american society for adolescent psychiatry

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Gregory P. Barclay, M.D., Editor **Summer 2008**

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FROM THE PRESIDENT FABIAN SALEH, M.D.

ASAP has begun a new chapter in its life. For the first time in its history, ASAP membership is extended to non-physician colleagues and to physicians who are not psychiatrists but interested in working with adolescents and their families. ASAP remains the only professional society that dedicates its entire time and efforts to the mental health and substance abuse needs of adolescents. For those of you who may have been denied membership in the past, the doors are now open and the welcome mat is out! We need and want new members so that we may grow and become stronger because of our size and diversity. ASAP must remain a **relevant** force in advocating for the rapidly increasing needs of teens with mental health and substance abuse problems and all members, existing and prospective, can help by joining or renewing your membership!

While enjoying the outstanding professional program and ambiance at our annual March meeting in Boston, ASAP's Governing Board took time to meet and address our organizational growth and financial concerns. ASAP is no different from other professional societies when it comes to the realities of declining membership, increased costs of doing business, and the challenges to conduct advocacy and professional benefits to members while staying within a budget. While we have not increased our dues in recent years and have no plans to increase them soon, we have had to make other changes that will reduce costs while maintaining our primary mission objectives. Among these changes include:

- The newsletter and annals will no longer be printed but will instead be available on-line via our website.
- Our annual meeting will continue, but will no longer be hotel-based as in the past.
- Instead, the next meeting will be held in a New York academic venue with members making their own accommodations at nearby hotels. This will be more cost effective for ASAP and members attending the meeting.
- The fall business meeting this year will be conducted at no cost to the organization
- Administrative expenses have been reduced through to the end of this year.

In spite of these changes, ASAP still needs **your** help! Here is what you can do today to help assure that ASAP remains relevant and alive to assist the needs of teenagers:

- Please pay your 2008 dues! At last count, there were over 60 of our members who had not paid their annual dues. Mailing requests for dues pay-

Why ASAP is Important

by: Gregory P. Barclay, M.D., Editor

I joined ASAP in 1994 after attending what was then the curriculum review course in adolescent psychiatry. This course was designed to assist general psychiatrists like me in preparing for the certification exam in adolescent psychiatry, which had only recently become an option. Earlier, as a resident in the Navy, I had applied for fellowship training in child psychiatry but the Navy then needed adult psychiatrists so my application was denied. By the time I completed my Navy obligations it wasn't possible to go back for more training while supporting my growing family. So, when I learned of the opportunity to become Board Certified in Adolescent Psychiatry, I took the course, studied extensively, and ultimately passed the exams. I was now "legitimately" able to work with adolescents! **ASAP offers legitimacy** - to those of us who work with youth but don't have formal fellowship training in child and adolescent psychiatry.

In the years since then I have remained a member of ASAP. I liked the format and educational opportunities membership afforded us at annual meetings that were always of high quality, yet small enough that it was possible to get to know others. Also, ASAP was one professional organization whose scientific meetings included presentations and seminars focused in many meaningful areas, not just neurobiology and pharmacology. This appealed to me. For example, last year's pre-conference seminar was devoted entirely to issues of teen sexuality – an area that any adolescent psychiatrist must be comfortable and knowledgeable to be effective. ASAP's meetings provide us the opportunity to stay "cutting edge" in our clinical work with teens. **ASAP offers relevancy** – to those of us interested in keeping abreast with current research and therapies for adolescents.

In the past 25 years services designed to assist emotionally troubled adolescents have been cut at all levels in the public and private sector. There are few organizations in existence with sufficient muscle to advocate at a national level for the mental health needs of our youth. ASAP may be small, and we certainly aren't the AARP, but we do have a voice nonetheless and therefore the privilege and responsibility to advocate for troubled youth. Please read the message from our president, Dr. Fabian Saleh, to learn more about what we each may do to further strengthen ASAP. **ASAP offers us a voice** – to advocate for the growing numbers of adolescents who desperately need mental health services.

These are just a few reasons why ASAP is important. This issue of the newsletter contains information that reinforces ASAP's legitimacy, relevancy, and advocacy roles. First, for those of you unable to attend our annual meeting in Boston, Dr. Dominic Ferro has graciously summarized two outstanding presentations, one on the current state of juvenile violence risk assessment and the other addressing the needs of MR/DD adolescents. Take a few moments to visit the gallery of photos of friends and colleagues taken at the meeting. I am delighted to include two clinically relevant summaries in this issue: "Mental Health Needs of Native American Adolescents", by Drs. Michael Harlow and Christopher Davidson and "Addiction Medicine for the Adolescent Psychiatrist" by ASAP member Dr. Waqar Waheed. Please read Perry Bach's summary of the proposed changes in our by-laws that require your vote to be enacted. Therefore, send your ballot as soon as possible. Finally, take time to read Lois Flaherty's updates regarding the international scene and the future of the Annals.

Like the Annals, this edition of the newsletter is only available on-line. I am anxious about how this change will affect our ability to effectively share organization news with membership. If you are a member and unable to print a copy from our website or when sent via e-mail, please contact our executive director, Frances Roton-Bell, at our central office and she will be happy to print and mail one to you. I always need book reviewers and articles for the newsletter, so please volunteer if you are able! Do you have a practice tip, story or a case history to share? Please send any information you would like for consideration in the newsletter to me at gpbmd@aol.com.

Continued from the President's column

ment will only increase our administrative costs. For those members who paid their annual dues promptly, you have our thanks. When you receive your 2009 dues notice in December, please pay promptly!

- Go out and recruit at least one new prospective member to ASAP. Do you know a non-psychiatric medical colleague or non-physician mental health professional colleague who cares about adolescents? Approach them and invite them to join us!
- Register for, attend, **and participate in** our 2009 annual meeting in New York.
- Call or e-mail our executive Director or me at the ASAP office and ask what you can do to help.

So, let us move forward to write a vibrant and exciting chapter in ASAP's life. Join me, please!

Mental Health Issues in Native American Adolescents

Michael C. Harlow, M.D., J.D.
Christopher M. Davidson, M.D.

Mental illness in the Native American community is a public health crisis. Native Americans are at greater risk for mental disorders than most other American ethnic and racial groups.[1] In one study, 35.7% of Native American women and 50% of Native American men have suffered from a mental disorder, with high co-morbidities between depression/ anxiety and substance abuse disorders.[2] Five of the top ten causes of death among Native Americans, including suicide, are associated with alcohol abuse.[3] Prime contributors to elevated mental illness in Native Americans include poverty, lack of employment, disrupted communities, and family adversity.

This mental health crisis extends to Native American youth. In a study of Great Plains Native American children, 23% met criteria for a mental illness and 9% met criteria for two or more disorders.[4] Among Native American adolescents, the most prevalent mental disorders were depression, anxiety, alcohol abuse, and polysubstance abuse.[5]

Substance abuse disorders among Native American adolescents are more frequent than most other American adolescent ethnic and racial groups. These youth are at higher risk to initiate substance abuse at a younger age,[6] and to develop greater co-morbid mental disorders than other non-Native American adolescents do.[7]

Native American teens are vulnerable to mental illness, in part, due to problems of poverty, lack of resources, and family disruption. In addition, these adolescents are at heightened risk of mental illness if they live with a female caretaker who suffers from either depression or alcohol abuse.[8] Moreover, American Indian adolescents are subject to heightened risk of drug and alcohol abuse due to stressors that also afflict adolescents of other cultures. These common risk factors include peer pressure, desire for experimentation, and a need to cope with stress.[9]

The impact of mental illness on Native American adolescents is reflected in disproportionately elevated mortality rates from accidents, homicide, and suicide. A survey of Native American and Alaskan adolescents noted that 17% of adolescents had previously attempted suicide.[10] Alaskan adolescents were one and one half times more likely to have made a prior suicide attempt than had adolescent Native Americans from other tribes.[11] Suicide risk rates between adolescents of different tribes often parallel a respective tribe's level of support systems and community cohesion.[12]

The co-morbid Native American adolescent stressors of substance abuse, mental illness, and life frustrations also manifest themselves in increased frequency of antisocial behaviors.[13] A study of Cherokee Native American adolescents revealed a strong correlation between substance abuse and juvenile delinquency.[14] Co-morbid mental disorders, independent of conduct disorder diagnoses, correlated with increased risk of adolescent crimes. Native American adolescents arrested for severe and violent crimes had high rates of substance abuse and other types of mental illnesses.[15] In this study, no significant differences in criminal offense rates were observed between Native American and non-Native American adolescents after accounting for variable poverty conditions.[16]

While studies of mental disorders in Native American adolescents have revealed high levels of psychiatric disturbances, such studies are relatively few in numbers. Population studies of American Indian adolescents have been hindered by geographic distances, relatively small sample sizes, and the diverse cultural conditions among Native American tribes.[17]

In addition to a lack of knowledge regarding American Indian adolescent mental health problems, resources necessary to provide mental health care to this population group have often been inadequate. This relative unavailability of mental health care has been compounded by Native American parents' reluctance to utilize outside health care resources for their children.[18] This underutilization of resources occurs despite available and affordable mental health care.[19]

The impact of Native American adolescent cultural identity on respective mental illnesses has yet to be clearly defined. In addition, the levels of cultural identification or acculturation, respectively, among Native American adolescents have not been determined to be direct contributors of substance abuse disorders.[20] However, high levels of culturally-specific programming in Native American adolescent substance abuse treatments is conducive to successful treatment outcomes for these youth.[21]

Culturally specific substance abuse treatment for Native American adolescents offers the advantage of greater appeal to the intended target audience. Culturally specific therapies are deemed more effective than non-culturally based treatments because they generate fewer value conflicts and better appreciate the social realities facing Native American adolescents.[22] Culturally sensitive substance abuse treatment works to ameliorate ethnic distrust which can hinder achievement of treatment goals. Such therapies are most effective if they promote support from within a tribal community.[23]

Native American adolescents face a constellation of mental health challenges. While more research is needed to better understand this population's mental health needs, the apparent level of psychiatric co-morbidities warrant improved mental health care access and treatment. However, an addi-

tional core component in remedying this mental health crisis is greater efforts at reducing the poverty conditions under which Native American adolescents live. Such efforts are necessary to safeguard a group of adolescents at risk of being lost.

Dr. Harlow received his BA from Johns Hopkins University and his J.D. from Washington University in St. Louis. He completed his M.D. and psychiatric residency at University of South Dakota School of Medicine. He is presently a forensic psychiatry fellow at University of California at Davis School of Medicine. He is a member of the APA, American Academy of Psychiatry and the Law, and the American Bar Association.

Dr. Davidson is a native South Dakotan. He completed his medical training and general psychiatry residency at the University of South Dakota. His work focuses on treating adolescents and adults in the South Dakota correctional system and in addiction treatment centers. He enjoys teaching medical students and residents and gives weekly lectures on psychopharmacology and addiction.

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[23] Ibid

For Your Calendar

<u>XIV World Congress of Psychiatry</u>
September 19-25, 2008
Prague, Czech Republic
[raboch@mbox.cesnet.cz]

<u>ASAP Fall Business Meeting</u>
October 11, 2008
DFW Airport Terminal D - Admiral's Club
Dallas, TX

From the 2008 Annual Meeting…

The State of Juvenile Risk Assessment

Summarized By Dominic Ferro, M.D.

At the Annual Meeting, Joel Andrade, LICSW, gave a thorough presentation on Juvenile Risk Assessment. He started by reviewing youth crime and violence statistics. He noted that juveniles make up only 8% of population, but that they perpetrate 16% of violent crimes and 32% of property crimes overall. A recurring theme was that during adolescence and early adulthood, the incidence of violent and criminal behavior peaks. Mr. Andrade stated, "Aggressive and delinquent behavior is near normative, and desists for most youths." Eight of ten males have a record of some police contact, and one of two boys admits to engaging in some violent act. One in four girls admits to engaging in a violent act.

Although violence is common during adolescence, the rate of violence will decrease as most adolescents mature. However, a small cohort is described as "life course persistent offenders". This group generally begins engagement in violent behavior at a younger age, as early as six, and the rate peaks by nine years of age, which is three years before the general adolescent cohort. Identifying this high risk group of offenders is important because 5% of the population perpetrate 50% of all violent acts.

The concept of risk assessment has evolved over several decades, starting initially with the application of "clinical judgment", which has been shown in subsequent studies to be less accurate than a coin toss (Monahan, 1981). The second generation of risk assessment involved the use of actuarial tools effective at identifying and empirically validating specific risk factors associated with violence. These instruments confirmed that the presence of Antisocial Personality Disorder, with high scores on the Psychopathy Checklist predicting future violence. Previous violence and young age of first violent offense were also strong predictors of future violence. Other empirically identified risk factors include a number psychiatric and social factors including substance use, and the presence of a mental disorder such as Attention Deficit Hyperactivity Disorder and Conduct Disorder. However, severe psychopathology is not itself a risk factor. Personality traits, such as impulsivity or lack of remorse or empathy are associated with violence. A poor response to past mental health treatment attempts is an additional risk factor.

A wide spectrum of social factors affects risk. Any type of significant loss or social stress has a negative effect, as does the experience of physical or sexual abuse. Family factors include single parent homes, out of home placements, paternal antisocial behavior, parental alcohol use, neglect, poor parental supervision and family discord. Victims of domestic violence are particularly at risk. The child's peer group has an impact, as well. Children who are alienated from their peers are at increased risk, as are children who are involved with deviant peers of who have a favorable attitude toward deviance.

School factors include academic failure, dropping out, the presence of a learning disability and a lack of intervention resources at the school. General community factors that increase risk are a disorganized neighborhood with a high crime rate, poverty and unemployment. Legal factors are also important. Young age at first contact with law enforcement and young age at first commitment are significant. Delinquency, a greater number of prior arrests, longer previous incarcerations and more serious crimes are also significant.

The use of actuarial tools has also identified a number of protective factors that reduce the risk of future violence. Positive peer relationships are protective, as is the presence of a positive mentoring figure. Positive academic achievement also has a positive effect. Academic achievement is even more protective for females than it is for males.

ASAP's current President, Dr. Fabian Saleh, elicited one problem with actuarial tools: these instruments have generally not been validated with adolescent populations, so their use with adolescents raises ethical concerns. Another problem with actuarial instruments is that they produce a static number indicating a level of risk. However, referral sources such as schools, a juvenile justice court or a correctional facility, are also interested in knowing if the level of risk can be altered through treatment. Actuarial instruments cannot help with this prediction, which has led to the third generation of risk assessment.

The third generation of risk assessment, the current state of the art, is "structured clinical judgment," which combines the benefits of clinical judgment and actuarial assessments. The structured aspect of the assessment forces the clinician to obtain data pertinent to known risk factors for future violence. Risk assessment requires a comprehensive examination including criminal, psychiatric, developmental, educational and violence histories. This identifies which children present a low risk, a moderate risk or a high risk for future violence. Identifying the child's risk level then informs clinical judgment. High-risk children should be directed toward more structured treatment settings in order to protect both themselves and the community.

Mr. Andrade reminded us that in the case of adolescents, risk assessments have "a short half life." Risk will change as the child matures, and the risk level will require frequent reassessment. Referring agencies will appreciate accurate risk stratification and a plain language description of risk factors. They will also appreciate a focus on malleable risk factors, recommendations about appropriate treatment to address those risk factors and specific recommendations about how they can manage a child's risk in their setting.

Update on the Evaluation of Adolescents with MR & DD

Summarized by: Dominic Ferro, M.D.

At the 2008 Annual Meeting, Laurie Charlot, PhD, treated us to an excellent update on the assessment and treatment of patient's with Mental Retardation and Developmental Disabilities, a population now referred to as having Intellectual Disabilities, or ID. She structured her talk in an entertaining fashion, as the "Top 10 Things to Remember When Evaluating People with ID."

Her first point was that developmental features alter the presentation of psychiatric disorders. People with ID use similar cognitive strategies as children who have the same mental age. At different stages, all children exhibit 'symptoms' such as concrete thinking, rambling speech, or a poor distinction between fantasy and reality. People with ID may plateau in these stages of cognitive development and exhibit these strategies throughout their lives. And, as is true of all children, the use of these cognitive strategies is exaggerated in times of stress.

Dr. Charlot's second point was that diagnosing psychiatric disorders in this population is challenging. The presenting problem to a psychiatrist is almost always aggression. Those making the referral are usually most concerned with externalizing symptoms, but internalizing symptoms are often overlooked. The patients are often lacking in their ability to report depression and anxiety. She noted that they are often eager to please the psychiatric evaluator and will often answer "Yes" to all questions. Depending on how they are asked, they may endorse hallucinations, delusions and suicidal and homicidal ideation, even when these symptoms are not present. For this reason, Dr. Charlot emphasized the importance of speaking to multiple informants and she encouraged the psychiatric evaluator to insist on eliciting the informants' direct observations, as opposed to their conclusions.

These first two points led to three generalizations regarding psychiatric diagnosis in this population. Psychotic disorders and Bipolar Disorders may be over diagnosed. She cautioned, "Beware of cycling," which has become a buzz word, and may be leading to the overuse of mood stabilizing medications, in a population who is subject to labile mood and hyperactivity under stress. The flip side is that depression and anxiety, disorders that rely heavily on the self report of internal feeling states, may be under diagnosed. Anxiety may lead patients to respond with escape-based aggression, which may be misinterpreted as psychosis or mania.

Another three points centered on confusion around the meaning of aggressive behavior. Dr. Charlot cautioned, "Everyone is agitated!" Aggression is a final common behavioral pathway indicating that something is wrong. Even if a psychiatric condition is present, it does not mean that it is the root cause of the aggressive behavior: "Phenomenology is not etiology." All behaviors, including aggressive behavior, occur in a context. One survey of over 16,000 patients with ID found that 62% were receiving psychotropic medications with an average of 2.75 medications per person. Pharmacotherapy will not correct the stress from problems in a patient's family or peer group, nor will it correct the stress of inappropriately high expectations in other settings. Despite increased awareness, behavior therapy interventions are still under utilized. Dr. Charlot commented that behavioral psychology has become more sophisticated in the approach to more remote antecedents that may be lowering the individual's threshold for aggressive behavior.

Dr. Charlot emphasized that medical problems are also under diagnosed and that pain and discomfort can be important causes of disordered behavior. She cited a patient who had a long psychiatric hospitalization for behavior problems that turned out to be the result of constipation, which was likely exacerbated by the multiple medications the patient was taking.

Dr. Charlot counted down her 10 points, a la David Letterman. And, the number one Thing to Remember When Evaluating People with ID was…Comprehensive assessment is needed for treatment. Evaluating people with Intellectual Disabilities requires full consideration to all possible etiologies for disordered behavior. Psychiatrists should be prepared to employ their full knowledge of human behavior: cognition, principles of behavior, developmental issues and psychopathology.

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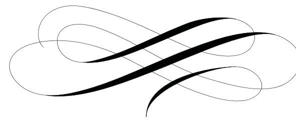
Annual Meeting Photo Gallery

Fabian Saleh

James Gilfoil

Martin Fine (L) welcomes first Associate Member, Eric Fine (R)

Lois Flaherty and Fabian Saleh



Glen Pearson and Fabian Saleh

Richard Ratner, Dom Ferro, Perry Bach

Fabian Saleh and Mohan Nair

Governing Board Votes to Increase the Number of its Members-At-Large and to Change ASAP's Relationship With ABAP

By: Perry S. Bach, M.D.

The Governing Board, at its meeting on March 30, 2008 in Boston voted to amend the ASAP Bylaws to increase the number of Members-at-Large on the Governing Board and to absorb the American Board of Adolescent Psychiatry (ABAP) into ASAP. They also passed "housekeeping" amendments for the Bylaws. The ASAP membership now has the opportunity to endorse or nullify the Governing Board actions,

As required by the Bylaws, here are brief descriptions of the amendments and statements in favor and in opposition.

MEMBERS-AT-LARGE

Description: Increase the Governing Board's Members-at-Large from two to four.

Statement in Favor: The Governing Board should have more than two Members-at-Large who are not officers and therefore have no other responsibilities than to represent the interests of ASAP members.

Statement in Opposition: There are already at least ten voting members on the Governing Board and increasing the number would further complicate its functioning.

ABSORB ABAP INTO ASAP

Description: Creation of a new council within ASAP to succeed ABAP.

Statement in Favor: Both ABAP and ASAP will be stronger organizations by combining them. This will reduce overall costs and provide additional support for Board Certification in Adolescent Psychiatry. Financially, ASAP will recover funds that were loaned to ABAP many years ago. ASAP will be able to plan and implement programs that will assist ABAP diplomates in preparing for certification or recertification.

Statement in Opposition: ABAP should continue as an independent and separate organization, and not become a subsidiary of ASAP.

HOUSEKEEPING AMENDMENTS

Description: These amendments correct typos, clarify intent, and simplify processes.

Statement in Favor: Bylaws should be accurate, clear, and consistent.

Statement in Opposition: None

The most controversial of the amendments was to absorb the American Board of Adolescent Psychiatry (ABAP) into ASAP as a new Council. Historically, ASAP created and provided initial funding for ABAP to establish standards, examine, and certify psychiatrists in adolescent psychiatry. At the time, it was thought that ABAP should exist as a separate organization with the hope that it or a similar Board would be accepted as a subspecialty within the American Board of Psychiatry and Neurology. While that did not occur, hundreds of psychiatrists passed the examination and were certified by ABAP in adolescent psychiatry. The ASAP Governing Board believes that combining the two organizations at this time would strengthen them and the field of adolescent psychiatry. The Governing Board respects and will continue to support the ABAP commitment to provide maintenance of certification testing for the current ABAP diplomates.

Copies of the actual Bylaws and the specific proposed amendments being proposed are available to ASAP members from the Executive Director. If you have any questions, please contact Ms. Frances Roton-Bell, ASAP Executive Director, and she will forward them to a member of the Governing Board for response.

Following is a ballot that can be copied and e-mailed, faxed, or sent by regular mail to the ASAP office with your votes to endorse or nullify the Governing Board actions.

I am an ASAP member in good standing. Please record my vote as follows:

Amendment

Endorse
Nullify
Abstain

1. Increase the number of Members-at-Large on the Governing board from two to four.

2. Absorb ABAP into ASAP as a new Council

3. Accept Bylaws "Housekeeping" Amendments

Print Name ______________________________

Signature ______________________________

Please copy and send to:
Frances Roton Bell, ASAP Executive Director

by **August 31, 2008**, via one of the following:

E-mail: frda1@airmail.net
Fax: (972) 613-5532
Mail to: P.O. Box 570218
Dallas, TX 75357-0218

Addiction Medicine for the Adolescent Psychiatrist

By: Waqar Waheed, M.D., FRCPC

As identified in the final opinion delivered by U.S. District Court Judge Gladys Kessler in *United States v. Philip Morris* (August 2006), tobacco companies have been known to focus a significant portion of the marketing of their products over the past half-century on the pre-teen and teen population. For those of us working with adolescents, this simply highlighted what we already knew: *Adolescents are at high risk of developing lifelong addictions to substances such as alcohol, cigarettes and illicit substances.* Society pays a high cost for the natural consequences of these addictions. Outcomes for addiction treatment are not robust when viewed on a long-term basis, especially when we take into account the development of maladaptive compensatory behaviors.

How are we then, as healthcare professionals, to tackle this burden of adolescent addictions in the face of guarded prognoses and a healthcare system which does not always support the treatment of addictions at par with other "medical" conditions? There is increasing consensus that our answer lies in the development and utilization of primary prevention approaches similar to those used for other major health conditions such as coronary artery disease. Knowledge of the factors which impart risk for and which protect against the development of adolescent substance misuse provides the foundation for preventive efforts.

Individual risk factors include:

- a family history of alcoholism (four-fold increase in risk),
- prenatal toxin exposure (lead and alcohol in particular),
- perinatal complications (anoxia, low birth weight),
- traumatic brain injury,
- ADHD and accompanying conduct disorders,
- social marginalization, low religiosity, and sub-cultural attitudes favorable to drug use,
- young age of onset of use.

Means of intervention may include prenatal education for expectant mothers and women planning to have children, early identification and treatment of behavior disorders, promotion of pro-social community/recreational activity involvement, and supporting functional communication between adolescents and their parents.

Family factors that promote the risk of adolescent substance use include:

- substance use by family members,
- permissive parental attitudes towards substance use
- involvement of children in parental substance use behavior.

Preventive measures include limiting the use of alcohol or other substances in the child's presence and not involving children in substance use behaviors such as pouring drinks. Healthcare professionals may also promote learning and practicing effective parenting strategies that reinforce social responsibility.

Other identified risk factors include:

- Academic problems and failure
- Affiliation with a peer group that includes friends who drink alcohol, smoke cigarettes or use other drugs.
- Community disorganization (high population density, high rates of crime)

Protective factors include pro-social community involvement, above-average intelligence, resilient temperament and strong bonds and attachments to adults within the community or family.

SAMHSA's *Building Blocks for a Healthy Future* is a primary prevention program for parents and educators aimed at the 3 to 6 year old population. It supports parents in using positive parenting approaches to help their children grow up making healthy decisions. Ideas are provided for conversation starters, positive discipline, and fun family activities. *Too Smart to Start* is underage alcohol use prevention SAMHSA initiative for parents, caregivers, and their 9-to-13 year-old children.

In the pediatric population, screening for alcohol, tobacco and drug use should begin with the prenatal visit and continue throughout adolescence. Ideally, the primary care or mental health setting screening process should be influenced by an awareness of risk factors and protective factors described above. Stepwise elements of the adolescent interview include a discussion of general lifestyle issues, asking about dietary patterns, inquiring about prescribed medication, asking about over-the-counter medication, moving on to successive queries regarding tobacco use, alcohol use and finally the use of any illicit drugs (Comerci 1998). One method for organizing historical data is the "HEADS FIRST" approach (Goldenring and Cohen 1998) which includes Home, Education, Abuse, Drugs, Safety/Sexuality, Friends, Image, Recreation, Spirituality, and Threats/Violence. Physical examination may provide useful data when combined with a positive screen by interview.

Co-occurring disorders in adolescents that may herald the identification of substance use disorders include depressive disorders, bipolar disorder anxiety disorders, schizophrenia, organic mental disorders, attention deficit/hyperactivity disorder, conduct disorder, antisocial/borderline/narcissistic personality disorders/traits, and eating disorders. The likelihood of current co-morbidity is greater among adolescents than in

the adult population. Hence, maximally treating the co-occurring disorder is critical to minimizing substance abuse risk.

If an adolescent is identified as having or being at risk of developing a substance use disorder, the first step is to match the level of severity and likelihood of compliance with the level of service for treatment provision. The American Society of Addiction Medicine (ASAM) has developed matching guidelines or placement criteria that are applicable to adolescents with substance use disorders.

Specific issues differentiating treatment of this population from adults include:

- the need to consider the level of cognitive development and emotional maturity
- the need to include family members in the treatment process
- the greater likelihood of the use of "club" drugs
- the greater incidence of co-morbidity

Specific treatment measures identified for this population include: family therapy, twelve-step approaches, cognitive-behavioral therapy, therapeutic communities, motivational treatments, intervention workbooks, and community reinforcement approach (CRA).

Among adolescents who have completed a 28-day program, approximately 1/3rd will relapse in the three months after the program. Pathways for relapse (Jaffe 1994), in order of descending primacy include:

- involvement with peers who drink alcohol or use drugs
- the presence of co-morbid psychiatric illness
- denial associated with the belief that the adolescent can use a substance "in moderation"
- the subconscious re-arrangement of one's life to increase one's proximity to drugs.

Awareness of a promise of confidentiality is important from the developmental perspectives of adolescents striving for autonomy in decision-making and establishing an identity distinct from their parents. The ethical principle of non-maleficence overrides confidentiality, however, in necessitating disclosure of information such as significant risks of self-harm, violence, abuse or neglect. When the clinician has decided that grounds exist for a breach of confidentiality, the adolescent should be given advance notice and be included in planning of how to make the disclosure. Different rules of confidentiality may apply in special circumstances such as court-ordered treatment and treatment as a condition for returning to school.

Dr. Waheed completed his residency training in Psychiatry at Vanderbilt University and fellowships in Child and Adolescent Psychiatry and Forensic Psychiatry at Johns Hopkins University and New York Medical College, respectively. He is Board Certified in General, Child and Adolescent, and Forensic Psychiatry as well as Psychosomatic and Addiction Medicine

His research interests include pharmacotherapy of mood disorders and disruptive behavior disorders, competence and criminal responsibility of juvenile offenders and approaches to assessment and management of adolescent violence. He has presented research findings at the annual meetings of the American Psychiatric Association, American Academy of Forensic Sciences, American Academy of Psychiatry and Law, American Society for Adolescent Psychiatry, Canadian Psychiatric Association and the European College of Neuropsychopharmacology.

He is currently the Educational Director of Undergraduate and Postgraduate Training in Child and Adolescent Psychiatry in the University of Calgary's Dept. of Psychiatry, Medical Director of the Inpatient and Day Mental Health Program at Alberta Children's Hospital (ACH), Medical Director of Emergency Services at ACH, Medical Director of the Multi-sectoral-Liaison Clinic at ACH and consultant psychiatrist at the Forensic Adolescent Program.

Classified and Drop-In
Advertising Available

Ads must be received at the ASAP office by the following deadlines: Summer issue – June 30; and Winter issue – December 1st. Copy should be typed and doubled space.

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 product.

Regarding classified ads, 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.

From the Editor of Adolescent Psychiatry

At our recent Annual Meeting in Boston, ASAP made the difficult decision to discontinue the printed version of Adolescent Psychiatry and move instead to online publication.

The reasons for this decision are multiple. The world of publishing has changed enormously since the first edition of the Annals was published in 1971. Methods of obtaining information have shifted from printed journals to the Internet resources. Traditional publishing has become more expensive with on-line publishing increasingly popular. Accordingly, libraries have reduced their subscriptions to printed journals. While many journals are published in both on-line and print versions, others are now only available on-line.

Concurrently with changes in the publishing industry, ASAP has also changed. Our membership, the main base of support for purchasing the Annals, has declined to approximately 200 members. In the past, ASAP had a contractual buyback provision in that guaranteed the purchase of sufficient copies for all the members plus a few extra copies. When there was a larger membership, the buyback provision ensured that the Annals were profitable for our publishers. With diminishing membership and declining sales, we renegotiated the number of volumes included in the buyback provision, thus increasing the cost per volume and, eventually this was unprofitable for any publisher to publish for us. The net result is that, at this time ASAP is no longer able to support the publication of the Annals in a printed version.

Naturally, I am saddened by this development, as I am sure many of you will be. Nonetheless, having given this matter much thought, I believe there are advantages to ASAP and our colleagues in what the future on-line publication will offer. I expect the Annals to be an open-access publication, which will greatly increase the prospective audience for this work. It will allow for more rapid publication of articles. In addition to scientific articles, the on-line Annals will also include summaries and slide shows presented at our annual meetings. It is our hope that at some point we will be able to have all of the print versions of the Annals scanned so that they will be available on-line.

Adolescent Psychiatry will continue to be peer-reviewed. Part of the change to an on-line format will include the exclusive use of e-mail for submission and review of manuscripts and presentations. Currently most of the submissions and reviews are already done in this fashion. In preparation for more submissions in the future, I would now like to expand the current roster of reviewers and the editorial board. Are you interested and willing to assist us in this new endeavor? If so, please contact me if you are interested in serving in either capacity.

Lois T Flaherty, MD
Editor, Adolescent Psychiatry
AnnalsEditor@aol.com or Lflaher770@aol.com

About Our Members…

- **Richard Pesikoff** *was named among 2007 "Best Doctors"* and *2007 "Best Docs for Kids" in the H Texas Magazine.*
- **William Bernet** has co-authored ***Children of Divorce: A Practical Guide for Parents, Therapists, Attorneys, and Judges*** *(2nd ed., Krieger, 2007) – see review in this newsletter!*
- **Walter R. Byrd** *was named Associate Professor of Psychiatry, Dept. of Behavioral Medicine and Psychiatry, West Virginia University School of Medicine.*
- **Carol Anne Paras** *is now employed half time as a school district psychiatrist and requests contacts with members with similar school district affiliations. Please call or email our central office for her contact information.*
- **Todd Clements** *has co-authored the book* ***What I've Learned Since I Know It All*** *(Tyndale House).*
- **Chandra Weerasinghe** *was certified in psychopharmacology.*
- Our condolences to **Richard Ratner** on the loss of his beloved wife, Linda, on June 19th.

Book Reviews by Lois Flaherty, M.D.

Out of the Woods: Tales of Resilient Teens, by Stuart T. Hauser. Joseph P. Ailen and Eve Golden, 321 pages, 2006, Harvard University Press, $27.95.

Children in Family Contexts, 2nd Edition, Edited by Lee Combrinck-Graham, Guilford Publications, 2006, 524 pages, $55.00.

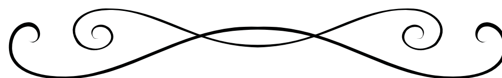
Two recent books by child and adolescent psychiatrists who have labored long in the field will be of interest to those who work with adolescents. Both present information based on what is currently described as “qualitative” research -- direct observation and in-depth interviews by the researchers who are, in effect, participant observers.

Out of the Woods: Tales of Resilient Teens is based on the lead author’s long term follow-up research of 70 adolescents hospitalized in the time when long-term psychiatric hospitalization was the treatment of choice for teens with severe behavior problems. The book presents detailed narratives of adolescents who were interviewed at various times during and subsequent to their hospitalizations. In the initial chapter, “The Puzzle of Resilience”, the authors present a cogent analysis of resilience, which is an extraordinarily complex subject. They point out that the ability to identify and form relationships with helping adults is, in itself, a resilience factor. Those relationships then foster further growth.

This book’s intention is to understand not only the adolescents’ views of their unique difficulties, but their perception of the effectiveness of helping professionals in creating a positive adulthood outcome. The authors’ underlying interest is in identifying what makes for resilience. In reading these detailed histories, one suspects that some of these youngsters were innately strong yet broad sided by adversity. Therefore, the environmental manipulation set in motion by hospitalization was effective. For others, the processes of growth and development produced salutary changes. Significantly, most of the improved teens attributed their success to their own efforts rather than to the efforts of therapists and other outside factors. While this might be a bit deflating at first, those of us who work with adolescents know that their tendency to minimize and devalue out efforts as part of their developmentally-appropriate need to be self-sufficient. This book is written for a lay audience, but will be of interest to professionals who welcome something a little less dry than the typical data-based publication.

Children in Family Contexts is an edited book containing chapters from many familiar names, including Stuart Copans, Alan Josephson, Geri Fox and Pirooz Sholevar. Regardless of the limiting title, there is a considerable focus on adolescents throughout the book, with evident distinction between the two in terms of their developmental tasks and needs. This book might also benefit from the subtitle “Working with Real World Situations”. It is not a book about family therapy technique, but rather about how the role of the family is an essential part of understanding the child’s presenting problems. An effective treatment plan must include interventions with the significant adults in the child’s world. This book is extremely rich in clinical examples that typify what one sees in the public sector as well as the more difficult private practice situations. For example, in a chapter on the family and the legal system, Pirooz Sholevar presents examples of litigious parents whose underlying agenda was to maintain their child’s symptoms in order to obtain maximum monetary gain. Other chapters address families of children with disrupted attachments, remarried parents, deceased parents, chronic illnesses, etc. There are several chapters that focus on out-of-home placements, including work with the child’s current adopted and/or foster family and the biological family. One case addressed the meaningful involvement of an incarcerated biological mother in her child’s inpatient treatment.

People who have obviously dirtied their hands in the real world of difficult clinical challenges write all of the chapters. In describing how they approached these extremely difficult situations, they offer much useful information to clinicians of **all** levels. If I were still a residency training director I would make this book “required reading” for all residents. It is a welcome counterbalance to the limited and partial symptom-focused formulations that rely solely on DSM diagnoses, and view psychopathology as localized within the child or adolescent.



Book Review by Gregory P. Barclay, M.D.

Children of Divorce: A Practical Guide for Parents, Therapists, Attorneys, and Judges, by William Bernet, M.D., and Jon R. Ash, J.D., M.J.S. (Krieger, 2007, 189 pp.)

ASAP Member, William Bernet and his colleague Jon Ash have written this concise and practical guide for parents and professionals who deal with children affected by divorce. This is a unique book for us as clinicians to have on hand for parents of the teens we see, since it is not a compilation of clinical syndromes with suggested treatments. Rather, it is, as the title suggests, a practical guide that spells out the facts and issues in a no-nonsense, non-technical fashion so that the points made are crystal clear to any reader regardless of whether or not they have a clinical perspective.

Children of Divorce is divided into 21 relatively concise and brief chapters, each addressing a relevant topic. For example, several chapters are devoted to conventional and non-conventional parenting arrangements, the impact of divorce trials and custody hearings, and the benefits of parenting education. Others focus on the challenges of blended families and step parenting, the proper roles of grandparents, and appropriate methods to address holiday visitation. Several chapters are devoted to the destructive consequences of continued parental fighting, either directly or indirectly through disparaging remarks made to children by divorced parents about the other parent. The concluding chapters address unique issues such as the pitfalls mental health professionals who agree to testify in custody proceedings, with well-stated guidance about setting limits at the outset in regard to testimony.

Although this book provides good, practical information, it is done in a unique fashion that always stresses the child's perspective, which is frequently overlooked by embittered, divorced parents and their attorneys. In particular, chapters titled "Trying to Love Both Parents" and "Living in Two Homes" are essential ones for parents to read, several times if necessary. The book concludes with its own version of the Ten Commandments, titled "Ten Steps for Raising Children in Divorced Families" followed by a list of resources and websites to assist parents. The "Ten Steps" should be reproduced, with permission of course, and posted in any therapist's waiting room and made available in handout form.

Children of Divorce belongs on the "resource" bookshelf or waiting room of any mental health professional who works with children or adolescents.

Welcome New Members!

Jeremy Huaton Colley, M.D.
New York, NY

Nicole Foubister, M.D.
New York, NY

Robert Buser, M.D.
Santa Fe, NM

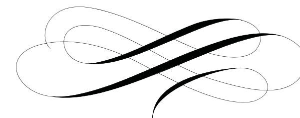
Michael Thomas Witkovsky, M.D.
Middleton, WI

Eric Fine, Psy.D.
Deerfield, IL

Michael Harlow, M.D.
Aberdeen, SD

Rodney Canete, M.D.
New York, NY

Lorerky Ramirez Moya, M.D.
Paramus, NJ



Annual Meeting
Mohan Nair and Fabian Saleh

Book Review by:

Solange Margery, M.D., Fellow, Forensic Psychiatry
and **Stephen B. Billick, M.D.**, Clinical Professor of Psychiatry New York Medical College

Treating Trauma and Traumatic Grief in Children and Adolescents, Cohen, J.A., Mannarino, A.P, & Deblinger, E. Guilford, 2006, 256 pp.

Judith Cohen, Anthony Mannarino, and Esther Deblinger have done extensive research on the evaluation and treatment of trauma in children and have developed a trauma -focused cognitive behavioral therapy (TF-CBT) that has been used effectively for the past 20 years. The authors have developed a book that draws on their collective research and experience in this area as well as incorporating recent challenges, in particular the evaluation and treatment of children and adolescents who where traumatized by the September 11, 2001 terrorists attacks.

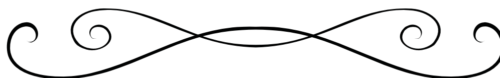
The book is organized in three sections. The first, "Trauma-Focused Cognitive Behavioral Therapy", is composed of short chapters that explain basic elements of childhood trauma, clinical problems that may develop, and how TF-CBT may be helpful. This part describes how each child may respond differently to trauma and the wide range of possible symptoms they might manifest. The authors encourage the use of flexibility and clinical judgment. The book explains how some children and adolescents might need an "attenuated version" of TF-CBT. Children and adolescents with self destructive behaviors may need an initial emphasis of "Affect Modulation", a treatment component.

The book's second section, "Trauma- Focused Components", contains practical "how to do it" information. The "Relaxation" section has paragraphs written as if a therapist were teaching relaxation techniques to a child. This approach is helpful to those of us who prefer examples of how to apply a treatment model. The section on "Affective Expression and Modulation" highlights a dialogue between a therapist and a child. In the script, the therapist revises effective social skills with a child. At the end of the dialogue, both of them work on a problem-solving worksheet that is included. Other particularly important chapters are those about engaging the child in creating the "Trauma Narrative", correcting its inaccurate or unhelpful cognitions, and preparing the parent to hear it. The book includes examples of trauma narratives as well as methods to encourage children to go through the process of writing or drawing it. Other Trauma- Focused components include: "Parenting Skills", "In Vivo Mastery", and "Conjoint Child – Parent Sessions."

The third section of the book, "Grief- Focused Components", is similarly divided in chapters that elaborate on each of the components of grief- focused treatment of traumatized children. Included is a section addressing the resolution of ambivalent feelings towards the deceased and surviving parents and they present methods for working this through. Other components include: "Grief Psychoeducation" and "Redefining the Relationship with the Deceased and Committing to Present Relationships."

Each chapter in the book's second and third sections teaches how to incorporate the parents in that component of the treatment. It addresses important issues such as when parents are also dealing with trauma and when their behavior negatively affects the recovery process. The book also examines the treatment situation in which the child or adolescent has lost both parents and no adult is involved in treatment. Each section ends with questions and answers about particular problems regarding the approaches suggested. These "Troubleshooting" questions and answers reinforce the fact that this book was written to help clinicians and is not merely a collection of research data. This is a particularly helpful aspect of this wonderfully useful book.

At the end, the book includes a section on "Treatment review and closure" which reviews important elements to address during the termination process. The appendices include additional practical material, such as psychoeducational handouts and references to additional training resources. This book is a "must-have" book for clinicians working with traumatized children and adolescents. It is invaluable as a "how to do book" and also as an important reference.



Adolescent Psychiatry--The International Scene

Lois Flaherty, M.D.

I missed the APA this year for the first time in recent memory, and instead attended the International Association of Child and Adolescent Psychiatrists and Allied Professionals (IACAPAP) biannual conference in Istanbul, Turkey. This conference, held April 30-May 4, 2008 will be in Beijing in 2010. It was a little like the APA--even to the point of having industry sponsored symposia every day at lunch (box lunches were included for all registrants so there were no lavish meals). It brought together large numbers of participants from all over the world and there were presentations ranging from a description of a youth wilderness program in Alaska to issues involved in setting up mental health services in developing countries in Africa. In addition, there were presentations on possible neurophysiological phenotypes of ADHD and the controversy over diagnosis of juvenile bipolar disorder--namely, whether stretching the criteria to include chronic irritability was justified. Sir Michael Rutter, Myron Belfer, and others gave keynote addresses. Annette Streeck-Fischer, the incoming president of ISAPP, organized a symposium on relational disorders and attachment with several of us from ISAPP—including Enrico de Vito (Italy), Veronique Delvenne (Belgium), and Nikos Zilikis (Greece). Those of us who attended our annual meeting in Boston will remember Annette, who presented a paper on skinheads in Germany.

There has been an explosion of interest in child and adolescent psychiatry in Eastern Europe, even in former Soviet bloc countries such as Romania and Bulgaria. A meeting last year in Romania (at which Mike Kalogerakis, an ASAP member, presented) focused on the needs of the large numbers of Romanian children reared in orphanages. Academic psychiatry has been well developed in Greece and Turkey, and there have been several meetings focusing on the mental health needs and research in these countries. Nikos Zilikis, a child and adolescent psychiatrist from Thessalonika, Greece and a member of the ISAPP Executive Committee, sent this report on another recent conference in Turkey:

"The Child and Adolescent Mental Health Association of Turkey regularly organizes a conference on Adolescent Psychiatry. They call it "Adolescent days" and this time it was the 12th, held in Istanbul, 14-17 November 2007, organized by the University of Marmara Child and Adolescent Psychiatry Dept, chaired by Professor Meral Berkem. I had the chance and the honor to be among the invited speakers, who also included Nancy Andreasen, Boris Birmaher, James Leckman, and Attila Turgay (the latter a child and adolescent psychiatrist of Turkish origin working at the University of Toronto). It was a very well organized conference and the atmosphere was very warm and friendly. From the number of participants and attendants as well as from my personal feeling I can tell that there is a very lively interest on all issues regarding adolescent psychiatry. The program covered all aspects, from the very biological to psychodynamic ones, and started with six courses given by Turkish professors (topics included psychopharmacology, developmental disorders, adolescent and family relations, development of identity and self, mood disorders and suicide). The remaining three days included conferences by the invited speakers and panels with exclusively Turkish participants. There were also 30 poster presentations, some of them in English. The content was really rich and comprehensive, covering practically the whole range of problems of adolescence in all their aspects: clinical, diagnostic, therapeutic, psychosocial etc."

Annual Meeting
John Flaherty, Len Henschel, Bert Slaff, Perry Bach

Annual Meeting

L-R: Adam Raff, Bert Slaff, Glen Pearson, Robert Weinstock, Richard Rosner, Mohan Nair, Lois Flaherty, Richard Ratner, Dom Ferro

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