



# american society for adolescent psychiatry

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

**Summer 2013**

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## FROM THE PRESIDENT R. GREGG DWYER, M.D., Ed.D.

With spring ending and summer upon us I hope everyone has had an enjoyable year thus far. Spring represents that time of year when there is growth, renewal, beginnings, and moving forward. It is a perfect analogy, as ASAP is evolving to remain a viable entity able to serve and represent at the national level those clinicians whose primary or exclusive client base is adolescents. Our growth is targeted at expanding physician membership and increasing the breadth of our membership to other disciplines. To that end we must increase the value of membership. Building on the efforts started during the previous year, we have recently made several steps forward along this path.



The formal and informal feedback from the 2013 ASAP conference in Charleston was overall very positive. Although 61% of attendees were physicians, we also had psychologists, social workers, and counselors present, which was a goal of this year's conference. I am hoping we will continue to attract other mental health disciplines to both our future conferences and our membership. Being able to offer CEUs for these other professions for the first time is most likely a factor in both. Discussions continue between the ASAP Governing Board and the CME/CEU staff at the Medical University of South Carolina Department of Psychiatry and Behavioral Sciences with hopes of establishing an ongoing relationship enabling ASAP to award continuing education credits across multiple disciplines as a benefit to membership and attendance at our annual conferences. Associated with the education credits are plans to expand the interactive capacity of the ASAP website to allow for the earning of CME credits online as an exclusive ASAP membership benefit. This will be a useful option for those current members who cannot attend a particular conference and, ideally, an attractive reason for others to join our organization. There are other plans for the revised website to include a publicly accessible referral database composed of members as another benefit for clinicians who join and maintain membership in ASAP. Plans are also underway to re-develop a path towards ASAP-sponsored additional certification in Adolescent Psychiatry linked to practice focus and completion of annual meeting-linked core education programming.

I urge all to submit your suggestions for increasing our membership roll, new benefits to consider developing for members, and options for improving our existing services to ASAP governing board members. This is an exciting time for us as an organization and as individual members with multiple new benefits in place and on the horizon. Welcome to ASAP's renewal, growth, and moving forward!

**R. Gregg Dwyer, M.D., Ed.D.**  
ASAP President

**ASAP Web Site:** <http://www.adolpsych.org> • e-mail: [adpsych@aol.com](mailto:adpsych@aol.com)

### Mark Your Calendar

The 2014 ASAP annual meeting will take place in Baltimore, Maryland March 28-30, 2014. The theme of the 3-day conference will be "The Review and Update of Adolescent Psychiatry in the 21st Century". The return to a 3-day format will allow for enhanced CME credits.

Sheldon Glass, M.D.  
Program Chair



### 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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## From the Editor

Gregory P. Barclay, M.D., Editor

### *Reflections on San Francisco's 2013 APA Meeting*

In May I attended my first APA meeting in 19 years. My wife and I honeymooned in San Francisco that very weekend in 1984 and had never been back. When we saw that the annual APA meeting would be held there this year, we decided to return there for a time of reminiscence together, now through the eyes of middle-aged adults instead of love-struck young newlyweds, while I attended the APA Assembly and some educational seminars.



I remember my last APA meeting, in Philadelphia in 1994. I had attended to sit for the examination for board certification in Adolescent Psychiatry. This was back in the days when the examination was newly offered as a legitimate pathway to recognition through board certification as a specialist in adolescent psychiatry. As many of you know, in the 1980s ASAP spawned the American Board of Adolescent Psychiatry, which developed its own board certification process, involving a written and oral examination modeled on that of the general psychiatry examination of the American Board of Medical Specialties. Over 500 diplomates were certified by this process, and most of those have been recertified as required. While we now have come to accept the fact that board certification in Adolescent Psychiatry under the auspices of the ABMS, as we originally envisioned, will never come to pass, plans are currently underway to develop an alternative process for an ASAP-sponsored Certification in Adolescent Psychiatry. This process will allow current diplomates to continue to be recertified and new certificates to be issued to qualified individuals wishing certification.

While at that Philadelphia meeting, however, I was struck by the glitz and "free" food of the "industry-sponsored symposia" and the at times noxious influence of the ever-present pharmaceutical industry. All of us recall that the 1990's was the heyday of APA's enmeshment with big Pharma. I also recall the contrast on the streets outside the convention center, where vocal demonstrators chanted and rallied against "psychiatry's drugging of the mentally ill". Now, almost 20 years later, and a few years after APA divorced itself from big Pharma, I was curious to see how things might be different in San Francisco.

Ironically, I began reading E. Fuller Torrey's book The Insanity Offense while on the flights from Iowa to San Francisco, a sobering and sometimes gripping account of the plight of the homeless mentally ill, most notably in California (Please see my review of the book in our book review corner). As we stepped off the BART train near our downtown hotel, luggage in hand, and ascended the stairs to street level (the escalator and elevators were not working), we saw for ourselves right up front and close evidence of what Dr. Torrey described. Throughout much of the downtown area, there were homeless people, many of them obviously schizophrenic, many begging while others were picking through garbage cans in broad daylight, most sleeping on the streets or in alleys. This was a sharp contrast to the San Francisco I last saw in 1984, the result of 30 years of deinstitutionalization, civil rights legislation, and endless cuts in public funding for care to the

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severely and persistently mentally ill.

Meanwhile, those of us attending the APA convention walked the same streets, carrying our APA tote bags and many sporting their name tags while blocks from the Moscone Center, eating at nice restaurants and staying at nice hotels and viewing the city sights, which incidentally were especially nice due to perfect weather conditions. The contrast was stunning – here among the marginalized and ignored severely mentally ill on the streets we all were while attending the annual meeting of the organization representing those whose job it is to care for them, yet were unable or unwilling to do so because of a combination of sociocultural and economic factors. APA, being the largest organization representing American Psychiatry is certainly in a position to lobby on behalf of funding and effective treatments for the homeless mentally ill and perhaps that is a reason enough, although there are many other benefits as well, to become or remain an APA member. As I walked the convention center, it was obvious that the role of Big Pharma has been reduced considerably and gone were the industry-sponsored symposia or other “free” handouts so available in earlier times. In spite of this controversial divorce, the convention exhibit center seemed much more relaxed and less overwhelming than in the past.

Outside the convention center, along with the masses of homeless chronically mentally ill residents, I also encountered the “anti-psychiatry” demonstrations similar to what I had seen in Philadelphia in 1994. Across the street in a park, an anti-psychiatry organization had erected a large set of billboards with facts and figures with regard to the alleged overuse of psychiatric

medications, in particular among children. After being on the streets, seeing the demonstrations, and also knowing from years of experience as a consultant and reviewer that American psychiatry is guilty of over-reliance on psychiatric medications to the exclusion of other treatments, I had a momentary impulse to take off my name tag and join in with the demonstrations. While I did not do that, I did debate the positions held by several of them who portrayed us as wearing trench coats and grabbing children off the streets to medicate them for our own gratification, overlooking the fact that most patients, parents, and referring therapists expect that we prescribe and generally ask us for medications. I don’t know if it made any difference, but I felt better. One of ASAP’s attributes that has kept me involved has been its balanced perspective with regard to the biopsychosocial model which is reflected in our annual meetings, and our willingness to take an advocacy role (see, for example, Dr. DeCrise’s Right to Privacy article in this newsletter).

I am now curious as to what it will be like at my next APA convention, which given my pattern of attendance could be another 20 years from now when I am retired. I wonder if we, as organized psychiatry, will have made any progress with regard to influencing the factors that limit our ability to effectively treat the chronically and pervasively mentally ill of our society through advocacy for effective funding and treatments as well as challenging the laws that prevent or limit involuntary treatment. The chronically and pervasively mentally ill will still be among us and it will be interesting to see if they are still on the streets and we will still be looking the other way.



ASAP members Gregory Bunt, M.D. and Richard Ratner, M.D., join Frances Bell and Sally Barclay while at APA.



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## Right to Privacy in Disclosure of Sexual Orientation in Adolescents. United States 5th Circuit Court of Appeals; Wyatt v Fletcher and Newell.

Summarized by ASAP Past President, Dean De Crisce, M.D.

The American Society for Adolescent Psychiatry affirmed support as Amicus Curiae, along with the National Association of Social Workers, the National Association of School Psychologists and the American Academy of Child and Adolescent Psychiatry in a case recently heard before the United States Fifth Circuit Court of Appeals (No. 11-41359).

In Wyatt v Fletcher and Newell, the Appellee is represented by Winston and Strawn LLP; the case results from an appeal regarding the Civil Action suit (No. 6:10-cv-674) heard in the United States District Court for the Tyler Division of Texas by Magistrate Judge John Love. In brief, the case maintains that faculty disclosed information regarding the sexual orientation of SW to her mother, against her wishes, and in so doing, violated her right to privacy and placed her at risk for adverse outcomes.

The emotionally charged Amicus brief begins by bringing a number of examples in which extreme family and community responses have resulted from identifying an adolescent or young adult as gay, lesbian, bisexual or transgendered (LGBT). Examples included family rejection, beatings, and even tortuous, religious “conversion” therapies. The brief argues that these responses are not unusual, with accompanying harassment and physical violence towards lesbian, gay, bisexual and transgendered youth. Mistreatment and marginalization comes not only from peers, but also from parents, community leaders and school officials. A published article in Pediatrics is referenced in which “thirty percent suffer violence after ‘coming out’” (Himmelstein & Bruckner, Pediatrics, 2011, 127:49). Family rejection of these youth is estimated to be approximately fifty percent.

Adolescents often reveal their sexual orientation to others, prior to informing their families, if at all, as the result of perceived or actual negative outcomes. “The quality of life of many same sex attracted young people is compromised by hostility, invisibility and alienation in their daily lives” (Hiller & Rosenthal, J Adolescence, 2001, 24:1). The brief argues that such negative effects including rejection, taunting, and substance abuse can be persistent.

Therefore, “the right not to have intimate facts concerning one’s life disclosed without one’s consent...

is a venerable one” that should be protected and recognized. Sexual orientation is seen to fall under “intimate facts.” Various prior Supreme Court and Appellate Court decisions are cited to support Fourteenth Amendment ‘right(s) to privacy,’ an individual’s ‘interest in avoiding disclosure of personal matters,’ and protection against the ‘disclosure of personal information in ways that would embarrass or otherwise compromise the individual concerned.’ As to the inclusion of sexual orientation under ‘personal matters,’ Sterling, 232 F.3d at 196 states “[i]t is difficult to imagine a more private matter than one’s sexuality.”

In this particular case, the specific details of SW are not discussed. It is alleged that the Appellants Fletcher and Newell pressured SW (“fearfully, against her wishes”) to reveal personal information, which was then relayed to her mother. Her relationship with her family was strained; she was ostracized, and began displaying problematic behaviors, cited as cutting, truancy, and suicidality. “After she was outed, SW’s previously high standardized test scores dropped noticeably, she failed a class, and she reported that her career hopes had been dashed.”

The brief asserts that the Appellants violated SW’s right to informational privacy when they disclosed her sexual orientation to her mother without consent. Her youthful status does not diminish her rights to this privacy, in fact, it is argued, her young age makes her particularly vulnerable to adverse reactions to her sexual orientation both within the family unit, as well as within the school environment. The argument in this case is summarized as i) failure to maintain right to privacy, and ii) disclosure of information that could lead to bodily or psychological harm.

The brief urges the court to reaffirm the right of minors to informational privacy regarding their sexual orientation. Again, decisions are cited in various jurisdictions to support that “the privacy right at issue here-informational privacy in one’s sexual orientation-is not new, nor is its protection a novel application of constitutional jurisprudence...all three Court of Appeals to have directly considered the issue (general right to



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privacy) have found that the constitutional right to informational privacy extends to minors as well,' although the context of sexual orientation had not previously been specifically considered.

Youth are uniquely vulnerable to adverse outcomes as the result of disclosure of sexual orientation. They are likely to suffer family victimization and adverse educational outcomes. In the case of SW, "lesbians are most vulnerable to threats of, and actual physical abuse at the hands of their parents" (Ryan et.al, Pediatrics, 2009, 123:346). In fact, families may respond negatively to mere suspicions that their child may have a LGBT sexual orientation. Conversely, there was "virtually no incidence of attack among the non-disclosed" (D'Augelli et. al., Am J Orthopsychiatry, 1998, 68:361).

Long term sequelae of parental rejection are associated with psychiatric disorders in approximately a third of vulnerable LGBT teens (Mustanski et. al., Am J Pub Health, 2010, 100:2426). "LGBT youth, particularly those whose orientations have been disclosed to their families, are also much more likely than their peers to attempt suicide" (Hatzenbuehler Pediatrics, 2011, 127:896). Literature is cited to demonstrate increased incidences of substance abuse, depression, high risk behaviors, and relationship problems in LGBT youth who have had their sexual orientation revealed to family.

Youth also suffer negative outcomes as the result of revealing a LGBT orientation to peers, such as harassment, threats, and assaults. "The more open youths were about sexual orientation in high school, the more they were victimized" (D'Augelli et.al, Sch Psychol Q, 2002, 17:148). Such chronic harassment is associated with various disorders, social withdrawal, low self-esteem, and poor academic performance.

Furthermore, enforcement of the right to informational privacy for adolescents can reduce negative outcomes. The brief asserts that failing to afford LGBT youth the right to conceal their sexual orientation from these early stages of their sexual development, exposes vulnerable minors to victimization for long periods of time that may interfere with their educational progression, and personal safety. "Recognition of students' rights to informational privacy here-and the acknowledgement that SW and other minors have a clearly established right to informational privacy generally-undoubtedly will markedly reduce the above discussed health, academic, and social disparities experienced in the future by the population of youths who are actually LGBT or perceived to be LGBT."

It is acknowledged that privacy interest is limited in a public school setting where there is a State obligation

to maintain "discipline, health, and safety." However it is argued that informational privacy in this regards improves the health and safety of vulnerable LGBT youth. "Enforcing LGBT youth's right to disclose or not disclose sensitive personal information about their sexual orientations where no legitimate reason for its disclosure by school officials exists may reduce the risks that such youths will experience significant damaging harms at the hands of families, peers and even themselves." Such a confidentiality that respects personal information fosters an environment in which help and support will be sought from faculty and staff when needed.

Additional statements by Amici Curiae are as follows:

The National Association of Social Workers "supports the right of the individual to self-disclose, or to not self-disclose, sexual orientation for lesbian, gay, and bisexual clients and colleagues."

The National Association of School Psychologists, "embraces and respects diversity at all levels and aims to enhance its responsiveness to populations whose diversity may be expressed in terms of race, ethnicity, gender, and gender expression, sexual orientation, socioeconomic status, ability, religion, and/or language. NASP supports equal opportunities for all youth to participate in and benefit from school-based educational and mental health services regardless of sexual orientation, gender identity, or gender expression."

The American Society for Adolescent Psychiatry has "worked on various issues of concern to lesbian, gay, bisexual and transgendered adolescents including bullying, therapeutic interventions in family rejection of LGBT youth, and same sex parenting. ASAP recognizes the importance of sexuality in adolescent development, the particular need for sensitivity in issues of confidentiality, and the right of youth to supportive and accepting environments."

Finally, the American Academy of Child and Adolescent Psychiatry recognizes that "telling a person's sexuality before they are ready...can be traumatic and takes the position that gay, lesbian, or bisexual adolescents should be allowed to decide when and to whom to disclose their homosexuality."

Unfortunately, on May 31, 2013 the Fifth Circuit Court issued an opinion in this matter, and the result was unfavorable. The Court concluded that there is no clearly established law holding that a student in a public secondary school has a privacy right that precludes school officials from discussing the student's "private sexual matters" with a parent.

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## From the 2013 Annual Meeting...

### “The Impact of Sexual Abuse on Children: Effective Responses”

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

At the 2013 meeting, Ben Saunders, Ph.D. spoke about the impact of sexual abuse on children. He started by showing a picture of two boys carrying a girl, who was intoxicated to unconsciousness. When the girl subsequently reported that she had been raped, the case was not viewed as a clear instance of rape. News correspondents directed attention to the impact of criminal prosecution on the perpetrators. Dr. Saunders asserted that, although child sexual abuse is universally considered abhorrent, controversy arises when the details of a case are considered.

Common responses include disbelief and victim-blame. For instance, in the case above, the victim's intoxication was referred to in almost every news piece covering it. Often blame turns to degradation, impugning the character of the victim, as well as the victim's behavior. Another response is to explain the sexual assault on the basis of the situation, for instance that the victim attended a party with strangers.

Sexual abuse may be defined in a number of ways. One definition is that the sexual activity is forced or coerced. Coercion includes physical force, threats and both physical and psychological intimidation. The sexual activity must be unwanted, or undertaken without consent. Developmental immaturity can preclude consent, even if the sexual behavior was not clearly unwanted. People with physical or mental disabilities may also lack the capacity to consent to sexual activity. In addition, drugs and alcohol may impair the victim's capacity to consent. This definition of sexual assault is not limited by characteristics of the victim, offender or situation.

Sexual assaults can involve physical contact, most seriously with penetration of the vagina, anus or mouth with a body part of the perpetrator, or with an object. Non-contact sexual offenses include voyeurism and exposure to pornography.

The prevalence of child sexual abuse is difficult to ascertain. The behavior for the most part occurs in secret. Estimates based on police records are low, as only a small fraction of the incidents of sexual abuse are reported to authorities. Victims are often reluctant to disclose the assault. The effect of blaming the victim

in the media is one source of this reluctance. Also, there is a general reluctance to believe victim reports. In addition, young victims may not understand that the behavior bears disclosure. Professionals are reluctant to screen for sexual assault effectively, and they may not be adequately trained in effective screening. There is no ongoing public health effort to track sexual assaults.

Even community victimization surveys are limited in their efficacy. A percentage of cases would not be labeled as abuse by the victim or by the offender. The manner in which the question is asked makes a significant difference in the reported rate of rape. For example, if one asks victims and perpetrators if they have been involved in “rape” a low incidence is reported. However, if asked about having been pressured to engage in a sexual act and then narrowing to the above definition of sexual abuse results in a much higher reported incidence.

The National Survey of Adolescents – Replication found that 11.5% of girls and 3.8% of boys reported at least one incident of sexual assault with physical contact at some time in their lives. Variations by race and nationality were not so wide; however the rate of victimization rose steadily with age among 12 to 17 year-olds. Less than 20% of the perpetrators were strangers. One third of the incidents occurred as a series of offenses by the same offender. 17% of males and 40% of females feared they would be injured or killed at the time of the offense. Less than 30% of the victims indicated that they had reported the incident to the authorities.

The mental health impact of childhood sexual assault is considerable. One in four victims will subsequently meet diagnostic criteria for Post Traumatic Stress Disorder. Over a third of victims experience an episode of depression. Both disorders are five times more likely to occur in victims of sexual abuse than in those who were not abused. Sexual disorders and substance use disorders are more likely, as are delinquent and violent behavior. Other social and emotional sequelae include inappropriate guilt and shame, as victims often describe



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themselves as “damaged goods.” Also, they are less hopeful, and more likely to believe that the world is a dangerous place. Relationship, academic and vocational problems are more common. The rate of suicide attempts among the population of sexually abused children with suicidal ideation is greater than among those with suicidal ideation who were not abused.

Interventions found useful included psychoeducation, in vivo exposure, imaginal exposure and breathing retraining. Cognitive Processing Therapy for Rape Victims (Patricia Resick) is appropriate for adults and older adolescents. Dr. Saunders has found that girls have enjoyed this structured approach. EMDR has demonstrated effectiveness; it entails exposure therapy coupled with “bilateral stimulation.” For younger children, Trauma-Focused CBT has been shown to have high rates of effectiveness. Training is available free on the internet by MUSC ([www.musc.edu](http://www.musc.edu)).

Sexual abuse cannot be completely prevented; however

the incidence can be reduced through appropriate public policies. Increasing the perpetrators’ concern about detection can help. Screening and ongoing training of people volunteering to work with children is one method. Appropriate response to allegations of abuse and questionable behaviors, along with vigorous prosecution of detected incidents are other methods that can enhance deterrence.

Dr. Saunders noted that many factors oppose prevention. Sexual abuse is embarrassing, and people are reluctant to confront it head-on. Fears of offending potential perpetrators, as well as fears of liability to both victims and the accused, inhibit efforts. The lack of clear policies in response to suspicions and training in those policies also make prevention less likely. Dr. Saunders urged policy makers to put the safety of children first and to be proactive in establishing and implementing preventive measures.

### ***From the International Society of Adolescent Psychiatry and Psychology***

By Former ASAP President and ISAPP President-Elect, Lois Flaherty, MD

I am pleased to announce that details about the 2015 Joint ASAP and ISAPP Meeting have been finalized.

The meeting will be June 24-28, 2015 in New York City at the New York Marriott East Side Hotel, 525 Lexington Avenue (<http://www.marriott.com/hotels/travel/nycea-new-york-marriott-east-side/>).

This hotel has an excellent location near Grand Central Station in Manhattan, and is within walking distance to Times Square and other major attractions. Buses and subway are also close by. The hotel is currently being renovated. Frances Bell, our Executive Director, and I have visited it and believe it will provide an outstanding venue for our meeting. Mrs. Bell has negotiated a room rate of \$279 (US) per night, which is an excellent rate for New York. A block of rooms is being held for ISAPP/ASAP attendees. There are other hotel options in the vicinity as well.

We have planned for the meeting to start Thursday morning and go through Sunday afternoon. As has been the case with previous meetings, it will involve a combination of plenary speakers and concurrent sessions as well as posters and exhibits. Gregory Barclay, who will be ASAP President Elect, and I will be jointly planning the program, with the help of a program committee composed of ISAPP and ASAP members. I hope you will consider submitting proposals for presentations at the meeting.

This will be the first joint meeting of ASAP and ISAPP and will follow the tradition being set by the ISAPP meeting in November 21-24 in Ankara, Turkey, which I hope many of you will attend. (see [www.isappregional2013.org/](http://www.isappregional2013.org/) for more information).

I hope I can count on your support for this meeting. As a first step, please begin publicizing it among your friends and colleagues.

Also, I hope I can count on you to help recruit presenters and plan the program. Please send me your suggestions for speakers and topics. And, mark your calendars for the meeting!



## 2013 Annual Meeting



In spite of flooding and gloomy weather, the Sunday meetings went on.



ASAP President, Gregory Bunt M.D., addresses the meeting attendees.



Drs. Dwyer and Bunt at award ceremony.



Gregory Bunt, Gregg Dwyer, Frances Bell, and Greg Barclay huddle during Sunday's ASAP business meeting.



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## APA DOINGS...May 2013

By  
ASAP member Richard Ratner, M.D.

Once again your faithful reporter and representative attended the annual Assembly of the American Psychiatric Association, which occurred just before the scientific sessions. This year we had the pleasure of meeting in San Francisco, CA, and I was delighted to be joined during part of the proceedings by your newsletter editor, Gregory Barclay, M.D.

Other than the city, one highlight of this meeting was the release of DSM-5, timed to coincide with the meeting. According to my friend, Roger Peele, at the time of release the volume was already #12 on Amazon's list of bestsellers, despite, or perhaps because of, the greater level of conflict surrounding this edition compared to in the past. The APA is encouraging various programs around the country to help us become familiar with the new classification system, which, among other things, does away with the multi-axial system, eliminates the 'bereavement exception' for major depression, and makes a host of other changes.

The volume has already experienced disdain, as from Thomas Insel, M.D., of the NIMH (for not, in essence, resting on a molecular understanding of mental illness—as if it could at this point); and hostility, especially from Allen Frances, MD, one of the guiding spirits behind previous DSM's. Frances has come out with a new book in which he critiques the new DSM as well as providing a kind of alternate classification system based on the earlier DSM's. While some of the conflicts are intellectual, it is hard to miss the overtones of personal hostility that have been evident between him and the principal organizers of the new volume, Darrel Regier, MD, and David Kupfer, MD.

Another milestone at this meeting was the announcement by Jay Scully, MD, medical director, that he was stepping down after several years of distinguished service. His replacement is Saul Levin, MD, a local (DC) colleague who has worked in both private and public mental health positions and is a veteran representative of APA at the AMA. His knowledge of the worlds of both public health and electronic media helped get him chosen, according to what I heard.

As compulsive readers of this column know, my role representing ASAP is as a member of the Assembly's "affiliated organizations liaison," of which we are one

of several. This group constitutes an Assembly committee of its own, of which, probably because others ran the other way, I have managed to become deputy chair. We each have one vote in the Assembly; since a fair share of the Assembly's decisions are done by voice vote, one can have a slightly disproportionate influence if one shouts "Aye" or "Nay" loudly enough.

The Assembly's job is to hear, modify, and pass action papers and send them forward to the Board (or another committee), hopefully for final approval. This year there were the usual issues brought up in Action Papers, including maintenance of certification, passing and retiring certain position papers, (e.g., for humane treatment of illegal immigrants with mental illness, against marijuana as a treatment for PTSD based on the lack of evidence, retaining a 1995 statement on medical psychotherapy in favor of a new one that attempted to replace it). One topical issue was gun violence, and a number of papers and position papers were combined into a long statement entitled, "Firearm access, Acts of Violence, and the Relationship to Mental Illness and Mental Health Services." In essence, it supports background checks, waiting periods, limiting access to weapons among people identified as potentially dangerous to themselves or others, limiting civilian access to high capacity magazines and semi-automatic weapons, further training for mental health types to help identify high risk individuals, and removing barriers to mental health care. One other part of the paper opposes certain statutes that actually prohibit mental health people from discussing firearms with their patients.

Papers were passed recommending self-defense training for psychiatric residents, doing more to revitalize public perception of the APA by bulking up the its Office of Communications and Public Affairs, and providing the electronic version of DSM-5 to all members of the Association.

For the first time the Assembly approved an action paper dear to the hearts of all of us AAOL'ers: it would fund our representatives to the same degree that it funds



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District Branch reps. This includes travel and housing for the Assembly meeting in the fall and for certain other local meetings, though not to the annual meeting. Even though the Assembly passed it, many people think that the Board will not approve it, even though, with the income stream coming in from DSM-5, APA is likely to be more or less awash in money for the next few years. The likelihood that this motion will be vetoed by the Board, which in fact is a snub that places no value on what the affiliated organizations have brought to the APA over the years, has left some of the reps of other affiliated organizations thinking that there is not much point in continuing to be part of the Assembly. Most of us, however, felt that it is worth hanging on and seeing what actually happens.

Jeremy Lazarus, MD, a psychiatrist, is president of the AMA this year. He is the first psychiatrist in this position since 1939 and only the third ever. He gave an overview of issues common to the two organizations including, among many others, scope of practice challenges that both organizations oppose. At the time of the meeting there was a particularly malignant bill extending prescriptive authority to psychologists in front of the Illinois legislature; subsequently, however, it was defeated to the great relief of all of us. He quoted predictions that some 62 million more people may have access to mental health care with the beginning of the Affordable Care Act; the need for new psychiatrists may approach the dire in just a few years. Institutionally, however, he remains an optimist. In that regard, Lazarus was the first person I've heard talking about notions afoot to finance medical school for more physicians, including somehow shortening the traditional four year stint. All very preliminary stuff.

Considerable resistance, and resentment, still exists toward the new requirements for Maintenance of Certification. In this regard, we discovered that a new person has taken over the chairmanship of the American Board of Medical Specialties (ABMS), which is the

body that has imposed these changes on the ABPN and other specialty boards. The new chair has apparently decided to place a moratorium on further implementation of the changes, and it is reported that one reason is her recognition that each specialty should not in fact necessarily be treated in the same way as others. This is the closest thing to a victory, of sorts, for many of us, who feel that especially when it comes to the notion of being rated by our patients, our situation is a very different one.

By now the impact of the new CPT codes has been felt by the rank and file. With plenty of struggles, the people in my locality are adjusting as best they can to the new (for many of us) E&M codes. I personally don't understand the impetus to these changes, but I don't think the APA dares to raise questions, because using these medically oriented codes keeps us more closely anchored to the 'house of medicine', even if using E&M means squeezing what we do into (my personal view) Procrustean beds.

On a final note, this was one of the best-attended meetings in several years, perhaps in part because of DSM-5 but also because San Francisco is one of the most exciting cities in the country. The range and quality of restaurants is superb, and the cultural resources are great. What's more, it is a jumping off point for many wonderful tourist locales, like the wine country (Napa, Sonoma), or Lake Tahoe. Many attendees planned to take advantage of these opportunities after they had had their fill of science. If any of you were there, hope you had as good a time as I did. If not, there's always next year.

--RAR

*Editor's Note: Dr. Ratner receives no financial support from ASAP for attending the Semi-Annual APA Assembly meetings on our behalf.*

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## Book Review Corner:

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### *The 10 Best-Ever Anxiety Management Techniques Workbook*

by Margaret Wehrenberg (2012, W. W. Norton & Company), 228 pgs., paperback, \$19.95 US, ISBN 978-0-393-70743-4.

Reviewed by Kevin J. Zimmerman, M.S., Iowa State University, Ames, Iowa.

Drawing on her experience treating clients with anxiety disorders, Dr. Margaret Wehrenberg walks the reader through examples, exercises, worksheets, and tips designed to alleviate anxiety symptoms. Wehrenberg presumes her readers to be anyone suffering from anxiety, and her inclusion of examples related to school performance or awkward social circumstances familiar to teenagers, such as attending a school dance, indicate that she intends to include adolescents in her audience.

Before discussing the ten techniques, Part 1 helps readers assess what kind of anxiety that afflicts them, including panic disorder, agoraphobia, generalized anxiety, social anxiety, a specific phobia, PTSD, or OCD, and to understand the neurophysiologic effects of stress. Part 2 covers techniques 1-4 for managing the anxious body, Part 3 presents techniques 5-8 for managing the anxious mind, and Part 4 offers the final two techniques to help manage anxious behavior.

The workbook includes a CD with ten author-led exercises that correspond with the ten anxiety-management techniques. Wehrenberg's voice on the CD is mellow and sultry, recorded with added bass and reverb, evoking the voice of Superman's biological mother as it resonates within Superman's cavernous ice palace.

Of particular value in the workbook is Wehrenberg's definition of anxiety as "the emotional and physical state that results when you do not know what is happening, what will happen, or what to do about what is happening" (p. 115). Simply understanding that anxiety comes from not knowing can encourage clients to seek the information they need to reduce their anxiety. Also valuable is her understanding of neurobiology, as reflected in her explanation that "every time you think a thought, it is easier for your brain to think that thought again [and] ...every time you stop the thought without continuing it, you weaken the trace" (p. 120). I also found many of the exercises to be valuable, such doing the most dreaded tasks first or making a prioritized list of tasks with clear deadlines.

There are, however, some problems with the workbook. For example, although Wehrenberg mentions sleep and exercise in Chapter 4, she underemphasizes what the research clearly shows is the considerable role of adequate sleep and exercise in reducing anxiety. There are also editing issues throughout the book that diminish its level of professional attractiveness. The end of chapters covering techniques 1-9 include a S.I.M.P.L.E. plan (standing for symptom, impact, method, practice, lifework, and evaluate) that I found neither simple nor clearly explained.

I generally recommend a book to other professionals if I find it useful. I have found myself incorporating some of the concepts from the book into my own practice, so on these grounds I can recommend the book to other therapists. Most clients with anxiety are likely to find that only certain sections are applicable to their situation, so they are likely to benefit most by meeting with a therapist who can strategic apply the relevant ideas or exercises.

*Mr. Zimmerman is a Ph.D. candidate at Iowa State University and is also an individual, family, and couples therapist affiliated with Barclay & Associates, P.C., in Ames, Iowa.*

*Continued on pg. 13*



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## *The Insanity Offense – How America’s Failure to Treat the Seriously Mentally Ill Endangers its Citizens*

By E. Fuller Torrey, M.D. (2012, W. W. Norton & Company) 284 pages, paperback, \$16.95 US,  
ISBN 978-0-393-34137-9

Reviewed by Gregory P. Barclay, M.D., Newsletter Editor

I read this book by Dr. E. Fuller Torrey while en route to the 2013 APA annual meeting in San Francisco, California. It is ironic that I picked this particular book up off the stack of “to be reviewed” books in my office as I left for the airport. The central theme of the book – the consequences of deinstitutionalization, funding cuts, and civil rights legislation over the past 30-40 years were staring my wife and I in the face as we emerged from the BART train in downtown San Francisco later that day. The book is a well-written, fact-filled and cited account that is a mandatory read for all practicing psychiatrists, particularly those serving in the public sector.

The Insanity Offense begins with a review of the two major forces that have led to the current despairing status of many chronically and pervasively mentally ill individuals who now inhabit the streets of most American cities. These include the deinstitutionalization movement that began in the 1960’s with the arrival of first generation antipsychotics and lithium carbonate and continued at a rapid rate for the next two decades prior to reaching a relative steady state baseline by 1995. The second force was the passage of the 1969 Lanterman-Petris-Short (LPS) Act, which severely curtailed the ability to involuntarily treat mentally ill patients by stipulating the necessity to prove imminent dangerousness to justify continued hospitalization. Although a California law, its influence led to similar laws shortly afterwards in all 50 states.

In subsequent chapters, Dr. Torrey draws on statistical information with many case examples to outline the consequences of deinstitutionalization and the LPA. Citing the observation that most, if not all, individuals with psychotic disorders suffer from anosognosia, e.g. a lack of insight, a fundamental premise of the LPA (that patients with mental illnesses are competent to decide for themselves whether to accept or refuse treatment), is flawed. Yet, because of state laws patterned after the LPA, once no longer imminently dangerous patients must be released from care and because of their anosognosia, typically discontinue treatment. As a result, at any given time, there are an estimated 500,000 severely mentally ill adults who are neither incarcerated or in any treatment and, of those, 50,000 have a history of having committed violent acts and consequently are at risk to act violently again.

Dr. Torrey uses case examples to highlight the violence perpetrated against family members, high visibility officials or stars, treating professionals, and inmates (if incarcerated) by individuals suffering from untreated psychotic disorders. He also describes the increasing trend in our society to incarcerate severely mentally ill adults who commit crimes, where they are frequently victimized and assaulted by other inmates or mistreated by facility staff unaware of their inability to reason logically or follow their orders obediently. Other clinical examples are presented that bring home the realities of suicide among the untreated chronically mentally ill, the plight of their families desperate to obtain treatment yet, because of laws and funding, unable to secure it, and homicides committed by against mentally ill by their own family members. The issue arising throughout these chapters relates to how, in an attempt to assure the rights of the mentally ill to refuse treatment and prevent involuntary treatment except under the condition of “imminent dangerousness”, the consequences of civil rights laws and deinstitutionalization now routinely violate the civil rights and safety of all members of society.

The book concludes with a call to action, using evidence to identify the target populations most in need of involuntary treatment and citing some model programs designed to facilitate continuing treatment and thus diminish violent crimes committed by the severely and chronically mentally ill. The book, although designed for a lay audience, is an excellent reference and resource for the practicing clinician and for family members. I found it sobering and enlightening, and recommend it for your bookshelf. It will definitely stay on mine.



## In Memorium

***Muriel Straetz, M.D.***

*By Nancy Benton*

Former New York ASAP Branch President (1974-75) Muriel Straetz, MD, died peacefully of pneumonia at the end of a long illness on January 7, 2013. She was a graduate of Smith College, University of Rochester School of Medicine, and The Columbia Psychoanalytic Institute. She is survived by her daughters, Elizabeth Benton and Nancy Benton; her son-in-law, Jim Largent; her granddaughter, Sara Largent; her great-granddaughter, Rosie Sobel; and her brother Arnold (Bud) Relman. Prior to her retirement, she was a staff psychiatrist at the Martin Luther King/Drew Medical Center in Los Angeles. Before moving to California, she spent many years on the staff of Hillside Hospital in Glen Oaks, NY, and was Director of the Adolescent Pavilion there for a number of those years.

***Daniel Offer, M.D.***

***1929 -2013***

*by Lois Flaherty, M.D.*

Dr. Daniel Offer, described in the obituary notice on the Northwestern University website as “a giant in adolescent psychiatry,” died on May 13 at the age of 83 at his home in Mercer Island, Washington. He had been on kidney dialysis for nearly fourteen years, and had retired and moved to the Seattle area in 2008 to be near his family. He was a past-president and founding member of ASAP, and a frequent presenter at our meetings. He can certainly be considered one of the fathers of adolescent psychiatry, both in terms of his contributions to the field and to our organization. He authored 12 scientific books and monographs, 67 scientific articles, and three psychological tests and interpretive manuals.

Dr. Offer was born Thomas Hirsch in Berlin, the son and grandson of doctors at Berlin University. His family fled rising anti-Semitism in 1935, moving to Palestine. When war broke out in 1948 between newly independent Israel and the Arabs, he fought as a commando in the Israel army and also changed his name to a less German-sounding one. He moved to the US to attend college but remained in close contact with many Israeli colleagues throughout his life.

Nearly Dr. Offer's entire long professional career was spent in Chicago. He received his MD degree from the University of Chicago and trained in psychiatry at the Institute for Juvenile Research and Michael Reese Hospital, where later became chair of the department of psychiatry. Michael Reese was a leading center for research, training and patient care in psychiatry, and was also one of the first programs to develop a training program in adolescent psychiatry. In 1990 Dr. Offer went to Northwestern University, serving on the faculty in psychiatry, and at the time of his death he was emeritus professor there.

His studies of 73 male high school freshmen were among the first to study normal adolescents. His findings cast doubt on the idea that most adolescents experienced their adolescent years as emotionally turbulent. His books, “The Psychological World of the Teenager,” (1969) and the 1975 “From Teenage to Young Manhood: A Psychological Study” have remained classics in the field. In an ASAP meeting in 2003, together with his wife Marjorie Kaiz Offer, he presented a forty year follow-up study of (incredibly) 94% of his original subjects. One of his findings at the time of follow-up was that the memories the now-middle-aged men had of their adolescent years had a no greater than chance probability of being accurate (this paper, “The Altering of Reported Experiences,” was published in the *Journal of the American Academy of Child and Adolescent Psychiatry* in June 2000). Dr. Offer also served as many years as Editor-in-chief of the *Journal of Youth and Adolescence*, a leading research journal.

Despite his illness Dr. Offer continued to enjoy life and to travel, and remained active in scholarly activity. He

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often spoke about dialysis to groups and co-authored the book “Dialysis without Fear; A Guide to Living Well on Dialysis for Patients and Their Families” (Oxford Univ. Press, 2007) with his wife and one of his daughters.

In an e-mail informing me of his death, his wife Marjorie, commented, “He had an incredible life and appreciated every moment.” He was a beloved colleague and friend to many around the world. In addition to his wife Marjorie, whom he married in 1979, he is survived by daughters Tamar Yehoshua and Susan Szafir; a son, Raphael Offer; brothers Michael Offer and Juval Shenhar; and six grandchildren. His first wife, Judith Baskin Offer, died in 1976.

His family suggested that donations in his name may be made to the American Associates of Ben-Gurion University of the Negev, 240 Tamal Vista Boulevard, Suite 260, Corte Madera, CA 94925.



## 2013 Annual Meeting (Cont.)



Incoming ASAP President, Gregg Dwyer, M.D., congratulates outgoing president, Gregory Bunt, M.D. upon completion of his term.



Dr. Raley with Staples Award.



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March 2013

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Annual Meeting March 28-30, 2014  
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Departments of Psychiatry and Education,  
Pre Conference March 28, School Mental Health  
March 29-30, 2014  
Review and Update of Adolescent Psychiatry  
in the 21<sup>st</sup> Century  
Grand Historic Venue  
225 N. Charles Street, Baltimore, MD



Joint Meeting of the International Society for  
Adolescent Psychiatry and Psychology  
and  
The American Society for Adolescent Psychiatry  
June 24-28, 2015  
Marriott East Side Hotel  
New York, New York