Advancing Mental Health Services for Francophone Children and Youth in Ontario

Part 2 –Evidence Based and Promising Treatments: Recommendations for the Francophone Sector

Institut Valor • Services aux Enfants et Adultes Prescott-Russell

Barwick, M. (2007). Advancing mental health services for Francophone children and youth in Ontario – Part 2: Evidence Based and Promising Treatments: Recommendations for the Francophone Sector. Ontario: Institut Valor / Les Services aux Enfants et Adultes Prescott-Russell.

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Main Messages

The implementation and adoption of evidence based practices in the Francophone sector of children's mental health services requires a system for the screening of mental health concerns and for assessing response to treatment and treatment outcome. This, in turn, allows for a commo) metric to be used in determining the effectiveness of treatments provided, whether these treatments are considered 'promising' or whether they have an established evidence base as reported in the scientific literature. The use of a 'common' metric across multiple settings is useful for regional, sectoral, and provincial planning purposes, and allows for similar points of comparison across jurisdictions and organizations.

The availability of evidence based practices is not sufficient to bring about practice change. Also necessary are action plans, partnership andcollaboration, sustainable supports for training, implementation, and clinical application of new methods, as well as consideration of several important factors relating to the organization, the EBT, and user, and the context.

There is a tremendous shortage of published French language empirical work. The majority of work published in French is comprised of empirical studies, on a range of mental health topics, followed by descriptive studies, prevalence/incidence studies, and reviews. There are very few treatment studie.

With very little French language published literature, and even fewer manuals or treatments available in French for child and youth mental health, the way ahead points to the selection, translation, and validatin of English language EBTs. This, in and of itself, however, it not sufficient to move the advance mental health services for Francophone children and youth in Ontario

With the translation of the Child and Adolescent Functional Assessment Scale and the Brief Child and Family Phone Interview into French now completed, the tasks remaining are to establish the validity of the tools for Francophone children and youth, and to improve uptake among organizations serving the Franchophone sector. Services aux Enfants et Adultes de Prescott Russell could play a leadership role across the province relative to the validation of the French CAFAS, and to it's implementation and best practice use in Francophone communities.

With limited FL-EBTs and FL-PPs available, it would be worthwhile to partner with other French speaking jurisdictions, such as Quebec and New Brunswick, to share the costs associated with translating English programs into French, practitioner training, and validation studies.

Project Overview

The definitive goal of this project is to improve the quality of French language services to Ontario's children and youth and their families, to increase practitioner satisfaction with service delivery, and to ensure a greater effectiveness in the services offered in French. The project is divided into two parts: the first comprised a survey of service delivery characteristics, research utilizations, and readiness for change; and the second is a review of evidence-based practices available in French and/or proven reliable with French speaking children and youth.

The project was undertaken in partnership between the Institut Valor and Les Services aux Enfants et Adultes Prescott-Russell (SEAPR), a children's mental heath agency located in eastern Ontario. Dr. Melanie Barwick, Health Systems Consultant, was retained to conduct the survey, review the literature, and write the reports. Mr. Martin Hubert acted as Project Manager. The project team also included Ms. Julie Clement, Director, Institut Valor, and Ms. Dominique Guillaumant, Senior Policy Analyst, Corporate Policy Unit, Ministry of Children and Youth Services, rounded out the team.

This report covers Part 2 of the project. We begin with an account of the availability of evidence-based and promising treatments available in the French language. This is followed by a description of evidence based treatments (English) that are available to address the areas of greatest concern identified in Part 1 of this project (see companion report). Lastly, the report provides an action plan, detailing the utility of Ontario's mandated screening and outcome measurement tools, already implemented across Ontario in 120 child and youth mental health organizations. In addition, we propose possible partnerships and professional development that could be realized in order to advance French language child and mental health services in Ontario.

Toward French Language Evidence Based Treatments in Ontario

The implementation and adoption of evidence based practices in the Francophone sector of children's mental health services requires several steps; not unlike those taken in the Anglophone sector since 2000. For instance, the implementation of systematic and standardized practices for the screening of mental health concerns and for assessing response to treatment and treatment outcome is a necessary first step. Necessary because it allows for a (common) metric to be used in determining the effectiveness of treatments provided, whether these treatments are considered 'promising' or whether they have an established evidence base as reported in the scientific literature. The use of a 'common' metric across multiple settings is useful for regional, sectoral, and provincial planning purposes, and allows for similar points of comparison across jurisdictions and organizations. The measures implemented to date across Ontario, including in some Francophone agencies, will be discussed further in the report.

The second step toward the use of evidence based practices in Francophone children's mental health organizations is to ascertain the availability of French language evidence based treatments (FL-EBTs), determine whether they have been empirically evaluated and published, and whether they have been implemented in practice and are producing adequate effect sizes. Where there are limited FL-EBTs it is worth exploring the use of French language promising practices (FL-PP) that can be evaluated and applied in the appropriate settings. If, as we expect, there is a paucity of FL-EBTs, consideration must be given to the translation of English language EBTs (manuals, scales, forms, etc) and the provision of French language supports for training, implementation, clinical application, supervision, and fidelity controls.

The existence of evidence based practices is not sufficient to bring about practice change. Recent developments in the area of knowledge translation and implementation science have identified the need for action plans, collaboration, constant availability of supports for training, implementation, and clinical application of new methods, as well as consideration of several important factors relating to the organization, the EBT, and user, and the context (Barwick et al 2002, 2005).

Review of Published French Language Evidence-Based Treatments

Electronic searches were conducted in PsychINFO (1986-2006),CINAHL (1982 – December 2006) and MEDLINE 1996 to November Week 3 2006. Subject headings included "mental health intervention", "mental health treatment" and "mental health" or "mental disorders". Searches focused on children/adolescents (ages 2 to 18 years) and French language publication.

Table 1 Search Parameters

Keywords = (treatment or intervention) and (mental health) or (mental disorders)
Date range: 1987 – 2007
Limited to: Published Works Only; Language is French; Age is Childhood (birth-12 yrs) or Neonatal (birth-1 mo) or Infancy (1-23 MO) or Preschool Age (2-5 yrs) or School Age (6-12 yrs) or Adolescence (13-17 yrs)
130 results found in multiple databases, of which 113 were peer-reviewed journal articles
151 results found in Web Resources Related to the Social Sciences/Humanities

Search Results

The electronic search yielded 219 articles meeting the search critera detailed above The consultant reviewed the titles and abstracts and selected relevant articles for further review. An annotated bibliography of articles deemed relevant is provided in Appendix A. Relevant articles were coded according to type (see Appendix A).

Table 2 Relevant Articles According to Type

	Number of Citations		
	PsychINFO[1]	CINAHL[2]	MEDLINE[3]
empirical study	22	1	4
prevalence / incidence study	7	0	1
descriptive study	24	0	4
epidemiological study	2	0	2
review	4	0	7
treatment or intervention study	6	0	1
drug study	2	0	0
service utilization	3	0	3

Of the articles retrieved, only 7 could be classified as treatment or intervention studies (see Table 3). Overall, there is a tremendous shortage of published French language empirical work. The majority of work published in French are empirical studies, on a range of mental health topics, followed by descriptive studies, prevalence/incidence studies, and reviews. There are very few treatment studies.

Table 3 Published French Language Treatment or Intervention Studies

⊙ Beauroy, R., Benhamou, H., Causse, H., & Fortineau, J. (1989). "Clairiere": The experience of an alternative, part-time, local-jurisdiction institution/La clairière: L'expérience d'une institution d'intersecteur alternative à temps partiel. *Perspectives Psychiatriques*, *28*(17) 105-107.
ABSTRACT: Describes a clinical service that offers **intensive treatments to children**

[1] PsychInfo: The major index for scholarly literature in psychology from the 1800's to the present. PsycInfo includes material of relevance to practitioners, researchers and students working in all areas of psychology, the behavioural sciences, and other related disciplines. Records from 1967 to the present are indexed using the Thesaurus of Psychological Index Terms. PsycInfo is published by the American Psychological Association (APA). Sources in PyscInfo include over 1800 professional journals, chapters, books, reports, theses and dissertations. Additionally, there are more than 8 million cited references in 185,000 journal articles, books, and book chapters.

[2] The Cumulative Index to Nursing & Allied Health (CINAHL) database provides authoritative coverage of the literature related to nursing and allied health. Virtually all English-language publications are indexed along with the publications of the American Nurses Association and the National League for Nursing. Primary journals are indexed from the following allied health fields: Cardiopulmonary technology, emergency services, health education, medical laboratory technology, medical assisting, medical records, occupational therapy, physician assistant, radiologic technology, technology therapy, *social services* and health care, surgical technology. Selected journals are also indexed in the areas of consumer health, biomedicine, and health sciences librarianship. In total, more than 1200 journals are regularly indexed; online abstracts are available for more than 800 of these titles. There are more than 7000 records with full text now included and 1200 records with images. The database also provides access to healthcare books, nursing dissertations, selected conference proceedings, standards of professional practice, educational software and audiovisual materials in nursing. More than 10,000 CINAHL subject headings provide specific access to NAHL citations. Approximately 70 percent of CINAHL headings also appear in MEDLINE. CINAHL supplements these headings with 2,000+ terms designed specifically for nursing and allied health. All explodable headings have been pre-exploded by Ovid.

[3] MEDLINE (MEDlars onLINE) is the National Library of Medicine's (NLM) premier bibliographic database covering the fields of medicine, nursing, dentistry, veterinary medicine, the health care system, and the preclinical sciences. The MEDLINE file contains bibliographic citations and author abstracts from approximately 3,900 current biomedical journals published in the United States and 70 foreign countries. The file contains approximately 9 million records dating back to 1966. Coverage is worldwide, but most records are from English-language sources or have English abstracts.

with psychopathologies every evening after school and on Wednesday afternoon. This evening care unit represents an intermediate stage between existing treatment centers and the schools, allowing the young patients to avoid the segregation associated with full-time day hospitalization. The main aspects of this treatment are (1) play activities, including group play and expressions of creativity, supervised by an analyst not involved in interacting with the patients' families and (2) psychopedagogical activities to maintain children's interest in school activities. Received at the center immediately after school, children participate in field trips on Wednesdays. The maximum age for attending the evening unit is usually 13 yrs. (English abstract)

⊙ Emery, J., & Toupin, J. (1997). Assessment of a case-method primary prevention program used in a day care center: An intervention designed to prevent the development of psychosocial problems in preschool children/Évaluation du programme "la carte des cas vécus" offert en garderie: Une expérience de prévention des difficultés d'adaptation chez les enfants d'âge préscolaire. Revue Canadienne de Psycho-Education, 26(2) 95-111.

ABSTRACT: Studied the effects on children and their parents of a **case-method primary prevention program** used in day care settings to prevent the development of psychosocial problems. Human Ss: 24 male and female Canadian preschool children (aged 4-5 yrs) (some with psychosocial maladjustment) (1-parent [mother] and 2-parent families) (experimental group). 21 male and female Canadian preschool children (aged 4-5 yrs) (some with psychosocial maladjustment) (1-parent [mother] and 2-parent families) (control group). Normal Canadian adults (parents of the preschool children). Normal Canadian adults (teachers of the preschool children). Ss were selected from 15 day care centers. The experimental group participated in 10 program sessions over 6 mo. Ss were tested before the program, at the end of the program, and 6 mo later. Tests used: The Child Behavior Checklist (CBC), the Direct Observation Form of the CBC (T. M. Achenbach, 1986), the Teacher's Report Form (T. M. Achenbach, 1991), the Questionnaire on Parental Behaviors (R. Tessier et al, 1985) and the Questionnaire on Parental Attitudes and Behaviors (L. Bergeron et al, 1992). (English abstract)

⊙ case study Frare, P., & Lebel, A. (1996). Use of "arrested thoughts" in the treatment of a 9-year-old girl with obsessive-compulsive disorder/Utilisation de "l'arrêt des pensées" dans le traitement d'un trouble obsessionnel-compulsif chez une fillette de neuf ans. Canadian Journal of Psychiatry, 41(6) 367-370. Retrieved January 4, 2007, from the PsycINFO database.

ABSTRACT: Used a **pharmacobehavioral approach employing modified techniques of exposure, prevention of the response, and thought stopping in the treatment of obsessive-compulsive disorder** (OCD) in a 9-yr-old girl. The diagnosis of OCD was made based on the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) criteria. The S was seen over 15 sessions, during which clomipramine was introduced and modified techniques of exposure, prevention of the response, and thought stopping were successively used. Follow-up extended over more than 18 mo after the end of therapy. The S learned and used the behavioral techniques easily, and the authors observed a rapid, complete, and sustained disappearance of the OCD symptomatology. *The authors conclude that use of a pharmacobehavioral approach in treating OCD in young children remains limited. Techniques used with adults and slightly modified to adapt them for children are an avenue of treatment worth exploring.*

☆⊙ Jalenques, I., Lachal, C., Geneste, J., & Coudert, A. (1989). Treatment of depressive

states in children/Traitements des états dépressifs chez l'enfant. Psychologie Medicale, 21(13) 2001-2007.

ABSTRACT: Discusses **effective treatments of depressive states in prepubertal children** in clinical and biological terms. Children's depressions were granted nosographic status by the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), with descriptions of their affective, cognitive, dynamic, and physical symptoms. Different psychotropics for treatment of children's depressive states are listed, along with their effects and possible side effects. *To address the psychological correlates of children's depressions, psychotherapies such as psychoanalysis and behavior therapy are suggested to complement psychotropes. (*English abstract)

⊙ Lacelle, J., & Séguin, M. (1998). Adolescent suicide: Elaboration of a postvention protocol in a secondary school in Outaouais/Le suicide chez les adolescents: Élaboration d'un protocole de postvention dans une école secondaire de l'outaouais. Revue Canadienne de Psycho-Education, 27(1) 31-45. Retrieved January 4, 2007, from the PsycINFO database.

ABSTRACT: Discusses the implementation of a **suicide postvention program in a secondary school** in the Quebec region of Outaouais with 1,763 students. The program, which emphasized regularly occurring activities related to suicide, was set up at the beginning of the school year so that fast and efficient intervention would be available during the school year if a suicide occurred. The program assessments of teachers and other school personnel, the emotional aspects and problems related to program implementation, administrative problems, and recommendations concerning adolescent suicide prevention are examined. (English abstract)

⊙ Manningham, S. (2003). In a regular school, children with severe mental health problems/Dans une école régulière, des enfants sévèrement réfractaires. Revue de Psychoéducation, 32(2) 249-271.

ABSTRACT: At the Seigneurie-des-Mille-Iles School Board, an increase of mental health problems along with their dramatic consequences for the children and their environment were observed. This led to the implementation of a **screening (depistage) and a treatment program in this school board**. In this school board, the professionals involved based their action on a psychoeducational approach that ensures quality of clinical services as well as the organization of the various practices. This paper describes the development of this program.

⊙ Tourigny M. Peladeau N. Doyon M. Bouchard C. [Efficacy of a treatment program for sexually abused children]. [French] Child Abuse & Neglect. 22(1):25-43, 1998 Jan.

ABSTRACT: OBJECTIVE: An evaluation study was conducted in order to evaluate the impact of the **treatment program for sexually abused children**. METHOD: Forty-one (41) children (aged 6-17 years), victims of a sexual abuse by a family member, were assessed at pre- and post-treatment (16 months following the pre-test). The evolution of children's psychological well-being was measured by the Children's Depression Inventory (CDI), the Picturial Scale of Perceived Competence and Acceptance for Young Children (PSPCA), the Children's Nowicki-Strickland Internal-External control scale (CNS-IE), the Children's Action Tendency Scale (CATS), the Revised Children's Manifest Anxiety Scale (RCMAS), and the Pediatric Behavior Scale (PBS). A hierarchical multiple regression analysis was used to assess the strength of the relationship between the level of participation in both individual (including dyadic and family therapy) and group therapy and the evolution of Ss' psychological well-being. RESULTS: *Results indicate that the child's mental health was generally positively related to the level of participation in individual therapy but not related or negatively related with the level of participation in group sessions except for the PBS. CONCLUSIONS: These results indicate the need: (a) to consider*

the adoption of a dose measurement in the appreciation of the therapeutic impact; (b) to have a better grasp of the nature and the effects of specific therapeutic activities included in a program; (c) to have a better understanding of the disparities observed between parents' and children's evaluation of the psychological status of the child.

Review of Unpublished French Language Evidence-Based Practices and Promising Practices

Unpublished French Languge Evidence-Based Treatments [FL-EBTs] and French Language Promising Practices [FL-PPs] reported here were identified from an internet search using the search engine, Google, for the terms “evidence based treatments in French,” “francophone mental health treatments,” “santé mentale pour enfants” “traitements basé sur les donnés probantes.” The majority of sites are French language translations of English sites, such as Children’s Mental Health Ontario, The Provincial Centre of Excellenc for Child and Youth Mental Health, and Canadian Mental Health Association.

In addition, some FL-PPs were identified in focus groups conducted by Martin Hubert for this project. Once identified, they were searched on Google (see below).

The Provincial Centre of Excellence for Child and Youth Mental Health has published a report of Clinical Guidelines for Child and Youth Mental Health, available on their website at http://www.onthepoint.ca/kec/documents/CPGannotbib.pdf. In addition, the Centre is actively seeking French language resources. If you know of clinical practice guidelines, or summaries of clinical practice guidelines, available in French, (contact person: agirardi@cheo.on.ca).

EBTs Requested for Use in French from Focus Group Participants

1. Nobody’s Perfect

Nobody’s Perfect is a parenting education and support program for parents of children from birth to age five. It is designed to meet the needs of parents who are young, single, socially or geographically isolated or who have low income or limited formal education. Participation is voluntary and free of charge. The program is not intended for families in crisis.

The Nobody’s Perfect Program was developed by Health Canada in partnership with the Departments of Health of the four Atlantic provinces: New Brunswick; Newfoundland and Labrador; Nova Scotia; and Prince Edward Island. Nobody’s Perfect was introduced nationally in 1987.
Nobody's Perfect parent materials were extensively revised and updated in 1997 and are published in both French and English. Nobody's Perfect is offered as a series of six to eight weekly group sessions. The program is built around five colourful, easy-to-read books which are given to the parents free of charge. During the meetings, trained facilitators support participants as they work together to discover positive ways of parenting. The Nobody's Perfect Program is based on the principles of adult education - it builds on what parents already know and do for themselves and their children. It starts with the parents' personal experiences and interests and actively involves participants in the learning process. It builds networks among parents and encourages them to see one another as sources of advice and support.
Several major evaluation and impact studies have found Nobody's Perfect to be successful at reducing isolation and increasing parenting skills and confidence. Nobody's Perfect has proven to be an effective program for parents who have limited access to sources of help or information. The program is offered in a broad range of settings in every Canadian province and territory. Nobody's Perfect is liked and used by many parents, including immigrant and Aboriginal parents.

Further information regarding the Nobody's Perfect Program or its implementation can be obtained by contacting the Ontario provincial coordinator:

Patricia Spadetto
Prevention/Early Intervention Supervisor
Timiskaming Child and Family Services
Timiskaming Brighter Futures
6 Tweedsmuir Road
Kirkland Lake, Ontario
P2N 1H9
Tel: (705)567-5926
Fax: (705)568-8787
E-mail: pspadetto@timiskamingchildren.org

The national contact person is:

Public Health Agency of Canada
Division of Childhood and Adolescence
Jeanne Mance Building
Tunneys Pasture
AL 1909C2
Ottawa, Ontario
K1A 0K9
Telephone: (613) 952-1220
Fax: (613) 952-1556
E-mail: DCA_public_inquiries@phac-aspc.gc.ca

2. Roots of Empathy (Gordon M 1996) http://www.rootsofempathy.org/

Roots of Empathy is an evidence-based classroom program that has shown dramatic effect in reducing levels of aggression and violence among school children while raising social/emotional competence and increasing empathy. The focus of Roots of Empathy in the long term is to build capacity of the next generation for caring and compassionate citizenship and parenting. In the short term, Roots of Empathy focuses on raising levels of empathy, resulting in more respectful and caring relationships and reduced levels of bullying and aggression. Part of the program's success is the universal nature of the program; all students are positively engaged instead of targeting bullies or aggressive children.

The heart of the program is a neighbourhood infant and parent who visit the classroom every three weeks over the school year. With a certified Roots of Empathy Instructor, students are coached to observe the baby's development, celebrate milestones, interact with the baby and learn about an infant's needs and unique temperament. The Roots of Empathy Instructor also works with the class the week before and the week after each family visit to prepare and reinforce teachings using a specialized curriculum that is developmentally appropriate for each of four age ranges.

The emotional literacy taught in the program lays the foundation for more caring classrooms. When children understand how others feel, they are less likely to hurt each other through bullying, exclusion and violence. In the Roots of Empathy program children learn how to challenge cruelty and injustice. Messages of social inclusion and activities that are consensus building contribute to a culture of caring that changes the tone of the classroom. Research results from national evaluations of Roots of Empathy indicate significant reductions in aggression and increases in pro-social behaviour.

Empathy is a key ingredient to responsible citizenship and caring parenting. Information on infant safety and development helps children to be more aware of issues of infant vulnerability such as SIDS and Shaken Baby Syndrome. Observations of a loving parent-child relationship give children a model of competent parenting.

The Roots of Empathy curriculum is comprehensive and sensitive to the development and interests of the children. The 639-page curriculum is divided into nine themes, with three classroom sessions supporting each theme (a pre-family session, family visit and post-family visit). Each of the nine themes is further broken down into four streams: Kindergarten, Primary (grades 1-3), Junior (grades 4-6) and Senior (grades 7-8).

In order to obtain their certification as a Roots of Empathy Instructor, all Instructors receive four days of intensive training from qualified Roots of Empathy trainers. All Instructors complete a written test, are supervised and participate in a year-end program evaluation. In Quebec, the provincial coordinator is Stéphanie Dupont, (514) 636-1497, sdupont@rootsofempathy.org.

Evidence-Based Treatments for Mental Health Concerns Identified in Part 1

Mental Health – General

1. Incredible Years

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Phone and fax: (206) 285-7565
Toll-free phone and fax: (888) 506-3562
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Resources

The Incredible Years Web site, www.incredibleyears.com, is a comprehensive resource that provides information on Incredible Years programs, training, workshops, evaluation, implementation, and materials.

The June 2000 *Office of Juvenile Justice and Delinquency Prevention (OJJDP) Bulletin Review* provides a comprehensive program overview: http://www.incredibleyears.com/research/article-Incredible-Years-ojjdp-6-00.pdf (PDF file).

For detailed cost information about the suggested budgets for each program component, visit the "Cost Planning for Administrators—Implementing the Incredible Years Programs" page on the Incredible Years Web site at: http://www.incredibleyears.com/workshop/cost-planning.htm.

The Incredible Years series is a set of comprehensive curricula targeting children age 2 to 10 years old and their parents and teachers. The curricula are designed to work jointly to promote emotional and social competence and to prevent, reduce, and treat children's behavioral and emotional problems.

Parent-Training Programs

The Incredible Years Parent-Training program includes four separate components targeting parents of high-risk children or children displaying behavior problems. In all four training components, facilitators use videotaped scenes to encourage group discussion, problem-solving, and sharing of ideas. The "BASIC Parent-Training Program—Early Childhood" (BASIC—Early Childhood) is a core component of the Incredible Years series and includes 12 to 14 two-hour weekly sessions targeting children age 2 to 7 years old. The BASIC—Early Childhood curriculum emphasizes parenting skills to promote children's social competence and to reduce behavior problems, and it teaches parents how to play with children, help children to learn, give effective praise and incentives, use limit-setting, and handle misbehavior.

The four add-on parent-training components, "Advance Parent Training Program—School Age (ADVANCE)," "BASIC Parent Training Program—School-Age (BASIC-School Age)," "Supporting Your Child's Education—School Age", and the school readiness supplements "Child-directed Play" and "Interactive Reading" may be offered as supplements to the early childhood BASIC component. ADVANCE targets school-age children 4 to 10 years old and includes eight to ten two-hour sessions that emphasize parents' interpersonal skills, such as effective communication, anger management, problem-solving between adults, and ways to give and receive support. The BASIC—School Age program is similar to the early childhood program but emphasizes strategies for older children,

including logical consequences, monitoring, helping children learn to problem solve with children, and family problem-solving. The Supporting Your Child's Education—School Age component for children age 5 to 10 involves four two-hour sessions and highlights approaches to parenting to promote children's academic skills, including nurturing reading skills, setting up homework routines, and building collaborative relationships with teachers. The school readiness supplements may be used with parents of 3- to 5-year-olds, and includes an emphasis on building children's social, emotional and academic skills, as well as fostering pre-reading and reading skills using the interactive reading approach.

Child Training Programs

There are two separate child-training components in the Incredible Years series. The first is the classroom program for children age 4 to 8 years. The Classroom Child-Training program uses the "Dina Dinosaur" curriculum which has more than 60 lesson plans (with preschool, kindergarten and grade one and two curricula), and may be offered over multiple years from preschool to grade two. The program seeks to improve peer relationships and reduce aggression both at home and at school. The curriculum is delivered to the entire classroom by regular teachers, two to three times a week through 20 - 30 minute group discussions followed by small-group practice activities. Home activity manuals encourage parents' involvement in teaching their children school rules, social skills, and problem-solving.

The second child-focused program is the "Dinosaur Child-Training" curriculum, a treatment program for small groups of children age 4 to 8 years who are exhibiting "conduct" problems (defined as high rates of aggression, defiance, and oppositional and impulsive behaviors). The curriculum emphasizes communicating feelings, empathy for others, friendship development, anger management, interpersonal problem-solving, and obeying school rules. The Dinosaur Child-Training program is offered to groups of five to six children in two-hour sessions held weekly for 20 to 22 weeks. The program can be delivered by counselors or therapists to treat conduct-disordered children in small groups, or can be used by schools as a "pullout" program for children with special behavioral and emotional needs.

Teacher Training Program

The training program for teachers emphasizes classroom management skills, such as the effective use of praise and encouragement, proactive teaching strategies, and ways to manage inappropriate classroom behavior and build positive relationships with students. Training can be provided through either four to six full-day workshops or 14 to 20 two-hour sessions.

The BASIC Parent-Training Program—Early Childhood component and the small-group Dinosaur Child-Training program have been rigorously evaluated, and the remainder of this description of the Incredible Years series focuses on these two components. The ADVANCE, BASIC—School Age, Supporting Your Child's Education, and school readiness parent-training components, the Teacher-Training program, and the Dina Dinosaur classroom curriculum currently do not have sufficiently rigorous research evidence that clearly assesses impacts on child outcomes.
The Incredible Years series targets children age 2 to 10 years who are at risk for, or who are exhibiting, conduct problems and their parents and teachers. Parents may be self-referred to the program or referred by a professional.

Program Design

Each training program targets different precursors of conduct problems in the home, classroom, and school setting and with the child individually in his or her peer group. Implementers of the Incredible Years can select the program and components that most closely meet their needs.

Curriculum: Parent-Training Program

All four of the components within the program (BASIC Parent Training Program—Early Childhood, Advance Parent Training Program—School Age, BASIC Parent Training Program—School-Age, and Supporting Your Child's Education—School Age), involve a collaborative training process utilizing group discussion guided by trained facilitators. Program materials include videotapes, detailed group-facilitator manuals (including questions for group discussion), parents' books and audiotapes, instructions for home activities, and notes for posting on the refrigerator and blackboard that reinforce and remind parents of key points from the videotape curricula.

Curriculum: Child-Training Program

- The small-group Dinosaur Curriculum emphasizes understanding and communicating feelings; friendship development; anger management; interpersonal problem-solving (e.g., waiting, taking turns); and following school rules (e.g., raising one's hand to speak, following teachers' instructions). The training program for children is targeted to small groups of children age 4 to 8 who are exhibiting conduct problems.
- The classroom Dina Dinosaur Preschool and School-Age programs use 30 to 60 lessons per year for use over three years' time targeting problem-solving, anger management, and social skills. Teachers use four steps to implement the program: planning, presenting (discussions with the whole class), practicing (in small groups), and promoting (done continuously throughout the day).

Curriculum: Teacher-Training Program

- The Teacher-Training program encourages teachers to be sensitive to individual developmental differences in children, such as variations in attention span, activity levels, and interest in novel situations, and teaches them how to respond to these differences in positive, accepting, and consistent ways. Additionally, teachers learn how to prevent peer rejection by teaching aggressive children appropriate problem-solving strategies and helping the children's peers to respond appropriately to aggression.
- For children with conduct problems, teachers, parents, and group facilitators jointly develop "transition plans" for children moving to a new grade or classroom that detail classroom strategies that are successful with each individual child; the goals achieved thus far and the goals that are remaining; and the child's characteristics, interests, and motivators.

Staffing

- Training is not required but is highly recommended by Incredible Years staff for effective program delivery. Workshops in the parent and child programs are offered regularly in Seattle and on request elsewhere in North America and the United Kingdom.
- Training for Incredible Years programs includes the content of the programs as well as the processes and methods of delivery. Trainers model group-leader skills and use videotape examples of actual interventions. Four types of program training are offered:
    - Parents' program (three days)
    - Children's small-group Dinosaur treatment program (two days)
    - Teachers' effective classroom management (three days)
    - Teachers' Effective classroom management and Dina Dinosaur school (three days)
- Incredible Years program staff also offer supervision and guidance via biweekly phone and e-mail consultations, critical review of videotaped sessions that are submitted by clients for feedback, and one- or two-day consultancy workshops (in Seattle or on site).

Bibliography

August, Gerald J., George M. Realmuto, Joel M. Hektner, and Michael L. Bloomquist, "An Integrated Components Preventive Intervention for Aggressive Elementary School Children: The Early Risers Program," *Journal of Consulting and Clinical Psychology*, Vol. 69, No. 4, 2001, pp. 614-626.

Baydar, Nazli, M. Jamila Reid, and Carolyn Webster-Stratton, "The Role of Mental Health Factors and Program Engagement in the Effectiveness of a Preventive Parenting Program for Head Start Mothers," *Child Development*, Vol. 74, No. 5, 2003, pp. 1433-1453.

Beauchaine, Theodore P., Carolyn Webster-Stratton, and M. Jamila Reid, "Mediators, Moderators, and Predictors of 1-Year Outcomes Among Children Treated for Early-Onset Conduct Problems: A Latent Growth Curve Analysis," *Journal of Consulting and Clinical Psychology*, Vol. 73, No. 3, 2005, pp. 371-388.

Brotman, Laurie Miller, Rachel G. Klein, Dimitra Kamboukos, Elissa J. Brown, Stephanie Irby Coard, and Laura Stout Sosinksy, "Preventive Intervention for Urban, Low-Income Preschoolers at Familial Risk for Conduct Problems: A Randomized Pilot Study," *Journal of Clinical Child and Adolescent Psychology*, Vol. 32, No. 2, 2003, pp. 246-257.

Gardner, Frances, Jennifer Burton, and Ivana Klimes, "Randomised Controlled Trial of a Parenting Intervention in the Voluntary Sector for Reducing Child Conduct Problems: Outcomes and Mechanisms of Change," unpublished, 2006. Online at http://www.incredibleyears.com (as of August 9, 2006).

Gross, Deborah, Louis Fogg, and Sharon Tucker, "The Efficacy of Parent Training for Promoting Positive Parent-Toddler Relationships," *Research in Nursing and Health*, Vol. 18, No. 6, 1995, pp. 489-499.

Gross, Deborah, Louis Fogg, Carolyn Webster-Stratton, Christine Garvey, Wrenetha Julion, and Jane Grady, "Parent Training of Toddlers in Day Care in Low-Income Urban Communities," *Journal of Consulting and Clinical Psychology*, Vol. 71, No. 2, 2003, pp. 261-278.

Hartman, Renée R., Scott A. Stage, and Carolyn Webster-Stratton, "A Growth Curve Analysis of Parent Training Outcomes: Examining the Influence of Child Risk Factors (Inattention, Impulsivity, and Hyperactivity Problems), Parental and Family Risk Factors," *Journal of Child Psychology and Psychiatry*, Vol. 44, No. 3, 2003, pp. 388-398.

Hutchings, Judy, Dave Daley, Karen Jones, Pam Martin, and Rhiain Gwyn, "Early Results from Developing and Researching the Webster-Stratton Incredible Years Teacher Classroom Management Training Programme in North West Wales," unpublished. Online at http://www.incredibleyears.com (as of August 8, 2006).

Hutchings, Judy, Eleanor Lane, Richard Ellis Owen, and Rhiain Gwyn, "The Introduction of the Webster-Stratton Classroom Dinosaur School Programme in Gwynedd, North Wales: A Pilot Study," *Educational and Child Psychology*, Vol. 21, No. 4, 2004, pp. 4-15.

Lees, Dianne G., and Kevin R. Ronan, "Parent Management Training for Solo Mothers of Children Diagnosed with Attention Deficit Hyperactivity Disorder: An Effectiveness and Multiple Baseline Evaluation," unpublished, 2005. Online at http://www.incredibleyears.com (as of August 16, 2006).

Linares, L. Oriana, Daniela Montalto, MinMin Li, and Vikash S. Oza, "A Promising Parenting Intervention in Foster Care," *Journal of Consulting and Clinical Psychology*, Vol. 74, No. 1, 2006, pp. 32-41.

Mørch, Willy-Tore, Graham Clifford, Bo Larsson, Per Rypdal, Torill Tjeflaat, Jim Lurie, May Britt Drugli, Sturla Fossum, and Charlotte Reedtz, "The Incredible Years—The Norwegian Webster-Stratton Programme 1998-2004," unpublished, 2004. Online at http://www.incredibleyears.com (as of August 16, 2006).

Olchowski, Allison, E. Michael Foster, and Carolyn Webster-Stratton, "Implementing Behavioral Intervention Components in a Cost-Effective Manner: An Assessment of the Incredible Years Program," unpublished, 2005. Online at http://www.unc.edu/~emfoster/papers/IYP_icer.pdf (PDF file; as of August 16, 2006).

Patterson, Jacoby, Jane Barlow, Carole Mockford, Ivana Klimes, Cecilia Pyper, and Sarah Stewart-Brown, "Improving Mental Health Through Parenting Programmes: Block Randomised Controlled Trial," *Archives of Diseases in Children*, Vol. 87, 2002, pp. 472-477.

Reid, M. Jamila, Carolyn Webster-Stratton, and Mary Hammond, "Follow-Up of Children Who Received the Incredible Years Intervention for Oppositional-Defiant Disorder: Maintenance and Prediction of 2-Year Outcome," *Behavior Therapy,* Vol. 34, No. 4, 2003, pp. 471-491.

Reid, M. Jamila, Carolyn Webster-Stratton, and Nazli Baydar, "Halting the Development of Conduct Problems in Head Start Children: The Effects of Parent Training," *Journal of Clinical Child and Adolescent Psychology,* Vol. 33, No. 2, 2004, pp. 279-291.

Reid, M. Jamila, Carolyn Webster-Stratton, and Theodore P. Beauchaine, "Parent Training in Head Start: A Comparison of Program Response Among African-American, Asian American, Caucasian, and Hispanic Mothers," *Prevention Science,* Vol. 2, No. 4, 2001, pp. 209-227.

Scott, Stephen, Quentin Spender, Moira Doolan, Brian Jacobs, and Helen Aspland, "Multicentre Controlled Trial of Parenting Groups for Childhood Antisocial Behaviour in Clinical Practice," *British Medical Journal,* Vol. 323, 2001, pp. 1-7.

Spaccarelli, Steve, Sheldon Cotler, and Doris Penman, "Problem-Solving Skills Training as a Supplement to Behavioral Parent Training," *Cognitive Therapy and Research,* Vol. 16, No. 1, 1992, pp. 1-18.

Taylor, Ted K., Fred Schmidt, Debra Pepler, and Christine Hodgins, "A Comparison of Eclectic Treatment with Webster-Stratton's Parents and Children Series in a Children's Mental Health Center: A Randomized Controlled Trial," *Behavior Therapy,* Vol. 29, 1998, pp. 221-240.

Webster-Stratton, Carolyn, "Advancing Videotape Parent Training: A Comparison Study," *Journal of Consulting and Clinical Psychology,* Vol. 62, No. 3, 1994, pp. 583-593.

Webster-Stratton, Carolyn, "Early-Onset Conduct Problems: Does Gender Make a Difference?," *Journal of Consulting and Clinical Psychology,* Vol. 64, No. 3, 1996, pp. 540-551.

Webster-Stratton, Carolyn, "Enhancing the Effectiveness of Self-Administered Videotape Parent Training for Families with Conduct-Problem Children," *Journal of Abnormal Child Psychology,* Vol. 18, No. 5, 1990a, pp. 479-492.

Webster-Stratton, Carolyn, "Individually Administered Videotape Parent Training: "Who Benefits?" *Cognitive Therapy and Research,* Vol. 16, No. 1, 1992, pp. 31-35.

Webster-Stratton, Carolyn, "Long-Term Follow-Up of Families with Young Conduct Problem Children: From Preschool to Grade School," *Journal of Clinical Child Psychology,* Vol. 19, No. 2, 1990b, pp. 144-149.

Webster-Stratton, Carolyn, "Predictors of Treatment Outcome in Parent Training for Conduct-Disordered Children," *Behavior Therapy,* Vol. 16, No. 2, 1985, pp. 223-243.

Webster-Stratton, Carolyn, "Preventing Conduct Problems in Head Start Children: Strengthening Parent Competencies," *Journal of Consulting and Clinical Psychology,* Vol. 66, No. 5, 1998, pp. 715-730.

Webster-Stratton, Carolyn, "Randomized Trial of Two Parent-Training Programs for Families with Conduct-Disordered Children," *Journal of Consulting and Clinical Psychology,* Vol. 52, No. 4, 1984, pp. 666-678.

Webster-Stratton, Carolyn, "Systematic Comparison of Consumer Satisfaction of Three Cost-Effective Parent Training Programs for Conduct-Problem Children," *Behavior Therapy,* Vol. 20, No. 1, 1989, pp. 103-115.

Webster-Stratton, Carolyn, "Teaching Mothers Through Videotape Modeling to Change Their Children's Behavior," *Journal of Pediatric Psychology,* Vol. 7, No. 3, 1982, pp. 279-294.

Webster-Stratton, Carolyn, and Mary Hammond, "Treating Children with Early-Onset Conduct Problems: A Comparison of Child and Parent Training Interventions," *Journal of Consulting and Clinical Psychology,* Vol. 65, No. 1, 1997, pp. 93-109.

Webster-Stratton, Carolyn, Jamila Reid, and Mary Hammond, "Social Skills and Problem-Solving Training for Children with Early-Onset Conduct Problems: Who Benefits?," *Journal of Child Psychology and Psychiatry and Allied Disciplines,* Vol. 42, No. 7, 2001b, pp. 943-952.

Webster-Stratton, Carolyn, M. Jamila Reid, and Mary Hammond, "Preventing Conduct Problems, Promoting Social Competence: A Parent and Teacher Training Partnership in Head Start," *Journal of Clinical Child Psychology,* Vol. 30, No. 3, 2001a, pp. 283-302.

Webster-Stratton, Carolyn, M. Jamila Reid, and Michael Stoolmiller, "Preventing Aggression and Improving Social, Emotional and Academic Competence: Evaluation of Dina Dinosaur Classroom

Curriculum in High Risk Schools," unpublished, 2006. Online at http://www.incredibleyears.com (as of August 16, 2006).
Webster-Stratton, Carolyn, M. Jamila Reid, M., and Mary Hammond, "Treating Children with Early-Onset Conduct Problems: Intervention Outcomes for Parent, Child, and Teacher Training," *Journal of Clinical Child and Adolescent Psychology,* Vol. 33, No. 1, 2004, pp. 105-124.
Webster-Stratton, Carolyn, Mary Kolpacoff, and Terri Hollinsworth, "Self-Administered Videotape Therapy for Families with Conduct-Problem Children: Comparison With Two Cost-Effective Treatments and a Control Group," *Journal of Consulting and Clinical Psychology,* Vol. 56, No. 4, 1988, pp. 558-566.

2. Attention Deficit - Hyperactivity Disorder

Sources:

PEDIATRICS Vol. 108 No. 4 October 2001, pp. 1033-1044, AMERICAN ACADEMY OF PEDIATRICS: Clinical Practice Guideline: Treatment of the School-Aged Child With Attention-Deficit/Hyperactivity Disorder**,** *Subcommittee on Attention-Deficit/Hyperactivity Disorder and Committee on Quality Improvement*

University of Buffalo,Center for Children and Families,
http://www.smbs.buffalo.edu/CENTERS/adhd/pdf/PsychosocialFactSheet.pdf

Comprehensive Treatment for ADHD should always include a strong psychosocial (that is, *not medical*) component. Most professionals believe that effective psychosocial treatment is the backbone of good treatment for ADHD. Medication is a very useful addition to psychosocial treatment in many cases, yielding a combination approach thatmay be even more effective than psychosocial treatments alone. The scientific literature on treatment for ADHD, the National Institute of MentalHealth, and many professional organizations say that there are two treatments that have a solid base of scientific evidence for short-term effectiveness: behavioral psychosocial treatments—also called behavior therapy or behaviormodification—and stimulant medication. Behavior modification is the *only* nonmedical treatment for ADHD with alarge scientific evidence base.

Behavior therapy represents a broad set of specific interventions that have a common goal of modifying the physical and social environment to alter or change behavior. Along with behavior therapy, most clinicians, parents, and schools address a variety of changes in the child's home and school environment, including more structure, closer attention, and limitations of distractions. Such environmental modifications have not undergone careful efficacy assessment, but most treatment plans include them. Behavior therapy usually is implemented by training parents and teachers in specific techniques of improving behavior. Behavior therapy then involves providing rewards for demonstrating the desired behavior (eg, positive reinforcement) or consequences for failure to meet the goals (eg, punishment). Repetitive application of the rewards and consequences gradually shapes behavior. Although behavior therapy shares a set of principles, it includes different techniques with many of the strategies often combined into a comprehensive program.

Behavior therapy should be differentiated from psychological interventions directed to the child and designed to change the child's emotional status (eg, play therapy) or thought patterns (eg, cognitive therapy or cognitive-behavior therapy). Although these psychological interventions have great intuitive appeal, they have little documented efficacy in the treatment of children with ADHD, and gains achieved in the treatment setting usually do not transfer into the classroom or home. By contrast, parent training in behavior therapy and classroom behavior interventions have successfully changed the behavior of children with ADHD.

Parent training typically begins with 8 to 12 weekly group sessions with a trained therapist. The focus is on the child's behavior problems and difficulties in family relationships. A typical program aims to improve the parents' or caregivers' understanding of the child's behavior and teaching them skills to deal with the behavioral difficulties posed by ADHD. Programs offer specific techniques for giving commands, reinforcing adaptive and positive social behavior, and decreasing or eliminating inappropriate behavior. Programs plan for maintenance and relapse prevention. Parent training improves the child's functioning and decreases disruptive behavior but (as with stimulant medications) does not necessarily bring the behavior of a child with ADHD into the normal range on parent rating scales.

Classroom management also focuses on the child's behavior and may be integrated into classroom routines for all students or targeted for a selected child in the classroom. Classroom management often begins with increasing the structure of activities. Systematic rewards and consequences, including point systems or use of token economy (see Table 2), are included to increase appropriate behavior and eliminate inappropriate behavior. A periodic (often daily) report card can record the child's progress or performance with regard to goals and communicate the child's progress to the parents, who then provide reinforcers or consequences based on that day's performance. Classroom behavior management also may improve a child's functioning but may not bring the child's behavior into the normal range on teacher behavior rating scales. Table 2 outlines specific behavior therapies that have been demonstrated as effective for ADHD.

TABLE 1

Effective Behavioral Techniques for Children With Attention-Deficit/Hyperactivity Disorder

Technique	Description	Example
Positive reinforcement	Providing rewards or privileges contingent on the child's performance.	Child completes an assignment and is permitted to play on the computer.
Time-out	Removing access to positive reinforcement contingent on performance of unwanted or problem behavior.	Child hits sibling impulsively and is required to sit for 5 minutes in the corner of the room.
Response cost	Withdrawing rewards or privileges contingent on the performance of unwanted or problem behavior.	Child loses free time privileges for not completing homework.
Token economy	Combining positive reinforcement and response cost. The child earns rewards and privileges contingent on performing desired behaviors and loses the rewards and privileges based on undesirable behavior.	Child earns stars for completing assignments and loses stars for getting out of seat. The child cashes in the sum of stars at the end of the week for a prize.

TABLE 2

Medications Used in the Treatment of Attention-Deficit/Hyperactivity Disorder

Generic Class (Brand Name)	Daily Dosage Schedule	Duration	Prescribing Schedule
Stimulants (First-Line Treatment)			
Methylphenidate			
Short-acting (Ritalin, Metadate, Methylin)	Twice a day (BID) to 3 times a day (TID)	3-5 hr	5-20 mg BID to TID
Intermediate-acting (Ritalin SR, Metadate ER, Methylin ER)	Once a day (QD) to BID	3-8 hr	20-40 mg QD or 40 mg in the morning and 20 early afternoon
Extended Release (Concerta, Metadate CD, Ritalin LA*)	QD	8-12 hr	18-72 mg QD
Amphetamine			
Short-acting (Dexedrine, Dextrostat)	BID to TID	4-6 hr	5-15 mg BID or 5-10 mg TID
Intermediate-acting (Adderall, Dexedrine spansule)	QD to BID	6-8 hr	5-30 mg QD or 5-15 mg BID
Extended Release (Adderall-XR*)	QD		10-30 mg QD
Antidepressants (Second-Line Treatment)			
Tricyclics (TCAs)	BID to TID		2-5 mg/kg/day†
Imipramine, Desipramine			
Bupropion			
(Wellbutrin)	QD to TID		50-100 mg TID
(Wellbutrin SR)	BID		100-150 mg BID

* Not FDA approved at time of publication.

† Prescribing and monitoring information in *Physicians' Desk Reference.*

3. Depressive Disorders

3.1. Coping with Stress Course

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The Kaiser Permanente Center for Health Research provides free downloads of the CWS therapist manual and the CWS teen workbook at http://www.kpchr.org/public/acwd/acwd.html.

The Coping with Stress Course (CWS) targets adolescents at risk for depression who are experiencing elevated depressive symptoms, or "demoralization." The program involves cognitive-restructuring techniques in which participants learn to identify and challenge negative or irrational thoughts that may contribute to the development of future mood disorders, such as depression. CWS is an adaptation of the Adolescent Coping with Depression Course (Clarke, Lewinsohn, and Hops, 1990), which targets adolescents already experiencing major depression or dysthymia. The program is intended for adolescents at risk for depression

Program Design

The theoretical background of the Coping with Stress Course is that teaching adolescents new coping strategies and strengthening their current coping skills provide them with some measure of "immunity" or resistance against the development of mood disorders later in life. The aim of CWS is to enhance at-risk adolescents' resilience in order to counteract their vulnerability to depression and other mood disorders.

Curriculum

Group size for the adolescent sessions is from six to ten adolescents, and the program consists of fifteen 45- to 60-minute group sessions. CWS uses cartoons, role-plays, and group discussions oriented to the developmental level of the participants.

Separate parent information meetings at the beginning, middle, and end of each adolescent course are optional. During these sessions, parents are informed about the general topics discussed, the skills taught in the adolescent groups, and the rationale for the use of the selected techniques.

Staffing

CWS groups are led by specially trained school psychologists and counselors who have a minimum of a master's degree in clinical, counseling, or educational psychology, and who have previous experience in conducting psychoeducational groups with adolescents. Before beginning the group sessions, therapists are provided with 40 hours of training, including mock intervention sessions, role-playing adolescent responses to exercises, homework, and videotaped feedback.

Bibliography

Clarke, Gregory N., Mark Hornbrook, Frances Lynch, Michael Polen, John Gale, William Beardslee, Elizabeth O'Connor, and John Seeley, "A Randomized Trial of a Group Cognitive Intervention

for Preventing Depression in Adolescent Offspring of Depressed Parents," *Archives of General Psychiatry*, Vol. 58, 2001, pp. 1127-1134.

Clarke, Gregory N., Peter M. Lewinsohn, and Hyman Hops, *Adolescent Coping with Depression Course*, Eugene, Oreg.: Castalia Press, 1990.

Clarke, Gregory N., Wesley Hawkins, Mary Murphy, Lisa B. Sheeber, Peter M. Lewinsohn, and John R. Seeley, "Targeted Prevention of Unipolar Depressive Disorder in an At-Risk Sample of High School Adolescents: A Randomized Trial of a Group Cognitive Intervention," *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 34, No. 3, 1995, pp. 312-321.

Lynch, Frances L., Mark Hornbrook, Gregory N. Clarke, Nancy Perrin, Michael R. Polen, Elizabeth O'Connor, and John Dickerson, "Cost-Effectiveness of an Intervention to Prevent Depression in At-Risk Teens," *Archives of General Psychiatry*, Vol. 62, No. 11, 2005, pp. 1241-1248.

3.2. Interpersonal Therapy

Interpersonal Psychotherapy (IPT), a time-limited, manualized psychotherapy, was first designed for the treatment of individuals with nonbipolar, nonpsychotic major depression. Currently, the Canadian and American Psychiatric Associations recommend IPT as a treatment for depression. Empirical evidence supporting its efficacy has grown since its early use, as has the breadth of its clinical application. This article reviews the principles and objectives of this type of treatment along with the relevant research supporting its efficacy.

Interpersonal therapy was initially developed to treat adult depression. It has since been applied to the treatment of depression in adolescents, the elderly, and people with Human Immunodeficiency Virus (HIV) infection. There is an IPT conjoint (couple) therapy for people whose marital disputes contribute to depressive episodes. IPT has also been modified for the treatment of a number of disorders, including substance abuse; bulimia and **anorexia nervosa**; **bipolar disorder**; and dysthymia. Research is underway to determine the efficacy of IPT in the treatment of patients with **panic disorder** or **borderline personality disorder**; depressed caregivers of patients with traumatic **brain** injuries; depressed pregnant women; and people suffering from protracted bereavement.

In IPT with adolescents, the therapist addresses such common developmental issues as separation from parents; the client's authority in relationship to parents; the development of new interpersonal relationships; first experiences of the death of a relative or friend; peer pressure; and single-parent families. Adolescents are seen weekly for 12 weeks with once-weekly additional phone contact between therapist and client for the first four weeks of treatment. The parents are interviewed in the initial session to get a comprehensive history of the adolescent's symptoms, and to educate the parents as well as the young person about depression and possible treatments, including a discussion of the need for medication. The therapist refrains from giving advice when working with adolescents, and will primarily use supportive listening, while assessing the client for evidence of suicidal thoughts or problems with school attendance. So far, research does not support the efficacy of antidepressant medication in treating adolescents, though most clinicians will give some younger clients a trial of medication if it appears to offer relief

The clinical dissemination of IPT has been slower than its research development. As a clinical intervention, it is becoming more widely used, especially in Europe, Australia and, increasingly, in Canada. IPT is included in many Canadian postgraduate psychiatry residency training programs: opportunities exist for continuing education (CE) courses through McMaster University, University of Ottawa and University of Toronto, and at the Canadian and American Psychiatric Association meetings.

To acquire clinical competency in IPT, ongoing clinical supervision is recommended in addition to a didactic CE course. Training programs in interpersonal therapy are still not widely available, so that

many practicing therapists base their work on the manual alone without additional supervision. It is unclear whether reading the manual alone is sufficient to provide an acceptable standard of care. While interpersonal therapy has been adapted for use with substance abusers, it has not demonstrated its effectiveness with this group of patients. Researchers studying patients addicted to opiates or cocaine found little benefit to incorporating IPT into the standard recovery programs. These findings suggest that another treatment method that offers greater structure and direction would be more successful with these patients.

Bibliography

Apple, Robin F. "Interpersonal Therapy for Bulimia Nervosa." *JCLP/In Session: Psychotherapy in Practice* 55, no. 6 (1999): 715-725.

Barkham, Michael, and Gillian E. Hardy. "Counselling and interpersonal therapies for depression: towards securing an evidence-base." *British Medical Bulletin* 57 (2001): 115-132.

Frank, Ellen, Ph.D., and Michael E. Thase, M.D. "Natural History and Preventative Treatment of Recurrent Mood Disorders." *Annual Reviews Medicine* 50 (1999): 453-468.

House, Allan, D. M. "Brief psychodynamic interpersonal therapy after deliberate self-poisoning reduced suicidal ideation and deliberate self-harm." *ACP Journal Club* 136 (January/February 2002): 27.

McIntosh, Virginia V. "Interpersonal Psychotherapy for Anorexia Nervosa." *International Journal of Eating Disorders* 27 (March 2000): 125-139.

Mufson, Laura, Ph.D., and others. "Efficacy of Interpersonal Psychotherapy for Depressed Adolescents." *Archives of General Psychiatry* 56, no. 6 (June 1999): 573-579.

Weissman, Myrna M., Ph.D., and John C. Markowitz, M.D. "Interpersonal Psychotherapy: Current Status." *Archives of General Psychiatry* 51, no. 8 (August 1994): 599-606.

3.3. Cognitive Behaviour Therapy

Cognitive Behavioral Therapy (CBT) is a brief form of psychotherapy used in the treatment of adults and children with depression. Its focus is on current issues and symptoms versus more traditional forms of therapy which tend to focus on a person's past history. The usual format is weekly therapy sessions coupled with daily practice exercises designed to help the patient apply CBT skills in their home environment.

There are several approaches to cognitive-behavioral therapy, including Rational Emotive Behavior Therapy, Rational Behavior Therapy, Rational Living Therapy, Cognitive Therapy, and Dialectic Behavior Therapy. Cognitive-behavioral therapy is evidence-based, which means that it is supported by research that proves that it is effective in helping people make emotional and behavioral changes. CBT for depression involves several essential features: identifying and correcting inaccurate thoughts associated with depressed feelings (cognitive restructuring), helping patients to engage more often in enjoyable activities (behavioral activation), and enhancing problem-solving skills. The first of these components, cognitive restructuring, involves collaboration between the patient and the therapist to identify and modify habitual errors in thinking that are associated with depression. Depressed patients often experience distorted thoughts about themselves (e.g. I am stupid), their environment (e.g. My life is terrible) and their future (e.g. There is no sense in going forward, nothing will work out for me). Information from the patient's current experience, past history, and future prospects is used to counter these distorted thoughts. In addition to self-critical thoughts, patients with depression typically cut back on activities that have the potential to be enjoyable to them, because they anticipate that such activities will not be worth their effort. Unfortunately this usually results in a vicious cycle, wherein depressed mood leads to less activity, which in turn results in further depressed mood, etc.

The second component of CBT, behavioral activation, seeks to remedy this downward spiral by negotiating gradual increases in potentially rewarding activities with the patient. When patients are depressed, problems in daily living often seem insurmountable. In the final process, the CBT therapist provides instruction and guidance in specific strategies for solving problems (e.g. breaking problems down into small steps).

Cognitive Behavioral Therapy is a scientifically well-established and effective treatment for depression. Over 75% of patients show significant improvements. The Depression Center offers both group and individual CBT with experienced and well-trained clinicians. Patients have the option to use the treatment alone (especially in mild to moderate cases) or in combination with medication.

Cognitive Behavior Therapy (CBT) **h**elps improve a child's moods and behavior by examining confused or distorted patterns of thinking. During CBT the child learns that thoughts cause feelings and moods which can influence behavior. For example, if a child is experiencing unwanted feelings or has problematic behaviors, the therapist works to identify the underlying thinking that is causing them. The therapist then helps the child replace this thinking with thoughts that result in more appropriate feelings and behaviors. Research shows that CBT can be effective in treating depression and anxiety.

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3.4. Psychodynamic Therapy

Psychodynamic Psychotherapy emphasizes understanding the issues that motivate and influence a child's behavior, thoughts, and feelings. It can help identify a child's typical behavior patterns, defenses, and responses to inner conflicts and struggles. *Psychoanalysis* is a specialized, more intensive form of psychodynamic psychotherapy which usually involved several sessions per week. Psychodynamic psychotherapies are based on the assumption that a child's behavior and feelings will improve once the inner struggles are brought to light.

4. Anxiety Disorders

4.1. Coping Cat

For information about research on the Coping Cat program, contact:

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The Coping Cat program is a cognitive-behavioral therapy intervention that helps children recognize and analyze anxious feelings and develop strategies to cope with anxiety-provoking situations. The program focuses on four related components: (1) recognizing anxious feelings and physical reactions to anxiety; (2) clarifying feelings in anxiety-provoking situations; (3) developing a coping plan (for example, modifying anxious self-talk into coping self-talk, or determining what coping actions might be effective); and (4) evaluating performance and administering self-reinforcement. By incorporating adaptive skills to prevent or reduce feelings of anxiety, the Coping Cat therapist uses a workbook to guide the child through consideration of previous behavior in situations in which the child felt anxious, as well as the development of expectations for future behavior in anxious situations. The Coping Cat workbook is used for children aged 8 to 13 years and the C.A.T. Project workbook is used for children aged 14 to 17 years. The C.A.T. Project differs from Coping Cat only in the use of developmentally appropriate pictures and examples for older ages.

Program Design

The Coping Cat program provides children and youth with information about anxiety and ways of coping with situations that previously caused anxiety and fear. Behavioral training strategies such as cognitive restructuring, modeling, guided imagery, simulation, real-life exposure, role-playing, relaxation training, and contingent reinforcement are used. Children are taught how to verbally reinforce their own successful coping and are encouraged to practice using the coping skills when anxiety-provoking situations arise.

Curriculum

The first eight sessions of the Coping Cat program involve an introduction of the basic concepts, followed by practice and reinforcement of the skill.

- In Session 1, the therapist builds a rapport with the child and collects specific information about the kinds of situations and experiences during which the child feels anxious, and the ways in which the child responds to that anxiety.
- Session 2 involves teaching the child to identify different types of feelings.
- In Session 3, children construct a hierarchy of anxiety-provoking situations so that they can distinguish anxious reactions from other types of reactions and can identify their own particular somatic responses.
- After Session 3, a meeting is held with the child's parents to review the treatment goals, share impressions and ideas, receive parental input on particular problem areas for each child, and encourage parental involvement in the treatment.
- In Session 4, children are taught how to relax outside of the sessions by listening to a cassette tape containing personalized relaxation content.
- Session 5 consists of teaching the child to recognize and assess self-talk during anxious situations and to reduce self-talk that is anxiety provoking.
- Session 6 emphasizes coping strategies such as coping self-talk and verbal self-direction, as well as developing appropriate actions to help cope with anxious situations.
- In Session 7, children learn how to self-evaluate and self-reward.
- Session 8 comprises reviewing concepts and skills covered in the previous sessions.

During the second set of eight sessions, the child practices the newly acquired skills by using both imaginary and real life experiences with individualized situations that vary from low stress, low anxiety to high stress, high anxiety.

- In Session 9, the child practices the newly learned skills in nonstressful, low-anxiety situations that begin with imaginary experiences and progress to real-life exposure. Practice includes therapist modeling and role-plays.
- In Sessions 10 to 13, the child is exposed to imaginary and real situations that cause increasing levels of anxiety.
- In Sessions 14 and 15, children practice in high-stress, high-anxiety situations.
- The final session is used to discuss the therapy experience, to review the skills, and to encourage the child to think about how to apply the skills in everyday life.

Staffing

Coping Cat therapists are trained providers with advanced degrees in psychology

Available Resources:

Flannery-Schroeder, Ellen C., and Philip C. Kendall, *Cognitive-Behavioral Therapy for Anxious Children: Therapist Manual for Group Treatment*, 1996, Workbook Publishing: Ardmore, PA.

Kendall, Philip C., and Kristina A. Hedtke, *Cognitive-Behavioral Therapy for Anxious Children: Therapist Manual, 3rd Edition (Child/Individual treatment manual)*, 2006, Workbook Publishing: Ardmore, PA.

Kendall, Philip C., and Kristina A. Hedtke, *Coping Cat Workbook, 2nd Edition*, 2006, Workbook Publishing: Ardmore, PA.

Kendall, Philip C., Muniya Choudhury, Jennifer Hudson, and Alicia Webb, "*The C.A.T. Project" Manual for the Cognitive Behavioral Treatment of Anxious Adolescents*, 2002, Workbook Publishing: Ardmore, PA

Kendall, Philip C., Muniya Choudhury, Jennifer Hudson, and Alicia Webb, *"The C.A.T. Project" Workbook for the Cognitive Behavioral Treatment of Anxious Adolescents*, 2002, Workbook Publishing: Ardmore, PA

To order books or DVDs/videos on Coping Cat, visit:
http://www.workbookpublishing.com/anxiety.htm
phone: (610) 896-9797, fax: (610) 896-1955

Training for Coping Cat therapists is often provided in workshops or at local and national professional meetings. To arrange for therapist training, contact Dr. Philip Kendall (as listed above).

Bibliography

Flannery-Schroeder, Ellen C., and Philip C. Kendall, "Group and Individual Cognitive-Behavioral Treatments for Youth with Anxiety Disorders: A Randomized Clinical Trial," *Cognitive Therapy and Research,* Vol. 24, No. 3, 2000, pp. 251-278.

Kendall, Philip C., "Treating Anxiety Disorders in Children: Results of a Randomized Clinical Trial," *Journal of Consulting and Clinical Psychology*, Vol. 62, No. 1, 1994, pp. 100-110.

Kendall, Philip C., Ellen Flannery-Schroeder, Susan M. Panichelli-Mindel, Michael Southam-Gerow, Aude Henin, and Melissa Warman, "Therapy for Youths with Anxiety Disorders: A Second Randomized Clinical Trial," *Journal of Consulting and Clinical Psychology,* Vol. 65, No. 3, 1997, pp. 366-380.

Nauta, Maaike H., Agnes Scholing, Paul M. G. Emmelkamp, and Ruud B. Minderaa, "Cognitive-Behavioral Therapy for Children with Anxiety Disorders in a Clinical Setting: No Additional Effect of a Cognitive Parent Training," *Journal of the American Academy of Child and Adolescent Psychiatry,* Vol. 42, No. 11, 2003, pp. 1270-1278.

4.2. Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

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The CBITS treatment manual is available for purchase through Sopris West Educational Services at (800) 547-6747 or online at: http://positiveschoolclimate.sopriswest.com/product.asp?productid=120.

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a group intervention for children in grades six through nine. The program is aimed at relieving symptoms of post-traumatic stress disorder (PTSD), depression, and general anxiety among children exposed to trauma. Types of traumatic events that participants have experienced include witnessing or being a victim of violence, experiencing a natural or man-made disaster, being in an accident or house fire, or suffering physical abuse or injury. Symptoms of PTSD, depression, and anxiety among children can include disorganized or agitated behavior, recurrent distressing recollections of an event, nightmares, attempts to reenact an event, intense psychological or physiological distress from cues that symbolize an aspect of the event, diminished interest or participation in certain activities, feelings of detachment or estrangement, difficulty falling asleep or staying asleep, and outbursts of anger. Children in CBITS work on processing traumatic memories, expressing their grief, learning relaxation skills, challenging upsetting thoughts, and improving their social problem-solving. These techniques and skills are learned through the use of drawings and through talking in both individual and group settings.

The CBITS program has been used most commonly for children in grades six through nine. Preliminary versions of CBITS have been used for children as young as eight years old.

Program Design

The CBITS program consists of ten one-hour group sessions with five to eight children, usually conducted once a week in a school or mental health or other office settings. The group sessions include exercises related to six cognitive-behavioral areas:

- Education about common reactions to trauma
- Relaxation training to combat anxiety
- Cognitive therapy (developing an understanding of the link between thoughts and feelings; combating negative thoughts)
- Real-life exposure to traumatic cues (developing avoidance and coping strategies)
- Exposure to stress or trauma memory through use of the imagination, drawing, or writing
- Social problem-solving.

Additional between-session activities that each student does as homework help strengthen his or her skills and allow group members to apply those skills to real-life problems. In addition to the group sessions, participants receive one to three individual sessions. Furthermore, the CBITS program includes two parent-education sessions and one teacher-education session to help adults to assist children in solidifying the skills learned during the program.

Curriculum

Reduction in symptoms of PTSD and depression is accomplished in CBITS via cognitive techniques (e.g., relaxation therapy and real-life exposure to traumatic cues) and trauma-focused memory work

using the imagination, writing, and drawing. In each session, a new set of skills is taught to children through the use of age-appropriate examples and games. Participants then use those skills to address their problems through homework assignments collaboratively developed by the child and the CBITS social worker.

Staffing

Typically, CBITS counselors are trained psychiatric social workers who are required to attend a two-day training session and receive ongoing supervision from a local clinician with expertise in cognitive-behavioral therapy.

Bibliography

Kataoka, Sheryl H., Bradley D. Stein, Lisa H. Jaycox, Marleen Wong, Pia Escudero, Wenli Tu, Catalina Zaragoza, and Arlene Fink, "A School-Based Mental Health Program for Traumatized Latino Immigrant Children," *Journal of the American Academy of Child and Adolescent Psychiatry,* Vol. 42, No. 3, 2003, pp. 311-318.

Stein, Bradley D., Lisa H. Jaycox, Sheryl H. Kataoka, Marleen Wong, Wenli Tu, Mare N. Elliott, and Arlene Fink, "A Mental Health Intervention for Schoolchildren Exposed to Violence: A Randomized Controlled Trial," *Journal of the American Medical Association,* Vol. 290, No. 3, 2003, pp. 603-611.

5. Substance Use Disorders

5.1. Guiding Good Choices (Dr. David Hawkins and Dr. Richard Catalano)

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Channing Bete Company summarizes Guiding Good Choices at www.channing-bete.com/positiveyouth/pages/FTC/FTC-GGC.html.

Office of Juvenile Justice and Delinquency Prevention (OJJDP) provides information on Guiding Good Choices (formerly known as Preparing for the Drug Free Years) at http://www.ncjrs.org/html/jjbulletin/9907/contents.html.

Guiding Good Choices (GGC) (formerly known as Preparing for the Drug Free Years) is a program designed to teach parent skills that can help prevent drug and alcohol abuse in their families. Dr. David Hawkins and Dr. Richard Catalano developed the program based on the social development model, which holds that strong bonding to positive influences reduces problem behaviors, such as delinquency and substance abuse. This is combined with research that has identified both risk and protective factors in the development of behavior problems. Risk factors include a low level of communication between parents and children, poorly defined and communicated expectations for children's behavior, excessively severe and inconsistent discipline, and high levels of negative interaction or family conflict. Protective factors include regular communication or parental warmth and affection, presentation of clear and pro-social expectations, monitoring of children, and consistent and moderate discipline.

The primary goal of GGC is to increase family involvement that is rewarding and enhances parent-child bonds. The program is offered in a series of sessions, each designed to focus on one of five areas. The program begins with increasing parents' knowledge of the risk factors associated with drug abuse. It then focuses on teaching parents the skills that help mitigate these risk factors, such as how to clearly communicate expectations for behavior, how to reduce family conflict, and how to encourage the expression of positive feelings and love. One of the sessions teaches both parents and children various ways to resist peer and social pressures to engage in inappropriate behavior.

The GGC curriculum was designed for a general public, and is primarily intended for parents with children age 9 to 14. The program was pilot-tested in ten Seattle public schools. Among the participating students, 52 percent were minorities, 48 percent were from low-income families, and 39 percent were from single-parent homes. The evaluation studies looked at 209 families in the central Midwest, where the families were predominantly white. It has been used to train more than 120,000 urban, suburban, and rural families in several states.

The goal of the program is to reduce drug abuse and behavioral problems by increasing involvement and interaction between parents and children, reducing family conflict, increasing the promotion of good behavior through better and more consistent family management. The program targets parents with children age 9 to 14, a time when they are facing increasing numbers of outside risk factors. Recruiting and retaining parents for the full five sessions can be challenging. The most successful approaches use multiple strategies focused on overcoming the common barriers to participation and that are specifically tailored to a community's needs.

***Curriculum**:*

The program is divided into five two-hour sessions, or ten one-hour sessions. Each session has a particular theme and parents are given activities to complete at home with the entire family.

Session 1, "Getting Started: How to Prevent Drug Abuse in Your Family," provides an overview of the risk factors associated with adolescent substance abuse and the theory of why social bonding may help mitigate those factors.

Session 2, "Setting Clear Family Expectations on Drugs and Alcohol," focuses on parenting skills. Parents learn how to develop family guidelines, how to effectively convey their expectations for children's behavior, and how to establish consequences for bad behavior. Parents also involve their children in a family meeting to develop a family policy about alcohol and other drugs.

Session 3, "Avoiding Trouble," is the one session that requires the children's attendance with the parents. The session discusses the social and peer pressures adolescents will face regarding substance abuse, and then teaches skills to resist such pressures. The session focuses on the risk factors of peers who use drugs. Together, parents and children practice skills to resist peer influences using the five steps of "Refusal Skills."

Session 4, "Managing Family Conflict," is aimed at reducing risks related to family conflict, negative interaction, and rebelliousness. Among other things, parents are taught ways to properly express and control anger without damaging family bonds and how to teach their children these same skills.
In Session 5, "Strengthening Family Bonds," parents learn ways to expand family involvement. The session also emphasizes the benefits of expressing positive feedback and love.

***Staffing**:*

The sessions are usually led by two trained community volunteers who attend a three-day training workshop where they are taught to used a structured, standardized curriculum for conducting interactive workshops.

***Bibliography**:*

Kosterman, R., and J. David Hawkins, "Effects of a Preventive Parent-Training Intervention on Observed Family Interactions: Proximal Outcomes from Preparing for the Drug Free Years," *Journal of Community Psychology,* Vol. 25, No. 4, 1997, pp. 337-352.

Park, J., Kosterman, R., Hawkins, J. David, et al., "Effects of the 'Preparing for the Drug Free Years" Curriculum on Growth in Alcohol Use and Risk for Alcohol Use in Early Adolescence," *Prevention Science,* Vol. 1, No. 3, 2000, pp. 125-138.

Spoth, R.L., Guyll, M., and Day, S.X., "Universal Family-Focused Interventions in Alcohol-Use Disorder Prevention: Cost Effectiveness and Cost-Benefit Analyses of Two Interventions," *Journal of Studies on Alcohol,* Vol. 63, No. 2, 2002, pp. 219-228.

5.2. LifeSkills Training

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Internet: http://www.lifeskillstraining.com

The LifeSkills Training (LST) program is a school-based substance abuse prevention curriculum for middle and junior high school students. The LST program was developed in the late 1970s and aims to modify drug-related knowledge, attitudes, and norms; teach skills for resisting social influences that encourage drug use; and foster the development of general personal and social skills.

The LST program originally focused on preventing cigarette smoking, and the curriculum was later expanded to include preventing the use of alcohol and other drugs. Typically, the LST curriculum is taught over three consecutive school years, beginning in the 6th and 7th grade. The program consists of 15 lessons in the first year, followed by 10 “booster” lessons during the program’s second year and 5 booster lessons in the third year. The booster lessons are designed to reinforce earlier material and to provide additional opportunities for skill development and practice. Regular classroom teachers usually implement the LST curriculum; however, the program can also be implemented by outside health professionals or older student peers.

The LST program is designed for middle and junior high school students. It has been studied extensively with white, middle-class participants from suburban and rural areas of New York State, as well as with African-American and Hispanic youth in urban New York City.

Program Design: The LST program uses social-resistance skills training and techniques designed to develop adolescents’ key personal and social skills. The prevention curriculum addresses the major cognitive, attitudinal, psychological, and social factors related to adolescent cigarette smoking. LST incorporates five major components that:

- Provide information concerning the short-term consequences of substance use, prevalence rates, and the current social acceptability of smoking and other drug use
- Facilitate critical thinking and independent decision-making

- Help students develop skills for coping with anxiety
- Teach social skills and assertiveness skills
- Facilitate self-improvement and a sense of personal control.

***Curriculum*:**

A combination of teaching techniques is used to teach substance use prevention skills to students, including group discussion, demonstration, modeling, behavioral rehearsal, feedback and reinforcement, and behavioral "homework" assignments for out-of-class practice. The complete LST curriculum consists of a Teacher's Manual, Student's Guide, and a relaxation tape available through the National Health Promotion Associates (NHPA). The NHPA also provides one- or two-day training workshops at a cost of $100 per day. A version of the program is available for both middle and elementary school students.

In addition to teaching skills for the enhancement of personal and social competence, the LST program teaches students specific skills related to resisting pressures for substance use, including how to apply assertiveness skills in situations in which they might experience pressure to smoke, drink, or use drugs. Unlike traditional prevention approaches, only minimal information concerning the long-term health consequences of drug use is provided. Instead, information hypothesized to be more relevant to prevention is given, such as information concerning the immediate negative consequences of drug use, the addictive nature of certain substances, the decreasing social acceptability of use, and the actual prevalence rates among adults and adolescents.

LST program materials include a teacher's manual with detailed lessons plans, student handouts, and videotape material demonstrating the personal and social skills being taught in the prevention program.

***Staffing**:*

Regular classroom teachers usually teach the LST program. Training is provided through National Health Promotion Associates and consists of a one- or two-day training workshop that is designed to familiarize teachers with the program and its rationale, and to provide them with an opportunity to learn and practice the skills necessary to deliver the curriculum. Peer leaders may also be used to assist classroom teachers in presenting the program, or may implement the curriculum themselves.

Bibliography

Botvin Gilbert J., Steven P. Schinke, Jennifer A. Epstein, and Tracy Diaz, *Effectiveness of Culturally Focused and Generic Skills Training Approaches to Alcohol and Drug Abuse Prevention Among Minority Youths* 1994. Psychology of Addictive Behaviors, 8: 116-127

Botvin, Gilbert J., and Anna Eng, *The Efficacy of a Multicomponent Approach tothe Prevention of Cigarette Smoking* 1982. Preventive Medicine, 11: 199-211

Botvin, Gilbert J., and Anna Eng, *A Comprehensive School-Based Smoking Prevention Program* 1980. The Journal of School Health, 50: 209-213

Botvin, Gilbert J., Anna Eng, and Christine L. Williams, *Preventing the Onset of CigaretteSmoking Through Life Skills Training* 1980. Preventive Medicine, 9: 135-143

Botvin, Gilbert J., Eli Baker, Anne D. Filazzola, and Elizabeth M. Botvin, *A Cognitive-Behavioral Approach to Substance Abuse Prevention: One-Year Follow-Up* 1990a. Addictive Behaviors, 15: 47-63

Botvin, Gilbert J., Eli Baker, Elizabeth M. Botvin, Anne D. Filazzola, and Robert B. Millman *Prevention of Alcohol Misuse through the Development of Personal and Social Competence: A Pilot Study* 1984a. Journal of Studies on Alcohol, 45:(6) 550-552

Botvin, Gilbert J., Eli Baker, Linda Dusenbury, Elizabeth M. Botvin, and Tracy Diaz *Long-Term Follow-up Results of a Randomized Drug Abuse Prevention Trial in a White Middle-Class Population* 1995a. Journal of the American Medical Association, 273(14): 1106-1112

Botvin, Gilbert J., Eli Baker, Nancy L. Renick, Anne D. Filazzola, and Elizabeth M. Botvin, *A Cognitive-Behavioral Approach to Substance Abuse Prevention* 1984b. Addictive Behaviors, 9: 137-147

Botvin, Gilbert J., Horace W. Batson, Sylvia Witts-Vitale, Valerie Bess, Eli Baker, and Linda Dusenbury, *A Psychosocial Approach to Smoking Prevention for Urban Black Youth* 1989a. Public Health Reports, 104(6): 573-582

Botvin, Gilbert J., Jennifer A. Epstein, Eli Baker, Tracy Diaz, Michelle Ifill-Williams, *School-Based Drug Abuse Prevention with Inner-City MinorityYouth* 1997. In Gilbert J. Botvin and Steven Schinke, eds., The Etiology and Prevention of Drug Abuse Among Minority Youth, Binghamton, N.Y.: The Haworth Press, Inc., 5-19

Botvin, Gilbert J., Kenneth W. Griffin, Tracy Diaz, and Michelle Ifill-Williams, *Preventing Binge Drinking During Early Adolescence: One- and Two-Year Follow-Up of a School-Based Preventive Intervention* 2001b. Psychology of Addictive Behaviors, 15(4): 360-365

Botvin, Gilbert J., Kenneth W. Griffin, Tracy Diaz, and Michelle Ifill-Williams, *Drug Abuse Prevention Among Minority Adolescents: Posttest and One-Year Follow-Up of a School-Based Preventive Intervention* 2001a. Prevention Science, 2(1): 1-13

Botvin, Gilbert J., Kenneth W. Griffin, Tracy Diaz, Nicole Miller, and Michelle Ifill-Williams, *Smoking Initiation and Escalation in Early Adolescent Girls: One-Year Follow-up of a School-Based Prevention Intervention for Minority Youth* 1999. Journal of the American Medical Women's Association, 54: 139-143

Botvin, Gilbert J., Linda Dusenbury, Eli Baker, Susan James-Ortiz, and Jon Kerner, *A Skills Training Approach to Smoking Prevention Among Hispanic Youth* 1989b. Journal of Behavioral Medicine, 12(3): 279-296

Botvin, Gilbert J., Linda Dusenbury, Eli Baker, Susan James-Ortiz, Elizabeth M. Botvin, and Jon Kerner, *Smoking Prevention Among Urban Minority Youth: Assessing Effects on Outcome and Mediating Variables* 1992. Health Psychology, 11(5): 290-299

Botvin, Gilbert J., Nicole L. Renick, and Eli Baker, *The Effects of Scheduling Format and Booster Sessions on a Broad-Spectrum Psychosocial Smoking Prevention Program* 1983. Journal of Behavioral Medicine, 6(4): 359-379

Botvin, Gilbert J., Stephanie Tortu, Eli Baker, and Linda Dusenbury, *Preventing Adolescent Cigarette Smoking: Resistance Skills Training and Development of Life Skills* 1990b. Special Services in the Schools, 6(½): 37-61

Botvin, Gilbert J., Steven P. Schinke, Jennifer A. Epstein, Tracy Diaz, and Elizabeth M. Botvin, *Effectiveness of Culturally Focused and Generic Skills Training Approaches to Alcohol and Drug Abuse Prevention Among Minority Adolescents: Two-Year Follow-up Results* 1995b. Psychology of Addictive Behaviors, 9(3): 183-194

Griffin, Kenneth W., Gilbert J. Botvin, Tracy R. Nichols, and Margaret M. Doyle, *Effectiveness of a Universal Drug Abuse Prevention Approach for Youth at High Risk for Substance Use Initiation* 2003. Preventive Medicine, 36: 1-7

Spoth, Richard L, Cleve Redmond, Linda Trudeau, and Chungyeol Shin, *Longitudinal Substance Initiation Outcomes for a Universal Preventive Intervention Combining Family and School Programs* 2002. Psychology of Addictive Behaviors, 16(2): 129-134

5.3. Nurse Family Partnership

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The Nurse Family Partnership program (previously named the Prenatal and Infancy Nurse Home Visitation Program) provides home visits by registered nurses to first-time mothers, beginning during pregnancy and continuing through the child's second birthday. The program has three primary goals: (1) to improve pregnancy outcomes by promoting health-related behaviors; (2) to improve child health, development and safety by promoting competent care-giving; and (3) to enhance parent life-course development by promoting pregnancy planning, educational achievement, and employment. The program also has two secondary goals: to enhance families' material support by providing links with needed health and social services, and to promote supportive relationships among family and friends.

The program was originally developed to address the underlying causes of antisocial behavior – behavior that violate social rules or harm others. Antisocial behavior that begins at an early age (such as in preschool) is likely to be more severe and is more likely to persist than antisocial behavior that begins in adolescence. Three main factors have been found to be associated with early onset of antisocial behavior:

– The first factor is neurodevelopmental impairment of the fetus. Children of women who engage in risky behaviors (cigarette, alcohol, and drug use) are more at risk for this kind of impairment.
– The second factor is dysfunctional care giving, which generally refers to an inadequate parental provision of material and emotional care.
– The third factor is maternal life-course development. Children of women who are on welfare, are unmarried, are high school dropouts, or who have three or more children are more likely to have reported behavioral problems. The three primary goals of the program directly address these three main risk areas.

The content of the program is grounded in three theories: human ecology, human attachment, and the theory of self-efficacy.
- *Human ecology theory* emphasizes the importance of social context on human development. The program is introduced to first-time mothers because this represents a major change in the mother's life. The program continues into the early years of the child's life when the parent is still learning the parental role.

- *Attachment theory* argues that a caregiver's level of responsitivity to her child can be traced to her own childrearing history and attachment experiences. By helping the parent to see herself as someone who deserves support and attention, she begins to see her child as deserving the same.

- The *theory of self-efficacy* posits that differences in motivation and behavior are due to an individual's beliefs about how his or her efforts and the desired results are interconnected. Based on this theory, the program emphasizes helping mothers to set small achievable objectives that involve behavioral change and that will help them in dealing with similar problems in the future. This is one aspect of the program that has changed over time. It grew from field observations that the women with the most success in the program originally felt they had very little control over their lives.

The program is designed to serve first-time mothers. It is particularly aimed at new mothers who have additional risk factors, such as low socioeconomic status, being unmarried, or being young (under 19). Probable implementers include nurses; public health, social welfare, and criminal justice officials; obstetricians, and pediatricians. Most typically, public health departments, visiting nurse associations, and hospitals will carry out the program.

Program Design:

- The home visitors focus on improving maternal health, promoting competent parenting, and enhancing parental life-course development.
- The program serves first-time, low-income mothers and their families.
- The home visits begin during pregnancy and continue through the second year of the child's life.
- The home visitors are highly trained registered nurses who follow specific protocols during each visit and carry a maximum of 25 cases.
- Home visitors involve family members and friends in the program and help families to use other community health and human services

The nurse visits occur approximately every one to two weeks through most of the intervention, depending on the mother's delivery date or the age of the child. During the prenatal period, the nurses help women complete 24-hour diet histories and plot weight gains; try to facilitate a reduction in the use of cigarettes, alcohol, and drugs through behavioral analysis; and help women to identify the signs and symptoms of pregnancy complications and other health problems (urinary tract infections, sexually transmitted diseases, and hypertensive disorders).

After delivery, the nurses also educate women on how to recognize health problems with their child and whom to contact when their child becomes ill. They promote parent-child interactions by helping parents to understand a child's communicative signals, enhancing parents' interest in playing with their children, and creating safer households. Nurses also help women clarify their goals and solve problems that may have interfered with completing their education, finding work, or planning future pregnancies.

Curriculum*:*

The nurses are trained to follow a very specific set of protocols and home visit guidelines, which they then adapt to each family's strengths and needs.

Staffing*:*
Home-visiting registered nurses provide the core staff of the program. Program nurses typically are hired through local health departments, community health centers, or Visiting Nurses Associations. In some cases, the program has been administered through local hospitals or non-profit, private organizations.

Detailed visit-by-visit protocols, training, and technical assistance are made available to organizations that commit to conduct the program in accordance with the program model, and that have the financial resources and organizational capacity to do so. Specific training modules have been developed around issues of staff cultural competence. Further, program teaching materials have been translated into Spanish. An extensive list of publications is available on the research findings and the theoretical and clinical foundations of program.

Bibliograhy

Bandura, A. "Self-efficacy: Toward a Unifying Theory of Behavioral Change," Psychological Review, Vol. 84, No. 2, 1977, pp. 191-215.

Olds, D., et al., "Reducing Risks for Antisocial Behavior with a Program of Prenatal and Early Childhood Home Visitation," Journal of Community Psychology, Vol. 26, 1998, pp. 65-83.

Olds, D., P. Hill, and E. Rumsey. "Prenatal and Early Childhood Nurse Home Visitation," Juvenile Justice Bulletin, November 1998.

Olds, D. and J. Korfmacher, "Findings From a Program of Research on Prenatal and Early Childhood Home Visitation: Special Issue Introduction," Journal of Community Psychology, Vol. 26, No. 1, 1998, pp. 1-3.

Olds, D., et al., "Theoretical Foundations of a Program of Home Visitation for Pregnant Women and Parents of Young Children," Journal of Community Psychology, Vol. 25, 1997, pp. 2-25.
Olds, D. and J. Korfmacher, "The Evolution of a Program of Research on Prenatal and Early Childhood Home Visitation: Special Issues Introduction" Journal of Community Psychology, Volume 25, No. 1, 1997, pp. 1-7.
Karoly, L. A., et al. *Investing In Our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions*, Santa Monica, Calif: RAND, MR-898, 1998.
Kitzman, H., et al. "Effect of Prenatal and Infancy Home Visitation by Nurses on Pregnancy Outcomes, Childhood Injuries, and Repeated Childbearing: A randomized Controlled Trial" *Journal of the American Medical Association*, Vol. 278, No. 8, 1997, pp. 644-652.
Korfmacher, J., O'Brien, R., & Olds, D., "Differences in Program Implementation Between Nurses and Paraprofessionals Providing Home Visits During Pregnancy and Infancy: A Randomized Trial," *American Journal of Public Health*, Vol. 89, No. 12, 1999, pp. 1847-1851.
Olds, D., et al., "Does Prenatal and Infancy Nurse Home Visitation have Enduring Effects on Qualities of Parental Caregiving and Child Health at 25-50 months of life?" *Pediatrics*, Vol. 93, 1994, pp. 89-98.
Olds, D., et al., "Effects of Prenatal and Infancy Nurse Home Visitation on Surveillance of Child Maltreatment" *Pediatrics*, Vol. 95, 1995, pp. 365-372.
Olds, D., et al., "Improving the Delivery of Prenatal Care and outcomes of Pregnancy: A Randomized Trial of Nurse Home Visitation." *Pediatrics*, Vol. 77, 1986, pp. 16-28.
Olds, D., et al., "Improving the life-course Development of Socially Disadvantaged Parents: A Randomized Trial for Nurse Home Visitation," *American Journal of Public Health*, Vol. 78, November 1988, pp. 1436-45.
Olds, D., et al., "Long-Term Effects of Nurse Home Visitation on Maternal Life Course and Child Abuse and Neglect: Fifteen-Year Follow-up of a Randomized Trial," *JAMA*, Vol. 278, No. 8, 1997, pp. 637-643.
Olds, D., et al., "Long-term Effects of Nurse Home Visitation on Children's Criminal and Antisocial Behavior: 15-Year Follow-up of a Randomized Controlled Trial," *JAMA*, Vol. 280, No. 14, 1998, pp. 1238 – 1244. O
Olds, D., et al., "Reducing Risks for Antisocial Behavior with a Program of Prenatal and Early Childhood Home Visitation," *Journal of Community Psychology*, Vol. 26, 1998, pp. 65-83.

6. Violent Behaviour

6.1. Multisystemic Therapy

For further information about program development, treatment model dissemination, and training, contact:

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Multisystemic Therapy (MST) is an intensive, family-based treatment approach for improving the antisocial behavior of serious juvenile offenders. MST seeks to reduce youth criminal activity and other kinds of negative behavior (for example, drug abuse) in a cost-effective manner by limiting the need for incarceration or other types of out-of-home placement.

Developed in the 1970s, the MST model is based on the belief that youth behavior is determined by multiple factors (such as characteristics of the youth, family relations, peer interactions, or community influences), and each of these factors can be targeted to promote positive behavioral change. Thus, depending on the youth's individual circumstances, MST treatment may aim to improve a caregiver's discipline practices, decrease the youth's interaction with deviant peers, improve the youth's school performance, or aim to produce other positive results.

MST treatment is conducted in natural settings (for example, in the youth's home, school, or community) under the premise that youths and their families must learn how to function more effectively within their natural environment if they are to sustain improvements after treatment concludes. MST treatment typically lasts about four months, and involves several hours of contact per week.

MST targets juvenile offenders and their families. The targeted youth are chronic, violent, or substance -abusing juvenile offenders at high risk of out-of-home placement.

MST programs are typically housed within public mental health organizations, or in private provider organizations that offer mental health services. MST programs typically interact with multiple local agencies (for example, juvenile justice, mental health, and social welfare agencies), as well as with schools and family courts.

Program Design:

MST uses techniques from cognitive, behavioral, and family therapies. Each MST treatment plan is designed in collaboration with the youth's family members, and is family-driven rather than therapist-driven. The overall objectives of MST treatment are to empower caregivers with the skills and resources they will need to address the inevitable difficulties associated with raising teenagers, and to empower youths with skills and resources for coping with family, peer, school, and neighborhood problems. Over the course of treatment, MST therapists place developmentally appropriate demands on the youths and family members so that they behave in an increasingly responsible manner.

Curriculum*:*

MST does not have a prescribed or set curriculum.

Staffing and Training:

Masters-level therapists, who work as full-time employees for the MST program, provide treatment. Each therapist carries a caseload of four to six families. The therapists are organized into "teams" of two to four; each team of therapists receives on-site supervision, usually by a Ph.D.-level mental health professional. MST therapists are required to track weekly progress and outcomes on each case by completing case paperwork and participating in clinical supervision and MST consultation.

Staff training and program development assistance are provided by MST Services, through licensing agreements with the Medical University of South Carolina and the Family Services Research Center.

The core services for program development and training include the following:

1. Organizational assessment and assistance;
2. an initial five-day training session;
3. weekly MST clinical consultations;
4. quarterly "booster" training sessions; and
5. ongoing monitoring for treatment fidelity and adherence.

Bibliography

Aos, S., P. Phipps, R. Barnoski, and R. Lieb *The Comparative Costs and Benefits of Programs to Reduce Crime* Olympia, WA: Washington State Institute for Public Policy, Version 3.0, May 1999. (http://www.wa.gov/wsipp/crime/pdf/costbenefit.pdf)

Borduin, C., B. Mann, L. Cone, S. Henggeler, B. Fucci, D. Blaske, and R. Williams *"Multisystemic Treatment of Serious Juvenile Offenders: Long-Term Prevention of Criminality and Violence,"* Journal of Consulting and Clinical Psychology, Vol. 63, No. 4, 1995, pp. 569-578.

Henggeler, S., C. Borduin, G. Melton, B. Mann, L. Smith, J. Hall, L. Cone, and B. Fucci, *"Effects of Multisystemic Therapy on Drug Use and Abuse in Serious Juvenile Offenders: A Progress Report from Two Outcome Studies,"* Family Dynamics of Addiction Quarterly, Vol. 1, No. 3, 1991, pp. 40-51.

Henggeler, S., G. Melton, M. Brondino, D. Scherer, and J. Hanley, *"Multisystemic Therapy with Violent and Chronic Juvenile Offenders and Their Families: The Role of Treatment Fidelity in Successful Dissemination,"* Journal of Consulting and Clinical Psychology, Vol. 65, No. 5, 1997, pp. 821-833.

Henggeler, S., M. Rowland, J. Randall, D. Ward, S. Pickrel, P. Cunningham, J. Zealberg, L. Hand, A. Santos, S. Miller, and J. Edward, *"Home-Based Multisystemic Therapy as an Alternative to the Hospitalization of Youths in Psychiatric Crisis: Clinical Outcomes,"* Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 38, No. 11, 1999b, pp. 1331-1339.

6.2. Nurse-Family Partnership (see above)

Elements of an Action Plan

With very little French language published literature, and even fewer manuals or treatments available in French for child and youth mental health, the way ahead points to the selection, translation, and validatin of English language EBTs. This, in and of itself, however, it not sufficient to move the advance mental health services for Francophone children and youth in Ontario. We also require a standardized and systematic approach to evaluate whether the services provided are achieving the intended effects. This piece of work has been achieved across the system over the last six years, through the training and implementation of two tools in 125 children's mental health organizations. These tools and their implications for advancing French language mental health services for children and youth, are described below.

Ontario's Mandated Screening and Outcome Measurement Tools: Implications for Francophone Services

Standardized screening practices can assist in the management of long waiting lists by identifying children at greatest risk. Outcome measurement can demonstrate which treatments are effective and for whom, and the proportion of children who improve as a result of service. Both methods assist clinicians in the tast of diagnostic formulation, treatment management, and treatment discharge. To this end, Ontario initiated systematic screening and outcome measurement in 1999 as part of a four-point plan for children's mental health that also saw development of intensive child and family services, mobile crisis services, and telepsychiatry.

A commissioned review of outcome measurement tools for children's mental health (Raphael, Weir, Weston, Lines & Pettingill, 1999) together with a feasibility study (Boydell, Barwick, Ferguson & Haines, in press) led to the adoption of two instruments across selected CMH organizations: 1) a standardized intake instrument to screen morbidity (Brief Child and Family Phone Interview / BCFPI; Cunningham, Pettingill & Boyle, 2000), and 2) a standardized outcome instrument to assess level of functioning and monitor the effectiveness of treatment (Child and Adolescent Functional Assessment Scale / CAFAS; Hodges, 2003). Children's Mental Health Ontario, an advocacy organization that promotes the well-being of children, youth, and their families, oversees BCFPI training and implementation with support from BCFPI Incorporated and the Offord Centre for Child Studies at McMaster University. CAFAS training and implementation is provided by the Community Health Systems Resource Group at The Hospital for Sick Children. An advisory group of service providers from across Ontario jointly support the implementation teams, as does the Research and Outcome Measurement Branch of the Ministry of Children and Youth Services.

Both tools have been translated into French, but they have not been evaluated with respect to validity for the Franchophone population. Several organizations throughout Ontario have been using the measures, as mandated, and have submitted data for inclusion in annual reports. Data submission also results in individualized reports being returned to participating organizations, for help in service provision. Organizations serving Franchophone children and youth that are already participating with use of these tools include: Centre Psycho-Social Pour Enfants et Families d'Ottawa-Carelton, Equipe D'Hygiene Mentale pour Enfants et Adolescents, Youville Centre Ottawa-Carleton.

Screening: The Brief Child and Family Phone Interview

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

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

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

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

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

Outcome Measurement: The Child and Adolescent Functional Assessment Scale

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Outcome measurement leads to improved treatment, enhances clinical science, provides accountability, and maintains the ethical responsibility of practitioners to examine service quality (Barlow, Hayes & Nelson 1984; Ogles, Lambert & Masters, 1996). All too frequently, children receive care that is based on outdated practices and narrowly defined outcomes as opposed to care that is based on increasing evidence of effectiveness and a wider spectrum of desired functional and quality of life outcomes (Huang, Hepburn & Espiritu, 2003). The field continues to rely on practices that have little supporting evidence or, at worst, have poor outcomes (Busch 2002; Dishion, McCord & Poulin, 1999) despite evidence that most children who receive an empirically supported treatment get significantly better and do so more quickly than with other treatments or no treatment (Chambliss & Ollendick, 2001; JCCP 1998).

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

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

Training can be accomplished independently by rating 10 reliability vignettes from the CAFAS Self-Training Manual (Hodges, 2003). This ensures that all raters use the same "rules' and definitions of terms. In Ontario, reliability training takes place in 2-day training workshops. Software and train-the-trainer workshops are also provided. To guard against "rater drift," booster exercises are completed

annually. In a study of rater drift among Ontario users interrater reliabilities for 315 raters proved to be in the moderate to high range (.848 to .995). Booster reliability training conducted one year later showed interrater reliabilities improved statistically on 3 subscales and drifted on 4 subscales but remained in the moderate to high range (.82 to .99). The feasibility of a train-the-trainer approach for establishing interrater reliability among practitioners new to the field demonstrated high correlations for 140 practitioners trained by on-site practitioner-trainers and (.84 to .99) (Barwick, Urajnik, Basnett, in revision).

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

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

Implementation

Ontario's measurement initiative involves substantial organizational and practice change. Changing practice is a formidable task that occurs slowly, requiring changes in clinician behavior, program restructuring, and an infusion of resources (Huang et al., 2003). To support the use of the tools, computer hardware is provided to service providers along with ongoing support. Organizations have incurred costs and disruptions related to substantial technological upgrading, while seeing a rise in computer literacy skills among clinicians and improvements in triaging, assessment, and monitoring of treatment response. The simultaneous implementation of CAFAS and BCFPI, although aimed at different functions of the organizations, has been challenging, particularly for those faced with accreditation, amalgamation, staff turnover, and rising demand for service. In recognition of these challenges, CAFAS and BCFPI teams have provided support through consultation, regional *community*

of practice meetings, clinical guidelines and manuals, web site support, and sustainability and capacity building activities (Barwick, Boydell & Omrin, 2002).

Following six years of implementation, over 600 intake workers and administrative personnel in 114 organizations have been trained in the reliable administration of the BCFPI, and 98% have implemented this instrument. Over 4 000 child and youth workers, social workers, psychologists, and psychiatrists have been trained to reliably rate CAFAS in 125 organizations. Data are collected quarterly, analyzed, and reports prepared for each organization. Annual aggregates reports were first produced in 2005, and can be located on the web (URL: http://www.cafasinontario.ca/html/related-reports.asp). Future challenges supporting the clinical utility of the tools through communities of practice, developing a best practice for use of the tools, and working with government and service provider organizations to develop policies and procedures for the collection, analysis, and reporting of aggregate level data. Developers of the tools continue to make improvements and modifications to improve ease and clinical utility. Linkage of data from these tools with other provincial data will continue to be a challenge in the absence of a unique identifier system for the social services, and represents a critical area for focus and development if this investment is to see full return.

Implications for Francophone Services

Survey data reported in Part 1 – companion report, and focus groups commentaries called for assistance in diagnosis/formulation, treatment selection, treatment management (outcome management) and case closure. The tools implemented in Ontario, particularly the CAFAS measure, are intended to assist the clinician with these activities.

With the translation of these tools into French now completed, the tasks remaining are to establish the validity of the tools for Francophone children and youth, and to improve uptake among organizations serving the Franchophone sector. Services aux Enfants et Adultes de Prescott Russell could play a leadership role across the province relative to the validation of the French CAFAS, and to it's implementation and best practice use in Francophone communities. Thus far, training on the CAFAS tool has been provided in French by an associate to CAFAS in Ontario, M. Marc Lefebvre. Such training continues to be available by request made to Ms. Karen Fennell [see contact information above]..

Partnership Development

With limited FL-EBTs and FL-PPs available, it would be worthwhile to partner with other French speaking jurisdictions, such as Quebec and New Brunswick, to share the costs of translating English programs into French and costs related to practitioner training.

Another potential partnership could be with the The Culture and Mental Health Services program at McGill University in Montreal. Funded by the Canadian Institutes of Health Research, the centre trains researchers to study the impact of cultural variations on the cause and course of psychiatric disorders and to evaluate the effectiveness of interventions and models of mental health services for multicultural populations. Among other goals, the Centre has a focus on studying models of mental health services and intervention that can respond to the cultural diversity of immigrants, refugees and ethnocultural communities. The contact person for the centre is Director: Laurence J. Kirmayer, MD, Division of Social and Transcultural Psychiatry, 1033 Pine Ave. West, Montreal, Quebec, H3A 1A1, Ph: 514-398-7302, Email: tc.psych@mcgill.ca.

The Douglas Mental Health University Institute in Montreal is another potential partner to consider. Within the Services, Policy, and Population Health stream, they have a unit that focuses on the **Validation of Questionnaires Used in the Evaluation or Planning of Mental Healthcare Services. Their premise is that p**rogram and service evaluation must rely on valid measurements. In order to help researchers conduct evaluations effectively, researchers have developed a transcultural guide to measurement instruments (generally, standardized questionnaires) used in mental health research, and have inventoried more than fifty such instruments that have been translated into French. This reference information has been made available to the broader research community on a web site. Researchers are also involved in the validation of a number of other questionnaires that have been developed in other centres and countries and that are being adapted to the Quebec context.

The unit recognizes that québécois and Francophone researchers are often confronted by the absence of measurement instruments in French. Nevertheless, they contend that French language measures do exist, even though they may not be widely known. Some are measures originally developed in French that are of excellent quality. Others, are in various stages of validation in the French language.

Their web page provides two resources: " A Guide for Transcultural Validation of Measurement Instrumnts in Mental Health / Un guide de validation transculturelle des instruments de mesure en santé mentale", and a directory of French language instruments / Un répertoire d'instruments de mesure en langue française.

It is important to note that this resource is for *measures* and not specific to interventions or treatments. Neverthess, this group may potentially make an important contribution to the development of French language interventions in the children's mental health sector.

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A multi-stakeholder partnership could also give rise to the development of a **Community of Practice in Mental Health Services for Francophone Children and Youth**, serving to move French language practices and interventions further through dialogue and knowledge exchange.

Professional Development

Training in evidence based treatments and practices is need in organizations providing mental health services for Francophone children and youth and their families. While some treatments and practices have already been translated and training provided (i.e., CAFAS, BCFPI), there is much work to be done in this area.

A regional approach to practitioner training in evidence based practices is needed. Regions must determine the types of EBT training required and make such training available to organizations. Of course, infrastructure and resources would be required for such an approach. For Francohone sector organizations, additional consideration must be given to the translation of material and provision of

French language training and supports to the field. This may involve working directly with treatment developers or purveyors.

Other training considerations may involve technological training, specifically where treatments are electronically based, such as the CAFAS and BCFPI. This component adds a significant cost and training requirement to the implementation of any EBT, regardless of language.

Conclusion

Recently, Ontario's Ministry of Children and Youth Services published a policy framework entitled,"A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health." The framework calls for further improvement in several areas of mental health service provision, including "enhanced use of what works in practice." Specifically, the document notes that "there is a growing body of evidence about what works in mental health practice, however there are gaps between what is known to improve mental health and service delivery practices. Improving dissemination of knowledge, and putting it into practice, will benefit children, youth, and their families/caregivers and service providers" (p.3, MCYS 2005).

Such an effort, however, necessarily requires improvements in practitioner training to provide evidence based knowledge, and there is no operationalization as yet as to how this will take place across the province. The report further identifies the following priority area for action: "enhance the use of evidence-based knowledge and practice within the child and youth mental health sector to support continuous improvements in professional practice and improved outcomes for children and youth" (p. 15, MCYS 2005).

Much of what needs to be done to move the field toward evidence-based practice is similar for both Anglophone and Francophone sectors. We require interventions that are proven to be empirical sound and to produce results of acceptable statistical and clinical significance; resources that can support the evaluation of promising practices, in either language sector; support for training, implementation, and sustainability of practice change; and methods for screening and measuring the outcomes of services, regardless of language sector.

Since much of the empirical work is conducted in English, the Francophone sector must contend with translation and re-validation. These are costly but necessary steps that must be undertaken. Partnerships with other Francophone jurisdictions, such as Quebec and New Brunswick, may serve to distribute both effort and cost, and may lead to improved knowledge regarding existing treatments and/or efforts to translate and validate existing measures.

From a Canadian, and even a North American or global perspective, the Ontario children's mental health system is a recognized leader in system-wide standardized screening and outcome measurement. As such, we can leverage this achievement to improve the Francophone system. This will require leadership on the part of Franchophone and bilingual child and youth mental health organizations. Services aux Enfants et Adultes de Prescott Russell is well positioned to lead this effort.

References

Barlow, D.H., Hayes, S.C., & Nelson, R.O. (1984). *The scientist-practitioner: research and accountability in clinical and educational settings*. New York: Pergamon.

Barwick, M.A., Boydell, K.M., Cunningham, C. E., & Ferguson, H. B. (2004). Overview of Ontario's screening and outcome measurement initiative in children's mental health. *Canadian Child and Adolescent Psychiatry Review, 13(4),* 105-109.

Barwick, M. A., Boydell, K. M., Stasiulis, E., Ferguson, H. B., Blase, K., & Fixsen, D. (2005). *Knowledge transfer and evidence-based practice in children's mental health*. Toronto, ON: Children's Mental Health Ontario.

Barwick, M.A., Omrin, C., & Basnett, D. *(under review*). Maintaining reliability in Ontario's outcome initiative: training approaches and rater drift on the Child and Adolescent Functional Assessment Scale.

Barwick, M.A., Dilico Ojibway Child and Family Services, & Hodges, K. (2004). *Culturally competent evaluation: clinical considerations for rating the Child and Adolescent Functional Assessment Scale with Aboriginal children and youth*. Toronto, ON: The Hospital for Sick Children

Barwick, M., Boydell, K., & Omrin, C. (2002). *A knowledge transfer infrastructure for children's mental health in Ontario: Building capacity for research and practice*. Toronto, ON: The Hospital for Sick Children.

Boydell, K.M., Barwick, M.A., Ferguson, H.B., & Haines, R. (*in press, Journal of Behavioral Health Services & Research*). A feasibility study to assess service provider perspectives regarding use of the Child and Adolescent Functional Assessment Scale in Ontario.

Boyle, M.M., Offord, D.R., Racine, Y., Sanford. M. et al. (1993). Evaluation of the original Ontario Child Health Study scales. *Canadian Journal of Psychiatry,* 38, 397-405

Boyle, M.H., Offord, D.R., Racine, Y., Fleming, J.E., Szatmari, P., & Sanford, M. (1993a). Evaluation of the Revised Ontario Child Health Study Scales. *Journal of Child Psychology and Psychiatry*,34, 189-213.

Busch, A.B. (2002). Validity, reliability, and other key concepts in outcome assessment and services research. In W. W. IsHak, T. Burt & L.I. Sederer (Eds). *Outcome measurement in psychiatry: A critical review, pp.35-55*. Washington, DC: American Psychiatric Publishing.

Chambliss, D., & Ollendick, T.H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review Psychology*, 52, 685-716.

Cunningham, C.E., Pettingill, P., & Boyle, M. (2000). The *Brief Child and Family Phone Interview* (BCFPI). Hamilton, ON: Canadian Centre for the Study of Children at Risk, Hamilton Health Sciences Corporation, McMaster University.

Cunningham, C.E., Pettingill, P., & Boyle, M.H. (2001). *The Brief Child and Family Phone Interview (BCFPI) Interviewer's Manual*. Hamilton, ON: Canadian Centre for the Study of Children at Risk, Hamilton Health Sciences Corporation, McMaster University.

Dishion, T., McCord, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behavior. *American Psychologist,* 54, 755-764.

Duchnowski, A., Hall, K., Kutash, K., & Friedman, R. (1998). The alternatives to residential treatment study. In Epstein M, Kutash K, Duchnowski A, eds. *Outcomes for children and youth with behavioral and emotional disorders and their families: Programs and evaluation best practices* (pp. 55-80). Austin, TX: Pro-ed.

Herman, S.E. (1990). *Reliability study: Children's Global Assessment Scale*. Lansing, MI: Department of Mental Health.

Hodges, K. (2004). Evidence-based treatments for children and adolescents: A compilation of resources and guide for matching CAFAS profiles to evidence-based treatments. Ypsilanti, MI: Eastern Michigan University.

Hodges, K. (2003). *Child and Adolescent Functional Assessment Scale* (3rd ed.). Ypsilanti, MI: Eastern Michigan University.

Hodges,. K., Doucette-Gates, A., & Kim, C.S. (2000). Predicting service utilization with the Child and Adolescent Functional Assessment Scale in a sample of youths with serious emotional disturbance served by Centre for Mental Health Services-funded demonstrations. *The Journal of Behavioral Health Services & Research*, 27, 47-59.

Hodges, K., & Kim, C.S. (2000). Psychometric study of the Child and Adolescent Functional Assessment Scale: Prediction of contact with the law and poor school attendance. *Journal of Abnormal Child Psychology*, 28, 287-297.

Hodges, K., Doucette-Gates, A., & Liao, Q. (1999). The relationship between the Child and Adolescent Functional Assessment Scale (CAFAS) and indicators of functioning. *Journal of Child and Family Studies*, 8, 109-122.

Hodges, K., & Wong, M.M. (1997). Use of the Child and Adolescent Functional Assessment Scale to predict service utilization and cost. *Journal of Mental Health Administration*, 24, 278-290.

Hodges, K., & Wong, M.M. (1996). Psychometric characteristics of a multidimensional measure to assess impairment: The Child and Adolescent Functional Assessment Scale (CAFAS). *Journal of Child and Family* Studies, 5, 445-467.

Huang, L.N., Hepburn, M. S., & Espiritu, R.C. (2003). To be or not to be evidence-based? *Data Matters*, *6*, 1-3. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.

JCCP. (1998). Empirically supported psychosocial interventions for children. *Journal of Clinical Child Psychology*. *Special Issue*, 27, 138-226.

Lambert, M.J., Whipple, J.L., Smart, D.W., Vermeersch, D.A., Nielsen, S.L., & Hawkins, E.J. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research*, 11, 49-68.

Manteuffel, B., Stephens, R., & Santiago, R. (2002). Overview of the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program and summary of current findings. *Children's Services: Social Policy, Research, and Practice*, 5, 3-20.

Maruish, M.E. (Ed.). (1999). *The use of psychological testing for treatment planning and outcomes assessment* (2nd ed.). Mahwah, NJ: Erlbaum.

Newman, F.L., Ciarlo, J.A., & Carpenter, D. (1999). Guidelines for selecting psychological instruments for treatment planning and outcome assessment. In M. E. Maruish, (Ed). *The use of psychological testing for treatment planning and outcomes assessment, 2nd edition*,(pp.153-170). Mahwah, NJ: Lawarence Erlbaum Associates, Inc.

Ogles, B.M., Lambert, M.J., Masters, K.S. (1996). *Assessing outcome in clinical practice*. Boston: Allyn & Bacon.

Quist, R.M., & Matshazi, D.G.M. (2000). The Child and Adolescent Functional Assessment Scale (CAFAS): A dynamic predictor of juvenile recidivism. *Adolescence*, 35,181-192.

Raphael, D., Weir, P., Weston, A., Lines, R., & Pettingill, P. (1999). *Outcome measurement in children's mental health*. Report commissioned by the Ontario Ministry of Community and Social Services. Toronto, Ontario.

Rosenblatt, J., & Furlong, M. (1998). Outcomes in a system of care for youths with emotional and behavioral disorders: An examination of differential change across clinical profiles. *Journal of Child and Family Studies*, 7, 217-232.

Walrath, C., Mandel,l D., & Leaf, P. (2001). Responses of children with different intake profiles to mental health treatment. *Psychiatric Services*, 52, 196-201.

Annotated Bibliography

Keywords = (treatment or intervention) and (mental health) or (mental disorders)
Date range: 1987 – 2007
Limited to: Published Works Only; Language is French; Age is Preschool Age (2-5 yrs) or School Age (6-12 yrs) or Adolescence (13-17 yrs)

PsychINFO Database

132 results found in multiple databases, of which 37 were peer-reviewed journal articles

- empirical study
- prevalence / incidence study
- descriptive study
- epidemiological study
- review
- treatment or intervention study
- drug study
- service utilization

Study Type	Citation and Abstract

Albert, E., Halfon, O., Mouren-Simeoni, M. C., & Dugas, M. (1988). A comparative study of two groups of patients with anorexia nervosa followed in a child and adolescent psychiatry clinic/Etude comparative de deux groupes d'anorexiques mentaux examinés dans un service de psychiatrie de l'enfant et de l'adolescent. *Psychiatrie & Psychobiologie, 3*(2) 87-98.

ABSTRACT: Studied the incidence of **anorexia nervosa** in prepubertal children compared with adolescents. 53 patients diagnosed with anorexia nervosa according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) and treated at a French clinic were divided into 2 groups: 14 Ss under 13 yrs of age and 37 aged 13-22 yrs. 10 Ss in Group 1 and 16 in Group 2 were also diagnosed with a pathological personality according to the DSM-III. Results show Group 1 Ss with sophisticated food-avoidance strategies and body-image, physical hyperactivity, laxative ingestion, induced vomiting, and psychosomatic symptoms similar to those of older Ss. (English abstract)

Bailly, D., Alexandre, J. Y., Collinet, C., & Beuscart, R. (1990). Depression in adolescents: A study in a high school student population/La dépression chez l'adolescent. À propos d'une enquête réalisée auprès d'une population d'adolescents scolarisés. *European Psychiatry, 5*(6) 363-373.

ABSTRACT: Studied the prevalence, manifestations, and correlates of **major depressive disorders** (MDDs) in adolescents. Human Ss: 744 male and female French adolescents and young adults (aged 14-23 yrs) (secondary school students). Ss completed questionnaires assessing symptoms of depression and a wide range of sociodemographic and psychosocial factors. 728 Ss also completed a semistructured clinical interview assessing Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R) criteria for MDDs. The 32 Ss who met DSM-III--R criteria for MDDs were compared with the remaining sample in terms of their questionnaire responses. Gender differences were determined. Tests used: A French version of the Center for Epidemiologic Studies Depression Scale. (English abstract)

Bailly-Lambin, I., & Bailly, D. (1999). Separation anxiety disorder and eating

disorders/Angoisse de séparation et troubles du comportement alimentaire. *L'Encéphale, 25*(3) 226-231.
ABSTRACT: Conducted an epidemiological retrospective study of 81 inpatients in France with **anorexia nervosa (AN) or bulimia nervosa (BN)** according to Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R) criteria to investigate the possible association between eating disorders and childhood separation anxiety disorder (SAD). The current and lifetime psychiatric histories of 4 male and 41 female adolescents and adults (aged 13-42 yrs) with AN and 1 male and 35 female adolescents and adults (aged 14-47 yrs) with BN were assessed with the Structured Clinical Interview for DSM-III-R Personality Disorders and the Schedule for Affective Disorders and Schizophrenia. Psychopathological profiles were assessed with the SCL-90. The results show that approximately 20% of Ss with AN and BN had a history of childhood SAD. This subgroup differed significantly from Ss without this history in terms of associated anxiety and depressive disorders.

⊙ Beauroy, R., Benhamou, H., Causse, H., & Fortineau, J. (1989). "Clairiere": The experience of an alternative, part-time, local-jurisdiction institution/La clairière: L'expérience d'une institution d'intersecteur alternative à temps partiel. *Perspectives Psychiatriques, 28*(17) 105-107.
ABSTRACT: Describes a clinical service that offers **intensive treatments to children with psychopathologies** every evening after school and on Wednesday afternoon. This evening care unit represents an intermediate stage between existing treatment centers and the schools, allowing the young patients to avoid the segregation associated with full-time day hospitalization. The main aspects of this treatment are (1) play activities, including group play and expressions of creativity, supervised by an analyst not involved in interacting with the patients' families and (2) psychopedagogical activities to maintain children's interest in school activities. Received at the center immediately after school, children participate in field trips on Wednesdays. The maximum age for attending the evening unit is usually 13 yrs. (English abstract)

🖂 Beck, C. A., Williams, J. V. A., Wang, J. L., Kassam, A., El-Guebaly, N., & Currie, S. R. et al. (2005). L'utilisation des médicaments psychotropes au Canada/Psychotropic medication use in canada. *Canadian Journal of Psychiatry.Special Issue: The Canadian Academy of Psychiatric Epidemiology (CAPE) look at the Canadian Community Health Survey, Cycle 1.2, 50*(10) 605-613. Retrieved January 4, 2007, from the PsycINFO database.
ABSTRACT: Background: **Psychotropic medication** use can be employed as an indicator of appropriate treatment for mental disorders. The Canadian Community Health Survey: Mental Health and Well-Being (CCHS 1.2) offers the first opportunity to characterize Canadian psychotropic medication use on a national level within diagnostic groups as assessed by a full version of the Composite International Diagnostic Interview (CIDI). Method: We assessed the prevalence of antidepressant, sedative-hypnotic, mood stabilizer, psychostimulant, and antipsychotic use over 2 days overall and in subgroups defined by CIDI-diagnosed disorders and demographics. We employed sampling weights and bootstrap methods. Results: Overall psychotropic drug utilization was 7.2%. Utilization was higher for women and with increasing age. With any lifetime CIDI-diagnosed disorder assessed in the CCHS 1.2, utilization was 19.3%, whereas without such disorders, it was 4.1%. Selective serotonin reuptake inhibitors (SSRIs) were the most commonly used antidepressants for those with a past-year major depressive episode (17.8%), followed by venlafaxine (7.4%). Among people aged 15 to 19 years, antidepressant use was 1.8% overall and 11.7% among those with past-year depression; SSRIs made up the majority of use. Sedative-hypnotics were used by 3.1% overall, increasing with age to 11.1% over 75 years. Conclusions: International comparison is difficult because of different evaluation methods, but antidepressant use may be higher and antipsychotic use lower in Canada than in recent European and American reports. In light of the relative lack of contemporary

evidence for antidepressant efficacy in adolescents, it is likely that antidepressant use among those aged 15 to 19 years will continue to decline. The increased use of sedative-hypnotics with age is of concern, given the associated risk of adverse effects among seniors.

❄ Bergeron, E., Poirier, L., Fournier, L., Roberge, P., & Barrette, G. (2005). Les determinants de l'utilisation des services chez les jeunes canadiens souffrant de troubles mentaux/Determinants of service use among young canadians with mental disorders. *Canadian Journal of Psychiatry.Special Issue: The Canadian Academy of Psychiatric Epidemiology (CAPE) look at the Canadian Community Health Survey, Cycle 1.2, 50*(10) 629-636. Retrieved January 4, 2007, from the PsycINFO database.

ABSTRACT: Objective: To identify the determinants of service use by young Canadians with mental health problems. Methods: Data were drawn from a recent large Canadian mental health survey. The analyses were conducted on a subsample of 1092 Canadians aged 15 to 24 years and identified as presenting a **mood disorder, an anxiety disorder, or a substance-related disorder** in the 12 months preceding the survey. We classified variables potentially associated with any type of service use for a mental health problem over a 12-month period according to predisposing, enabling, and need factors. We conducted weighted multivariate logistic regressions to determine the association of each factor with **service use**. Results: In the final model, being female and living alone were the predisposing factors associated with service use. None of the enabling factors predicted help seeking. In regard to the perceived need factors, those who had difficulties with social situations were more likely to use services. Having a mood disorder and (or) having a diagnosed chronic illness were the evaluated need factors associated with service use. Conclusion: Certain groups of young Canadians are less likely to seek help for mental health problems and could be the target of interventions aimed at increasing service use.

Bergey, C., Verdoux, H., Assens, F., Abalan, F., Liraud, F., & Gonzales, B. et al. (1999). Assessment of the administrative incidence of psychotic disorders/Evaluation de l'incidence hospitalière des troubles psychotiques. *L'Encéphale, 25*(1) 30-36. Retrieved January 4, 2007, from the PsycINFO database.

Studied the incidence of 1st hospitalizations for **psychotic disorders**. Human Ss: 59 male and female French adolescents and adults (aged 16-60 yrs) (consecutively 1st-admitted psychiatric inpatients at a state facility over a 1-yr period). The Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) diagnoses were made with the Mini International Neuropsychiatric Interview (Y. Lecrubier et al, 1997) and with data obtained from Ss and their relatives. A complementary study was performed in private psychiatric institutions and at a military hospital to assess the representativeness of the inpatients at the state hospital. Sex differences and age differences in incidence rates were calculated. (English abstract)

Birot, E. (1993). Body image and mental functioning in suicidal adolescents/Image du corps et fonctionnement mental de l'adolescent suicidant: Vicissitudes de leurs liens. *Bulletin de la Société du Rorschach et des Méthodes Projectives de Langue Française, 37* 57-69. Retrieved January 4, 2007, from the PsycINFO database.

Studied the relationship between body image disturbances and psychological problems in adolescents who have **attempted suicide**. Ss included 60 male and female French adolescents (suicide attempt). Shortly after their suicide attempts, Ss completed clinical interviews and projective techniques. Based on Rorschach Test responses, body image disturbances were identified and analyzed in relation to other psychodynamic problems. Results from Ss with neurotic disorders, narcissistic-personality disorder, and borderline personality disorder were compared. (English abstract)

Blin, O., Lecrubier, Y., Azorin, J. M., & Souche, A. (1988). The devising and preliminary

validation of an original scale for the assessment of anxiety in psychotics: The "PAS" (psychotic anxiety scale)/Construction et étude préliminaire de validation d'une e_chelle originale d'évaluation de l'anxiété chez le psychotique: La "PAS" (psychotic anxiety scale). *Psychiatrie & Psychobiologie, 3*(4) 255-261.
ABSTRACT: When administered to 27 male and 18 female patients (aged 16-36 yrs) suffering from Diagnostic and Statistical Manual of Mental Disorders (DSM-III) diagnosed **schizophrenic disorders** and 7 male and 8 female patients (aged 19-48 yrs) with anxiety neuroses, the PAS proved to be reliable in measuring severity of psychotic anxiety, patient's inhibitions, self-directed aggressivity, and progress of anxiety over time. The presence of anxiety varying simultaneously with other symptoms in psychotic patients was confirmed. (English abstract)

⌑ Bossé, M., & Cormier, J. (1988). How research projects can develop in intervention environments/Comment des préocuppations de recherche peuvent se développer dans un milieu d'intervenants. *Revue Canadienne de Psycho-Education, 17*(1) 52-61.
ABSTRACT: Discusses the evaluative research activities carried out under university sponsorship in rehabilitation centers for **emotionally- and socially dysfunctional** children in Canada in an attempt to assess institutional and follow-up-program outcomes, while establishing procedure for systematic evaluation of their intervention policies and practice. The author evaluates the research achievement of one of these centers. This evaluation project is examined in light of current evaluative research, recommending an even-larger role for evaluative research in rehabilitation-center settings. (English abstracts)

Bursztejn, C., & Jeammet, P. (2002). Autism and children's psychoses in the CFTMEA R-2000/Autisme et psychoses de l'enfant dans la CFTMEA R-2000. *Annales Médico-Psychologiques, 160*(3) 216-219.
ABSTRACT: Describes specific revisions in the CFTMEA R-2000, the 4th version of the French Classification of Mental Disorders in Children and Adolescents, regarding **autism and psychoses**. Terms used to describe mental conditions in children and adolescents, categories of autistic and psychotic disorders, and correspondence with the previous version of the CFTMEA and with the ICD-10 are considered. Modifications in the description and classification of psychotic and mood disorders in adolescents are also discussed.

☆ Chevallier, P. (1989). Prevalence and sociodemographic factors/Prévalence et facteurs sociodémographiques. *Psychiatrie de l'Enfant, 32*(2) 543-591.
ABSTRACT: The results of **25 epidemiological studies**, mainly Anglo-Saxon or Scandinavian, revealed a sociodemographic profile of children and adolescents having problems, and this profile was compared to French patients seeking treatment. Most of the sociodemographic variables appear to be discriminatory in child psychiatry but not in a regular manner for prevalence or treatment. To go from the observation of a covariation between a sociodemographic attribute and a state of mental health to identifying a risk factor involves the precise specification of the nature and meaning of the relationship and the understanding of the causative mechanisms. (English & Spanish abstracts)

☆ Choquet, M. (1989). The body image of suicidal adolescents: An epidemiological approach/Le vécu du corps par les adolescents suicidaires. approche épidémiologique. *Psychologie Medicale, 21*(4) 449-452.
ABSTRACT: Reviews data on adolescents' **body image** from several epidemiological studies on physical and mental health variables in general and suicidal adolescent populations. Results indicate that adolescents who have attempted suicide tend to have more health problems (somatic and psychosomatic) and more substance-abuse problems than do members of general adolescent populations. Implications for prevention and treatment of suicidal behavior are discussed. (English abstract)

- Cohen, D. J., Paul, R., & Volkmar, F. R. (1988). The classification of pervasive and other developmental disorders: Toward the DSM-IV/La classification des troubles globaux du développement et de divers autres troubles: Vers le DSM-IV. *Psychiatrie de l'Enfant, 31*(1) 151-172. Retrieved January 4, 2007, from the PsycINFO database.
  ABSTRACT: Discusses the advantages and disadvantages of the treatment of **developmental disorders** and associated conditions in the multiaxial model proposed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Deficiencies in this system's diagnostic model for autism are considered. (English & Spanish abstracts)

- Cuendet, C. (1991). Follow-up of 18 severely disturbed adolescents and their parents/Évaluation de 18 adolescents et de leurs parents deux ans après la fin de l'intervention psychothérapique. *Thérapie Familiale, 12*(3) 257-271. Retrieved January 4, 2007, from the PsycINFO database.
  ABSTRACT: Studied the efficacy of **psychotherapeutic treatment of severely disturbed adolescents** at a 2-yr follow-up. Ss were 18 Swiss children and adolescents (aged 12-18 yrs). Information on treatment results was obtained via semistructured interviews and Ss' records. Ss were evaluated according to self-concept, tolerance of separation, and autonomy of action and thought. Ss' parents were evaluated according to their individual goals and attitudes toward their child. Results were assessed according to the original diagnoses and degree of disturbance, adaptability of the family to change, hierarchical family functioning, and degree of adolescent and family disturbance and change after 2 yrs. (English abstract)

- Currie, S. R., Patten, S. B., Williams, J. V. A., Wang, J. L., Beck, C. A., & El-Guebaly, N. et al. (2005). La comorbidité de la dépression majeure et des troubles liés à une substance/Comorbidity of major depression with substance use disorders. *Canadian Journal of Psychiatry.Special Issue: The Canadian Academy of Psychiatric Epidemiology (CAPE) look at the Canadian Community Health Survey, Cycle 1.2, 50*(10) 660-666. Retrieved January 4, 2007, from the PsycINFO database.
  ABSTRACT: Objectives: In the Canadian adult population, we aimed to 1) estimate the 12-month prevalence of **major depressive disorder** (MDD) in persons with a diagnosis of harmful alcohol use, alcohol dependence, and drug dependence; 2) estimate the 12-month prevalence of harmful alcohol use, alcohol dependence, and drug dependence in persons with a 12-month and lifetime diagnosis of MDD; 3) identify socioeconomic correlates of substance use disorder-major depression comorbidity; 4) determine how comorbidity impacts the prevalence of suicidal thoughts; and 5) determine how comorbidity affects mental health care used. Methods: We examined data from the Canadian Community Health Survey: Mental Health and Well-Being (CCHS 1.2). Results: The 12-month prevalences of MDD in persons with a substance use disorder (SUD) were 6.9% for harmful alcohol use (95% confidence interval [CI], 5.2 to 8.5), 8.8% for alcohol dependence (95%CI, 6.6 to 11.0), and 16.1% for drug dependence (95%CI, 10.3 to 21.9). Conversely, the 12-month prevalences of harmful alcohol use, alcohol dependence, and drug dependence in persons with a 12-month diagnosis of MDD were 12.3% (95%CI, 9.4 to 15.2), 5.8% (95%CI, 4.3 to 7.3), and 3.2% (95%CI, 2.0 to 4.4), respectively. Regression modelling did not identify any socioeconomic predictors of SUD-MDD comorbidity. Substance dependence and MDD independently predicted higher prevalence of suicidal thoughts and mental health treatment use. Conclusions: SUDs cooccur with a high frequency in cases of MDD. Clinicians and mental health services should consider routine assessment of SUDs in depression patients.

- Dazord, A., Manificat, S., Gérin, P., & Beyer, H. (1993). Difficulties of the child as perceived by the family and care professionals: An interested inquiry/Les difficultes de l'enfant: Representations de la famille et des soignante: Interet d'une enquete. *Psychiatrie*

de l'Enfant, 36(1) 151-176. Retrieved January 4, 2007, from the PsycINFO database.
ABSTRACT: The study was conducted in 7 consultation centers of child psychiatry in the Lyon region. The aim was to evaluate the **influence of the care professional's response to the demands of the consultants** in terms of the evolution of the child. The investigation was based upon what was said about the child's difficulties as perceived by care professionals, parents, and children. Relevant instruments and a valid methodology were used to assess the various parameters. Results indicate that what happens in the 1st interview might be more important than the effective type of intervention in determining the evolution of subsequent intervention. (English & Spanish abstracts

- de Mont-Marin, F., Hardy, P., Lépine, J. P., & Halfon, P. (1993). Validation of a french version of the general health questionnaire (GHQ-28) in a diabetic population/Validation d'une version française du general health questionnaire (GHQ-28) dans une population de diabétiques. *L'Encéphale, 19*(4) 293-301.
  ABSTRACT: Studied the **validity of a French version of the GHQ-28** by D. P. Goldberg and V. F. Hillier (1979) among patients with diabetes. 46 17-80 yr olds with Type I or Type II diabetes completed the GHQ-28 and the Composite International Diagnostic Interview by L. N. Robins et al (1988), a procedure for assessing psychiatric symptoms according to the Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R). Ss' responses to the GHQ-28 were scored using 2 methods, and results from the 2 scoring methods were compared with regard to their sensitivity and specificity in detecting psychiatric symptoms. (English abstract)

- du Pasquier, Y. (1989). Mothers' depressions and children's adaptation and disorders/Dépressions des mères. adaptation et troubles de leurs enfants. *Information Psychiatrique, 65*(8) 777-781. Retrieved January 4, 2007, from the PsycINFO database.
  ABSTRACT: Discusses the effects of **maternal depression on children's mental and physical development** and on their adaptive strategies. The effects of postpartum depression, as well as negative and positive effects of maternal depression are considered. The relation of maternal depression to autism, developmental delay, cognitive and psychomotor development, self-esteem, ego organization, and adolescent problems is examined. (English, Spanish & Italian abstracts)

- Dugas, M., & le Heuzey, M. -. (1988). Nosology and ways of data recording in child and adolescent psychiatry/Nosologies et systèmes de recueil des données en psychiatrie de l'enfant et de l'adolescent. *Psychiatrie de l'Enfant, 31*(1) 5-47. Retrieved January 4, 2007, from the PsycINFO database.
  ABSTRACT: Discusses **classification systems** used in child and adolescent psychiatry: the World Health Organization's International Classification of Diseases-9, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III), the system proposed by the Group for the Advancement of Psychiatry, A. Freud's classification, French classifications, and classifications derived from multivariate statistical analyses. The need for different systems at different ages is considered. Data collection with semistructured interviews, assessment scales, and questionnaires is discussed. (English & Spanish abstracts)

- Dugas, M. (1987). Psychostimulants in pediatric psychiatry/Les psychostimulants en psychiatrie de l'enfant. *Psychologie Medicale.Special Issue: In recognition of Professor P.Deniker, 19*(10) 1773-1775.
  ABSTRACT: Discusses administration of **behavior-modifying drugs** to disturbed children. It is suggested that psychostimulants are especially effective with hyperactive children, and their long-range positive effects include improvement in Ss' self-control, attention, and learning and memorization capabilities, and better scholastic, familial, and social adaptation. Side effects are temporary. Further research into the

neuropsychobiological effects of psychostimulants in children is recommended. (English abstract)

- Dugré, S., Trudel, M., & Valla, J. (2001). Individual and cultural considerations concerning the mental health of children: Use of the dominic-R/Considérations individuelles et culturelles en santé mentale des enfants: Le dominique à l'épreuve. *Revue Canadienne de Psycho-Education, 30*(1) 119-138.
  ABSTRACT: Studied the **mental health of school-age children in Canada with the Dominic-R** (J. P. Valla et al, 1997), a structured questionnaire that combines visual and auditory stimuli to assess diagnoses made with the Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R). Ss were 334 French and Canadian males and females aged 6-9 yrs. 70 Ss were assessed individually, and 264 Ss were assessed collectively. Similar psychometric results were obtained. Principal component factor analysis with varimax rotation revealed differences between adult assessments and self-report applications of the instrument. Contrary to adult assessments, self-reports revealed an association between depression and externalizing symptoms. Males reported more externalizing symptoms and females presented more internalizing symptoms, but there were no sex differences in the occurrence of depression. Anxiety and separation anxiety were the most prevalent symptoms, independent of age, sex, or cultural background. Reported symptoms generally increased with age, but only externalizing symptoms increased significantly.

- Emery, J., & Toupin, J. (1997). Assessment of a case-method primary prevention program used in a day care center: An intervention designed to prevent the development of psychosocial problems in preschool children/Évaluation du programme "la carte des cas vécus" offert en garderie: Une expérience de prévention des difficultés d'adaptation chez les enfants d'âge préscolaire. *Revue Canadienne de Psycho-Education, 26*(2) 95-111.
  ABSTRACT: Studied the effects on children and their parents of a **case-method primary prevention program** used in day care settings to prevent the development of psychosocial problems. Human Ss: 24 male and female Canadian preschool children (aged 4-5 yrs) (some with psychosocial maladjustment) (1-parent [mother] and 2-parent families) (experimental group). 21 male and female Canadian preschool children (aged 4-5 yrs) (some with psychosocial maladjustment) (1-parent [mother] and 2-parent families) (control group). Normal Canadian adults (parents of the preschool children). Normal Canadian adults (teachers of the preschool children). Ss were selected from 15 day care centers. The experimental group participated in 10 program sessions over 6 mo. Ss were tested before the program, at the end of the program, and 6 mo later. Tests used: The Child Behavior Checklist (CBC), the Direct Observation Form of the CBC (T. M. Achenbach, 1986), the Teacher's Report Form (T. M. Achenbach, 1991), the Questionnaire on Parental Behaviors (R. Tessier et al, 1985) and the Questionnaire on Parental Attitudes and Behaviors (L. Bergeron et al, 1992). (English abstract)

- Fericelli-Broun, F. (2002). Adolescents and young adults with psychic disorders: Parental guidance/Travail de guidance auprès des parents d'adolescents et de jeunes adultes en difficulté psychique. *Neuropsychiatrie de l'enfance et de l'adolescence, 50*(8) 577-582. Retrieved January 4, 2007, from the PsycINFO database.
  ABSTRACT: **Parental guidance** is frequently used in child psychiatry, especially with young children. Meanwhile--if we refer to literature--parental guidance seems to be less usually practiced with adolescents and even less with young adults. Nevertheless, adolescence is a period of revival of precocious relationships and early interactions, a period during which an intra psychic reorganization takes place. All these changes strongly requests parents and parenthood, especially when the adolescent is strongly disturbed. Beyond the only support for parents, parental guidance at this age of life presents its own specificities. By another way, this work with parents can often allow the adolescent to have

access to psychic cares for himself, whereas the frequent reticence of the adolescent to consult a mental health professional is well known.

⊙ case study Frare, P., & Lebel, A. (1996). Use of "arrested thoughts" in the treatment of a 9-year-old girl with obsessive-compulsive disorder/Utilisation de "l'arrêt des pensées" dans le traitement d'un trouble obsessionnel-compulsif chez une fillette de neuf ans. *Canadian Journal of Psychiatry, 41*(6) 367-370. Retrieved January 4, 2007, from the PsycINFO database.

ABSTRACT: Used a **pharmacobehavioral approach employing modified techniques of exposure, prevention of the response, and thought stopping in the treatment of obsessive-compulsive disorder** (OCD) in a 9-yr-old girl. The diagnosis of OCD was made based on the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) criteria. The S was seen over 15 sessions, during which clomipramine was introduced and modified techniques of exposure, prevention of the response, and thought stopping were successively used. Follow-up extended over more than 18 mo after the end of therapy. The S learned and used the behavioral techniques easily, and the authors observed a rapid, complete, and sustained disappearance of the OCD symptomatology. The authors conclude that use of a pharmacobehavioral approach in treating OCD in young children remains limited. Techniques used with adults and slightly modified to adapt them for children are an avenue of treatment worth exploring.

⌑ Girardon, N., & Bourcier, G. (2003). The involvement of the public sectors of psychiatry of child and adolescent in adolescent hospitalization: The experience of the community center of meeting and care for adolescents/L'implication des secteurs de psychiatric infantojuvénile dans le travail d'hospitalisation des adolescents: L'expérience du centre communautaire d'accueil et de soins pour adolescents (CCASA). *Neuropsychiatrie de l'enfance et de l'adolescence, 51*(4) 229-233.

ABSTRACT: After a general introduction of a full live **hospitalisation unit for adolescents suffering from acute or subacute psychiatric disorders**, the authors support the interest of working in a tight network with the partners of the public sectors of psychiatry of child and adolescent. They discuss the theorical and pratical implications in this special place out of the central hospital, with a population of adolescents questioning most particulary the issue of family links.

⌑ Gisseleire, J. -. (1988). The therapeutic effects of the relational pedagogy of language (PRL) act: Reflections on the mechanisms at work in reeducation/Les effets thérapeutiques de l'acte PRL: Réflexions sur les mécanismes opérants dans la rééducation. *Pratique des Mots, 63* 9-12, 17-18. Retrieved January 4, 2007, from the PsycINFO database.

ABSTRACT: Discusses the relationship between **psychological disturbance and cognitive anomalies** in children. A **reeducative approach to treatment** of such conditions is described, using examples from clinical practice.

⌘ Gisselmann, A., Grillet, C., Aho, S., & François, I. (1990). Evaluation of services provided by a psychiatric sector to inpatients and outpatients diagnosed using axes I, II, IV, and V of the DSM-III/Evaluation des soins dispensés intra et extra muros par un secteur psychiatrique à une population définie à partir des axes I, II, IV, V du DSM III. *Psychologie Medicale, 22*(1) 51-56.

ABSTRACT: Studied the relation among the **distribution of psychiatric care services and clinical diagnosis, personality factors, and levels of stress and social adaptation of psychiatric inpatients and outpatients**. Human subjects: 600 French adolescents and adults (aged 15 yrs and older). Types of psychiatric services included psychiatric consultation, medical consultation, hospitalization, home visits, and day care. Patient diagnosis, personality factors, and levels of stress and social adaptation were determined using Axes I, II, IV, and V of the Diagnostic and Statistical Manual of Mental Disorders

(DSM-III). The relation among distribution of care, diagnosis, personality, stress, and social adaptation was presented in bar graphs. (English abstract)

- Gravel, R., & Béland, Y. (2005). L'enquête sur la santé dans les collectivités canadiennes: Santé mentale et bien-être/The canadian community health survey: Mental health and well-being. *Canadian Journal of Psychiatry.Special Issue: The Canadian Academy of Psychiatric Epidemiology (CAPE) look at the Canadian Community Health Survey, Cycle 1.2, 50*(10) 573-579.
  ABSTRACT: As part of the Canadian Community Health Survey (CCHS) biennial strategy, the provincial survey component of the first CCHS cycle (Cycle 1.2) focused on different aspects of the mental health and well-being of Canadians living in private dwellings. Moreover, the survey collected **data on prevalences of specific mental disorders and problems, use of mental health services, and economic and personal costs** of having a mental illness. Data collection began in May 2002 and extended over 8 months. More than 85% of all interviews were conducted face-to-face and used a computer-assisted application. The survey obtained a national response rate of 77%. This paper describes several key aspects of the questionnaire content, the sample design, interviewer training, and data collection procedures. A brief overview of the CCHS regional component (Cycle 1.1) is also given.

- Hayez, J. (1992). Sexual abuse of underage children: Incest and extra-familial sexual abuse/Les abus sexuels sur des mineurs d'age: Inceste et abus sexuel extra-familial. *Psychiatrie de l'Enfant, 35*(1) 197-271.
  ABSTRACT: Defines the concept of **sexual abuse** and its limitations and shows how the confrontation with sexual abuse may provoke countertransference in staff and spoil the quality of help programs. The author outlines the pathogenesis of the concept and describes acute or chronic clinical signs presented by the abused child. The diagnostic process involves diverse disclosure situations, and the reliability of the revelations is discussed. Two intervention methods (crisis and treatment) are discussed. Crisis intervention focuses on collecting information, support for the child, active protection of the child, and cooperation with judicial authorities. Treatment intervention focuses on helping the family, support groups, and judicial punishment. (English & Spanish abstracts)

- Houillon, P., & Abdelfattah, A. (1989). Language and communication/Langage et communication. *Psychiatrie Française, 20*(Spec Issue) 96-98.
  ABSTRACT: **Distinguishes between language and communication**, citing the example of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), which purports to establish a nosological consensus among members of the international psychiatric establishment through a common language but, through a failure in communication, fosters dissent and controversy instead. The psychopathogenic adolescent quest for sensory stimulation through drugs, music, songs, dance, and TV images represents a failed attempt at compensating for a lack of communication. Another example of communication failure is the publication of the results of paraclinical investigations to define diseases. (PsycINFO Database Record (c) 2006 APA, all rights reserved)
- Hughes, C., Soares-Boucaud, I., Hochmann, J., & Frith, U. (1998). Social behaviour in pervasive developmental disorders: Effects of informant, group and "theory-of-mind."/Comportement social chez les enfants porteurs de troubles envahissants du développement: Effets du groupe, de l'informateur et de la "théorie de l'esprit.". *Approche Neuropsychologique des Apprentissages chez l'Enfant, 10*(3) 78-85.
  ABSTRACT: Studied **theory-of-mind skills and everyday social behavior in normal children vs children with pervasive developmental disorders (PDD).** Ss were 21 male and female British school-age children (mean age 7.4 yrs) (13 Ss with au autistic disorder and 8 Ss with PDD not otherwise specified) (mean IQ of 55.2); 22 normal male and female British preschool children (mean age 4.5 yrs); and normal British adults (parents, teachers,

and therapists). Adults were interviewed with the Vineland Adaptive Behavior Scales and the Social Adaptation Scale for Children. Their ability to differentiate subtle forms of social problems in daily-life behaviors between subgroups of children diagnosed subsequently with autism or PDD not otherwise specified according to Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R) criteria was assessed. A series of ANOVAs was performed. Informant effects for subgroups considered separately or jointly were analyzed. (English abstract

☆⊙ Jalenques, I., Lachal, C., Geneste, J., & Coudert, A. (1989). Treatment of depressive states in children/Traitements des états dépressifs chez l'enfant. *Psychologie Medicale, 21*(13) 2001-2007.

ABSTRACT: Discusses **effective treatments of depressive states in prepubertal children** in clinical and biological terms. Children's depressions were granted nosographic status by the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), with descriptions of their affective, cognitive, dynamic, and physical symptoms. Different psychotropic for treatment of children's depressive states are listed, along with their effects and possible side effects. To address the psychological correlates of children's depressions, psychotherapies such as psychoanalysis and behavior therapy are suggested to complement psychotropes. (English abstract)

⌘ Kairouz, S., Nadeau, L., & Siou, G. L. (2005). Variations régionales de la prévalence de l'utilisation de substances, et des habitudes et problémes de jeu au québec: Une analyse multiniveau/Area variations in the prevalence of substance use and gambling behaviours and problems in quebec: A multilevel analysis. *Canadian Journal of Psychiatry.Special Issue: The Canadian Academy of Psychiatric Epidemiology (CAPE) look at the Canadian Community Health Survey, Cycle 1.2, 50*(10) 591-598.

ABSTRACT: Objectives: This study aimed to examine whether variations among regions in Quebec existed after we controlled for individual characteristics in the prevalence of 1) **alcohol, cannabis, and gambling behaviours and 2) substance-related disorders and pathological gambling.** Methods: Using data derived from the Canadian Community Health Survey: Mental Health and Well-Being (CCHS 1.2), we nested 5332 respondents from the province of Quebec within 374 regions equivalent to census subdivisions (CSDs). Outcome variables included 1) drinking status (past 12 months), alcohol consumption (last week), and 12-month diagnosis of alcohol dependence; 2) cannabis use (past 12 months and lifetime) and diagnosis of illicit drug dependence; and 3) gambling status, severity of gambling problems, and number of reported gambling activities (past 12 months). Multilevel regression models with individuals (Level 1) nested in regions (CSDs, Level 2) assessed the variations among regions in the prevalence of various outcomes and disorders when individual characteristics were controlled for. Results: Variance component models revealed that all alcohol-related variables, the prevalence of cannabis use (12 months), and problem gambling did not vary among areas. Gambling rates and the average number of reported gambling activities varied among areas, even when individual-level variables were accounted for in the models, whereas for lifetime cannabis use, variations among areas became nonsignificant. Conclusion: Intervention programs may need to address the environment as a relevant determinant of health-related behaviours and lifestyles.

⊙ Lacelle, J., & Séguin, M. (1998). Adolescent suicide: Elaboration of a postvention protocol in a secondary school in Outaouais/Le suicide chez les adolescents: Élaboration d'un protocole de postvention dans une école secondaire de l'outaouais. *Revue Canadienne de Psycho-Education, 27*(1) 31-45. Retrieved January 4, 2007, from the PsycINFO database.

ABSTRACT: Discusses the **implementation of a suicide postvention program** in a secondary school in the Quebec region of Outaouais with 1,763 students. The program, which emphasized regularly occurring activities related to suicide, was set up at the beginning of the school year so that fast and efficient intervention would be available

during the school year if a suicide occurred. The program assessments of teachers and other school personnel, the emotional aspects and problems related to program implementation, administrative problems, and recommendations concerning adolescent suicide prevention are examined. (English abstract)

Lafortune, D., Laurier, C., & Gagnon, F. (2004). Prevalence and factors associated with psychotropic drug prescription among subjects placed in a youth center/Prévalence et facteurs associés à la prescription de médicaments psychotropes chez les sujets placés en centre jeunesse. *Revue de Psychoéducation, 33*(1) 157-176.

ABSTRACT: For 30 yrs, psychotropic drugs have been regularly prescribed to minors. Interest for this practice is increasing throughout the world. In a more specific way, the aggressive, impulsive behaviors and the exteriorized disorders represent frequent reasons for pharmacological intervention, but also for placement in institutions. In the province of Quebec, the place that psychopharmacology occupies in residential treatment facilities is not well-known. The aim of this research is to **evaluate the prevalence of the prescription of psychotropic drugs in Youth Center of Monteregie and of Laval**, to clarify the associations between the prescription of psychotropic drugs to minors and socio-demographic, symptomatic and contextual sets of variables. The authors estimate the current prevalence (in the last 12 mo) of the prescription of psychotropic drug to youth placed in residential treatment facilities. To this goal is associated the analysis of various classes of drugs and of cases of multiple prescriptions. Socio-family factors associated to the prescription of psychotropics are identified. The context surrounding the decision to propose or recommend a psychotropic drug is studied. The authors analyze, for example, former use of services by mental health professionals and age at the moment of the first placement. The diagnosis characteristics associated with medications are also described.

LeBlanc, M. (1990). Community services and the readaptation of maladjusted children/Les services externes et la réadaptation des jeunes en difficulté. *Revue Canadienne de Psycho-Education, 19*(1) 43-62.

ABSTRACT: Discusses issues associated with the **development and diversification of community mental health services for maladjusted children in Quebec.** Types of readaptation and rehabilitation services currently offered in Quebec; and the goals, objectives, and quality of these services are examined. The results of a recent survey of 43 community readaptation programs for maladjusted children in Quebec are presented (M. LeBlanc and H. Beaumont, 1987). The question of whether community readaptation services should concentrate on treatment or prevention is also considered. (English abstract)

Lecavalier, L., & Tassé, M. J. (2001). Translation and transcultural adaptation of the Reiss screening test for maladaptive Behavior/Traduction et adaptation transculturelle du reiss screen for maladaptive behavior. *Revue Francophone de la Déficience Intellectuelle, 12*(1) 31-44.

ABSTRACT: Studied the **translation, transcultural adaptation, and validation of the French version of the Reiss Screening Test for Maladaptive Behavior** (S. Reiss, 1988). Ss included 184 adult evaluators who screened 494 male and female adolescents and adults (aged 12-82 yrs) with various degrees of mental retardation. Factor analysis and other statistical tests were used. Scores for aggression, autism, psychosis, paranoia, behavioral and physiological depression, dependent personality, and avoidance disorders were determined. Implications for use of the instrument in screening for mental retardation are discussed.

Manningham, S. (2003). In a regular school, children with severe mental health problems/Dans une école régulière, des enfants sévèrement réfractaires. *Revue de*

Psychoéducation, 32(2) 249-271.
ABSTRACT: At the Seigneurie-des-Mille-Iles School Board, an increase of mental health problems along with their dramatic consequences for the children and their environment were observed. This led to the **implementation of a screening (depistage) and a treatment program** in this school board. In this school board, the professionals involved based their action on a psychoeducational approach that ensures quality of clinical services as well as the organization of the various practices. This paper describes the development of this program.

⌑ Manzano, J., & Fridman-Wenger, M. (1993). Psychiatric consultation for alcoholic parents' child/Les enfants de parents alcooliques. une étude clinique. *Annales Médico-Psychologiques, 151*(2) 134-138.
ABSTRACT: Studied the clinical characteristics and family situation of **children of alcoholic parents**. All of the Ss were receiving treatment at a child psychiatry service. Human Ss: 15 male Swiss preschool and school-age children (mean age 8.4 yrs) (mixed psychiatric diagnoses) and 10 female Swiss preschool and school-age children (mean age 5.5 yrs) (mixed psychiatric diagnoses). Ss' case records were analyzed for data on reasons for psychiatric consultation; symptoms; IQ; diagnosis; therapeutic measures; response to treatment; and family factors (e.g., parents' occupational status, number of children, parent(s) with whom Ss is currently living, and parent(s) with alcoholism). Results are compared with findings from a similar study (J. Manzano and F. Palacio, 1990) among children of parents with drug addictions.

✧ Marie-Cardine, M., Maussac, M., & Jacq, J. (1987). A french mental health surgery for outpatients: Outcome of three years' follow-up (1979-1980-1981)/Bilan d'activité d'un secteur d'hygiène mentale en france: Étude statistique des consultants adultes et enfants des années 1979-1980-1981. *Psychologie Medicale, 19*(14) 2569-2572.
ABSTRACT: Conducted an epidemiologic study of **new psychiatric outpatients** in Rhône, France. Human subjects: Male and female French children, adolescents, and adults (mental disorders). Ss' records were numbered to assure anonymity. Ss' main characteristics were determined, and the interaction of certain characteristics was studied. Data were factor analyzed. (English abstract)

⌑ Marty, F., Braik, S., & Chevrollier, J. (2000). Violence and adaptive disorder in the young adult/Violence et troubles de l'adaptation chez l'adulte jeune. *Annales Médico-Psychologiques, 158*(8) 656-659.
ABSTRACT: Studied the expression of **reactive violence** in 17 male and female adolescents and young adults (aged 16-24 yrs) in France who were admitted to an emergency room after **attempting suicide**. Ss were hospitalized for 1-4 days. Psychological assessment before discharge revealed clinical characteristics of adaptive disorder, according to the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV). Ss' suicide attempts were impulsive, and their desire to die was brief. Ss felt neglected or socially rejected, and they turned their anger vs themselves. It is maintained that the presence of their parents in the emergency room seemed to restore familial communication. The difficulties and importance of psychological follow-up in these cases are examined. A brief discussion section follows the main article

⌑ Maudoux, M., Maudoux, S., Prévost, P., & Repellin, F. (1992). Young arsonists: Psychopathology and cognitive development/Les jeunes incendiaires, psychopathologie et aspects évolutifs. *Annales Médico-Psychologiques, 150*(6) 417-422.
ABSTRACT: Studied psychosocial and clinical characteristics of 30 adolescents and young adults (mean age 18.5 yrs) referred for psychiatric evaluation for **fire-setting behavior**. Case records were reviewed for data on characteristics of the fire-setting act and on Ss' sociodemographic characteristics, family environment, medical and criminal history,

cognitive development, and psychiatric symptoms. (English abstract)

- Misès, R., Fortineau, J., Jeammet, P., & Mazet, P. (1987). Towards a French classification of mental disorders in children and adolescents/Vers une classification française des troubles mentaux de l'enfant et de l'adolescent. *Information Psychiatrique, 63* 289-302.
  ABSTRACT: Discusses a **biaxial classification scheme for mental disorders** in children and adolescents: (1) basic clinical categories, and (2) associated or preceding (etiologic) factors. The results of a preliminary study of the clinical axis are presented. Advantages of its use with very young children are considered. (English, Spanish & Italian abstracts)

- Misès, R., Fortineau, J., Jeammet, P., & Lang, J. -. (1988). A french classification of child and teenage mental problems/Classification française des troubles mentaux de l'enfant et de l'adolescent. *Psychiatrie de l'Enfant, 31*(1) 67-134.
  ABSTRACT: Presents a biaxial French **classification of childhood and adolescent mental problems** that includes a detailed glossary. The results of a preliminary trial conducted by child psychiatrists are considered. It is maintained that equivalences have been established with the World Health Organization's International Classification of Diseases-10. (English & Spanish abstracts)

- Misès, R., & Quemada, N. (1993). The epidemiological importance of the french classification system for mental disorders in children and adolescents (FCSMDCA)/L'apport de la classification française des troubles mentaux de l'enfant et de l'adolescent en épidémiologie. *Confrontations Psychiatriques, 35* 273-285. Retrieved January 4, 2007, from the PsycINFO database.
  ABSTRACT: Discusses the contributions of the **FCSMDCA** to epidemiological research. The FCSMDCA permits standardized collection of statistical data, and its congruence with the International Classification of Diseases promotes international cooperation. Applications of the FCSMDCA in epidemiological research on cognitive disturbances, psychoses, and risk factors for these disorders are described. (English abstract)

- Misès, R., Quemada, N., Botbul, M., Bursztejn, C., Durand, B., & Garrabé, J. et al. (2002). The CFTMEA 2000: A new version of the french classificaiton of mental disorders in Children/CFTMEA 2000: Nouvelle version de la classification française des troubles mentaux de l'enfant et de l'adolescent. *Annales Médico-Psychologiques, 160*(3) 213-215.
  ABSTRACT: Discusses changes in the CFTMEA 2000, the **4th version of the French Classification of Mental Disorders in Children and Adolescents**. The principles and the uses of the previous version remain unchanged. Changes in axis I descriptions, correspondence with the International Classification of Diseases and Related Health Problems (ICD--10), and the creation of specific axis I section for infants and young children (0-3 yrs) are reported. No changes are reported for the axis II categories.

- Muratori, F., Milone, A., Viglione, V., Romagnoli, G., & Palacio-Espasa, F. (2001). Behavioral problems at adolescence: Violence, agressiveness and identification/Les troubles de la conduite à l'adolescence: Violence, aggresivité et identification. *Psychiatrie de l'Enfant, 44*(2) 415-446.
  ABSTRACT: In **the French classification of child and adolescent mental disorders (CFTMEA)** the conduct disorders listed in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) do not constitute a category in themselves. They are included in the psychopathic organization of the personality. The complexity of the etiopathogenic factors implicated in these troubles brings the authors to propose a variety of therapeutic indications: individual psychotherapy, parental support, re-education, and medication. The objective is to intervene both at the level of the symptom and the personality. A clinical example shows that therapy demands empathy and flexibility so as to get beyond transferential attitudes, and aggressive or self-destructive acting out. Certain

moments of the therapy appear in detail where narcissism needs to be comforted, where we discover a need for dependence or a demand for limits.

⌑ Mury, M., Verdoux, H., Mammar, N., & Rousseau, M. (1995). A clinical study among patients hospitalized for eating disorders: Implications for DSM-III criteria for bulimia/Étude clinique d'une population de patients hospitalisés pour trouble des conduites alimentaires. discussion des critères diagnostiques DSM III. *L'Encéphale, 21*(2) 99-105.
ABSTRACT: Studied the appropriateness of Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R) criteria for **bulimia** in a sample of 95 inpatients (aged 16-35 yrs) with eating disorders (EDs). Ss' symptoms were evaluated with the Computerized Multiple Diagnostic Instrument for Eating Disorders, and the eating and purging behaviors of Ss with anorexia nervosa, anorexia-bulimia, normal-weight bulimia, and eating disorder not otherwise specified were compared. Results were analyzed to determine the utility of DSM-III criteria in distinguishing bulimia from the other EDs. (English abstract)

✍ Nguyen, C. T., Fournier, L., Bergeron, L., Roberge, P., & Barrette, G. (2005). Corrélats des troubles dépressifs et anxieux chez les jeunes Canadiens/Correlates of depressive and anxiety disorders among young canadians. *Canadian Journal of Psychiatry.Special Issue: The Canadian Academy of Psychiatric Epidemiology (CAPE) look at the Canadian Community Health Survey, Cycle 1.2, 50*(10) 620-628.
ABSTRACT: Objective: The current study presents data on the prevalence **of depressive and anxiety disorders** in the Canadian population aged between 15 and 24 years and examines their potential correlates. Methods: The study is based on the 2002 Canadian Community Health Survey: Mental Health and Well-Being (CCHS 1.2). This survey was administered to a representative sample of 36,984 Canadians. A subsample of 5673 Canadians aged between 15 and 24 years was available for the analyses. We used descriptive analyses to calculate lifetime and 12-month prevalence of depressive and anxiety disorders, and we used logistic regressions to measure odds ratios. Results: Among Canadian youths, 10.2% had suffered from depressive disorders during their lifetime, whereas 12.1% had suffered from anxiety disorders. For 12-month prevalence, the rates were 6.4% and 6.5% for depressive and anxiety disorders, respectively. Depressive disorders were more frequent among youth aged 20 to 24 years and among those no longer in school. Both disorders were more common among women and people under extreme stress. Conclusions: The prevalence rates found are comparable with other studies, and most of the correlates are concordant with the literature. Results indicate that there is a turning point for depression between late adolescence and adulthood that could be crucial for intervention planning.

☆ Othman, S., Bailly, D., Bouden, A., Rufo, M., & Halayem, M. B. (2005). Bipolar disorders in children and adolescents: A clinical study from 50 cases/Troubles bipolaires chez l'enfant et l'adolescent. une étude clinique à partir de 50 cas. *Annales Médico-Psychologiques, 163*(2) 138-146. Retrieved January 4, 2007, from the PsycINFO database.
ABSTRACT: Progress in knowledge about **bipolar disorders**, in their clinical, etiological and therapeutic aspects, led these last 20 years to an increase in interest in childhood and adolescence onset forms of these disorders, even if they are rare. In this way, numerous studies emphasized the difficulties encountered in making the diagnosis at this age, mainly because of the heterogeneity of the clinical picture observed. In this paper, the authors present the results of a retrospective, descriptive, clinical study performed from 50 cases attended in the Razi hospital child and adolescent psychiatry department in Tunis between 1996 and 2001. Among the 470 adolescents hospitalized in the Razi hospital child and adolescent psychiatry department in Tunis between 1996 and 2001, 50 were diagnosed as having bipolar disorder according to the DSM-IV criteria. Their clinical records were analyzed by means of an epidemiological card drawn from the WASH-U-SADS. Twenty-

eight girls and 22 boys were included in the study. The mean age of these subjects at their first hospitalization was 15.8 years; 30% were firstly hospitalized between the age of 14 and 15 years, 24% between the age of 18 and 19 years. The mean duration of their follow-up was 28 months (6-72 months). 44%had previously exhibited episodes of mild depressive manifestations, 16% undiagnosed major depressive disorder, and 14% (only girls) suicide attempts. Familial history of mental disorders was found in 40%: non-affective psychoses in 18% of the cases, bipolar disorders in 16%, major depressive disorder in 4% and alcohol dependence in 2%. 94% of the patients were diagnosed as having bipolar I disorder and 6% bipolar II disorder. The diagnoses at their first hospitalization were very heterogeneous: manic episode in 48% of the cases, major depressive episode with psychotic features in 30%, schizophreniform disorder in 14%, mixed episode in 4%, and adjustment disorder in 4%. The atypical diagnoses were found significantly more frequent in patients firstly hospitalized before the age of 16 years ($P < 0.005$). During the follow-up, 92 manic episodes were recorded. The analysis of the manic episode clinical features also showed that atypical manifestations (mixed episodes or with psychotic features) were significantly more frequent in the patients firstly hospitalized before the age of 16 years ($P < 0.02$). Concerning the therapeutic aspects, mood stabilizers were used from the first manic episode in 82% of the cases. The adjunction of an antipsychotic agent during the acute phase of the mood episodes was found relatively frequent, probably because of the frequency of the psychotic features observed during these episodes. These results confirm numerous data previously reported in comparable studies. More particularly, they agree with the recently evoked hypothesis of two separate phenotypes in juvenile bipolar disorders: the early onset forms, in the youngest people, are characterized by an onset usually depressive type and by the occurrence of mood episodes frequently atypical in their clinical and developing aspects; while the later onset forms look almost like the clinical picture usually observed in adulthood. These data also show that it is essential to assess carefully the mood condition in children and adolescents exhibiting atypical pathological episodes.

- Pedinielli, J., Bertagne, P., & Chabaud, B. (1988). Wrist cutting: Descriptive and quantitative approach/Les phlébotomies: Approche descriptive et quantitative. *Psychologie Medicale, 20*(3) 448-453.

  ABSTRACT: Studied the differences between **suicidal** Ss who slit their wrists and suicidal Ss who took medication overdoses. Human Ss: 764 male and female French adolescents and adults (some with psychiatric disorders). The presence of the deliberate self-harm syndrome (E. M. Pattison and J. Kahan, 1983) and isolated suicidal conduct and the type of suicidal intention were studied. Factor analysis of multiple correspondences in the findings was performed. Tests used: The Risk-Rescue Rating Scale (A. D. Weisman and J.-W. Worden, 1972) and Suicide Intent Scale (D. W. Pierce, 1977). (English abstract)

- Petot, D. (1999). Specific cognitive disturbances among hyperactive children and attention disorder/Enfants hyperactifs: Troubles cognitifs spécifiques et troubles de l'attention. *Enfance, 51*(2) 137-156.

  ABSTRACT: Studied the specificity of the intellectual functioning of 6-12 yr old children with **attention deficit hyperactivity disorder (ADHD)** using some refinements in the Wechsler Intelligence Scale for Children--Revised (WISC--R) interpretation. The WISC-R, the Kaufman Assessment Battery for Children, and the Rorschach were administered to 31 hyperactive boys, diagnosed with the Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R), and 22 normal boys (control group) in France. Hyperactive Ss scored lower than controls on (1) WISC-R global scales, (2) WISC-R Verbal Comprehension, Perceptual Organization, and Distractibility factors, and (3) Kaufman Sequential Processing, Simultaneous Processing, Composite Mental Processing, and Achievement subscales. The findings suggest that the cognitive deficits observed in the hyperactive Ss may be due to a more central cognitive impairment rather than to attention

deficit, however.

- Planche, F. (1988). Survivors of attempted suicide by jumping: Follow-up study/Devenir des rescapés de T. S. par précipitation. *Psychologie Medicale, 20*(3) 424-426. Retrieved January 4, 2007, from the PsycINFO database.
  ABSTRACT: Conducted a 7-yr study of the adaptive functioning of Ss who jumped off the Saint-Jacques viaduct in France and survived (**suicide attempt**). Human Ss: 36 male and female French adolescents and adults (some with mental diseases). Seven of the 36 Ss survived: 2 schizophrenics, 1 psychopath, 1 obsessive neurotic, 1 melancholic, and 2 Ss without evident pathology. Treatments: Five Ss received regular psychiatric or medical care and were integrated into their previous social-professional lives. (English abstract)

- Polo, M. (1987). The institution in the treatment of psychoses/L'institution dans le cadre du traitement des psychoses. *Perspectives Psychiatriques, 26*(8) 167-170. Retrieved January 4, 2007, from the PsycINFO database.
  Describes a French **experimental institution** for children with severe mental handicaps and psychoses that tries to "demedicalize" mental illness along psychoanalytic lines. Rejecting segregation by kind or degree of psychopathology this open institution accepts autistic and psychotic children and children with mental deficits and severe neuroses. Patients are allowed to mix with the outer world and undergo psychoanalysis outside the institution, which provides a stable (rather than rigid) environment, allowing the children freedom of movement and expression. Caregivers include adults without specialized training, who can "converse silently" with the children, facilitating the latter's access to symbolization. (English abstract)

- Portelli, C., Frydman, F., & Mises, R. (1989). French classification of mental disorders in child and adolescent: Presentation of an expert system, JPSY/Classification française des troubles mentaux de l'enfant et de l'adolescent: Présentation d'un système expert, JPSY. *Annales Médico-Psychologiques, 147*(10) 1082-1086.
  ABSTRACT: Describes **an expert diagnostic system**--JPSY--that uses artificial intelligence methods and is based on a hierarchical, 2-axis classification of mental disorders in children and adolescents. The 3 system modules are discussed. Use of the system with a 6-yr-old girl presenting with significant language retardation and retarded organization of cognitive functions is described. A brief discussion follows the main article.

- Quemada, N., & Casadebaig, F. (1992). Psychiatric morbidity in childhood and adolescence: One year outcome in a cohort of treated children and adolescents/Morbidité psychiatrique infanto-juvénile: Devenir á un an de la prise en charge d'une cohorte d'enfants et d'adolescents. *Psychologie Medicale, 24*(1) 37-41. Retrieved January 4, 2007, from the PsycINFO database.
  ABSTRACT: Evaluated all children and adolescents seen for initial psychiatric consultations in both public and private sectors of Loire-Atlantique during 1985, at the time of the 1-yr follow-up. In 32% of the Ss, the length of therapy exceeded 1 yr, while 35% dropped out earlier. **Personal and family factors, reasons for initiating therapy, and therapeutic modalities were factors in early termination of treatment**. A clinical evaluation of results is presented. (English abstract)

- Rist, B., Dessane, A., & Plantade, A. (1990). Crisis states in adolescents: Practice issues in an emergency clinic/Crises et états aigus de l'adolescent: De la pratique à une clinique de l'urgence. *Perspectives Psychiatriques, 29*(23) 170-176.
  ABSTRACT: Presents an **overview of adolescent psychiatric emergencies illustrated by case studies**. Clinicians must evaluate the patient in terms of the meaning of the crisis and distinguish the medical from the social aspect. At the next phase, the meaning of the crisis

needs to be explored in terms of family dynamics vs individual problems. The changeable nature of adolescent symptomatology is discussed, as well as the diagnostic and treatment problems this entails. Questions are raised as to the need for hospitalization vs other forms of crisis intervention. (English abstract)

- Sareen, J., Cox, B. J., Afifi, T. O., Clara, I., & Yu, B. N. (2005). Le besoin peru de traitement de santé mentale dans un échantillon national représentatif du Canada/Perceived need for mental health treatment in a nationally representative canadian sample. *Canadian Journal of Psychiatry.Special Issue: The Canadian Academy of Psychiatric Epidemiology (CAPE) look at the Canadian Community Health Survey, Cycle 1.2, 50*(10) 643-651
  ABSTRACT: Objective: The optimal method of determining how many people in the general population need help for emotional problems remains unclear. This study aimed to examine the **prevalence and correlates of self-perceived need for mental health services** (that is, help seeking and perceived need) in a large, population-based sample. Methods: Data came from the Canadian Community Health Survey 1.2 (n = 36,816, respondent age 15 years and over, and response rate 77%). Respondents were asked whether they had sought help in the past year from any professional for emotional problems and whether they felt they needed help for emotional symptoms but had not sought treatment. The Composite International Diagnostic Interview (CIDI) was used to make DSM-IV mental disorder diagnoses. Results: The past-year prevalences of help seeking and perceived need were 8.7% and 2.9%, respectively. After adjusting for the presence of DSM-IV disorders assessed in the survey, sociodemographic factors, illness severity, social supports, and the presence of physical health conditions were associated with help seeking and perceived need. Independent of DSM diagnoses, sociodemographics, and social supports, perceived need and help seeking were associated with increased levels of distress, disability, and suicidal ideation and attempts. Conclusions: This study illustrates that, in addition to the presence of a DSM diagnosis, the respondent's self-perceived need for mental health treatment is important in the assessment of need for mental health services in the community.

- Schaffer, A., Cairney, J., Cheung, A., Veldhuizen, S., & Levitt, A. (2006). Enquête dans la collectivité sur le trouble bipolaire au canada: Prévalence à vie et caractéristiques de la maladie/Community survey of bipolar disorder in canada: Lifetime prevalence and illness characteristics. *Canadian Journal of Psychiatry, 51*(1) 9-16.
  ABSTRACT: Objective: This study reports on the lifetime prevalence and illness characteristics of **bipolar disorder** (BD) in a large, representative sample of Canadians. Method: Data were obtained from the Canadian Community Health Survey: Mental Health and Well-Being. This representative, cross-sectional survey, conducted by Statistics Canada in 2002, examines the mental health of Canadians aged 15 years and over. The national response rate was 77%. We determined the prevalence rate of BD, correlates of a bipolar diagnosis, and illness characteristics. Results: The weighted lifetime prevalence rate of BD was 2.2% (95% confidence interval [CI], 1.94% to 2.37%). Younger age, low income adequacy, lifetime anxiety disorder, and presence of a substance use disorder in the past 12 months were each significantly associated with the presence of a BD diagnosis ($P < 0.001$ for each). The largest effect found was for the presence of an anxiety disorder (odds ratio 7.94; 95% CI, 6.35 to 9.92). A lifetime history of anxiety disorder was reported by 51.8% (955% CI, 47.1% to 56.5%) of the respondents with BD, with both panic disorder and agoraphobia each being more frequent among women, compared with men ($P = 0.01$ and $P < 0.001$, respectively). The mean age at onset of illness was 22.5 years, SD 12.0. Conclusions: According to the estimated lifetime prevalence of BD found in this study, over 500 000 Canadians likely suffer from this condition. Identifying those at highest risk for BD may assist in developing more effective community-based identification and intervention strategies.

- Seletti, B., Launay, C., Garnier, B., Brun-Ney, D., Boulard, J. C., & Petitjean, F. (2001). Treating psychiatric emergencies in the emergency room of a university hospital, within a mental health network/Accueil des urgences psychiatriques au sein d'un centre hospitalier universitaire. intérêt de l'intégration dans un réseau de soin sectorisé. *Annales Médico-Psychologiques, 159*(3) 160-166.
  ABSTRACT: Conducted a retrospective study of all adolescent and adult patients referred to a psychiatrist by an emergency room medical doctor in France during a 3-mo period in 1999. (Functional psychiatric units were created within hospital emergency departments as a result of a law passed in France in 1995). Ss were 372 males and females aged 15-97 yrs. **Diagnosis and treatment modalities** are discussed. 27% of Ss were diagnosed with dementia, alcoholism, drug addiction, anxiety disorders, and eating disorders. In these cases, it is maintained that treatment required active collaboration between medical and psychiatric staff. A brief discussion section follows the main text.

- Simonnet, P. (1990). The dynamics of identifications using the narrative structure of the TAT/La dynamique des identifications à travers la structure narrative du T.A.T. *Bulletin de Psychologie, 43*(396) 691-695.
  ABSTRACT: Studied the double structure of roles and narrative functions in the TAT. Human Ss: 23 male French adolescents (behavioral problems and personality disturbances) (inpatients at a psychotherapy facility) (spent more than 2 yrs in an institution) (had parents with psychological problems). 19 male French adolescents (behavioral problems and personality disturbances) (inpatients at a psychotherapy facility) (spent more than 2 yrs in an institution). 20 male French adolescents (behavioral problems and personality disturbances) (inpatients at a psychotherapy facility) (spent more than 2 yrs in an institution) (mother or a substitute was absent during the 1st 3 yrs of life). 23 normal male French adolescents (secondary school students) (control group). The performance of the 4 groups on the TAT was compared.

- Smolla, N., & Lebel, A. (1998). Child psychiatry day-care centers for clients aged 0-12 years in Quebec/Les centres de jour pédopsychiatriques pour la clientèle des 0-12 ans au québec. *Canadian Journal of Psychiatry, 43*(7) 714-721.
  ABSTRACT: The **review lists the child psychiatry day-care centres in Quebec, evaluates their capacity, and describes them according to the age range for admission, the psychopathologies treated, and the parent involvement required**. The 26 programs selected, which are all associated with a hospital centre, assess and treat children aged 0-12 yrs on a day-care basis. Organization, clinical operation, and research are addressed during a semisupervised interview. The average capacity is 18 children (4 to 40), with a total capacity of 454 children. The number of preschool patients can be compared with the number of school patients. Few programs are dedicated to invasive development disorders, and one-third treat behavioural or emotional disorders. The larger capacity programs treat patients of both genders. Most programs are eclectic and encourage but do not require parental involvement. Results take into account different theoretical influences, the controversy about integration criteria and parent involvement, and the specificity of the child psychiatry mission.

- Starkes, J. M., Poulin, C. C., & Kisely, S. R. (2005). Besoin non comblé de traitement de la dépression dans le canada atlantique/Unmet need for the treatment of depression in atlantic canada. *Canadian Journal of Psychiatry.Special Issue: The Canadian Academy of Psychiatric Epidemiology (CAPE) look at the Canadian Community Health Survey, Cycle 1.2, 50*(10) 580-590
  ABSTRACT: Objective: Most people with depression do not receive treatment, even though effective interventions are available. Population-based data can assist health service planners to improve access to mental health services. This study aimed to examine the **determinants of untreated depression in Canada's Atlantic provinces**. Method: This

study used data from the Canadian Community Health Survey Cycle 1.1. Logistic regression models explored the prevalence of depression and associated patterns of mental health service use among population subgroups. Results: Of the respondents, 7.3% experienced major depression in the previous year, as measured by the Composite International Diagnostic Interview Short Form. Individuals with the following characteristics were at increased risk for depression: female sex; widowed, separated, or divorced marital status; low income; and 2 or more comorbid medical conditions. Only 40% of respondents with probable depression reported any consultation about their condition with a general practitioner or mental health specialist. Less than one-quarter of Atlantic Canadians with depression reported receiving levels of care consistent with practice guidelines. Vulnerable groups, including older individuals, people with low levels of education, and those living in rural areas, were significantly less likely to receive treatment in either primary or specialty care. Conclusions: These findings suggest inequitable access to services and the need to target interventions to at-risk populations by raising awareness among the public and health care providers. Health systems in the Atlantic region must work toward achieving consistent longitudinal care for a larger proportion of individuals suffering from depression by studying the underlying factors for service use among underserved groups.

- Tassé, M. J. (1999). The role of parents in the evaluation and intervention of children with dual diagnosis/Le rôle des parents dans l'évaluation et l'intervention auprès des enfants présentant un "double diagnostic.". *Revue Francophone de la Déficience Intellectuelle, 10*(1) 55-59.
  ABSTRACT: Describes the **construction of an instrument designed to assess mental disorders and behavioral problems in children and adolescents (the French version of the Nisonger Child Behavior Rating Scale)** based on parent and teacher ratings and a research project designed to train the parents of adolescents with aggressive behaviors in crisis intervention and functional assessment. The need for the active collaboration of parents in the assessment of and interventions with children and adolescents with mental disorders and behavioral problems is emphasized.

- Thompson, A. H. (2005). Les variations de la prévalence des troubles psychiatriques et des problèmes sociaux entre les provinces canadiennes/Variations in the prevalence of psychiatric disorders and social problems across canadian provinces. *Canadian Journal of Psychiatry.Special Issue: The Canadian Academy of Psychiatric Epidemiology (CAPE) look at the Canadian Community Health Survey, Cycle 1.2, 50*(10) 637-642.
  ABSTRACT: Objective: To determine provincial 12-month **prevalence rates for selected psychiatric disorders** and to assess the association between these and the Canadian Social Problem Index (SPI). Method: Psychiatric data for depression, mania, panic disorder, social phobia, and agoraphobia were derived from the results of the 2002 Canadian Community Health Survey: Mental Health and Well-Being. The Canadian SPI was updated for 2002, and correlations were calculated between the SPI and the 5 diagnostic prevalence values across provinces. Results: The results showed that the SPI had maintained its tendency to increase from east to west in Canada, a trend reflected by depression and mania. The psychiatric disorders did not show strong correlations with the SPI in 2002, but depression and mania did show relatively strong associations with index values from earlier years. High-to-low ratios across provinces for individual social problems averaged over 5, and the results were essentially of the same magnitude for the ranges of particular psychiatric diagnoses. Conclusions: The differences in need found here suggest that per capita allocation of funding for mental health and social programs may not be appropriate. The mixed findings on the association between mental disorders and social problem behaviour across provinces leads to more research questions than research answers.

Toupin, J., Pauzé, R., & Déry, M. (2005). Quebec youth centers services for adolescents with conduct problems I: Compatibility with youth and families' impediments/Les services des centres jeunesse offerts aux adolescents ayant des troubles de comportement I: Associations avec les difficultés des jeunes et des familles. *Revue de Psychoéducation, 34*(2) 191-213.

ABSTRACT: The frequency of **conduct problems** in adolescents, their relative stability, as well as recurrent Youth Centers' **service utilization** by a segment of these adolescents and their families underscore the need for increased knowledge on the available services. Indeed, examining compatibility between the youths' and families' impediments and the different custodial interventions offered by the Youth Centers (external follow-up, foster home, residential setting) is timely. This study targeted 92 adolescents referred to a Quebec Youth Center for conduct problems, in accordance with the Youth Protection Law. Three groups were formed based on the main intervention offered within the first three months of referral: external follow-up (n = 24), foster home (n = 20) and residential setting (n = 48). Our results demonstrate that adolescents placed in residential settings are most subject to mandatory measures, claim worse relationships with their mothers and are more likely to exhibit oppositional behaviors and alcohol abuse. However, group differences on these dimensions are modest and, on their own, do not elucidate the type of service provided. In fact, the results suggest there are more similarities than differences between groups in observed rates of diverse mental disorders as well as on parental and familial characteristics. Such findings question the criteria underlying the Youth Centers' decisions pertaining to differential service delivery.

Vasiliadis, H., Lesage, A., Adair, C., & Boyer, R. (2005). L'utilisation des services pour des raisons de santé mentale: Les différences interprovinciales de taux, de déterminants et d'équite d'accés/Service use for mental health reasons: Cross-provincial differences in rates, determinants, and equity of access. *Canadian Journal of Psychiatry.Special Issue: The Canadian Academy of Psychiatric Epidemiology (CAPE) look at the Canadian Community Health Survey, Cycle 1.2, 50*(10) 614-619.

ABSTRACT: Objectives: In 2002, Canada undertook its first national survey on mental health and well-being, including detailed questioning on service use. Mental disorders may affect more than 1 person in 5, according to past regional and less comprehensive mental health surveys in Canada, and most do not seek help. Individual determinants play a role in health resource use for mental health (MH) reasons. This study aimed to provide **prevalence rates of health care service use** for MH reasons by province and according to service type and to examine **determinants of MH service use** in Canada and across provinces. Methods: We assessed the prevalence rate (95% confidence interval [CI]) of past-year health service use for MH reasons, and we assessed potential determinants cross-sectionally, using data collected from the Statistics Canada Canadian Community Health Survey: Mental Health and Well-Being (CCHS 1.2). We estimated models of resource use with logistic regression (using odds ratios and 95%CIs). Results: The prevalence of health service use for MH reasons in Canada was 9.5% (95%CI, 9.1% to 10.0%). The highest rates, on average, were observed in Nova Scotia (11.3%; 95%CI, 9.6% to 13.0%) and British Columbia (11.3%; 95%CI, 10.1% to 12.6%). The lowest rates were observed in Newfoundland and Labrador (6.7%; 95%CI, 5.3% to 8.0%) and Prince Edward Island (7.5%; 95%CI, 5.8% to 9.3%). In Canada, the general medical system was the most used for MH reasons (5.4%; 95%CI, 5.1% to 5.8%) and the voluntary network sector was the least used (1.9%; 95%CI, 1.7% to 2.1%). No difference was observed in the rate of service use between specialty MH (3.5%; 95%CI, 3.2% to 3.8%) and other professional providers (4.0%; 95%CI, 3.7% to 4.3%). In multivariate analyses, after adjusting for age and sex, the presence of a mental disorder was a consistent predictor of health service use for MH across the provinces. Conclusions: There is up to a twofold difference in the type of service used for MH reasons across provinces. The primary care general medical system is the most widely used service for MH. Need remains the strongest predictor of use, especially

when a mental disorder is present. Barriers to access, such as income, were not identified in all provinces. Different sociodemographic variables played a role in service seeking within each province. This suggests different attitudes toward common mental disorders and toward care seeking among the provinces.

- Zdanowicz, N., Janne, P., Reynaert, C., & Naviaux, A. F. (2002). Comparing family expectancies of "healthy" and "pathological" students/Comparaison de attentes d'étudiants "sains" et "en souffrance" par rapport à leur famille. *Annales Médico-Psychologiques, 160*(2) 130-137.

  ABSTRACT: Examined ideal **family differences** between a group of 814 healthy students (aged 10-25 yrs) and a 358 adolescents with mental disorders. The Ss completed the Olson questionnaire concerning their native and ideal families. The healthy teenagers belonged to distinctly more cohesive and adaptable families than the adolescents from the pathological group. The healthy teenagers also expected a still more cohesive and adaptable family. Gender had no influence on the native family description, but acted as a defining factor in the expectations concerning the ideal family among the girls of the healthy population. In the healthy group, age determined at once a gradual cohesion decline in the native families and a cohesion rise in the ideal family. It is concluded that if healthy adolescents expect more cohesion and adaptability from their future family, pathological adolescents should show a decreased dream ability. Such a decrease could be related with the lower cohesion and adaptability levels described into the native family. (PsycINFO Database Record (c) 2006 APA, all rights reserved)

CINAHL Database

The Cumulative Index to Nursing & Allied Health (CINAHL) database provides authoritative coverage of the literature related to nursing and allied health. Virtually all English-language publications are indexed along with the publications of the American Nurses Association and the National League for Nursing. Primary journals are indexed from the following allied health fields: Cardiopulmonary technology, emergency services, health education, medical laboratory technology, medical assisting, medical records, occupational therapy, physician assistant, radiologic technology, technology therapy, social services and health care, surgical technology.

Selected journals are also indexed in the areas of consumer health, biomedicine, and health sciences librarianship. In total, more than 1200 journals are regularly indexed; online abstracts are available for more than 800 of these titles. There are more than 7000 records with full text now included and 1200 records with images. The database also provides access to healthcare books, nursing dissertations, selected conference proceedings, standards of professional practice, educational software and audiovisual materials in nursing.

More than 10,000 CINAHL subject headings provide specific access to NAHL citations. Approximately 70 percent of CINAHL headings also appear in MEDLINE. CINAHL supplements these headings with 2,000+ terms designed specifically for nursing and allied health. All explodable headings have been pre-exploded by Ovid.

#	Search History	Results
1	(((treatment or intervention) and mental health) or mental disorders).mp. [mp=title, subject heading word, abstract, instrumentation]	15746
2	limit 1 to ((preschool child <2 to 5 years> or child <6 to 12 years> or adolescence <13 to 18 years>) and yr="1987 - 2007")	3157
3	limit 2 to ((preschool child <2 to 5 years> or child <6 to 12 years> or adolescence <13 to 18 years>) and **french**)	1

- empirical study
- prevalence / incidence study
- descriptive study
- epidemiological study
- review
- treatment or intervention study
- drug study
- service utilization

Study Type	Citation and Abstract
	Toupin J. Pauze R. Yergeau E. Dery M. Fortin L. Mercier H. Children with conducts disorder and using psychoeducational services: a social, psychological and family portrait [French]. Sante Mentale Au Quebec. 2003 Spring; 28(1): 232-57. (79 ref) ABSTRACT: Contemporary studies suggest that most of the children who manifest **conducts disorder** also present personal as well as family problems. This is particularly true for children whose disorder is precocious. The identification of personal characteristics as well as social and family risk and protection factors associated with children with such problems are of great use for intervention planning and service organization for them and their families in Quebec. In

consequence, the objectives of this study are to identify the social, family and psychological factors that characterize children presenting conducts disorder. To do so, 62 children in treatment between the ages of 7 and 12 and with a diagnosis of conducts disorder are compared with 36 children of the same age without such diagnosis. Results show that children with conduct problems come from less stable and cohesive families as well as a lower socio-economic level. Moreover, their network of social support is less developed. The study reveals that the parents of children with conducts disorder use punishment more often. Finally, the research demonstrates that the children of this group have a much higher probability of presenting an exteriorized disorder (66%) than the children of the other group (8%). All these distinctive characteristics allows to correctly classify 93,8% of the children of this study in the 2 groups. The results indicate the need to improve the parents'educational practices, increase the child's social network as well as reduce the conducts of opposition and inattention of the child. Finally, the complexity of the problems raised with the child and families commands a concerted professional intervention.

MEDLINE Database 1996 to November Week 3 2006

#	Search History	Results
1	(((treatment or intervention) and mental health) or mental disorders).mp. [mp=title, original title, abstract, name of substance word, subject heading word]	40637
2	limit 1 to ((preschool child <2 to 5 years> or child <6 to 12 years> or adolescence <13 to 18 years>) and yr="1987 - 2007") [Limit not valid in: Ovid MEDLINE(R); records were retained]	5996
3	limit 2 to ((preschool child <2 to 5 years> or child <6 to 12 years> or adolescence <13 to 18 years>) and french) [Limit not valid in: Ovid MEDLINE(R); records were retained]	86

- empirical study
- prevalence / incidence study
- descriptive study
- epidemiological study
- review
- treatment or intervention study
- drug study
- service utilization

Study Type | **Citation and Abstract**

Callahan S. Rousseau A. Knotter A. Bru V. Danel M. Cueto C. Levasseur M. Cuvelliez F. Pignol L. O'Halloran MS. Chabrol H. [Diagnosing eating disorders: presentation of a new diagnostic test and an initial epidemiological study of eating disorders in adolescents]. [French] Encephale. 29(3 Pt 1):239-47, 2003 May-Jun.

ABSTRACT: Precise diagnosis of **eating disorders** has long been problematic. First off, although the DSM IV provides clear criteria, these are applicable to a very narrow range of disorders. Subclinical disorders, although well defined in the literature, are difficult to diagnose as no tool has been previously available. These subclinical disorders are particularly important if one considers that they are often precursors to more serious and life-threatening eating disorders. In addition, choice of diagnostic tool for eating disorders has also long been the cause of difficulty for both researchers and clinicians. Although interviews are favored for their in-depth approach, they are sometimes difficult to implement and often too long and costly to use on a regular basis. Most available questionnaires are limited by their approach to one or two diagnostic categories, and again, until now, no tool has fully addressed the issue of subclinical disorders. The goal of this work was to translate and use a new questionnaire, The Questionnaire for Eating Disorders (Q-EDD), which was developed in the United States and based on both DSM IV criteria as well as carefully developed subclinical disorder criteria. The Q-EDD can identify the major eating disorder categories while at the same time distinguishing between different qualities in each (for example restricting versus compensatory anorexia). Moreover, the Q-EDD can identify several subclinical disorder categories, providing useful insight into potentially dangerous evolution of these disorders. In collaboration with one of the original authors, the questionnaire was translated into French with careful attention to DSM IV

criteria in order to preserve its original validity. The questionnaire was read by several professionals in psychology as well as lay people to assure its face validity and ease of use. Once the questionnaire was adequately translated and corrected, it was used for an epidemiological study with a large sample of adolescents and young adults (n=1 001) from several Junior High and High Schools in the greater metropolitan area of Toulouse, France. The schools were located in a variety of neighborhoods and represented a wide range of population, some of them being more academic oriented, others being more oriented towards practical training. The population was composed of 703 females and 298 males, with an average age of 17.06 years. In addition, the population included several different ethnic categories, all of which are similarly represented in the general French population. The results from the Q-EDD showed levels of various clinical disorders to replicate data from previous epidemiological studies with 1.5% of the population suffering from a serious clinical DSM IV disorder; 7.9% suffering from DSM IV disorders NOS; and 20.9% suffering subclinical disorders. In addition to this finding of 30% of the population with an eating disorder, it was noted that a large number of these young people fell into the severe underweight and low weight categories. Indeed, nearly 10% of this group were within the weight criteria for anorexia, despite the fact that they did not meet the other criteria. This finding seemed to warrant additional investigation, and as a result, a different cut-off for severe underweight was established using literature references; this cut-off was set at the 10(th) percentile for BMI based on age. Yet, even with this new cut-off, 6% of this population still met a severe underweight criteria suggestive of anorexic pathology. These results led to the formulation of 2 hypotheses to explain this finding, the first of which examines morphological differences, the second of which suggests cultural differences in terms of eating habits and diet. The French version of the Q-EDD appears to follow the psychometric properties of the original version, moreover it provides useful and rich data regarding eating disorders in a format that is simple and efficient.

- Callahan S. Rousseau A. Knotter A. Bru V. Danel M. Cueto C. Levasseur M. Cuvelliez F. Pignol L. O'Halloran MS. Chabrol H. [Diagnosing eating disorders: presentation of a new diagnostic test and an initial epidemiological study of eating disorders in adolescents]. [French] Encephale. 29(3 Pt 1):239-47, 2003 May-Jun.

  ABSTRACT: Precise diagnosis of **eating disorders** has long been problematic. First off, although the DSM IV provides clear criteria, these are applicable to a very narrow range of disorders. Subclinical disorders, although well defined in the literature, are difficult to diagnose as no tool has been previously available. These subclinical disorders are particularly important if one considers that they are often precursors to more serious and life-threatening eating disorders. In addition, choice of diagnostic tool for eating disorders has also long been the cause of difficulty for both researchers and clinicians. Although interviews are favored for their in-depth approach, they are sometimes difficult to implement and often too long and costly to use on a regular basis. Most available questionnaires are limited by their approach to one or two diagnostic categories, and again, until now, no tool has fully addressed the issue of subclinical disorders. The goal of this work was to translate and use a new questionnaire, The Questionnaire for Eating Disorders (Q-EDD), which was developed in the United States and based on both DSM IV criteria as well as carefully developed subclinical disorder criteria. The Q-EDD can identify the major eating disorder categories while at the same time distinguishing between different qualities in each (for example restricting versus compensatory anorexia). Moreover, the Q-EDD can identify several subclinical disorder categories, providing useful insight into potentially dangerous evolution of these disorders. In collaboration with one of the original authors, the questionnaire was translated into French with careful attention to DSM IV criteria in order to preserve its original validity. The questionnaire was read by several professionals in psychology as well as lay people to assure its face validity and ease of

use. Once the questionnaire was adequately translated and corrected, it was used for an epidemiological study with a large sample of adolescents and young adults (n=1 001) from several Junior High and High Schools in the greater metropolitan area of Toulouse, France. The schools were located in a variety of neighborhoods and represented a wide range of population, some of them being more academic oriented, others being more oriented towards practical training. The population was composed of 703 females and 298 males, with an average age of 17.06 years. In addition, the population included several different ethnic categories, all of which are similarly represented in the general French population. The results from the Q-EDD showed levels of various clinical disorders to replicate data from previous epidemiological studies with 1.5% of the population suffering from a serious clinical DSM IV disorder; 7.9% suffering from DSM IV disorders NOS; and 20.9% suffering subclinical disorders. In addition to this finding of 30% of the population with an eating disorder, it was noted that a large number of these young people fell into the severe underweight and low weight categories. Indeed, nearly 10% of this group were within the weight criteria for anorexia, despite the fact that they did not meet the other criteria. This finding seemed to warrant additional investigation, and as a result, a different cut-off for severe underweight was established using literature references; this cut-off was set at the 10(th) percentile for BMI based on age. Yet, even with this new cut-off, 6% of this population still met a severe underweight criteria suggestive of anorexic pathology. These results led to the formulation of 2 hypotheses to explain this finding, the first of which examines morphological differences, the second of which suggests cultural differences in terms of eating habits and diet. The French version of the Q-EDD appears to follow the psychometric properties of the original version, moreover it provides useful and rich data regarding eating disorders in a format that is simple and efficient.

☆ Delmas C. [Hyperactivity in children]. [Review] [10 refs] [French] Soins - Psychiatrie. (224):42-4, 2003 Jan-Feb.
ABSTRACT:

☆ Daligand L. Gonin D. [Crime and psychopathology]. [Review] [8 refs] [French] Revue du Praticien. 52(7):739-42, 2002 Apr 1.
ABSTRACT: **Crime** does not necessarily involve the existence of a **psychopathologic disorder**. However, some psychiatric disorders as, for example, delirious psychosis, paranoia, melancholy or obsessional neurosis, might predispose to crime. Violence can lead the victim, by the way of stress or trauma, to develop some psychic trouble as neurosis or traumatic psychosis. Children in particular, while constructing, are very vulnerable victims, especially when their aggressor is also a member of their family. Therapy for the aggressors, as well as for the victims, is based on the assertion that both the aggressors and the victims are subject to law.

❄ Fombonne, E. Vermeersch, S. [Children from the GAZEL cohort: II--motive for contact with the medical-educational system by age and sex]. [French] Revue d Epidemiologie et de Sante Publique. 45(2):107-15, 1997 Apr.
ABSTRACT**:** An epidemiological survey of 2582 French children aged 4 to 16 has been conducted to assess **patterns of service use in relation to psychological disturbances**. Details on the design, sample, survey instruments, response rate, and 12-months prevalence rates of contacts with a range of different professionals were presented in a previous article. In this second article, the psychological motives leading to contact with family doctors, school-based professionals, speech and language therapists, and mental health specialists are analyzed. The age and gender effects are assessed for each motives. On the whole, consistent sex differences were found for the types of complaints presented by service users, with emotional symptoms being more

frequent amongst girls, and behavioural, developmental and learning difficulties being more frequent amongst boys. Mental health specialists were attended for a variety of reasons. Family doctors were contacted for minor emotional difficulties. Because family doctors were consulted by a high proportion of children and adolescents of our sample, the role of this professionals in the detection and management of minor psychological morbidity is emphasized.

✧ ❄ Fombonne E. Vermeersch S. [Children of the GAZEL Cohort: I--Prevalence of contacts with the medico-educational system for psychological reasons, and associated factors]. [French] Revue d Epidemiologie et de Sante Publique. 45(1):29-40, 1997 Mar.

ABSTRACT**:** An **epidemiological survey** of French children aged 4 to 16 was conducted in order to estimate the 12-months **rates of service utilization for psychological reasons** and to assess the factors associated with service use in this community sample. A large sample of 2582 children and adolescents was recruited from the families whose one parent was employed by the national electricity and gaz company (EDF-GDF). Of these employees, 20,000 have volunteered for a long-term prospective cohort study of their health and, since 1989, they have participated to annual surveys and additional ad hoc research programmes. Families with a child aged 4 to 16 in 1991 were selected. Only one child was selected in each family, and the sample was stratified by socio-economic status and family size according to census data. A survey questionnaire comprising a valid measure of child psychopathology (Child Behavior Checklist: CBCL) and an additional questionnaire including questions related to service use was used as a means of data collection. The response rate was 62.2% and factors associated with participation in the survey were analysed. The 12-months prevalence rate of contact for psychological motives were: 42.3% for general practitioners and family doctors, 7.8% for speech and language therapists, 9.5% for educational specialists, and 6.0% for mental health professionals. With the exception of general practitioners, rates of service contact were significantly higher for boys. Logistic regression analysis was used to identify separately factors associated with recent contact for each category of professionals. Results showed that, for all professionals, high scores on the CBCL measure was significantly associated with service use, the strongest association being found for mental health professionals. Family structure was also predictive of the latter, with higher rates of contacts for those children living in families whose parents are divorced, separated or widowed. Some differences for contacts with doctors were found according to the region; otherwise, no effects of socio-economic status, educational level of the parent, or other socio-economic indicators were found to predict service utilization. The implications for services are discussed.

☆ Gagne MH. [The parental practice of psychological violence: a threat to mental health]. [Review] [85 refs] [French] Canadian Journal of Community Mental Health. 20(1):75-106, 2001.

ABSTRACT: This literature review documents the risk associated with psychologically violent parental practices for the well-being and future mental health of youth, with regard to 3 aspects: the prevalence of parental practices of this kind, their etiological specificities in spite of their co-occurrence with other forms of maltreatment, and their potential detrimental impact on young victims. Summing up current knowledge about psychological violence, this analysis points out possible means of intervention in terms of prevention, screening, and support. However, it also calls for caution regarding the use of more intrusive modes of intervention, such as child protection

✧ Mathet F. Martin-Guehl C. Maurice-Tison S. Bouvard MP. [Prevalence of depressive disorders in children and adolescents attending primary care. A survey with the Aquitaine Sentinelle Network]. [French] Encephale. 29(5):391-400, 2003 Sep-Oct.

ABSTRACT: Since **depressive disorders** in children and adolescents have not been widely studied in the context of gene-ral medicine, we conducted an epidemiological survey among general practitioners (GP's) consulted by young subjects aged 7 to 17 years for various reasons. OBJECTIVE: The aims were the following: to estimate the prevalence of depressive disorders in general practice, to detect the eventual existence of particular clinical forms, to assess the frequency of comorbid disorders and to determine to what degree these disorders were diagnosed by GP's. METHOD: The study was conducted over 6 months in concert with 45 practitioners of the Aquitaine Sentinelle Network because of their strong experience in the field of epidemiological surveys, especially regarding psychiatric disorders. The population included all consecutive attenders aged 7 to 17 years. Consent to participate was obtained from children and adolescents and their parents. Finally 155 patients took part. A two-stage epidemiologic strategy was used, including screening tests in the first stage and semi structured interview by clinician in the second stage for diagnostic confirmation. During the first stage, information was obtained from children and adolescents and general practitioners using three questionnaires. The self-report questionnaire Center for Epidemiological Studies Depression (CES-D) was used for screening depression in 13 to 17 years old adolescents and the 20 items of the scale were modified to make it more comprehensible and relevant for children aged 7 to 12. The cut-off of 21 used in France appeared to be the more appropriate in both males and females and was taken to indicate high likelihood of depressive disorder. Therefore people with score 21 or more were approached for the second stage. The Child Behavior Checklist (CBCL), an instrument of well-established validity and reliability, provided information from parents about the child's behavior and competencies. Demographic and environmental data, as well as the reason for the visit and the presence of associated psychological factors were collected from a questionnaire devised for the study and completed by the practitioner. The 21 patients initially detected were invited to take part in the second stage. A total of 18 agreed to meet the psychiatrist. Sex-ratio female/male of this sample was 1,25 and mean age was 12,5 years. All of them underwent the Schedule for Affective Disorders and Schizophrenia for School Aged Children (Kiddie-SADS), a semi structured research interview of established validity. Diagnoses were made according to the DSM IV criteria (American Psychiatric Association). RESULTS: Results showed that more than one child out of 10 aged less than 13 years had a depressive disorder, and that the prevalence in the adolescent sub-group was 5%. Major depressive episode was present in 6% of the children sample, dysthymia in 4% and maladjustment disorder with depressive mood in about 1%. All depressive disorders were moderate. Atypical depression (in the Anglosaxon sense of the term) was present in half of the depressed adolescents. Other disorders included anxiety disorders with a rate of about 4% overanxious in the adolescent sample, obsessive compulsive disorder, panic disorder. Disruptive disorders were considerably less common. Psychiatric comorbidity, usually involving different types of emotional disorders, was present in about 50% of psychiatric cases, with a prevalence of anxiety disorders. The reasons why depressed subjects consulted were not specific. The most common reasons for visiting the GP were the somatic complaints with a rate of 50% in both populations, whatever the CES-D's score was. A few per cent of patients attending primary care presented with mental health complaints, and the rate was similar in the two populations. Frequency of consultation was not a discriminant factor of depression. Familial cohesion and school performance were not associated with the CES-D's score, nor familial psychiatric history. Personal psychiatric history was related to depression, whereas the occurrence of bereavement made the CES-D score positive but was not significantly associated with fully- blown depression. Finally, we estimated that 70% of diagnoses of depression were not made during the consultation with GP's. CONCLUSION: No particular characteristic of depressed children consulting GP's could be established. These findings underline the importance of training GP's in the

screening of depressive disorders in children and adolescents. A better knowledge that young general practice attenders have high rates of depressive disorders may facilitate more rapid referral for psychiatric assessment and treatment.

- Messerschmitt P. Bohu D. Charritat JL. [Children and adolescents at risk. A Study by the Child Psychiatry Department of Armand Trousseau hospital in Paris]. [French] Archives de Pediatrie. 11(3):269-75, 2004 Mar.

  ABSTRACT: Along the 12 months of 2002, our Child Psychiatry Department received 109 young patients "at risk", under 17 years old. A detailed study of 103 files evaluates the danger they ran in three fields, **suicide, abuse and neglect, and psychiatric pathology**. With an original "danger scale", the multidisciplinary team completes three assessments: the danger before hospitalisation (background), the present professional action (diagnosis, care, police and justice connections...), estimation of the risk after treatment. In most cases, patients situations are severe, they have lasted for a long time (more than 6 months), and they were already taken on charge. The hospital psychiatric intervention, even for a short time, means to us to interfere whatever the proceedings: medical care, institutions, justice...

- Payet J. Bouvard MP. [Biological approach to adolescent suicide]. [French] Revue du Praticien. 48(13):1415-8, 1998 Sep 1.

  ABSTRACT**:** The high rating of **suicide attempts and suicide** in the general population and among adolescents justifies a lot of research studies, aiming to better define the genetic and biologic factors. The most relevant model and the most admitted is the role of serotonin which at low concentration in the brain causes more violent suicides or suicidal behaviors, as well as more aggressiveness and impulsiveness. It is not excluded that variations linked to the age could determine, among other factors, specific suicidal behaviors related to the adolescence.

- Pommereau X. [Therapeutic approach to adolescent suicide]. [French] Revue du Praticien. 48(13):1435-9, 1998 Sep 1.

  ABSTRACT**:** Management of **suicidal behaviour** in adolescence raises a triple problem: first, one-third of the subjects make repeated suicide attempts, with a clear risk of subsequent death; second, 70% of the patients have no known mental disorders but show psychic suffering requiring appropriate assistance; third, few subjects can themselves request such care, being unable to recognize their disability. Thus, the author suggests classifying the suicidal act among disruptive behaviours that require early detection before any measures can be taken to prevent suicide. The author also asks that hospitals propose adapted treatment to young persons having suicidal behaviour. Aside from physical care, routine emergency room evaluation should be accompanied by a brief hospitalisation in a setting aimed at further evaluation of the crisis and providing mediation for the patient and the family. Such facilities render the act of suicide its deeply critical nature and favour the involvement of all the family members in subsequent therapy.

- Rahioui H. Benyamina A. Reynaud M. [Treatment of cannabis dependence]. [French]. Revue du Praticien. 55(1):64-70; discussion 71-2, 2005 Jan 15.

  ABSTRACT: **Cannabis** is the most regularly used illicit drug in the world. Yet, until recently, there existed no therapeutic intervention for the users of this product. This was due to the fact that cannabis has always been considered a substance that doesn't lead to dependence and thus didn't necessitate a management plan for quitting. The results of the first studies in the domain of cannabis dependence suggest that this pathology responds to the same types of treatments for alcohol and tobacco dependence.

- Renou S. Hergueta T. Flament M. Mouren-Simeoni MC. Lecrubier Y. [Diagnostic structured interviews in child and adolescent's psychiatry]. [Review] [79 refs] [French] Encephale. 30(2):122-34, 2004 Mar-Apr.

  ABSTRACT: **Structured diagnostic interviews**, which evolved along the development of

classification's systems, are now widely used in adult psychiatry, in the fields of clinical trials, epidemiological studies, academic research as well as, more recently, clinical practice. These instruments improved the reliability of the data collection and interrater reliability allowing greater homogenisation of the subjects taking part in clinical research, essential factor to ensure the reproducibility of the results. The diagnostic instruments, conversely to the clinical traditional diagnostic processes allow a systematic and exhaustive exploration of disorders, diagnostic criteria but also severity levels, and duration. The format of the data collection, including the order of exploration of the symptoms, is fixed. The formulation of the questions is tested to be univocal, in order to avoid confusions. In child and adolescent, researches in pharmacology and epidemiology increased a lot in the last decade and the standardisation of diagnostic procedures is becoming a key feature. This Article aims to make an assessment, a selection, and a description of the standardized instruments helping psychiatric diagnosis currently available in the field of child and adolescent's psychiatry. Medline and PsycINFO databases were exhaustively checked and the selection of the instruments was based on the review of four main criteria: i) compatibility with international diagnostic systems (DSM IV and/or ICD-10); ii) number of disorders explored; iii) peer reviewed Journals and iv) richness of psychometric data. After the analysis of the instruments described or mentioned in the literature, 2 structured interviews [the Diagnostic Interview Schedule for Children (DISC) and the Children's Interview for Psychiatric Syndromes (ChIPS)] and 4 diagnostic semi-structured interviews [the Schedule for Affective Disorders and Schizophrenia for School-Age Children (Kiddie-SADS), the Diagnostic Interview for Children and Adolescent (DICA), the Child and Adolescent Psychiatric Assessment (CAPA) and the Interview Schedule for Children and Adolescents ISCA)] were retained according to the 3 first criteria. All can be administered by clinicians, and x out of 6 can also be administered by lay-interviewers. All include a child/adolescent version and a parent version. Two instruments evaluate the presence of DSM IV axe II disorders: The ISCA explores the criteria of the Antisocial Personality Disorder. The CAPA evaluates Borderline, Obsessional-compulsive, Histrionic and Schizotypic Personality Disorders. Regarding the psychometric quality criterion, the selection was much more difficult because of the lack of data and the weakness of the samples studied in reliability studies. Interrater reliability appeared to be good for the 6 instruments, with kappas ranging from 0.5 to 1. This is usual in such instruments. The test-retest reliability was found to vary from bad to excellent depending on the instruments, the "informant" status (child/adolescent or parent), and the disorder explored, kappas ranging from 0.32 to 1. The worst results concerned face-to-face reliability studies which showed weak concordances for the diagnoses, whatever the procedure implemented: Diagnostic interview vs. i) Another diagnostic interview, vs. ii) An expert diagnosis or vs. iii) Scales and questionnaires. Overall, the K-SADS-PL appeared to be the instrument that has the best test-retest reliability for Anxious Disorders and Affective Disorders (the value kappa showing good to excellent reliabilities). Several important methodological observations emerged from this review. Firstly, the metrological data corresponding to the diagnoses according to DSM IV or ICD-10 criteria's were lacking. The face validity was globally satisfactory, but the data concerning their face-to-face validities and their test-retest reliability, although better than in the former versions, were limited because they were tested on small sample. In fact, it appeared that the agreements depend on the informant, the sample studied, the various diagnostic categories and the instrument used. Since the studies carried out by Cohen et al., with now obsolete versions of the DISC and K-SADS, no other study establishing a comparison between two EDS have been conducted. Consequently, the clinicians must be very careful before comparing DSM or ICD diagnoses generated by different instruments. The second point was the length of the interviews that appeared sometimes longer than instruments used in adults, considering the fact that diagnostic

procedure implies two independent interviews, one with the child/adolescent and one with the adult referent. The minimum duration was found to be 1 h 30 for the Chips in clinical setting, while it could reach 4 h or more for the DISC IV or the ISCA. The interviews had to be often carried out in several sessions, so the assessment became very difficult in easily tired and/or distractible subjects. The third point referred to the necessity to consider multiple data sources in young patients during the diagnostic procedure, and the weakness of the levels of agreement generally reported between sources. Empirically, it was observed that the investigator granted more weight to the report of the children than to the parent's one, when the clinical judgement was necessary to synthesize the data. On another level, studies showed a high agreement on the factual contents or on the specific events (ex: hospitalization), like on the obvious symptoms (ex: enuresis). The parents report more problems of behaviour, school and relational difficulties, whereas the children report more fear, anxiety, obsessions and compulsions, or delusional ideas. In other words, it appeared that children were better informants in describing their mental states (internalised disorders), and that adults would bring more reliable information in describing externalised disorders. Like McClellan and Werry, we think that further researches are needed to clarify if and when this is the case. The last major point concerned the problem of language. These instruments must be used in the maternal language of the interviewees and they were developed for most of them into English only. For example, there is only one instrument available into French (the Kiddie SADS). Nowadays, it remains difficult to conduct international studies in child and adolescent psychiatry and/or to compare data is this domain. To conclude, the use of the EDS and EDSS brings many benefits, in academic researches as well as in clinical practice, but a more systematic use is limited by a certain number of parameters. The instruments currently available in child and adolescent are far from being optimal in terms of quality and quantity. It seems necessary and useful to contribute to their development and their improvement. In particular, the following points should be considered: drastic reduction of the length of the interviews; simplification in the use of these instruments, during the interviews, but also in the treatment of the data collected during the final phase of diagnosis generation, the clinician having to carry out ceaseless returns to check the presence or not of each diagnostic criterion; reduction of the duration of the highly necessary training, which can be easily solved by the global simplification of the instruments; quantitative and qualitative improvements of psychometric properties, in particular in terms of sensitivity, specificity and face-to-face validity. Finally, it is highly necessary to continue to develop structured diagnostic interviews adapted to the assessment of child and adolescent psychiatric diagnoses keeping in mind simplicity, feasibility and reliability. Developing this kind of instruments is hard, expensive, and sometimes tiresome but it remains the inescapable stage to produce high quality data in the future.

☆ Smolla N. Lebel A. [Child psychiatric day treatment centers in Quebec for children 0-12 years of age]. [French] Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie. 43(7):714-21, 1998 Sep.

ABSTRACT**:** OBJECTIVES: The review lists the **child psychiatry day-care centres in Quebec, evaluates their capacity, and describes them according to the age range for admission, the psychopathologies treated, and the parent involvement** required. METHOD: The 26 programs selected, which are all associated with a hospital centre, assess and treat children aged 0 to 12 years on a day-care basis. Organization, clinical operation, and research are addressed during a semisupervised interview. RESULTS: The average capacity is 18 children (4 to 40), with a total capacity of 454 children. The number of preschool patients can be compared with the number of school patients. Few programs are dedicated to invasive development disorders, and one-third treat behavioural or emotional disorders. The larger capacity programs treat patients of both genders. Most programs are eclectic and encourage but do not require parental

involvement. CONCLUSIONS: Results take into account different theoretical influences, the controversy about integration criteria and parent involvement, and the specificity of the child psychiatry mission.

⊙ Tourigny M. Peladeau N. Doyon M. Bouchard C. [Efficacy of a treatment program for sexually abused children]. [French] Child Abuse & Neglect. 22(1):25-43, 1998 Jan.
ABSTRACT**:** OBJECTIVE: An evaluation study was conducted in order to evaluate the impact of the **treatment program for sexually abused children**. METHOD: Forty-one (41) children (aged 6-17 years), victims of a sexual abuse by a family member, were assessed at pre- and post-treatment (16 months following the pre-test). The evolution of children's psychological well-being was measured by the Children's Depression Inventory (CDI), the Picturial Scale of Perceived Competence and Acceptance for Young Children (PSPCA), the Children's Nowicki-Strickland Internal-External control scale (CNS-IE), the Children's Action Tendency Scale (CATS), the Revised Children's Manifest Anxiety Scale (RCMAS), and the Pediatric Behavior Scale (PBS). A hierarchical multiple regression analysis was used to assess the strength of the relationship between the level of participation in both individual (including dyadic and family therapy) and group therapy and the evolution of Ss' psychological well-being. RESULTS: Results indicate that the child's mental health was generally positively related to the level of participation in individual therapy but not related or negatively related with the level of participation in group sessions except for the PBS. CONCLUSIONS: These results indicate the need: (a) to consider the adoption of a dose measurement in the appreciation of the therapeutic impact; (b) to have a better grasp of the nature and the effects of specific therapeutic activities included in a program; (c) to have a better understanding of the disparities observed between parents' and children's evaluation of the psychological status of the child.

☆ Tursz A. [Mental disorders in children: the value of epidemiology]. [Review] [50 refs] [French] Archives de Pediatrie. 8(2):191-203, 2001 Feb.
ABSTRACT**:** **Epidemiological research** on the mental health of children is not well developed in France, as demonstrated by the very small number of publications on the subject, especially in French. The purpose of this article is to show the contribution of epidemiology to an understanding of childhood mental illness. We emphasize descriptive epidemiology (currently the most developed component), but discuss analytic and evaluative epidemiology as well. We have thus considered methodological issues related to the advantages and limitations of techniques employed, using concrete examples from international publications. For example, an extensive review of the literature reveals considerable disparity in figures on the prevalence of psychiatric disorders, chiefly because of problems of variation in definitions used and in the places and techniques of data collection (especially screening tools and diagnostic classifications). Only studies carried out in representative samples of the general population allow reliable evaluation of frequency, but these are particularly difficult and costly. The same may be said for follow-up studies, in particular those on birth cohorts, whose principle importance is that they enable the identification of predictive factors for mental disorders, starting from earliest childhood. Entire areas are currently in need of development, such as the genetic epidemiology in mental illness, clinical trials, or the evaluation of programs. Epidemiology enables the evaluation of service needs, the identification of 'risk groups' and a scientific approach to explanatory factors. In a country such as France where nearly all children are in the school system from the age of 3 years on, schools should become a place for early detection, which assumes a considerable increase in the means available and an innovative policy in the training of health personnel, especially in the area of mental health.

⌑ Van Hout A. [Management of stuttering in children]. [French] Archives de Pediatrie.

6(7):781-6, 1999 Jul.

ABSTRACT**:** This paper presents definition and characteristics of appearance, psychological consequences, risk factors, differential diagnosis, and management of **stuttering** in children. Stuttering requires early recognition and management in order to prevent the consequences of secondary psychological disturbances. Management associating speech and behavioral therapies must be entrusted to expert specialists.

Velin P. Alamir H. Babe P. Guida A. Four R. Montaz-Rosset N. Ponzio C. [Adolescents at the Lenval's children's hospital emergency unit in Nice in 1999]. [French] Archives de Pediatrie. 8(4):361-7, 2001 Apr.

OBJECTIVE: The goal of this survey was to investigate adolescents' health through their **utilization of a pediatric emergency unit.** METHODS: Prospective survey performed one week of each month in 1999 concerning the adolescents' (12 to 18 years) visits to the Lenval's children emergency care unit in Nice. RESULTS: During the study period, 1,096 adolescents were examinated and accounting for 18.6% of the children admitted in the year. The main reasons for visits were injury-related visits (55.5%), non-accidental somatic complaints (38.7%), psychiatric disorders (5.5%), and psychosocial problems (0.4%). Most adolescent visits (68.6%) were not severe emergencies requiring hospital technical equipment support; about one-third of the visits (28.6%) were non urgent consultations; severe emergencies were fewer than 1%; there was no death. Compared with the other pediatrics age groups, adolescents more often used the hospital technical equipment (65.1% vs 45.4%), required a longer visit (62 +/- 33 vs 57 +/- 37 min), and had a higher hospitalization rate (13.4% vs 10.1%). CONCLUSIONS: Adolescent emergency care requires multidisciplinary skills, such as traumatologic, gynecologic, psychiatric, and psychosocial compentence. Two units, absent at Lenval at the time of this survey, seem to be important for good care: space for very short hospitalization in the emergency unit and an adolescent-specific unit in the pediatric ward.

Vila G. [Psychological crisis interventions in schools for traumatic events]. [French] Archives de Pediatrie. 10(8):742-7, 2003 Aug.

Yeo-Tenena YJ. Diawar Te Bonle M. Assi-Sedji C. Kone D. Yao YP. Bakande SS. Delafosse RC. [Psychiatric consultations in school settings: 170 cases at a school and university health center (CSSU) from 1995 through 2001]. [French] [Journal Article] Sante. 15(4):259-62, 2005 Oct-Dec.

ABSTRACT: This retrospective study of 170 files from the School and University Health Center in the municipality of Plateau shows that **psychiatric disorders** affected students at all levels, with 72.4% of the cases involving secondary school students. Depressive disorders were most common, accounting for 49% of the cases. Almost no students (5.3%) suspended their studies during the school year. This observation contrasts with the common belief that pupils with mental disorders leave school permanently.

Zipper E. Vila G. Dabbas M. Bertrand C. Mouren-Simeoni MC. Robert JJ. Ricour C. [Obesity in children and adolescents, mental disorders and familial psychopathology]. [French] Presse Medicale. 30(30):1489-95, 2001 Oct 20.

OBJECTIVE: The purpose of this study was to evaluate the type and frequency of **psychopathological disorders observed in obese children and adolescents**. We also looked for a correlation between psychic disorders in the obese children, the degree of obesity and paternal psychopathology. PATIENTS AND METHODS: The study group included 84 obese children and adolescents aged 5 to 16 years (mean age 10.9 +/- 2.8 years). There were 55 girls and 29 boys. The z-score expressing deviation from the ideal body mass index (IMC) varied from +2 to +10.6 (mean 4 + 1.9).

Psychopathological disorders observed in these obese patients were compared in children and adolescents with insulin-dependent diabetes mellitus. The standard diagnostic interview (K-SADS PL) and self-administered questionnaires (Sielberger STAIC-Trait for anxiety and CDI for depression in children or CBCL or GHQ for their parents) were also used to evaluate psychic disorders. RESULTS: More than half of the obese children (47 out of 84) had a DSM-IV diagnosis, often involving anxiety (n = 28). The rate of internalized and externalized psychopathological disorders (measured by STAIC-Trait and CBCL) was higher in the obese children than in the diabetics. The children's psychopathological disorders were more marked if their parents were perturbed, particularly when their mother had an internalized disorder. No correlation was found between the degree obesity and psychopathological disorders in the obese children and adolescents. CONCLUSION: Our findings show the frequency of mental disorders in obese children and point out the importance of parental psychopathology. This underlines the usefulness of a pedopsychiatric approach implicating the entire family for therapeutic management of these patients.