



american society for adolescent psychiatry

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Summer 2012

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FROM THE PRESIDENT GREGORY BUNT, M.D.

Dear ASAP members:

It is with great enthusiasm that I extend my greetings to all members of the American Society for Adolescent Psychiatry. The organization, devoted solely to the advancement of the Profession of Adolescent Psychiatry, is now in its 45th year of operation. At this moment, I would especially like to thank Dr. Dean DeCrisse for his extraordinary leadership, service and many accomplishments during this past year as President of the Society.



Our 2012 annual conference, held in New York City this past March, attracted nationally acclaimed speakers such as Glenn Saxe, Jess Shatkin, Steve Jaffe and Stephen Ross. Topics included Dual Diagnosis in Adolescents, Designer Drugs, Anti-Bullying Legislation, Adolescent Neurobiology & Spirituality, Juvenile Justice, and International Issues in Adolescent Psychiatry. Thanks to the indefatigable efforts of Governing Board Member Dr. Manuel Lopez-Leon, and our dedicated Executive Director, Francis Bell, the conference held at the Farber Auditorium of Bellevue Hospital was a remarkable success. We hope that those of you who attended were able to network with colleagues and enjoy the weekend in New York, as well as learn about state-of-the art concepts in Adolescent Psychiatry. And we eagerly look forward to the annual ASAP conference to be held March 23-24, 2013 in Charleston, South Carolina and hosted by The Medical University of South Carolina Institute of Psychiatry and faculty member, President-elect Greg Dwyer, M.D.

The official newsletter of the American Society for Adolescent Psychiatry, edited and organized by Dr. Gregory Barclay, is published semi-annually and distributed free to members and invited contributors from abroad. Additionally, I am pleased to bring your attention to our new website with updated information and features thanks to the work of Past President, Dr. Joe Kenan. Adolescent Psychiatry, the official journal of the American Society of Adolescent Psychiatry, edited by Dr. Lois Flaherty, aims to provide mental health professionals who work with adolescents with current information relevant to the diagnosis and treatment of psychiatric disorders in adolescence. The American Society for Adolescent Psychiatry contracts with Bentham Science Publishers to distribute the Journal, and offers members a unique opportunity to read and publish peer-reviewed articles. Also our soon-to-be released textbook, The Clinical Handbook of Adolescent Addictions, edited by Dr. Richard Rosner, is now available for pre-ordering through Wiley-Blackwell.

ASAP has recently strengthened its ties with the International Society for Adolescent Psychiatry, due to no small measure to the efforts of Dr. Lois Flaherty who is actively involved with the boards of both organizations. Our affiliation with the International Society for Adolescent Psychiatry has led to plans for co-hosting the annual conference of ASAP and ISAP in 2015 where members

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Mark Your Calendar

We have reserved March 23-24, 2013 for the Annual ASAP Meeting in Charleston, South Carolina at the Medical University of South Carolina (MUSC).



Classified and Drop-In Advertising Available

Ads must be received at the ASAP office by the following deadlines: Summer issue – June 30; and Fall 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.

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may take advantage of opportunities to network with colleagues in adolescent psychiatry from around the globe.

Membership in the American Society for Adolescent Psychiatry has many important benefits. Among the many vital themes that resonate with members, publications, communications and regional meetings are: adolescent development, adolescent addiction, bullying, classification of adolescent psychiatric disorders, EHR, the internet and adolescents, forensics, and psychopharmacology specific to adolescents. Also, practical considerations in developing, maintaining and improving upon practice in adolescent psychiatry are addressed with mentoring, practicum-oriented meetings/symposia and the development of certification standards. Furthermore, members are able to acquire the leadership skills and abilities to advance in the field of Adolescent Psychiatry.

This is both a very exciting and challenging time to be the field of Adolescent Psychiatry. Our field is so rapidly evolving due to changes in the technological, social, political and interpersonal environments of our day. Events that are transformative in society have the strongest impact on adolescents. Adolescents represent our future, and it is their mental health and well-being that is paramount to our profession. The growing recognition of the need for and importance of Adolescent Psychiatry nationally and worldwide will reinforce and advance the accomplishments and value of our society.

Gregory Bunt
ASAP President
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ASAP Past Presidents Adam Raff, Glen Pearson, and Perry Bach

New Members, Where Art Ye?

At the 2012 annual meeting, the ASAP governing board directed me to organize a membership development committee to constructively address our problems with dwindling membership. A committee cannot function unless it has both a clearly defined mission and members with ideas and energy to carry forth with that mission. Our mission is clear - to increase membership in the only US professional society whose mission is to advocate for the mental health needs of adolescents - yet we lack ideas, energy, and a strategy. Therefore, please help us by volunteering to join this committee! We would meet virtually by telephone and/or videoconference twice before our 2013 annual meeting so as to design a reasonable strategy to increase membership which I will present to the governing board at that time. If you are interested, please contact me at <mailto:drb@drbarclay.com>. We need your input!



In this edition of our semi-annual newsletter, I have included two clinically focused articles, one being a review of an excellent presentation on Adolescent Sleep Physiology from the 2012 annual meeting, summarized by ASAP member Dominic Ferro, M.D. The other is a summary of current ideas with regard to treating prodromal schizophrenia, summarized from the latest issue of our journal “Adolescent Psychiatry” by Lois Flaherty, M.D. In addition, we will hear from our APA representative, Richard Ratner, M.D. about the APA Assembly’s actions at the May APA meeting. I am also pleased to introduce two guest book reviewers, Diana Mullis, M.D., and Amy Badding, LMHC, RPT, who provided reviews of two new and exciting books relating to Autism Spectrum Disorders. And, naturally, we have included some pictures taken at our 2012 annual meeting in New York, which was a resounding success, chaired by current ASAP President, Greg Bunt.

As ever, I am always in need of submissions for our newsletter and reviewers for books (you get to keep the book if you do a review!). Please contact me at drb@drbarclay.com should you wish to contribute or write a review!



2012 ASAP Past Presidents Dinner

From the 2012 Annual Meeting...

Sleep Physiology and Adolescents

Summarized by ASAP Past President, Dominic Ferro, M.D.



At the 2012 Annual Meeting, Jess P. Shatkin, M.D., M.P.H. spoke about how sleep physiology develops throughout adolescence. The presentation began with a review of sleep cycles, circadian rhythms and sleep physiology, and then addressed the effects of sleep deprivation, sleep disorders and sleep problems in adolescents with psychiatric disorders.

Review of Normal Sleep Physiology

Normal sleep cycles begin with a relaxed drowsy state, during which EEG readings are dominated by alpha waves. Alpha waves are slightly slowed, synchronous version of the busy little beta waves of wakefulness. When a person enters Stage 1 sleep, EEG readings shift to predominantly theta waves, which are even slower, and a bit more rolling than the alpha waves. This pattern of brain activity is what occurs when a person is “zoned out” in a repetitive activity, such as driving or running. It is the state enhanced by the practice of mindfulness. Lighter sleep concludes in Stage 2, during which there are mild disturbances (viewed on an EEG as “K complexes”), followed by sleep spindles, which seem to be the activity of the cortex that maintains sleep. Paul McCartney’s reports on his creative process suggest that he wrote “Yesterday” while in Stage 2 sleep.

Deep sleep used to be divided into two stages, 3 and 4. The distinction is no longer viewed as significant, so now the entire phase is described as Stage 3/4 sleep, or slow wave sleep. EEG activity during slow wave sleep is characterized by large amplitude, low frequency rolling delta waves. In this state of sleep, subjects are difficult to arouse, and disoriented upon arousal. Adolescents spend close to 20% of total sleep time in slow wave sleep, as opposed to adults over 35, who only spend about 5% in that state.

The typical sleep cycle concludes with a period of REM (Rapid Eye Movement) sleep. EEG activity during REM sleep resembles the perky, high frequency, low amplitude waves of wakefulness, as the brain is active, and creative dreams are occurring. Sleep cycles typically last 90-120 minutes, and brief arousals are typical between cycles. Slow wave sleep lasts longer in the first half of the night, with short bursts of REM punctuating each cycle. But during the second half of the night REM periods last longer and occur more frequently.

Sleep and Body Rhythms

Cycles of sleep occur in the larger context of daily

rhythms. These circadian rhythms control sleep and wakefulness, along with a host of other biological activities. Cycles of sleep and wakefulness are described by the Two Process Model of Sleep. Process S is the drive for sleep, which builds during the course of the day peaks at bedtime, and recedes during the course of the night, reaching its lowest point at waking in the morning. Process C is the circadian rhythm. Energy increases in the morning, meeting Process S minimum drive for sleep. Energy declines in the mid-afternoon due to a burst of melatonin, which is the biological reason for the custom of taking a siesta. A second peak of alertness occurs in the evening, holding at bay the increasing drive for sleep until bedtime, when both processes conspire to induce sleep. The circadian rhythm of adolescents is naturally pushed toward the right, or delayed; consequently they find it easier to stay awake later and harder to wake up early.

A number of biological rhythms, in addition to alertness, are tied to the circadian rhythm. Stomach acid reaches maximum concentrations between 10 p.m. to 2 a.m. Coupled with decreased swallowing during sleep, symptoms of GERD are exacerbated, and sufferers’ sleep is more often disrupted by arousals to clear the acid. Adolescents are less vulnerable to this. Cortisol levels are also controlled by circadian rhythms, peaking at the end of sleep, around 6 a.m. Most myocardial infarctions occur during this cortisol peak.

Hunger and satiety hormones also vary according to circadian rhythms. Leptin, which promotes satiety, is highest during sleep, then levels dip in the morning and remain moderate throughout the day. Ghrelin, which promotes hunger, increases through the night, and then peaks before each meal. The more one sleeps, the less hunger one experiences. On the contrary, sleep deprivation increases ghrelin and decreases leptin, which promotes weight gain. Sleep deprivation induces an increase in intake of 350 to 500 calories per day. Unfortunately, the more overweight the subject, the more the increase in calories consumed is aggravated by sleep deprivation.

Core body temperature also varies with circadian rhythm. By around midnight, core temperature decreases by 1.5-2 degrees F. The drop in temperature promotes the onset of slow wave sleep, and this may be manipulated to induce sleep. For instance, increasing peripheral body temperature,

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which lowers core temperature, promotes sleep. So, a quick hot shower before bed makes you sleepy, but a 20-minute hot bath tends to produce the opposite effect due to the accompanying core body temperature elevation. Even wearing socks promotes sleep by lowering core temperature. There is some suggestion that benzodiazepines promote sleep, in part, by lowering body temperature.

Neurocognitive performance varies with core body temperature. Numerous studies support the finding that higher core body temperature increases cognitive performance. Studies in which school times are shifted to later in the day have shown improved academic performance. Other studies show that even one hour of sleep deprivation decreases measurably cognitive performance. Obstructive sleep apnea in children decreases academic performance, and even just snoring is associated with academic delays. In animals, sleep deprivation causes increased neuron loss in the hippocampus and the prefrontal cortex.

In addition to the circadian controlled physiologic functions, sleep is entwined in the regulation of other functions. For instance, plasma growth hormone levels peaks during sleep. Process S controls growth hormone, meaning the peak only occurs during sleep, not according to circadian rhythms. Immunological memory is also affected by sleep, as antibody titers following inoculation were much lower when subjects were sleep deprived.

Other functions depend on the phase of sleep. For instance, during non-REM sleep parasympathetic activity is increased, blood flow is decreased and sexual functioning is suppressed. The opposite is true of REM sleep, when sympathetic activity is increased. So, nocturnal asthma is an issue for some as non-REM sleep promotes asthma.

Sleep Physiology and Neuropsychiatric Disorders

Because of the role that sleep plays in regulating physiologic properties, especially neurocognitive functioning, the detection of sleep disorders is an important part of the care of children and adolescents. The bias of the phrase, "Sleeping like a baby," is not born out by research: up to 50% of preschool children, 25% of school age children, and up to 40% of adolescents will experience a sleep problem. Development of the BEARS questionnaire has been shown to double the rate of sleep disorders identified over regular clinical exams. BEARS is an acronym for Bedtime problems, Excessive daytime sleepiness, Awakening at night, Regularity of the time of sleep onset and awakening, and Snorning or other sleep related breathing problems.

Snoring is correlated with obstructive sleep apnea. Detecting sleep apnea is important because the arousals interfere with sleep cycles, and the catecholamine bursts throughout the night and day result in chronic increases in blood pressure, increasing the risk of heart attack and stroke. The di-

agnosis is also important to make because the treatments for sleep apnea are specific to the pathophysiology of the disorder. CPAP machines and surgery may be necessary. Other interventions include sleeping on one's side and avoiding sedative medications that interfere with arousal during periods of hypoxemia.

Non-REM parasomnias are also common during childhood. Episodes consist of confusional arousals and somnambulism. They occur during deep sleep, and last between one and twenty minutes. It is difficult to arouse the patient during the episode, and there is a high potential for injury while in this confused state. Afterward, the subject has no recall for the episode, and any violent behavior that ensued is not likely to be repeated. Interventions include avoiding sleep deprivation (which makes episodes more likely), and avoiding disruptions to sleep such as loud noises. It is wise to limit fluid intake prior to bed, as the urge to urinate can disrupt sleep and cause a confusional episode. It is also wise to safeguard the home as much as possible, for example keeping windows locked, safeguarding staircases, and sequestering lethal objects. Pharmacologically, benzodiazepines and tricyclic antidepressants both interfere with slow wave sleep and may be helpful.

Promoting sleep hygiene is often recommended, but Dr. Shatkin pointed out that it has not really been validated. The first step in assuring proper sleep hygiene is to educate the patient that some arousals during the night are part of normal sleep cycles. Other elements include establishing a regular sleep/wake cycle, exercising daily (but finishing exercise at least 4 hours before sleep), and avoiding caffeine, cigarettes, alcohol and any other drugs for at least 6 hours before sleep. A half-ounce of alcohol before bed is sleep promoting, but more alcohol will decrease restorative, deep sleep. A relaxing bedtime ritual is recommended while avoiding light sources, such as television or other screens, once settling down for sleep. Light interferes with the secretion of melatonin, which helps maintain sleep. In general, the patient's bed should only be used for sleep, and if appropriate, sexual activity.

No medications have been approved for use in adolescent insomnia. Many non-benzodiazepine hypnotics used in adults affect memory only, so people simply feel rested upon arising because they do not remember their arousals and believe that their sleep was better. Dr. Slatkin encourages the use of melatonin, starting at 3 mgs per night, and increasing up to 6 or 9 mgs as needed. Valerian may also be sleep-promoting, as can chamomile tea, or a small meal before bed.

Sleep problems commonly occur in patients with psychiatric disorders. Children with Attention Deficit Hyperactivity Disorder are five times more likely to have all forms of sleep disorders. They have difficulty falling asleep, their

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sleep is more fitful, they are harder to arouse, and they are more likely to snore. Enforcing sleep hygiene is important. Less stimulant medication should be used late in the day, although small doses at night may be sleep-promoting. Changing from stimulants to Atomoxetine may also be beneficial if sleep problems persist in children with ADHD.

90% of children with Pervasive Developmental Disorder have some sleep problems. Since they are not so tied into social cues, they miss the cues for effective sleep hygiene. Bright light therapy in morning and melatonin in the afternoon have been shown to help. Pharmacological grades of melatonin might be ordered on line.

Sleep problems are both a common consequence of mood disorders, and a clinical marker for mood disorders. Adolescents with sleep problems are much more likely to have mood disorders, as well as to use caffeine, nicotine and al-

cohol. Sleep problems are common in adolescents with depression, including up to 50% of depressed adolescents who report early morning waking. Adults with depression experience reduced REM latency, more time in REM sleep and a shifting of REM sleep to earlier in the sleep cycle. Treatment of the primary mood and anxiety disorders is recommended, as there are no clear data showing benefit of treating sleep problems independently. Studies with adults have made it abundantly clear that promoting sleep is therapeutic in mania, and Dr. Shatkin opined that this was likely the case for manic adolescents as well.

An understanding of normal sleep physiology is an important component of sound psychiatric care. Sleep disorders occur commonly in psychiatric patients, and no less so in adolescent patients. The effective management of sleep problems will facilitate effective care for our patients.



Long Time ASAP members Richard Ratner and Richard Rosner

Early Intervention in Prodromal Schizophrenia— Ground-Breaking Prevention or Waste of Time?

Lois T. Flaherty, M. D., Editor-in-Chief, *Adolescent Psychiatry*



It has long been known that symptoms precede the onset of overt schizophrenic psychosis by a considerable period of time, often many years. The Israeli High Risk Study, an early study of risk children born to a parent with schizophrenia found that the mean age of onset of first symptoms was about age 14, seven years earlier than overt psychosis¹. And in June, a meta-analysis by an international group of researchers confirmed that the prodrome is associated with significant cognitive impairment. (Fusar-Poli et al., 2012). Thus early detection and intervention that could prevent this devastating illness makes sense.

In recent years, there have been a number of very promising interventions, and the practice of early detection and intervention has been adopted on a community-wide basis in many parts of the world, most notably the U.K. and Australia. At a keynote speech at the ISAPP meeting last fall, Patrick McGorry, a leading advocate of early intervention, stated that we now have the knowledge that early intervention works, and the means to implement it; all that remains is to do it. While early intervention may involve treatment with antipsychotic medications, more often it involves patient and family psychoeducation, supportive psychotherapy, and cognitive behavioral approaches.

The topic of early detection and intervention in prodromal psychotic states was the subject of a special issue of *Adolescent Psychiatry* published in April 2012². Researchers from various programs that part of a multisite study in the U.S. funded by the Robert Wood Johnson Foundation reviewed the methodology and efficacy of early intervention and presented compelling arguments for it to be generally implemented.

Soon afterwards, an article appeared in the *British Journal of Medicine* that questioned the wisdom of trying to intervene in early stages of psychosis. Commenting on this article for *Psychiatric Times*, Allan Francis asserted that the issue was settled once and for all, and confirmed the wisdom of the APA's decision to demote prodromal psychosis from the proposed DSM V listings to a special section for conditions needing further study. So, who is right?

The BMJ article seemed to show that the risks and costs of incorrectly identifying and treating people who were never destined to develop psychosis outweighed the possible benefits. The study, which is freely available on PubMed Central, (Morrison et al., 2012) was aimed at determining “whether cognitive therapy is effective in preventing the worsening of emerging psychotic symptoms experienced by help seeking young people deemed to be at risk for serious conditions such as schizophrenia.” It utilized 288 participants aged 14-35 years who presented to 5 clinical sites within the UK for treatment. The participants were randomized

into two groups, one of whom received cognitive therapy plus “monitoring of their mental state,” while the other group received monitoring of their mental state only. In both groups, which were followed from 12-24 months, the rate of conversion to psychosis was quite low, averaging only 8% for the whole group, and did not differ significantly between the two groups. The individuals who received cognitive therapy did show a reduction in severity of their psychotic symptoms.

However, critics of this study (and there were many) pointed out that the exclusion criteria used were such that many people who might have been at the highest risk were not included in the study, and thus it comprised a relatively low risk group. (For example, people who did not seek treatment but had prodromal symptoms might have been in worse shape than those who were concerned about their symptoms.) Furthermore, the intervention of monitoring of mental state provided to the control group may have been an active intervention.

A fairly recently published Cochrane Systematic Database Review of early intervention in psychosis (Marshall & Rathbone, 2011) found that there were too few studies of prodromal states (as opposed to first episode psychosis) for proper meta-analysis. They noted that many of the trials were small and done by “pioneering researchers.” They did note, however, that taken as a whole, the approach held promise, and urged further studies. They concluded:

There is emerging, but as yet inconclusive evidence, to suggest that people in the prodrome of psychosis can be helped by some interventions. There is some support for specialised early intervention services, but further trials would be desirable, and there is a question of whether gains are maintained. There is some support for phase-specific treatment focused on employment and family therapy, but again, this needs replicating with larger and longer trials.

So the final answers are not in. But this is a field that is advancing rapidly and I think we are likely to see major breakthroughs in the coming decade. Not too long ago, clinicians hesitated to share their diagnostic findings with patients and families—especially with respect to psychotic illnesses—the term “adjustment disorder” was overused, and the symptoms were unacknowledged or minimized. The patients and families who told their stories in a series of first person accounts in the special issue of *Adolescent Psychiatry* all reported a sense of relief when their condition was finally correctly diagnosed—often after an extensive process of alliance formation with the mental health professionals involved in their treatment. I think they would be the first to say that obfuscation is not helpful,

¹ The initial reports from this study were published in a special issue of the *Schizophrenia Bulletin* (Volume 11, issue 1) in 1985, and follow-up work appeared in the same journal in 1995. All of the articles in these issues are freely available in PubMed Central ©.

² To read the editorial, Table of Contents and Abstracts of this issue, go to <http://benthamscience.com/contents-JCode-APS-Vol-00000002-Iss-00000002.htm>

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and being able to give a name to what is wrong, and a roadmap of what to do about it, is very helpful. They would agree with the designation prodromal psychosis. Others worry about unnecessary treatment and stigmatization. I think both concerns are warranted, but in my experience prodromal states are under diagnosed rather than over diagnosed.

The DSM is designed to serve many stakeholders—patients, clinicians, researchers, administrators, and policy makers. It is unlikely any diagnostic system could adequately address the needs of each of these groups. While the DSM is not designed to serve the needs of pharmaceutical manufacturers, they are the elephant in the room, as many of the controversial proposed changes may have consequences (unanticipated or not) on prescribing patterns of psychotropic medications. The controversy over prodromal psychosis is just one of many going on. Stay tuned during the next year.

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In Memoriam



Irving Berkovitz, M.D.

By Sheldon Glass, M.D.



Dr. Irving K. Berkovitz ("Irv"), a long time member of ASAP died on May 27, 2012 at the age of 87. Irv attended Harvard University, served in World War II and attended Boston University Medical School. He taught and supervised at UCLA Neuropsychiatric Institute. He made major contributions to school mental health. He served on the APA task force for school mental health. He was the senior consultant for schools at the Los Angeles County Department of Mental Health. His several professional publications included "Adolescents Grow in Groups: Exercises in Adolescent Group Psychotherapy," "Expanding Mental Health Interventions in Schools," and "When Schools Care: Creative Use of Groups in Secondary Schools." Irv was a respected colleague who made significant contributions, and will be missed.



Charles McCafferty, M.D.

by Lois Flaherty, M.D.



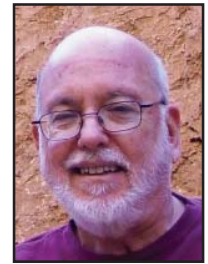
Former ASAP President Charles McCafferty, M. D., of St. Paul, Minnesota, died on May 7 at the age of 76, leaving his wife, Norah, sons Sean, Michael, and Emmet and daughters Patricia (a psychiatrist) and Bridget. ASAP members will remember Charlie's jovial presence at our meetings. John and I will always remember sailing with him and Sean on a Catalina 42 to (fittingly) Catalina Island during one of our meetings. After staying overnight, we sailed back to San Diego, and were joined by Bobby Roddy; we all stayed on the boat during the meeting, which was at a nearby Marriot in San Diego. Born in Derry, Ireland, Charlie attended medical school and completed his internship in Belfast, then came to the Mayo Clinic for psychiatry training and remained in Minnesota where he practiced for nearly 50 years. Charlie's Irish connections always remained strong, along with his brogue and gift for storytelling.

APA DOINGS...

from the 165th Annual Meeting of the APA

By

Richard Ratner, MD



Greetings again from the floor of the APA Assembly, which meets the three days preceding the APA Scientific meeting, this time in Philadelphia, Pennsylvania over the first weekend in May. To remind, the Assembly is the vox populi of the APA, a mainly geographically-represented group of delegates along with some representing other groups, such as minority & underrepresented members as well as affiliated organizations such as ASAP. The main frustration over many years has been the perception that the Board of Trustees, which represents the APA's ultimate power, tends to ignore the Assembly when it wants to, and accordingly many techniques have been applied to coax it to pay more attention to us.

Most years seem to have some major issues that come to characterize the Assembly proceedings. This year the major ones were more or less continuations of issues that have preoccupied the past couple: MOC (maintenance of certification), DSM 5, the wisdom of having excluded pharmaceutical industry sponsors from their former large role in the scientific portions of the meeting, and the short & intermediate term concerns about individual and organizational finances. In addition this year, our representative to the codes and reimbursements panel announced that Medicare will likely be eliminating most of the 908-- codes that many of us use by January, 2013. Instead, members will need to utilize the E&M (Evaluation and Management) codes. It is expected that the private insurance carriers will soon follow suit.

MOC

As reported in the past, many people (mainly old-timers it seems) are unhappy about the portion of the new MOC requirement termed "PIP" (performance in practice), and their main upset is regarding the portion of this module that calls for getting feedback from patients. A major ethical concern is the notion that one could be seen as using the patient for one's own ends. Those of us who still believe in the concept of transference and attend to the notion of how power is distributed in a doctor patient relationship are distressed that in cases where such 'feedback' must be secured, the relationship will be up-ended to the detriment of the therapeutic alliance.

Because of a failed referendum in which the APA would have taken a stand against the current MOC structure, some initiatives have come about to change the way such votes are

scored - in essence making it easier for them to be passed. While that referendum had garnered 80% approval, it failed because fewer than 40% of voting members had weighed in (existing rules). In light of the fact that the number of APA members voting in general elections has fallen over the past few years from more than 33% to less than 20%, an action paper proposed changing the rules so that passage could be assured by a 2/3rds majority of at least 15% of the membership. This was passed by the Assembly and will go to the Board of Trustees for consideration.

In the meantime, American Psychiatric Publishing, Inc. has agreed to distribute, free as a member benefit, the materials published in its journal *Focus* regarding how to properly meet the MOC PIP requirements. This decision resulted from an earlier Assembly action paper; consequently the Assembly has passed another requesting that the entire *Focus* journal be made available as an included member benefit free so as to help members succeed with the substantive (CME) parts of the re-certification process.

DSM 5

DSM 5 continued to generate much interest and surfaced in reports to the Assembly by David Kupfer as well as in an Assembly committee monitoring DSM 5 developments. Major criticisms include the integration of the Autistic Disorder diagnosis into an "autism spectrum", the addition of diagnoses that could be seen to pathologize conditions that are not yet, or shouldn't be, diagnosable mental disorders such as bereavement, and the personality disorders overhaul that eliminates some and introduces cross-cutting dimensional factors. The DSM 5 field trials have been completed, and a final draft will be sent to the Assembly for the fall meeting. DSM 5 should officially debut at the annual meeting in San Francisco next May. I should mention that DSM 5 will do away with Axes II and III; all of these diagnoses will now appear on Axis I.

Pharma

As to the continuing debate over the role of the pharmaceutical industry at the meetings, an action paper to return the industry supported symposia that were a big part of the APA scientific meetings just a few years ago was introduced. It pointed out that attendance at the meetings had dropped

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significantly since the symposia were discontinued and that the principal competitive meeting, the US Psychiatric Congress, had neither registered such a drop-off nor ones as large as the last two APA meetings. The coincidental drop-off in attendance by foreign psychiatrists was noted, relating possibly to what was suspected unofficially, e.g. that Pharma companies had previously paid travel and registration expenses for large numbers of international attendees. I was told that their only requirement in those days was to attend the sponsored presentations and when these were eliminated, the companies probably saw no reason to continue this expenditure for purely altruistic reasons. The action paper went down by a very substantial margin, however. I think that if he approached it differently, e.g. suggesting a task force to re-examine whether there could be any areas in which cooperation could be reinstated, sufficient Assembly delegates might support that.

Organizational and Individual Finances

The APA lost around \$300K this past year based on lost revenue from its meetings and from sales of DSM IV, which will soon be obsolete. Also, the membership is aging, with 21% age 71 and over, and membership has continued to decline with consequently less revenue in membership fees. Despite all this, improvements in investments, continued advertising revenues, and careful budgeting have left the organization in better shape than it has been for some time.

The advent of DSM 5 is anticipated with barely restrained enthusiasm, not only for its intrinsic value but also because it is expected to bring in a huge new revenue stream to the APA's coffers. This may allow some more innovative approaches to retaining and bringing in new members, conceivably even involving a dues reduction (but you didn't hear that from me).

As to members' own future financial health, the APA has been busy lobbying on issues of importance, including continuing to fight for parity and for increased Medicaid reimbursement. A number of colleagues are in the forefront of trying to integrate psychiatry into primary care settings. There is also the sense that telepsychiatry may be about to come of age; one of my colleagues appears to have been successful setting up a commercial venture whereby his group has contracts with many far-flung settings where his doctors supply psychiatric services via tele-link.

Finally, a potpourri of other action papers were passed including, for example, advocating for insurance reimbursement for urine drug screening; distributing APA course materials to members after meetings; and calling on APA to lobby to reduce deductibles for persons with serious mental illnesses. Also, new officers of the Assembly were elected. Mindy Young, previously Recorder, has risen to Speaker-Elect (Scott Benson is now the Speaker), and Jenny Boyer is now Recorder-Elect.

After the Assembly, I attended a couple of days worth of the scientific meetings, including the Fonagy lecture noted above as well as some lectures on an Ethics track, and a workshop on bullying put together by AAOL members. The presentations were uniformly excellent. I felt the drug sponsored symposia were always of high quality, but I also feel that the atmosphere is now more serious with fewer people looking to find the presentation that also provides lunch or dinner. On balance, I'd be against bringing back those symposia in the old format but am willing to consider other alternatives.

Thanks for your attention. Another report will be forthcoming after the Fall Assembly meeting in Washington, DC.

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The American Society of Adolescent Psychiatry (ASAP) now has a Facebook page. If you are interested in information about ASAP, please check out our page and "like" or "friend" it! The Facebook page will be a great resource for information about Adolescent Psychiatry, ASAP conferences, ASAP educational training, and membership information. Click the link to visit our page: <https://www.facebook.com/adolpsych>

Book Review Corner:

Autism Spectrum Disorders through the Life Span. Digby Tatum. London, UK: Jessica Kingsley, 2012. 550 pp., \$125, ISBN 978-1-84310-993-8.

Reviewed by Diana Mullis, M.D., Assistant Professor, Medical University of South Carolina, Institute of Psychiatry, Charleston, South Carolina

Autism Spectrum Disorders through the Life Span was written by Digby Tatum. The author is an internationally recognized expert and has spent 30 years doing clinical work with adolescents and adults that have Autism Spectrum Disorders (ASD). The author's stated intent and purpose of writing this book was to discuss the sciences that are basic to the understanding of ASD and to provide a detailed clinical overview. The book is comprehensive, well researched, and has an extensive bibliography. I read this book with the interest of acquiring more knowledge about ASD due to the increasing prevalence of diagnosed cases requiring treatment.

The author presented vast and comprehensive detailed information about ASD throughout the lifespan. In the introduction, he included the historic recognition and development of the diagnoses and changing viewpoints in the medical field regarding these disorders. This was followed by the Part I of the book that addressed neuroanatomy and structural and functional changes in ASD as compared to normal function. Part II addressed the clinical aspects of autistic spectrum from infancy to adulthood, criteria for diagnoses, and clinical management. He included discussion about cultural and social economic factors and identified thresholds at which symptoms were considered to be indicative of a disorder. He also described how there are variations in thresholds based on cultural differences and social economic status.

The book contained information about numerous areas of brain abnormalities that have been found on scans of people with ASD. Included were discussions about the theories of anatomical, genetic, developmental and environmental factors that could be causing the ASD. The author indicated that more research and clinical data will be needed in order to determine brain and genetic abnormalities that might become defined as pathogenomic for ASD, but stated and supported his opinion that autism is a disorder of nonverbal communication. He discussed that unusual brain disorganization is linked to ASD, and that these disorders are not simply a social construction.

In the chapters on clinical assessments and management, the author included normal development for the different life stages to provide a baseline for comparison of the clinical findings. Also included in these chapters were extensive lists of other neurodevelopmental disorders that should be considered when evaluating for possible ASD. He noted that transitions between life stages are marked by increased referrals for ASD assessments in later stages. These stages often require adaptation which is difficult for people with ASD, and thus resulting in referrals for evaluation.

I found that this book contains extensive information about research on the assessment, diagnosis, treatment, as well as the social and financial impact of ASD. The author comprehensively covered ASD without evidence of bias and my objectives for reading this textbook were met. This book was enjoyable to read and the case examples were excellent. I would highly recommend this book to anyone who is interested in learning more about ASD. This book will likely become a reference for any professional who works with patients that have ASD.

Practical Social Skills for Autism Spectrum Disorders: Designing Child-Specific Interventions, Kathleen Koening (W.W. Norton and Company, 2012) \$32.95 cloth, ISBN number: ISBN-13: 978-0-393-70698-7

Reviewed by: Amy Badding, LMHC, PRT, Mental Health Therapist with Barclay & Associates, P.C., Ames, Iowa

I have worked with children and families in the mental health field for that past 15 years. It seems that more often children/adolescents and their parents enter my office because of ongoing issues with socialization and emotional dysregulation. I am always looking for new resources on how to help the children and families I work with. Dr. Gregory Barclay, the medical director at the group practice I work, came across this new book and asked that I write a review for the ASAP newsletter. I was happy to do this to not only expand my own knowledge, but to help others find a useful resource for their own work with children with an Autism Spectrum Disorder (ASD). I would recommend this book for any professional who works with children and adolescents with ASD. While the book is designed for professionals who have regular daily contact with these youth, many of the interventions

Continued on pg. 12

can be modified for professionals who may only see these patients on a weekly basis.

The book introduces the reader by giving a general description of the three types of ASD: Autism, Asperger's Syndrome, and Pervasive Developmental Disorder. It then outlines social development for a normal developing child as compared to the social development of a child with ASD. The book then talks about evidence based practice and what that means to the professional working with the child. It then discusses integration and how integration is really the key to effective intervention - how can the child use these skills in the school, community, and at home? Before we start to plan goals and interventions, we need to understand the following:

1. The child's learning profile.
2. The family issues.
3. The relevant learning goals for the child.
4. The plan for teaching and generalizing skills.
5. The methods for measuring progress.

Next, it is essential for the team of professionals to assess the child's adaptive and social functioning. Two measures that may be used are: Vineland Adaptive Behavioral Scale (VABS) and Pervasive Developmental Disorders Behavioral Inventory (PDD-BI). The VABS is a reliable and valid measure of adaptive learning for ages 2-90 years of age. The PDD-BI is also a reliable and valid instrument that focuses on the core deficits as well as the behavior challenges. Both instruments allow professionals to understand the child's day to day functioning.

Once a thorough assessment is complete, the book then goes into further detail on intervention strategies to promote social development. It outlines an intervention for a specific

goal, then gives sequential steps on how to use the intervention with the child, and finally puts it into perspective with a case example. Strategies outlined in the book are:

- Applied Behavioral Analysis (ABA)
- Visual Strategies and Supports
- Scripts and Role-Play
- Developmental Play Approach
- Video Modeling
- Peer-Mediated Approaches
- Technology-Based Instruction
- Group Social Skills Instruction
- Developing Self-Regulation and Self-Monitoring Strategies
- Cognitive-Behavioral Treatment
- Parent-Delivered Intervention
- Social Stories

Finally, the book stresses the importance of collaborative efforts when assisting the child with ASD. This type of work can be exhausting for everyone involved. The book talks about how "burn out" among these professionals can occur due to limited support from school administration, conflicts between other professionals, time and paperwork pressures, and expectations from parents and others to do the impossible. Also, parents of the child with ASD often come in with their own issues of family conflict, grieving the loss of a normal child, as well as dealing with their own mental health issues of stress, anxiety, guilt, and depression. If a supportive team works together many of these issues can be resolved so the team can remain focused on the child's needs.

In conclusion, I would highly recommend this book to professionals who want to learn effective strategies when working with children, adolescents, and families who have been diagnosed with an Autism Spectrum Disorder.

From Our Members...

Doris Soghor, M.D. has retired as Medical Director, Juvenile Justice Mental Health, for Los Angeles County Department of Mental Health after 40 years of service. Congratulations, Dr. Soghor, on your retirement!

Photo Gallery



ASAP Governing Board members Jesse Raley and Gregg Dwyer



David Sharer and ASAP Past President Perry Bach



ASAP members Saleem Khan, Steve Jaffe, Dorothea DeGutis



ASAP Governing Board Member Manny Lopez-Leon, aka proud dad



ASAP Past Presidents Robert Weinstock and Perry Bach



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ASAP members Jenna Berman and Gene Jacobs

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