always refreshing to see how the editors summarize findings of this large volume and how it compares or differs from one's humble attempts of reviewing this scholarly work. However, I decided that such mental torture is unnecessary. I am looking for something clinicians can use to help a child with autism. The authors have undertaken a monumental task of looking for answers to why an individual with autism would not develop imitation, intersubjectivity, or affordance learning.

In my world, I want to borrow the knowledge base from these powerful researchers to shift a child with autism from a single to at least dual and later multiple relational worlds.

Would I read this book again? Yes, but not the way I did this time. My next reading of this volume will be to seek out clinically relevant information and start incorporating in augmenting my understanding of individuals diagnosed with autism. This book should be in departmental libraries. It is more likely to be useful to researchers and educators who are involved in exploring what causes autism than clinicians who want to know how to help an individual with autism.

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Social & Communication Development in Autism Spectrum Disorders: Early Identification, Diagnosis, & Intervention
Charman, T. & Stone, W. (Editors). Guilford Press: New York, 2006, 348 pp. US $42.00.

This book is edited by two world-renowned authorities in the autism field and contains powerful contributions from various experts in the field of autism spectrum. What I most like about this book is the new information presented in a matter-of-fact manner that looks simplistic in style but with profound meaning. It is a clinician friendly book and starts with the clinician's difficulties regarding children with autism spectrum disorders (ASD). That focus is maintained throughout the eleven chapters (divided into four parts), even when researchers are explaining their lab-based observations of, let us say, imitation studies.

A clinician's first impulse is to find out how to accurately appraise a clinical problem, and the editors seem to have sensed it. The first part opens with an overview of assessment and diagnosis. Especially appealing is the discussion on early diagnosis of children with ASD.

The second concern most clinicians express is regarding how serious the problem of screening is in their community, and part two of this book does full justice in addressing this concern. There is a scholarly discussion on screening for ASD in populations, and an extremely informative chapter by Wendy Stone, one of the editors, on the early screening for ASD in clinical practice setting. What readers get from these two aspects of screening for ASD, in populations and in clinical settings, is that we are far from making robust diagnostic

predictions based on available screening tools, as all these instruments have limitations in the sensitivity and specificity. A similar situation exists for the second level of screening for ASD where the challenge is mainly to translate these screening instruments from research setting to community settings.

Part III describes "evidence-based interventions." In chapter five, authors Yoder and McDuffie inform us of the intricacies in understanding joint attention. The definition of joint attention is clarified for readers, followed by critical examination of programs and their ability to enhance the joint attention process. Authors suggest potential predictors that will determine the response to joint attention treatments in children with autism. These predictors are described as the degree of social interest, awareness or interest in language, and play level or degree of preservative object use (page 138).

The next chapter gives an authoritative description of three approaches for language development in young children with autism. These include the didactic behavioral approach, the naturalistic behavioral approach, and the developmental language approach. I found that the questions raised by the author (Sally Rogers) were very helpful in understanding the current controversies over merits and advantages of several language based interventions used in ASD treatment options. Questions raised have immense practical applications. For example, should all nonverbal children with autism be taught an alternative communication system even when there is no evidence base? For parents trained in giving didactic teaching or naturalistic behavioral language training, should they also receive ongoing individual training?

Chapter seven takes readers to the intricacies of designing quality peer play interventions for children diagnosed with ASD. The authors describe the Integrated Play Groups (IPG) model in detail and how children with ASD benefit from play based interventions by improving their social interactions and communication.

I found the next chapter interesting for several reasons. It describes the use of imitation as a basis for intervention approach in children with ASD. First, it did not try to simplify the very complex process of imitation, but expands the potential of immediate imitation. Second, it explains how a three-step procedure set to examine imitation can distinguish children with autism. Third, the chapter elaborates that children with autism display spontaneous imitation and that often it is correlated with the developmental age than a chronological age. This chapter was not an easy read.

The chapter on alternative communication system is particularly well written. It resonates the clinician's frustrations when many interventions are given to children with ASD without a known evidence base. Use of signing, picture communication systems, picture exchange communication systems, social stories, written communication, computerized systems and facilitated communication are described as alternatives to enhance communication. Furthermore there is a lengthy description on how functional communication training (different from facilitated training) can help us understand the appropriateness of seemingly maladaptive behaviors. Multiple communication systems approach is the combination of several interventions that may involve signing and other symbols. The studies using this approach did not show generalization to untrained settings, and maintenance required adult prompting. There is a helpful table about assessing the alternative communication strategy on the merits of the characteristics of the system. The factors to look for are the portability, speed, permanence, whether it could easily shape the desired goal, phrases possible, iconicity, reciprocity, and demands on other's understanding. Moreover, child skills such as motor skills and cooperative attitude in executing alternative communication also were emphasized.

Part IV describes the developmental and neurobiological issues involved in early social communication. This part could have constituted a mini book in itself. Somehow, this part seemed to stand on its own, with little connection with the other chapters. I wonder if this information, so vital in understanding autism, should not have been placed in the first chapter. There is an extremely eloquent description of the neural substrates of Initiating Joint Attention (IJA) and Responding to Joint Attention (RJA). Whereas the RJA are related to the "social brain circuit" (page 303), IJA are associated with the dorsomedial frontal cortex and the anterior cin-

gulate. IJA therefore have an association with the anterior attention system. Interestingly, the authors (Mundy and Thorp) ask a crucial question that most of us would ask, "What is the clinical application of this research?" The authors conclude that even if there are no clear cut answers, this process of linking neurobiology in understanding clinical phenomena at least raises good testable hypotheses. Some of these hypotheses discussed were the learning processes in children with autism and connections with IJA and functions of dorsomedial frontal brain and anterior cingulate. The second hypothesis is about what kind of behavioral interventions would best address the development of IJA and RJA? The authors suggest that RJA type of interventions are relatively easy to institute and may be sensitive to external rewards, which is not the case for IJA where internal motivation and executive constraints are important. This part gives up-to-date information on the neurobiological processes written in a clinician-friendly manner. I did get lost in many abbreviations in chapter 11 — imagine, IJA, RJA, STS, STG, BA, ESCS and so on.

This book is well referenced. It provides up-to-date information on the social and communicative development in autism spectrum disorders. It is however, not a basic reading on the subject. Clinicians who are providing interventions that target the social and communication deficits in ASD will find this book useful, and therefore, is applicable to the practice of psychologists, psychiatrists, speech and language therapists and educators.

This is a type of book that needs to be re-read in order to grasp all of the compacted information. At the same time, one would not re-read it with a grudge.

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Treating Tourette Syndrome: A Guide for Practitioners

Woods, D. W., Piacentini, J. C. & Walkup, J. T. (Editors). Guilford Press: New York, 2007, 287 pp. CA $38.00.

All three editors of this book are prominent clinicians and researchers in the area of Tourette Syndrome (TS). The purpose of the book is to inform practitioners on comprehensive treatment of patients with TS. Each chapter of the book offers something unique, and though all of them could be pulled out and used separately, the authors recommend an integrated treatment approach afforded by the use of the whole book.

In the Forward, Dr. Peter Hollenbeck describes the progress since the description of TS by Gilles de la Tourette. He highlights the relatively recent development of Habit Reversal Therapy (HRT). HRT arose after decades of studies of the basal ganglia, which showed that the basal ganglia encode motor sequences, and that they can change and modify their circuitry in response to appropriate types of conditioning. In HRT, the therapist elicits in fine detail from the patient the premonitory urges, the circumstances around which the tics arise, and the cues warning the patient that the tics are coming. The patient is then instructed to develop and practice a competing response, usually an action opposite to, or incompatible with, the tic. This usually significantly reduces tic severity and functional impairment.

In chapter one, the editors report on the evolution in thinking about Tourette Syndrome, starting with Gilles de la Tourette's neurological and genetic view, to a psychodynamic view, and, as of the late 1960's, a medical view. As of 1999, the emphasis has been on an integrated biological, psychological and social approach. Based on this integrated conceptual model of TS, the Tourette Syndrome Association formed the Behavioural Sciences Consortium (BSC) in 2002.

Chapter two, Characteristics of Tourette Syndrome, mentions that Gilles de la Tourette's description of TS was accurate. We now see the disorder as a relatively common neurobehavioural disorder. A clinical description of tics is given, followed by the differential diagnosis of tic disorders, as well as the diagnostic criteria for the disorders. A brief summary of the course and prognosis, epidemiology, phenomenology and comorbidity follow. The chapter ends with a brief explanation of current explanatory models, from a neurological and environmental perspective.

Chapter three covers the differential diagnosis of tics and other movement disorders;

assessment of tic severity; premonitory sensations; and assessment of current functioning. Movement disorders which may resemble tics include myoclonus, dystonia, Sydenham or Huntington Chorea and restless leg syndrome. Practitioners not familiar with these disorders are advised to obtain a neurological consultation. A medical evaluation may help elucidate the cause of eye blinking, sniffing and throat clearing. Stereotypic movement disorders are usually single, do not wax and wane, and do not vary in anatomical location. If there is no presence nor history of simple tics of the head, and if the patient has a development disorder, then the disorder is more of a stereotypic nature. Tic severity includes factors such frequency, discomfort, pain, complexity, intensity and noticability. The Yale Global Tic Severity Scale (Leckman et al. 1989) is useful in assessing severity. Self-reporting scales, such as the Yale Tourette Syndrome List- Revised (Cohen, Detlor, Young, & Shaywitz, 1980), and parent reporting scales (the authors' questionnaire is included in Appendix 3.1) as well as direct observation and video recording are also useful. The latter can be deceiving because tics may be suppressed during interviews. Premonitory sensations can be assessed with the Premonitory Urges for Tics Scale (included in Appendix 3.3).

Chapter four describes the assessment of co-occurring psychiatric disorders, e.g. Attention Deficit Hyperactivity Disorder (ADHD), Obsessive-Compulsive Disorder (OCD), anxiety disorders and pervasive developmental disorders.

Chapter five elaborates on the genetic and neurobiological bases for TS. Genetic studies remain inconclusive; this could be caused by failure to include epigenetic factors. Neurological studies support the concept of an abnormality in the cortico-striatal circuitry.

Chapter six focuses on neurocognitive deficits in TS. There appears to be a consensus that Verbal IQ is significantly greater than the Performance IQ in many patients with TS, suggestive of problems in visuospatial, perceptual, and motor abilities. Studies also suggest difficulties with executive functions; for example, poorer divided attention abilities, problem-solving abilities, and response inhibition. There may be problems with procedural memory. The most consistent finding is visuomotor integration impairment. Fine motor skill dependent on visuoperceptual processes are consistently impaired in patients with TS, regardless of the presence of ADHD. Mild neurocognitive abnormalities are associated with TS from childhood to adulthood. Girls are slower than boys in Letter Word Fluency. Mounting evidence suggests that comorbidities such as ADHD and OCD exacerbate the cognitive impairments found in TS. Deficits in visuomotor integration and response inhibition may be specific to TS. These deficits impact on symptom presentation, such as aggressiveness, impulsiveness, mood disturbances and poor social skills, and on the treatment response. Treatment may be targeted toward the specific deficits.

Part II of the book covers the medical management of TS. Chapter 7 discusses the medical management, which consists of treatment of the most impairing conditions. Tics are very apparent and can distract from important comorbidities, especially internalizing ones. Tics were traditionally treated with typical neuroleptics, like haloperidol, pimozide or fluphenazine, though these medications are gradually being replaced by the atypical neuroleptics, like risperidone, olanzapine, ziprasidone, quetiapine, and aripiprazole, The use of other dopamine-modulating agents (pergolide, sulpiride, tiapride, tetrabenazine, levodopa, talipexole, rapinirole, metoclopromide), as well as alpha-adrenergic agents (clonidine and guanfacine) are discussed. Other tic suppression agents (baclofen, nicotine, mecamylamine and delta-9-tetrahydrocannibinol) are seen as not promising. The uses of penicillin and intravenous immunoglobulin in infection and in autoimmune-based treatments have not been proven effective. The authors then discuss the treatment of associated comorbid disorders — ADHD and OCD — and end with the discussion of treatment refractory cases and of complex cases.

Chapter eight discusses the psychosocial treatment of tics and of intentional repetitive behaviors associated with TS: contingency management, function-based interventions (examines under which circumstances the tics arise), massed practice (consists in voluntarily rapidly producing the tics), relaxation training, hypnosis, self-monitoring, exposure with response prevention, and habit reversal.

Particular attention was given to the latter. Medications rarely eliminate tics, and they have side effects which result in poor compliance; therefore the treatments discussed in this chapter can be useful.

Chapter nine discusses the management of comorbid internalizing disorders in TS; for example, OCD, anxiety disorder, depressive disorder, and the use of cognitive behavioral therapy for these disorders.

Chapter ten discusses the assessment, phenomenology and treatment (psychosocial and medical) of disruptive behaviour in patients with TS. Anger and non-compliance are a large part of this problem. The chapter reported on a large number of studies dealing with the issues. It is unclear whether tic severity contributes to difficult behaviour. The presence of ADHD worsens it.

Part three, Clinical Management of Secondary Problems, chapters eleven, twelve and thirteen deal with family issues, school issues, and social and occupational difficulties of persons with TS, and discusses when and how to intervene.

I enjoyed reading this book. It is thorough, and it gave a very good up to date review and critique of the literature on every aspect of TS. It is written in an authoritative manner, giving up to date methods for assessment and treatment of every aspect of this disorder and of its complications. I highly recommend it for all practitioners who deal with patients who suffer from TS.

Leckman, J. F., Riddle, M. A., Hardin, M. T., Ort, S. I., Swartz, K. L., Stevenson, J., et al. (1989). The Yale Global Tic Severity Scale: Initial testing of a clinician-rated scale of tic severity. *Journal of the American Academy of Child and Adolescent Psychiatry, 28*, 566, 573.

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Working with Parents Makes Therapy Work

Novick, K. K. & Novick, J. Jason Aronson, Rowman & Littlefield Publishers, Inc. Lanham, MD, 2005, 208 pp. US $35.00

Both authors are on the faculty of the Michigan Psychoanalytic Institute and are prolific writers in the field of child and adolescent psychotherapy and psychoanalysis. They are mostly known for their theory of *the two systems of self regulation* in the face of pathology (open adaptive /closed omnipotent - sadomasochistic).This book however is of great interest to all child practitioners regardless of their discipline or their theoretical framework. The title of the book is in itself a powerful statement and, while it is difficult to argue, it is far from certain that it is put into practice. Is it okay for the *same* therapist to also work with parents? And if so, do we have a model for that? This book gives a strong documented affirmative answer to both questions.

Contrary to some analytic writings, this book is written in an easy, fluid, widely accessible style and with a multitude of clinical vignettes to illustrate the text. It contains eleven chapters. The first two are introductory discussions on their work assumptions; the history of the resistance to work with parents and the presentation of a model to include parents in the treatment. The following seven chapters discuss in detail how this applies at each step of the treatment: evaluation; recommendations; the beginning phase; the middle phase; the pre-termination phase (an interesting addition to the conventional division); termination; and post termination. Chapter ten discusses further the application of their model to individual treatment with adults and the last chapter gives a summary and recapitulation of their two systems of self regulation as it applies to the subject of the book.

Traditionally, parents were seen by psychotherapist as an obstacle or as intruders in the individual work with the child or adolescent. We were trained to send parents somewhere else for their individual treatment with the hope that if issues around parenthood are being addressed that this will facilitate the therapy with the child. Typically, the working emotional unit was the individual child and not the parent-child interrelation. Furthermore, the conceptual boundaries between individual, couple or family psychotherapies were quite impermeable. The authors make a compelling analysis of the resistance to working with parents. From a social/historical perspective, they mention the ambivalent perception of the mother as being idealized while stripped of any power, and the gross neglect in the classical theory of the

importance of the pre-oedipal mother. From the theoretical perspective, they mention the exclusion of the parents due to the shift towards the internal world as the primary - if not the exclusive - interest of the therapist. On the political front, the only way for child psychoanalysis to gain credibility was to be as close to Freud and to the adult psychoanalytic model as possible. Added to that was the influence of adolescent psychoanalysts coming from an exclusive adult training. Psychoanalysis was viewed as the answer of most difficulties, and therefore parents, if needed, were referred for their own analysis. We know now that this doesn't always benefit the parent-child relation. Parent-child issues may be addressed only late in treatment; and since changes come slowly anyway, precious childhood years may have passed. Therapist may refrain from suggesting parenting issues directly in the treatment so as not to interfere with the transference. It is surprising how little the child is mentioned in a parent's treatment even though the child and parent pathology may be interrelated. The authors suggest as an explanation the wish for the parent to deny their importance. Added to that is also the fact maybe that in treatment the parent becomes somehow himself the child. The situation has now changed as a result of clinical knowledge and the attrition of the number of children in individual psychodynamic treatment.

According to the authors, parents should not only be included into the treatment process, but working with them is the most efficient and most economical way. This applies not only to preschoolers but equally to older children, adolescents and even young adults. An example is even given where treatment of a four year old child who was cross dressing, proceeded successfully without ever seeing the child (p. 31). The book describes a model that supports this kind of work with parents. The Novick's model rests on the following points: 1) expansion of the notion of therapeutic alliance in a way that incorporates the parents. 2) changes are the result of a dual goal: the "restoration of the path of progressive development" as stated by Ana Freud (p. 9) and restoration of the parent-child relationship to a life long positive resource for both. 3) changes must occur in both child and parent. Parenthood is therefore described as a complex developmental phase. 4) changes are seen as a transformation from a closed sado-masochistic system of self regulation based on a pathological omnipotent adaptation to an open adaptive one which is constructive and realistic. A table of these transformations at each phase challenge of development is presented at the end of the book. While the parent is not the designated patient, the work with him or her is also therapy with verbalization, reconstruction, interpretation and transference. Their premise is the notion of a "primary parental love" (p. 17) which is left not described, and in my opinion could be challenged.

A section is dedicated to the role of fathers. They note that mothers are more flexible to come to meetings. I have personally observed a corollary between the presence of both parents at follow up appointments and a positive outcome. Fathers may feel their masculinity assailed by the boy's emotionality. Specific issues attributed to fathers in cases of resistance are their tendency to underestimate their importance to the child, defenses against feelings of failure and externalization of blame. In addition, marital and parental issues may be intertwined. Counter transference issues associated to the therapist's age, gender, marital status or personal experiences can be quite powerful when children are at stake and should be recognized and worked through.

The authors offer plenty of practical details on the way they function which demands flexibility. One half hour is reserved to the first phone call and their evaluations are extended in time. They require a 30 day notice for any change and this also applies to the therapist. Confidentiality towards the identified patient is treated in a peculiar way: a distinction is made between privacy and secrecy. Thoughts are private but actions are public. I am not certain how this works out with adolescents and young adults.

As points of criticism, I deplore the neglect of the pioneer work of Winnicott in this subject (one citation) and the complete absence of object relations theory which would have deepened our understanding of both the parent-child relation and the authors' two systems of self regulation. Finally, while such an acknowledgement of the role of the parents is very impor-

tant, we are still lacking a comprehensive framework to conceptualize distinctive models of parent-child conflicts that would allow proper diagnosis and communication between professionals.

Despite the criticisms, this book represents a turning point in our child psychiatry practice which legitimizes a shift that many of us have adopted clinically several years ago. It should be read, discussed and improved upon by all child and adolescent practitioners.

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