



Newsletter

Leonard Henschel, MD, Editor

FROM THE PRESIDENT

WHAT A RIDE

I expected an active, exciting year, but this is more than I bargained for. Dozens (hundreds?) of emails later, with an Executive Committee



Mark A. Wellek, MD

that never rests and never really adjourns, ASAP is deeply involved in an accelerating, all out assault on legislation in twenty three states that permits the death penalty for kids who were sixteen or seventeen when they committed capital crimes.

This involvement began when our brilliant, socially active (and effective) Topical Studies chair, Charlie Huffine, presided over an email death penalty debate (which argument to use? moral or scientific? and what about the possible connection with the death penalty for adults?). To say that Bob Weinstock on the West Coast and Dick Rosner on the East heated up cyberspace is an understatement. I ran out of printer paper twice and had to start reusing the blank back sides to keep up.

Alex Weintrob, Dick Ratner, Sid Weissman Vivian Rakoff and Marty Fine inserted judicious comments when rare brief pauses in the virtually continuous East-West data stream occurred. Then something happened in

Washington DC.

In early June, Dan Borenstein, APA President, called a "let's all get on the same page and get something done" meeting of all the Presidents of the major psychiatric organizations (i.e. child, community, forensic, geriatric, psychoanalytic and of course adolescent). There sat 14 of us in the same room (Dick Harding, APA President-Elect, threw in enough good humor to keep the competitive tension at a "dull roar" level). I made good connections with many other presidents with the able help of our Executive Director, Frances Roton, and our perennial APA liaison rep. Past-President, Dick Ratner.

I was especially pleased to have a frank and open discussion with Clarice Kestenbaum, President of the Academy, and Virginia Anthony, Academy Executive Director. Clarice is a proud ASAP member who wants, as do I, a friendly team-mate relationship and to put aside the old rivalrous ASAP-Academy feelings. We made clear that we needed each other. In the midst of these good feelings Clarice requested that we send her our Youth Violence and Juvenile Justice (death penalty remands to adult court and adult prisons) policy as soon as we revised it. She concluded the policy is needed now and that going through the Academy bureaucracy would be too slow a process to churn out their own up-to-date standards. We both agreed that ASAP can more quickly and efficiently write policy, and besides, we both agreed ASAP most clearly represents adolescents.

As I write this, I have in hand Huffine's initial draft and Lois Flaherty's edit. (Great News! Lois is now under contract with ASAP to be the Editor of the Annals!) The next meeting of the "Joint Leadership" will occur in early September. I have placed youth violence, treatment and the adolescent death penalty on the agenda. As I did this, I received a telephone call from Stephen Harper, a Public Defender in Miami, who had learned of our Amicus Brief on the death penalty in 1988, asked that ASAP help him in his work with the Juvenile Justice Project of the American Bar Association (ABA) in a renewed push to stop the execution of people who perpetrated capital crimes when they were teenagers. Twenty three states still allow application of the death penalty for 16 and 17 year old kids. One kid is on death row right now in Georgia, and is scheduled to die

Continued on page 2

RAKOFF

NOTHING IS SIMPLE

Recently there has been an internal ASAP discussion via email about the applicability of



Vivian Rakoff, MBBS

the death penalty to eighteen year olds in the US. The discussion was serious and nuanced and in general expressed the sort of careful indignation you'd expect from people in ASAP, but reading the to-and-fro of the arguments from up here, north of

the border in Canada, I realized that I really was watching from a different country with a different ethos. To me it had the quality of a discussion in which people were considering which parts of a cannibalized body could be morally eaten: do you refuse the head as expressive of the person, or reject the heart because it was the center of emotion and humanness and therefore taboo?. And, by extension of this fanciful and gruesome analogy—once the head and heart have been removed—then cannibalism is OK because the body had now been rendered non-human and therefore fit for eating. Of course the proper answer to the normalizing of cannibalism is to say that it is absolutely wrong (although there are extreme circumstances in which even that absolute can be suspended.) What I am trying to say in this convoluted way is that capital punishment is wrong for all people no matter what their age and that to argue that the death penalty at 18 is acceptable, whereas at 17 years, 11 months, it is not is a grotesque distinction on the level of making a human cadaver Kosher.

The objective data are these. Almost all countries in the western world no longer exercise judicial capital punishment. The murder rates in countries which do not have a death penalty are lower than in the U.S. which does exercise the death penalty. There have been enough wrong decisions in capital murder cases, resulting in the execution of innocent people to give one pause. The process is horrifyingly imperfect. Then there are the more debatable

Continued on page 2

In This Issue ...

From the President	1
Rakoff	1
For Your Calendar	2
Book Review	3
Youth Violence	4
New List	6
In Memoriam Dr Martin	7
In Our Mail	8

For Your Calendar

ASAP Fall Business Meeting 10/28/2000, at the New York Renaissance Hotel, New York, NY

IACAPAP, The Promised Childhood, Jerusalem, 2000, 10/29/00, Millennium Congress. PO Box 5000, Tel Aviv, 61500 Israel, ph: 972 351 40000

American Academy of Addiction Psychiatry, Annual Meeting and Symposium. 12/7-10, 2000, Phoenix, Arizona. (913) 262-6161, addicpsych@aol.com or www.aaap.org.

53rd American Academy of Forensic Sciences, Annual Meeting, 2/19-24/2001. The Washington State Convention & Trade Center in Seattle, WA., write: PO Box 669, Colorado Springs, CO 80901-0669 Phone: (719) 636-1100, Fax: (719) 636-1993, E-mail: njackson@aafs.org

ASAP Annual Meeting, March 22-25, at the Doubletree Hotel in Philadelphia.

ASAP Officers

President: Mark A. Wellek, Phoenix AZ
President-Elect: Robert Roddy, MD of St. Paul, MN

Vice President: Sidney H Weissmann MD of Chicago, IL

Treasurer: Richard Rosner of New York City, NY

Members at Large: Vivian H. Rakoff, MBBS of Toronto, Canada.; Robert Weinstock of Los Angeles, CA

Immediate Past President: Martin Fine, of Chicago, IL

Past President: Mark Chenven, MD of San Diego, CA

Newsletter Editor, Leonard P. Henschel, MD of New York, NY

ASAP Office

Exec. Director, Frances Roton,
ASAP

P.O. Box 570218, Dallas, TX 75357-0218
(972) 686-6166 Fax (972) 613-5532 email:
adpsych@aol.com

Deadlines for Newsletter Material:
12/1/00, 3/20/01, 6/20/01

Web Site: <http://www.adolpsych.org>

Topical Studies Council:
chuffine@uwashington.edu

ASAP's email address is:
adpsych@aol.com

From the President Continued from page 1
soon. He committed a murder when he was 16. And incidentally, he is schizophrenic. The Children's Defense Fund, The Child Welfare League, ASAP and the ABA will participate in an Amicus Brief (much like ASAP's Brief in 1988) which says that kids are developmentally different than adults. I have sent an official ABA request letter that I received on to the Executive Committee for its perusal. Since time is of the essence, I elected to give ASAP's endorsement. Then came another telephone call.

The New York Times called to do an interview on the Adolescent Death Penalty. I anticipate reading about this in the Times sometime soon.

ASAP in the New York Times. What a ride! So, as the Joint Leadership Meeting in Washington approaches in early September, a feeling of excitement prevails. And the emails just keep rolling on.

Mark A. Wellek M.D. FASAP President,
American Society for Adolescent Psychiatry.

Rakoff Continued from page 1
ethical issues about whether it is morally proper for the state to take human lives in the name of justice. Ethical issues are always difficult in a secular society. One can ask what or who gives the authority for the ethical conclusion I have just stated other than a vaguely defined humanism and a belief in the sanctity of human life which I have simply declared as an axiom. But without this assumption anything is possible, even murder using the full panoply of Justice, Medicine, and the rituals of sanctity

...then cannibalism was ok...

provided by attendant priests etc. (It is interesting that the same people who are against abortion are also in favor of guns and the death penalty.)

But this piece is not, believe it or not, about the rightness or wrongness of capital punishment. It aims to be a reminder of how much of our clinical and therapeutic work is intimately bound up with the political/cultural assumptions of the general society. And precisely because those judgments are the result of the never ending flux of political/social/economic forces, our apparently objective science plus art is to a large extent a reflection of these forces.

Without subscribing to the full extent of Foucault's radical construction of "insanity" as some kind of failure of rational bourgeois society to allow human variety to exist freely and openly in the public space of society, it is true that "madmen," orphans, bankrupts and crimi-

nals were all pushed out of sight in what he called "the grand incarceration." Variation from the norm of rational money-earning resulted in exclusion from civil society.

And it wasn't full blown "madness" alone that followed the general social rules; the more familiar stuff of the practicing psychiatrist's case-book was also subject to the distorting lens of fashion (which is only the final common pathway of complicated factors.) And it wasn't and isn't only psychiatry which is affected in this way. Tuberculosis was linked to social decadence as was the poverty which was its frequent accompaniment. And German doctors trained in classical humanism as well as science to an unmatched degree in Europe, flocked shamelessly and almost eagerly in huge numbers to join and do the work of the Nazi cause

Now these are fairly obvious issues. We like to believe we've got beyond this kind of thinking. But have we? It wasn't that long ago that the APA subscribed to the belief that homosexuality was a mental disorder. This was a clinical expression of the legal position that it was criminal, which in turn was a reflection of the religious position that it was sinful. Our medical opinion about the right to abortion is still shaped in many constituencies by the legal position concerning abortion. Our central conception of the "adolescent" is as much socio-economic as it is developmental/psychological. With it goes our conception of childhood and responsibility.

Which brings me back to the death penalty. As a Canadian, I feel almost like an anthropologist watching an exotic society. Not any strange society, but one which is fascinatingly similar. Same language, same movies, same TV, same fundamental political beliefs yet tantalizingly and subtly different. In the U.S. there is a much greater expectation that people will be "self-reliant" and manage their own lives, compared with Canadians who, for the most part, expect a greater degree of help from the general community. Truly more committed to the marketplace, is what William James called "the cash value" of an idea. Not only in the vulgarized sense of cash money, but cash as a metaphor for the pragmatic and the workable. (And what wonders it has produced!) But from this side-by-side point of view it does seem that the metaphor of the money exchange has nudged other considerations to one side, not completely off stage, but reduced in its impact. How else can one explain a medical payment system which is determined more by the profits of insurance companies than by patient needs; which defines the treatment of patients by actuarial charts rather than the judgment of clinicians?

On this side of the border, things aren't that perfect either. Our system is financially

Continued on Page 8

Book Review Corner

Asperger Syndrome, Edited by Ami Klin, Fred R. Volkmar, and Sara S. Sparrow.



Lois Flaherty, MD

Guilford Press, 2000, 489 pages, \$45.00

Reviewed by Lois Flaherty.

The rediscovery of the syndrome described by Hans Asperger in Vienna has been one of the major developments in child and adolescent mental health in the past five years. The Seattle Times recently ran a feature article about it, and special classes are now being developed for it in school systems around the country. There is a lot of less than clear thinking about what this illness is and how to diagnose it. If you haven't already, you most likely will soon have parents come to you convinced that this is what is wrong with their child. If you have been in practice for a while, you will also realize, if you haven't already, that you have probably seen a number of these youngsters over the years without necessarily realizing what lay at the base of their difficulties. A chapter by Lorna Wing discusses the pros and cons of a diagnostic label applied without a full understanding of the disorder, reminiscent of ASAP's debates on conduct disorder. No one knows what the prevalence of it is; a prevalence of 3-7 per 1,000 is mentioned in one study cited. This would make it about 10 times more common than autism. As is pointed out in the book, the problems of children with this disorder are really part of a larger issue of children with social deficits who do not necessarily have learning disabilities. How to teach them to interact with others in a way that allows them to make their way through life with a modicum of happiness is a daunting challenge.

The book is organized into chapters on clinical presentation, diagnostic issues, assessment, cognitive and neurobiological functioning and treatment. There are chapters discussing the relationship between Asperger syndrome and autism, schizoid personality disorder, and non-verbal learning disabilities. There is one chapter on adolescents and young adults, which although fairly brief, gives a good picture of the challenges of working with this patient population.

This is a crisply and clearly written book, by people who have immersed themselves in this field. It is comprehensive but concise at the same time, and will be a useful resource for psychiatrists.

~*~

Affect Regulation and the Development of Psychopathology, by Susan J. Bradley, Guilford Press, 2000, 324 pages, \$40.00

This is a superbly written book by a psychiatrist who has both clinical and basic science perspectives. She has a true biopsychosocial outlook and views affect as the unifying force between psychology and biology. She presents a developmental perspective, which will be most illuminating to adolescent psychiatrists, explaining in a highly readable and understandable way how experiences affect brain development. From these experiences individuals learn to manage their affects and this in turn directs the course of their lives. Psychotherapy, simply put, teaches new ways of managing affects. Chapters include neurobiology, genetic and constitutional factors, the care-giving environment, stress, trauma and abuse, coping, and therapeutic considerations. About half of the book is devoted to chapters on clinical syndromes, including a chapter on disruptive behavior disorders which conceptualizes them as linked to affect dysregulation. The relationship between abusive care-giving and conduct disorders is explained cogently. This is definitely a book that will be of interest to clinicians.

~*~

The Sex Lives of Teenagers, by Lynn Ponton, Dutton, 2000, 285 pages, \$24.95.

This is the second book ASAP member, Lynn Ponton, has written for a lay audience. It is not, as the title might suggest, a Kinsey report on adolescents. Like her first book, *The Romance of Risk*, she uses a framework of stories about her clinical work with patients. These stories are engrossing to read and deal with issues such as teen pregnancy, sexual debut, and homosexual awakening. Lynn reports she has gotten letters from readers saying they are shocked at some of the language. I tried but couldn't find this part. What emerges most strongly from the accounts is the tremendous anxiety adolescents feel as they try to come to terms with new erotic feelings and the power of these feelings. The importance of working with parents to improve communication or in some cases, teach them how to talk with their teenage children is stressed. As before the flavor of the therapeutic alliance between the psychiatrist and the adolescent patient is presented in a realistic and inspiring way.

I wonder what she will do next.

Lois T. Flaherty, MD, FASAP

Books for review and also reviews should be sent to Dr. Lois Flaherty at 18765 Kenlake Pl, NE, Kenmore, WA 98028. ■

We regret that Dr. Jack Drescher's name was misspelled in our previous issue. His book,

Psychotherapy and The Gay Man, was very favorably reviewed.

~*~

A Tribe Apart: A Journey Into The Heart Of American Adolescence, by Patricia Hersch, Fawcett, New York, 1998

Reviewed by Michael Miller.

Patricia Hersch is a journalist and also the mother of three adolescents who spent three years hanging with the kids at her local middle and high schools researching her fine book. She attended classes, befriended and gained the trust of eight kids she interviewed in depth over the three years. We are presented with an astonishingly candid, poignant and at times disturbing portrait of our nation's youth which appears to be left relatively unattended by parents too busy with the demands of their own careers to know their own kids or much about the lives they lead.

Sex, drugs, violence and mental illness intrude into their lives. What disturbs the reader most is the moral vacuum and absence of traditional values or structures that would help these adolescents make sense of the chaos that they are struggling with as they seek to define themselves and their world. Parental involvement is sadly lacking as the kids, this generation of teens which comprise *A Tribe Apart*, appears not to be acting so much in rebellion but in reaction to parents who are uninvolved or who as children of the sixties, continue to get high themselves. The kids who make out best in her book are those who have strong interactive families and a web of relationships and activities that surround them consistently. Unfortunately, many of the kids we meet do not and they suffer as a consequence.

Hersch's book captures the experience of being a teenager in an American middle class suburb at the turn of the Millennium. She does us the service of placing that experience in the context of our society at large. Look for her at this year's ASAP in Philadelphia, she has agreed to address our group.

Michael Miller, MD. ■

ASAP WELCOMES NEW MEMBERS

Dominic Ferro, M.D., New York, NY
Colleen Ryan, M.D., Madison, IN
Patricia Lester, M.D., Los Angeles, CA

NIH PUBLISHES SCIENCE-BASED GUIDE TO DRUG ADDICTION TREATMENT

Thirty years of research forms the basis of a new publication outlining the components of drug addiction and the principles behind effective treatment. *Drug Benefit Trends* 12(2):9-10 BH, 2000
<http://psychiatry.medscape.com/20353.rhtml>

YOUTH VIOLENCE: ITS MEANINGS TO SOCIETY IN THE 21ST CENTURY.

by Charles Huffine, MD.

The following is meant for response from the membership. Any changes, additions etc. may be made at the next House of Delegates meeting prior to possible adoption by ASAP. Dr. Huffine is chair of the Council on Topical Studies.

Comments may be sent to him at chuffine@u.washington.edu (Charles Huffine) or to the ASAP Office.

Society is preoccupied with youth violence



despite evidence that the incidence of youth violence has actually been decreasing steadily since the mid 1980s. Recent highly publicized school shootings, reports of gang violence,

young people obsessed with violent video games, movies and song lyrics, and a media prone to publicize all incidents of violence no matter how tragic or trivial, have left many with a sense of crisis and immanent danger. Although media attention to violence by youth has spurred much important social debate, it has created a grossly distorted focus on this problem. Tragic as the school shootings are, the number of these deaths accounts for less than one percent of all teen homicide. But seeing the halls of learning turned into shooting galleries has understandably galvanized the American public's attention.

These incidents have provoked a great deal of soul searching and anguishing about the health of our society. Such a public reaction can and should prompt a more sober look at certain social phenomena that surround such incidents as school shootings. They should raise questions as to how families, schools and communities can intervene to prevent youth violence.

Uninformed reactions, born of frustration and a lack of understanding of adolescence, may have the effect of leading to policies that become part of the problem. The Congress and most state legislatures have passed laws designed to protect our communities from youth who are out of control. A policy of zero tolerance has been a key feature of many of these laws. Legislative action in the area of juvenile justice has emphasized increasingly harsh punishments. Some new laws aim to strip younger adolescents of their historical rights to protection in juvenile courts by remanding them to adult courts and adult punishments. Such reactive laws satisfy some in our society who wish to throw all troubled youth into a punitive system that will contain them forever. These new laws are, of course, vulnerable to being selectively practiced on youth of color, and those who are poor. In contrast to the barrage of harsh punitive measures, few resources have been allocated to understanding the phenomena of youth violence; to understanding etiology or the changes in prevalence, the meanings of violence to the youth involved, or the appropriate societal response when tragic incidents occur.

Historical Context

It has been said that American society has

always been a violent one. Historians trace a tradition of civil strife born of strong values placed on independence, suspicion of the state and the value of personal honor. These traits in our forefathers led to the founding of our country through violent revolution. These traditions were nurtured by white males in the social order of the old South. They were exported to the West with the march of settlers in the 19th century and sadly exploded in the American Civil War. The institution of slavery, endemic to American society from the beginning, has been called as brutal and violent an institution as has existed in the history of man. Traditions of proud, independent men claiming and defending their territory, or fighting the social order to redress grievances, are part of our 20th and 21st century life. Labor organizers warred with company agents, Southern men lynched blacks for presumed breaches of honor and the Black Panthers horrified us all by waving guns and threatening retribution. America is the great hope for the dispossessed around the world. Many immigrants, legal or not, contribute much to American society. But they also bring to our country the residuals of their trauma from the civil strife in their home countries. Some bring with them the effects of severe psychological trauma and an urge for retribution. Sometimes their continuing conflicts with their countrymen explode on our streets and become the content of a newspaper story on violence. Gangs of home grown socially disadvantaged youth roam the streets of poor neighborhoods and engage in fratricidal warfare; the poor killing the poor. But in the process such youth menace us all with their posturing. They play out a social drama whose meanings transcend the sad issues of who "disses" who in the 'hood. Most of us can insulate ourselves from this frightening drama. We don't want to know the history, or have to acknowledge it is there now, in front of our face. When forced to deal with the ugliness of violence and its social context we see it as aberrant and monstrous. We seek to isolate such terrifying drama because it scares us.

Trends in Youth Violence

There was a striking rise in youth violence from the mid 1980s to 1992 when the rates reached a peak. It began to decrease in 1993. Deborah Prothrow-Stith, MD makes a convincing case that social violence is endemic to American society. She defines the rise in violence in the 1980s as an epidemic on top of endemic violence and warns that the ingredients are there for another rise in violence. She believes that the subsiding of violence in the late 1990s is only a lull in the epidemic.

Since 1993 there has been a steady decline in reported incidents of violence by youth. Such acts, as measured in crime statistics, include murder, assault, rape and burglary with associated threats or violent acts. Although rates have declined significantly in the last 7 years, they are still substantially higher than in the period between the mid 1970s and mid 1980s. The only factor that seems clearly associated with the rise and fall of violence in society is the state of the economy. Economic difficulties are associated with a rise in violence in society while economic

booms correlate with its decline. This is true for both adult and youth although the amplitude of the fluctuations is greater for youth. Only one sub-factor has not declined with the overall improvement in youth violence statistics: murder by gunshot wound. Incidents of assault generally are less, but more of them are lethal due to their being associated with a gun. In other words the rate of death by gunshot has stayed high but stable; the incidents of assault are less, but are ever more associated with guns, thus yielding a higher percentage of deaths. This suggests that the ready availability of guns to our youth creates a dangerous climate and leads to more deaths. Easy availability of guns to adults assures easy availability to youth.

Lack of Public Focus on Social Problems Underlying Violence

It is striking what is not on the public's agenda given the horror over shootings in schools. Social affiliation patterns seem to be changing in our society. Families are ever more fragmented and overwhelmed as social institutions offer them less and less support. Youth spend less time with friends and when they do this time is less structured or focused. Little attention is given to evidence of alienation in our society, although sociological evidence abounds regarding our lesser degrees of social affiliation. Little attention is drawn to the social impact of welfare reform despite the growing data on the impact of psychological stress on a new cadre of working poor. Many in this group have inadequate child care, less mobility and less resources for solving family problems. Domestic violence and its most disturbing subset, the sexual and physical abuse of children, barely stays on our societal radar screen. Suicide remains one of the highest causes of death in the younger age groups. Violence towards oneself is much more often lethal when guns are readily available. These acts of violence are met with a societal denial reaction. It is the acts of violence by young men, often of a different race, perpetrated randomly on unsuspecting innocents that strike fear into our hearts and get us to take notice. We focus our fear on a dark force that embodies unknown evils. This is the modern day "boogie man," a social construct that is a derivative of both common psychological defenses and sociological forces. Adolescent psychiatrists, who integrate an understanding of psychological and social dynamics as part of their clinical work, are well qualified to comment on these phenomena as they relate to youth violence.

Youth Resilience

The vast majority of youth engage in the social developmental process of adolescence without endangering themselves or others. But most adolescents do suffer stress as they meet their many challenges. Many keep their worries to themselves, others tell them to their parents or close friends. Many express their complex feelings about the society they are entering through hair style, dress, or taste in music. For some, a fascination with violence in movies and song lyrics is a functional way of coping with their own concerns about aggression. But by and large they are

Continued on Page 5

successful in school, have friends, are mostly respectful to their families and emerge as productive young adults. Even most youth suffering the indignities of poverty, racism or the adjustments demanded of recent immigrants, seem to pass through the travails of adolescence without committing serious offenses. Many other children suffer from terrible family difficulties. They witness violence in their homes and are the victims of physical and sexual abuse. We know that such children are at much higher risk for expressing their frustrations in violence once they are adolescents. It is remarkable how many individuals who suffer such horrendous hardships do not pass on the violence by victimizing others. A remarkable percentage seem resilient. They somehow find the ingredients for a successful adolescent development.

Stress-diatheisis Model

Social conditions alone cannot explain why youth succumb to rage and alienation. More likely acts of violence are the product of social forces that impinge negatively on an individual and a complex interplay between some constitutional factors that lead to vulnerability. This is known as the stress/diatheisis hypothesis. Violent action is only occasionally the final outcome of this interplay. When an individual is stressed and blinded by complex emotions for which the end result is confused anger, violence is a risk. Such an individual feels like a bad person. Society teaches him or her what it is to act bad. Violent acts are shaped in accordance to what is perceived by a troubled individual to be most troubling for our society. These responses often reflect exactly that which is most feared and what most fascinates. Collective fear and fascination with violence are very effectively communicated in our media nightly on the evening news, by our entertainment media and in casual talk in our communities. For a teenager exposed to these influences it is not hard to know how to act the boogie man. It is even easier if one is from a minority culture. One learns what is expected of someone like oneself and proceeds, unconsciously, to act the part when the stress-diatheisis complex is activated.

Psychiatric Diagnoses and Violence

There is no single psychiatric diagnosis that explains youth violence, just as no set of social factors explains it. Many individuals with severe psychiatric illness are never prone to acts of violence. However, recent data indicate that if unrecognized and untreated, psychiatric illness can be a serious risk factor for acting violently. If a teen is suffering a psychiatric illness, the behavioral expression of the symptoms of the condition may very well be aggressive and offensive to society. Behavior is the primary means through which an adolescent communicates socially. Symptom expression is influenced by the social forces that are core factors in an adolescent's developmental process. Current formal diagnostic criteria do not account for a teenager's behavior. We need to interpret such criteria in behavioral language. For instance depression and suicidal ideation in a teenager may be expressed in terms of recklessness and the abandonment of regard for oneself or anyone else. A depressed teenage boy may direct rage at a peer and engage in a fight. If guns are available, that undisciplined rage and agitation may result in a homicide. Guns are a potent symbol in our culture. They convey a sense of power and control. Their misuse is often noted in the media with horror. For a depressed teenager, the negative social meanings of misusing a gun may be very congruent with feelings of powerlessness and self loathing. The experience of anxiety may be socially humiliating. If social slights and disrespect have been triggers for anxiety a teen may react violently towards a perceived tormentor in a defense against anxiety. Adolescents with mania, impulsivity and poor judgment, mixed with social developmental stress, may be exceptionally troublesome. If a teenager has been badly treated as a child and carries those memories in the form of post traumatic stress disorder, the memories may be expressed behaviorally in the form of perpetrating violent acts on others similar to what the individual had himself suffered.

Antisocial character features

A small number of young people have a personality constellation, formed early in their lives, that appears to predict a poor prognosis for ever becoming socialized. They are different from other teens who may commit acts as heinous, or manipulate as narcissistically. The rule of law applies to them as well. Few mental health professionals believe we know enough to hold them interminably in jails. Most will be at large in our communities between detentions. While we may consider their prognosis poor, we must look for cracks in their armor, for some cultural explanations, or some form of leverage, in order to attempt rehabilitation. A very

few will remain menacing and deeply troubling to us all.

Most teens who commit acts of violence do not have such a personality profile. But unfortunately this rare sociopathic teenager stands as an icon for many in society. The behavior of others, chosen unwittingly to create the most exquisite and horrifying social drama, invariably makes them superficially indistinguishable from the sociopath. This behavior creates a powerful effect because of its great social meaning. By committing such an act of violence the confused and distraught teenager, perhaps overwhelmed by stress, perhaps vulnerable due to a mental disorder, has created a nightmare for himself and society. He lives out the social meaning in the act of doing violence, often feeling quite justified with twisted moral logic. Later, as the consequences of his violent act accrue, this teenager may come to be aware of the meanings of these acts and suffer great remorse. Everyone struggles to understand. Why would a teenager commit the act most feared, most expected of rampaging youth, and which draws the most horrified fascination? It is as if that child is "bitten by Dracula" in the mind of most. He has become the boogie man and has committed the very act guaranteed to push him out of the social order.

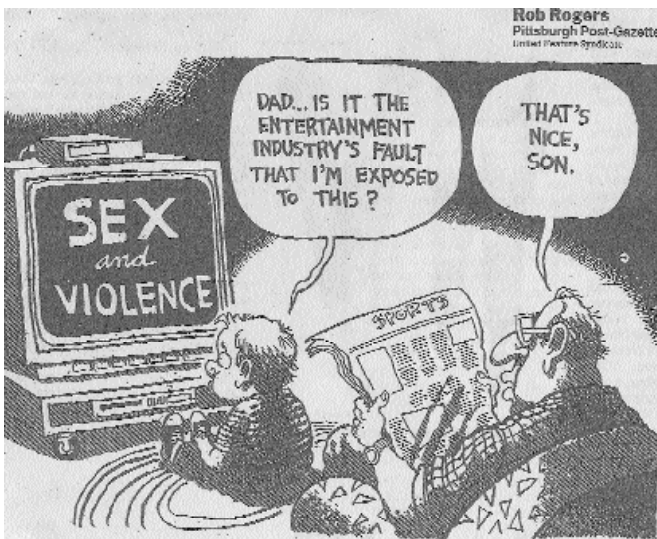
Measured Punishment vs. Social Retribution

What, then, is the appropriate societal reaction to violent youth? Those who, because of a mental disorder, commit acts of violence, must be regarded two ways at once. We must understand that they need to complete the expected social drama through an appropriate and constructive punishment, and we must be attentive to community safety in the process. And we must also remain aware that these offenders are not adults and be diligent in assuring that they are given all the resources necessary to get effective treatment for their underlying difficulties.

Youth who commit acts of violence need to be dealt with in a manner that assures public safety. Certain youth are dangerous and must be separated from society. Other youth do disturbing things, or obnoxious things, and must suffer the consequences. There is no essential conflict between protecting the social order from the misbehavior of youth and appropriate treatment of those whose mental illness manifests in disordered behavior. Psychiatrists and other mental health professionals focus on the aspect of a troubled youth's care that will lead to rehabilitation. But offensive behavior must be addressed with appropriate consequences as a part of the rehabilitation. Failure to address behavior with measured and appropriate responses is a form of child abandonment, it is actively harmful to troubled young people. The opportunities for intervention with a troubled child after an offense, even a violent and dangerous one, cannot be missed or squandered. Skilled individualized interventions for these juveniles will prevent future offenses and more effectively provide for public safety than blind retributive punishment.

Access to Adequate Care and Treatment

Our juvenile detention facilities are filled with



young people with clearly diagnosable conditions such as those noted above. Sometimes the relationship between the diagnosis and the socially offensive behavior is missed. Most often the diagnosis is missed altogether. Diagnoses such as Conduct Disorder or Oppositional Defiant Disorder are widely used to categorize behaviorally disruptive youth. These are of doubtful utility in understanding an adolescent's psychological functioning and may hinder accurate diagnosing of treatable conditions. As adolescent psychiatrists we know it is crucial that the population of youth who have committed acts of violence be evaluated by individuals with the training to recognize psychiatric illness in teenagers. It is tragic if a clearly indicated treatment is withheld from an individual who has a potential for rehabilitation when a good outcome hangs on the psychiatric illness being addressed. True access to treatment demands that those delivering the treatment have the time and setting to properly make an evaluation. It is even more important that there is sufficient opportunity for developing a relationship with the juvenile offender to forge a treatment alliance. Forming a treatment alliance with an angry, hurting, jailed teenager clearly requires special talent and training for the therapist. Allowing therapists to do effective work will take some thoughtful programming on the part of planners and administrators. There are some models in practice. MultiSystemic Therapy (MST) offers a method for gaining access to youth and their families so as to enable a viable treatment process. Psychiatrists can have meaningful involvement in the evaluation and management of young offenders by working on teams, as modeled in MST, with youth workers trained in a mental health discipline. Psychiatrists and the teams they affiliate with will succeed if they are supported in establishing close ties to the families of these young people. Cultural barriers to adequate care abound in a youth offender population. Access to appropriate cultural consultants and members of the youth's community is emerging as a key ingredient to the creation of meaningful access to treatment.

Early Identification

Vulnerable youth who may become violent can be identified based on good information we now have on risk factors. Populations of "at risk" youth must have access to screening and, when indicated, appropriate psychiatric care. Rarely do such youth and their families seek mental health services on their own. Fears of the stigma of mental illness are most exquisitely felt by members of society who are already marginalized due to racism, poverty or other adverse social conditions. Violence prevention programs must include creative ways of accessing such vulnerable youth for psychiatric evaluation and treatment. Once again the keys involve allying with family advocates, seeking cultural consultation and forming teams with youth workers and younger outreach workers who can most easily relate to the young people at risk. Psychiatrists cannot work alone effectively in this area. Creative program administration and a social policy that supports, rather than impedes, appropriate care are necessary. Adolescent psychiatrists can have a far reaching impact when they are involved in the planning for such programs. Assuring that psychiatrists are optimally used in

programs for violent teens demands the presence of a medical director empowered to assure programs support good clinical work.

Gun Control

One cannot review the literature on youth violence without coming to the conclusion that we cannot continue to tolerate the level of availability of guns to today's youth. Gun availability to teens leads directly to death. As physicians with a passion for the welfare of our adolescents, ASAP must stand with other medical groups and social advocates in calling for much tighter controls on the availability of guns in our society. We must challenge the social value that places more importance on the freedom to possess guns than on the needs of youth for protection. The alternative is likely to be a new wave of the youth violence epidemic.

Public Advocacy

Psychiatrists can be helpful far beyond their clinical role. They should participate in comprehensive intervention programs by being included in cross system planning and coordination. They can work together with administrators interested in policy change. They can be deployed in meetings with family advocates and community leaders. They can influence public policy by educating the public, especially lawmakers. Part of the solution to the problem of youth violence is to focus public attention on the complexity of the phenomenon of violence and foster discussion in a way that promotes clear thinking. Psychiatrists can be effective public educators and excellent representatives of youth intervention programs with the media. The task of assuring that public horror with acts of violence by youth is channeled into constructive directions belongs to all of us. Collectively we must assure that our society has the motivation and skills for effectively addressing the problem. It remains all of our responsibility to care for even the most troublesome children in our communities, including those who must be separated or monitored closely due to their potential for violence.



NEW LISTSERVE

A listserv has been created for the various ongoing discussions of adolescent psychiatry now taking place on-line. It can be used for any relevant purpose that interests our members, i.e., job postings, legislative alerts, etc. Once you have subscribed, it will be easy to post messages to the group. To subscribe to the list fill out an email letter as follows:

To: listserv@adolpsych.org

From: <<this field will automatically be filled in by your mail software>>

Subject: leave blank

Message: subscribe asapmail <<input your name>>

To send a message, simply address it to asapmail@adolpsych.org. It will go out to all members on the list. From there other members can respond to messages, post their own, and a fluid discussion can take place. There will be mailings of the various topics and responses to them sent out to subscribers to the list.

San Diego Collaborates

Bucking the perhaps somewhat cynical, but often too true witticism that "collaboration is an unnatural act performed in public by non-consenting adults under duress", the San Diego Society for Adolescent Psychiatry participated in co-sponsoring a Symposium entitled "Children's Mental Health—A System of Care Approach" on August 4th in association with: the American Academy of Child & Adolescent Psychiatry's Work Group on Systems of Care; the San Diego Psychiatric Society and the local County Mental Health Children's Services Division. A good time was had by all, and quite possibly, some good was done to advance the cause of children and youth with exceptional needs.

At the day long event, a cadre of child/adolescent psychiatrists from San Diego joined experts from around the nation to discuss the challenges and opportunities for public sector service enhancement that have come into existence under the rubric of the System of Care perspective. Ironically falling on the same date that the County announced its decision to rescind the years-in-the-offing RFP to bid out management of the proposed local system of care, the meeting provided perspective as to the complexity of system reform efforts. Reviewing the experiences of various communities, the presentations discussed opportunities for more rational governance and financing mechanisms, for more effective case management and oversight, and for more meaningful quality assurance and outcomes appraisal in public sector service delivery systems.

A luncheon plenary featuring Penny Knapp, M.D., Medical Director of the State of California's Department of Mental Health, addressed the challenges of developing programs to serve the mental health needs of very young children. Other presentations focussed on the challenges in providing services for at-risk older populations of youth and teens. Creative approaches in contracting for services were discussed by Al Zachik, M.D., Director of Children's Services for the State of Maryland Department of Mental Hygiene. The history and the future of System of Care approaches was discussed by the AACAP Work Group co-chair Andres Pumariega, M.D.

Program organizer, Mark Chenven, M.D., Past President of ASAP and a member of AACAP's Work Group on Systems of Care, noted the importance of joining community resources together as a key element to the success of the symposium and also as the key ingredient in successful system of care efforts. Copies of the slides of presentations from the program may be requested from ASAP's Executive Director, Frances Roton.

Mark Chenven. ■

APA's Council on Children, Youth and Families and the Council on Substance Abuse are seeking to develop a list of psychiatrists who treat adolescent substance abusers. Please contact Frances Roton at the ASAP Office or adpsych@aol.com

In Memoriam
Josephine D. Martin, M.D.

Dr. Josephine D. Martin, a long-time member of New York SAP and its Executive Committee, died July 6, at the age of 84. She was involved with social issues throughout her professional life.

Early on after two years in a sanitarium, recovering from tuberculosis, she worked with her husband organizing patients to promote better treatment for them. She began a program for mentally ill youth, setting up an educational system for them at Bellevue since the public schools at that time refused to accept them. She also founded a residence for homeless teens. She organized a parent's group in the 60's at the time when parents were considered to be "toxic."

She then took a vacation from Bellevue to begin working at the Mississippi Child Development Center which was a precursor of Headstart. She was noted for diagnosing the malnutrition of poverty in young children at that time. This led to her longtime involvement with the Civil Rights Movement. She was the physician to the Student Nonviolent Coordinating Committee (SNCC), and was involved in teaching sessions as well as with treatment for workers there. Those needing help were sent back to New York City since they couldn't trust either the doctors in the south or the local authorities. James Foreman of SNCC frequently turned to her for advice and help.

She had been jailed for demonstrating against facilities which refuse to admit blacks. She began working with the young people who joined the civil-rights movement dealing with their sometimes intense emotional reactions to those threatening times.

When she returned to New York City to St. Luke's-Roosevelt Hospital she organized and set up home-care psychiatric programs for the residents of welfare hotels.

This September 12, the 'Celebration of the Life of Josephine Martin,' held at the Academy of Medicine in New York, was emc'd by Ossie Davis. The attendees included James Foreman of SNCC; Unita Blackwell, the Mayor of a city in Mississippi, who recalled the Molotov cocktails exploding in her front yard, and who said, "this lady from up North was something we had never seen before, she was a white woman who was caring and loving"; and various artists and writers. All commented on her informality, her down to earth style and her compassionate work with the poor, the mistreated and homeless.

I spoke with Dr. Martin a year ago for an article for this Newsletter. At that time, she was planning to do a book on the experiences of the Medical Committee for Human Rights,



saying that no one knows about the doctors who took time out of their lives at their own expense as volunteers in the movement. They slept in black homes or churches, or

wherever. Her purpose was to pass on this history to young colleagues so they "could carry on the torch of service and volunteerism. This is what we did and now it is your turn to serve in the spirit of Hippocrates". "We didn't work in fancy offices, but we were on the front lines risking shooting and wanting to help those who were beaten, kicked, or ill with emotional breakdowns," she said. She mentions that sadly, few M.D.'s wanted to help. At the time of this interview she was still active with civil rights groups. She received the Vera Paster Award from the American Orthopsychiatry Society given to persons who have significantly contributed to the well-being of persons of color.

"She was an ordinary woman who did extraordinary things in the struggle for human dignity." In addition, Jo was always there, helpful and supportive for the New York SAP

Leonard Henschel. ■

~~~  
**A SPECIAL MEMORY**

I was one of the many psychiatrists who were part of the Medical Committee for Human Rights in the late 60's. We each spent one week at a location in the South, most of us in Selma, providing medical and psychological support for the civil rights workers, including Stokely Carmichael. While we each spent only a week, Jo spent a good part of her professional life there at that time. Just last year, she asked each of us to contribute a piece to a booklet she put together with a brief biography of each of us. (Unfortunately, I don't recall where in my bookcases I filed it.) Jo was a special presence in the New York Society for Adolescent Psychiatry. Her good humor and especially her great enthusiasm for taking up the needs of the underserved and communicating this to the rest of us will be sorely missed.

Alex Weintrob ■

Dr. Josephine Martin died after a long courageous battle with an autoimmune disorder, never complaining, stoic and still giving in her loving way.

Jo was a dedicated doctor who gave deeply of herself as a skilled and caring physician to

many patients, often without remuneration. She fought as activist for civil-rights throughout her adult life, including participation in the Mississippi Summer. Joe also practiced under the British health system in London for five years. At Bellevue, she established special programs to provide children with private instruction and placed them in homes. Dr. Martin for many years was a family and child psychiatrist at the Jewish Board of Family and Children's Service as from whom she received their annual award in 1988. She was a board member and served as President of the New York Society for Adolescent Psychiatry and was a founding member of the Physicians Forum, the Medical Committee for Human Rights and Physicians for Social responsibility.

Her dedication to the perpetual struggle for health care, human rights and opposition to all tyranny is an inspiration. We celebrate her wonderful life, warmth and giving love. Shall be sorely missed and her absence will make a difference in many lives.

Richard Rosner, President, NYSAP ■

---

**ABAP**

The next certification examination in adolescent psychiatry will be administered on Friday May 4, 2001 immediately prior to the American Psychiatric Association Annual Meeting in New Orleans.

Information regarding the examination may be obtained by calling the American Board of Adolescent Psychiatry's office at (301) 718-6520 or writing to: American Board Of Adolescent Psychiatry, 4340 East-West Highway, Suite 401, Bethesda, MD 20814. Email: abap@paimgmt.com

In addition to planning for the 2001 administration of the examination the Board has been working on a model for recertification in adolescents psychiatry. After further review by the Board the recertification process or as this process is now known, the maintenance of certification will be announced later this year.

The "Board" has received a number of inquiries regarding the use of the term Board Certified with particular reference to recently enacted legislation in California which has governed the use of this term. We would urge all California Diplomates to follow the guidelines of the California Medical Board. To assure appropriate identification of ourselves as specialists in adolescent psychiatry, diplomates of our board can identify themselves in one of two fashions. First as a Diplomate of the American Board of Adolescent Psychiatry or alternatively as Board Certified by the American Board of Psychiatry and Neurology and specializing in Adolescent Psychiatry. This latter designation of course does not apply to Diplomates of ABAP initially certified by the Royal College of Canada. If you

Continued on Page 8



*Maltreatment in Early Childhood-Tools for Research-based Intervention.* Edited by Kathleen Coulborn Faller, Ph.D., ACSW, DCSW. \$49.95 hardcover, \$24.95 softcover, 258 pages, Haworth Press, Inc.

This book examines strategies and ideas for professional training in child protection in the United States. It addresses current assessment issues, the intersection of child maltreatment and other social problems, the history of child protection, the intricacies of court room testimonies, forensic issues and interventions in child maltreatment cases is it and provides guidance for case management. The book explores child abuse from a historical and political context as it discusses key issues relating to all facets of the social problem. It

# In Our Mail



contains a validity check list to help determine the truthfulness of allegations.

Rakoff con't from Page 8 stretched, but for all the difficulties, the majority of Canadians hold to the principle of our one tier publicly funded open access medical system. Paradoxically, in the free market US there seems to be more bureaucratic control of medical practice than we have operating under a state system. Nothing is simple.

So here we are, continually buffeted by money, public opinion and prevailing orthodoxies. And we are supposed to be objective humane scientist humanists, always treading water and looking for firm ground to stand upon. The inevitable uncertainty could make one despair or become nihilistic. However, on

the other hand one can embrace it by being open to different opinions and not behaving as if we were in possession of some completely revealed truth—either of the psychodynamic or the reductionist pharmacological kind .

Vivian Rakoff ■

Weissmann con't from Page 8

interested in copy of the letter we received from the California Medical Board please let us know.

Sidney H. Weissmann, M.D. President, American Board of Adolescent Psychiatry ■

## CLASSIFIED AND DROP-IN ADVERTISING AVAILABLE

Ads must be received at the ASAP office by the following deadlines: Spring issue — April 12; Summer issue — July 30; Fall issue — September 30 and Winter issue — December 1st. Copy should be typed and double-spaced.

For Classified ads, a check to cover the cost at \$1.00 per word (minimum \$25.00 per ad) must accompany the order. For an additional \$12.50 an advertiser who does not desire to be publicly identified may use an ASAP "Box Number" and will be sent copies of resumes or other information sent to the box.

For drop-in ads, rates are as follows: Underwriting a complete issue, \$1500. This entitles the advertiser to exclusive advertising rights in that issue, with two full pages of advertising. Full Page ad: \$350; one-half page ad: \$250; one-quarter page ad: \$150.

The acceptance of advertising by this Newsletter does not in any way constitute endorsement or approval by *ASAP Newsletter* or ASAP of any advertised service or product.

Regarding Classifieds, the publisher reserves the right to accept or reject advertisement for *ASAP Newsletter*. All advertisers in this section must employ without regard for race, sex, age, nationality, or religion in accordance with the law. Readers are urged to report any violations immediately to the executive editor.

## ASAP NEWSLETTER

P.O. Box 570218, Dallas, TX 75357-0218

ph (972) 686-6166 Fax (972) 613-5532

email:adpsych@aol.com

Official organ of the American Society for Adolescent Psychiatry, published quarterly, distributed free to members and invited contributors from abroad. Subscription rates for others are \$10.00 per annum for US and Canada, \$15.00, abroad. Requests for subscriptions should be sent to ASAP, P.O. Box 570218, Dallas, TX 75357-0218  
Editor: Leonard Henschel, M.D., 80-49 Park Lane, Kew Gardens, NY 11415. Phone/Fax: (718) 849-6339. E-Mail Address: lenph@aol.com