



american society for adolescent psychiatry

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Roxanne Lewin, M.D., Editor

Winter 2015

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FROM THE PRESIDENT SHELDON GLASS, M.D.

In 1970, ASAP in its third year, held its first joint/international conference in Buenos Aires. A small group of ASAP members attended and presented including Jim Masterson, Bert Slaff, Roy Grinker and myself. It was a great experience for all of us.



This year under the direction and coordination of co-chairs Lois Flaherty and Greg Barclay, ASAP is hosting its first joint conference with ISAPP in New York City. The program will host an extraordinary faculty of national and international experts. The Annual Conference has been expanded to four days and has been approved for up to 27.25 CME credits. This year members will be able to sit for the certification exam in adolescent psychiatry.

ASAP continues to be the only national psychiatric organization dedicated solely to mental health and well-being of adolescents. As ASAP enters its 48th year, we are reflecting on the significant changes that have occurred since its inception and the variables that have remained the same. I would encourage you to attend the New York City conference for a stimulating opportunity.

Best wishes for the New Year. Look forward to seeing you in New York.

Sheldon D. Glass, M.Ed., M.D.
ASAP President

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Mark Your Calender

The 2015 ASAP Annual Meeting will take place in New York, New York March 26-29, 2015. The theme of the 3-day conference will be "The Art and Science of Adolescent Psychiatry and Psychology".

Lois Flaherty, M.D.
and Gregory Barclay, M.D.
Program Chairs



Classified and Drop-In Advertising Available

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

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

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

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

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

From the Editor

A few years ago I ran a smoking cessation group for patients enrolled in a methadone program. The participants were new admits to the program and I, a less than eager group facilitator because the group started at 6pm at one of our offsite locations.



My initial plan for the group was to tell the participants of the harmful effects of cigarette smoking while inserting a few motivational tidbits here and there. My plan failed. I was met by an overwhelming enthusiasm and a genuine interest in the discussion. It was an open group – our base remained stable and others kept joining. Although, I would have preferred to think it was my own doing that kept everyone engaged, I quickly realized that most folks had heard all or part of this message before and were somewhere between thinking of quitting and wanting to quit. We covered epidemiology of cigarette smoking. We discussed medical complications. We talked about daily routines. We did budgets. We listened to sad stories of neighbors and to inspiring tales of success. Around our table each week sat people from different ethnic backgrounds and social standing. We had heroin users, alcohol, cocaine, prescription pills and marijuana users.

Even though it was a smoking *cessation* group, most of our discussions centered around harm reduction – from as little as dropping one cigarette for the daily two packs users or waiting a few minutes longer until the next cigarette. People spoke freely about their drug and cigarette use to a receptive audience. I realized that I had underestimated the participants. Perhaps I was thinking that the goal of the group was too big to get done - by me? By them. At this time. This kept me from seeing what we were able to do and that sometimes the best help you can give your patients is to facilitate small steps toward the larger goal. The group responded well.

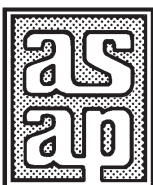
I am happy to have had this experience. Like the group participants, I too had heard some of the rhetoric of meeting patients where they are in order to facilitate change, but this experience really drove it home. The seamless two-way exchange and openness that percolated the small room each week taught me a few lessons of my own. My biggest take away was to make a better effort to listen and to talk with my patients about their harmful behaviors, even if it is just a brief check in at each visit.

Whether it is your chronically noncompliant schizophrenic patient or the fifteen year old with Bipolar disorder who professes the joys of marijuana use – keep intervening. In this season of resolutions, expectations, and giant changes, we should remember to embrace the small victories. It took a lot out of the patients to show up, share or just be supportive each week - but they did. Their many small steps made a difference and brought about change.

Happy 2015! Hoping to see everyone at the annual conference in NYC!

Yours Truly!

Roxanne Lewin M.D.



Early Bird Registration Rate Extended to February 14, 2015!!
**Joint Meeting of the American Society for Adolescent Psychiatry and
the International Society for Adolescent Psychiatry and Psychology**

March 26-29, 2015



Due to the inclement weather conditions this past week through much of the USA that may have interfered with registration for this conference, we have extended the early bird registration rate deadline to February 14, 2015! This is your premier opportunity to attend a clinically oriented meeting focused on critical issues in adolescent psychiatry. The meeting will begin at 8:00 am Thursday morning and go through 12:30 pm Sunday. There will be over 90 oral presentations plus New Research Posters. Invited speakers include David Baron, Robert Hendren, William Pollack, Lynn Ponton, Andres Pumariega, Nancy Rappaport, and Annette Streeck-Fischer. Topics include addictions and eating disorders, complementary and alternative medicine, cultural issues, psychopharmacology, psychotherapy, research on adolescent development, new treatments for schizophrenia, transition age youth, and youth violence.

Efrain Bleiberg, this year's Schonfeld Award winner, will present "The Mentalizing Model of Emerging Borderline Personality Disorder in Adolescence: The State of the Art" on Thursday afternoon. A track on difficult-to-treat psychiatric disorders will focus on obsessive-compulsive disorders, trichotillomania, deliberate foreign body ingestion, school avoidance, and sex offending.

To register for the meeting, [click here](#) for online registration, or [click here](#) to download the program and registration form from the ASAP website.

A block of rooms has been reserved at a rate of \$299 per night at the New York Marriott East Side Hotel, 525 Lexington Avenue, the meeting venue. To reserve a room at the Marriott do one of the following:

- [Click here](#)
- In the US call: 800-242-8684
- Outside the US, call the Marriott toll-free number for your country

Ask for the ASAP/ISAPP room block.

Accreditation and Credit Designation Statements

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of The University of Texas Southwestern Medical Center and the American Society for Adolescent Psychiatry. The University of Texas Southwestern Medical Center is accredited by the ACCME to provide continuing medical education for physicians.

The University of Texas Southwestern Medical Center designates this live activity for a maximum of 27.25 *AMA PRA Category 1 Credit(s)*[™]. Physicians should only claim credit commensurate with the extent of their participation in the activity.

ASAP and the Big Apple – A Great Team

By: Jim Gilfoil, M.D.

What is it with these ASAP leaders? They act as if we have some special rights on the Big Apple, what with our third or fourth annual meeting there in the last five. Hey, I'm not complaining, since it is the best restaurant city in the world. And this year ISAP is there too, so you can hang out with your international friends. Plus, we have a good hotel deal. If you've been to New York recently, as I have—doing research for this article, and, yes, someone has to do it—you know that hotel prices have gone insane. Our \$299 deal with Marriott is practically a steal, so sign up quick. And, make those reservations at your old faves and some new ones I'm suggesting.

On the high end, I usually go for *Per Se*, *Jean Georges*, or *Le Bernardin*. I know some people love *Eleven Madison Park*, but I don't find it as interesting as the above three. *Daniel*, which I've always considered just a notch below the big 3, lost a star in both the New York Times and Michelin. Someone in the restaurant business told me that the loss of a star from the Times meant around \$500 K in lost revenue. And you moaned the loss of a patient or two. Losing the Michelin star wouldn't be quite as much I would think, though it would certainly hurt with the European crowd. Maybe now's the time to go, with the restaurant trying to get that star back, but I've got some other options to suggest. I went to Michael White's *Marea* recently and it blew me away. It's an elegant space with lots of Brazilian teakwood, or something. With the attentive service and excellent food, I had one of those peak moments—thinking there's no place I'd rather be at this moment than right here. It's Italian seafood, and I had a wonderful Dover sole, and for dessert a granita with yogurt and dill. It doesn't sound like much, but it was sublime, and I can still smell that dill. To me, White is the best chef doing Italian food in the city now, and *Marea* is the flagship of his empire. His *Ai Fiori* is also supposed to be very good, but not quite at the level of *Marea*.

Another chef doing great work is Matthew Lightner at *Atera*. It's tasting menu only and it's expensive, but worth every penny. A million little bites or so, with an air of whimsy. We were served

a "churro" which was made out of some vegetable—I never found out what, but it was terrific, and it's interesting how things taste when you're surprised. To me, it adds to the fun and excitement of the meal. You'll sit at the counter around where the cooks are working, so you feel as though you're part of the process. We were served something that looked like a cracked egg, and a neighboring diner asked if it was, in fact, an egg. His server looked at him, and said, "After all you've seen tonight, sir, really?" Hey, did I say that the food is outstanding? Well it is, and, if you're at all adventurous, you need to go. Both *Marea* and *Atera* get two Michelin stars. I would give both three.



Don't forget some old standbys like *Gotham Bar and Grill*, *Bouley*, and *Gramercy Tavern*. I revisited *Gramercy* not too long ago and had a wonderful meal. You can also eat in the bar area, which has a great, fun vibe. Terrance Brennan's *Picholine* has long been one of my favorites, especially because Brennan isn't afraid of bold flavors, and, horror of horrors, salt, which is right up there with sugar in the food Nazi Hall of Shame. It's almost worth going for the cheese course alone, for, if you're into cheese, this is one of the best cheese courses in the world—and that includes France. Another longtime favorite of mine is Bill Telepan's *Telepan*, just a few blocks up the West Side from *Picholine*. He's a terrific, underrated chef in a city full of culinary superstars. I love *Minetta Tavern* for their evocation of an older time in the City, from the vintage photos to the great drinks, steaks and burgers, and that fabulous coconut cake.

Some newer haunts to consider are *Batard*, *Betony*, *Carbone*, and *NoMad*. *Batard* is restaurateur Drew Nieporent's latest venture in the space that formerly housed *Montrachet* and *Corton*. Nothing shows the evolution of fine dining more than the transition from *Corton* to *Batard*. The setting is much more rustic, and the menu is much more straightforward.

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No elaborate multi-course tasting, but a more simplified approach in which the ingredients are allowed to speak for themselves. Not that I ever knew ingredients to speak, but it seems as good a way as any to summarize what people are doing these days. Anyway, the food is terrific, and Nieporent, as always, has some great wines on offer, as well as one or two bargains, which I will not be telling you about. You've got to find those on your own. *Betony* is very good, and *Carbone* is like going back in time to Frank Sinatra's heyday, what with a \$50 veal parm and waiters in red tuxes. My other pick in this bunch would be *NoMad*, where *Eleven Madison Park* chef Daniel Humm has a more casual, yet still delicious menu. The chicken with truffles is memorable, as are the superb cocktails.

Speaking of drinking, other good cocktails can

be found in the King Cole Bar at the St. Regis Hotel, *Minetta Tavern*, *Betony*, and *Saxon and Parole*. If you're a wine geek, consider *Racines NY*, the *Aldo Sohm Wine Bar*, and *Pearl and Ash*. *Racines NY* has gotten gushing reviews and is an offshoot of a Parisian wine bar. The veal tartare is spectacular. Aldo Sohm is the *Le Bernardin* sommelier who was ranked the world's best in 2008, and the chef is none other than Eric Ripert, so you're guaranteed to get great wines and great food. *Pearl and Ash* has good food too, along with a more hipster vibe complete with loud soundtrack and din. For breakfast or brunch I love *The Breslin* with their great full English breakfast, and, on weekends, the wonderful lamb burger. This ought to last you for a few days, so see you in March.

Book Reviewers Needed!

How does the prospect of expanding your professional book collection at no charge sound to you? If you enjoy reading and writing, then "Adolescent Psychiatry's" book review editor would be interested in hearing from you! We need book reviewers to assist in writing regular reviews for our quarterly peer-reviewed journal. You could do as many or as few as you want to do and you get to keep the books!

Interested? Please contact Gregory P. Barclay, M.D., Book Review Editor, drb@drbarclay.com, with your contact information and interest areas.

Like and Friend us on Facebook!

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>

Welcome New Members:

Marta Brana Berrios, M.D., New York, NY
David George Ellis, M.D., Lumberton, N.J.

APA DOINGS...APA Assembly, November 2014

By

ASAP member Richard Ratner, M.D., DLFAPA, FASAP

Once again, the Assembly met for its fall deliberations at the JW Marriott Hotel near the White House the weekend of November 7-9. It's been meeting there for as long as I can remember, but next year it will move to the Shoreham, much closer to yours truly's office, which will help me getting back and forth. Following are some of the highlights of the meeting.

APA membership increased by 5% this past year, which is something of a record increase, and revenue projected is somewhere around \$ 4M over and above expenses. One can thank sales of DSM 5. Dr. Levin has also made some personnel changes including the heads of a new Communications department and the head of Government Affairs. He is, by the way, making efforts to stay in better touch w district branches and was present for nearly the entire Assembly meeting, which was not true of his predecessor.

AAOL

My presence at the meeting is by virtue of my representing ASAP in what had been called the Assembly Affiliated Organizations Liaison (AAOL), but the powers that be have decided over the past year to add some groups that are not affiliated organizations, including, for example, the Senior Psychiatrists' Caucus and the Southern Psychiatric Association. Accordingly, some considerable time was spent trying to figure out a new name for the group, and what people eventually came up with was Assembly Committee of Representatives of Subspecialties and Sections, which will henceforth be known by the acronym, ACROSS. Another change was to alter the requirements for membership in this group to reflect a membership of at least 100 psychiatrists of which at least 40% are APA members. This change was made largely to include in the Academy, which has lots of psychiatrists but also lots that are NOT members of APA.

At some point our organizations will have to submit membership lists so that APA can determine if we meet the minimum requirements for number

of APA members. I'm pretty sure that ASAP will have no problem meeting this requirement the next time it comes up for review, which is now every five years.

The only change that I would consider particularly favorable for ASAP is the removal from the Assembly Procedure Code language that requires "all costs of participation to be borne by the Allied Organization." Up till now, this language has prevented us from being able to talk APA into paying expenses, particularly for smaller and poorer organizations, to attend this fall Assembly meeting. The Assembly has already voted in favor of covering those costs (which, if passed, would make it possible for whoever succeeds me to attend the meeting even if (s)he lives at a remote distance from DC), but various reasons have prevented the action to be taken.

None of this changes the fact that each organization us has only one vote in the Assembly, which makes even the total of us a tiny fraction of votes cast. We are even more minuscule in votes by strength, because we are not allowed one vote per member, as are the various district branches.

ETHICS

The AMA has recently added a principle to its Principles of Medical Ethics indicating that a "physician should support access to medical care for all people," and the APA Ethics Committee proposed to add several annotations that are specifically pertinent to Psychiatry (it publishes a booklet called just that: Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry). On first reading they all seemed fairly benign, but most of the discussion in both committee and Assembly focused on whether these annotations made it more or less likely that a psychiatrist could be brought up on ethics charges or more vulnerable



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in a malpractice situation. Several of us, me included, felt that the net effect of these annotations was to limit exposure, but others felt just the opposite: that by being more specific they provided more guidance to those looking for reasons to bring complaints. While it passed the reference committee with changes, it failed on the Assembly floor, so currently there are no additional psychiatric annotations to that principle.

PRACTICE GUIDELINES

Last spring, the APA Board wanted us to pass a series of so called practice guidelines for psychiatric evaluation, which we have been apparently under pressure to do. The purpose is for submission to a guideline repository in the Agency for Healthcare Research and Quality's National Guideline Clearinghouse and is apparently in response to a call for 'more rigorous standards' by the Institute of Medicine. Last spring, since almost no one in the Assembly had reviewed them, we voted to postpone consideration until this session. In the interim, various really needed changes were made to make them at least marginally more practitioner-friendly, largely by making them less rigid and prescriptive. The changes include specifically indicating that not everything that is considered part of an initial visit be necessarily performed at that visit and the recognition that some 'recommended questions will not always be indicated for specific patients.'

This time, all nine guidelines passed, including some troubling (to me) ones on 'assessment on medical health' and 'documentation of the psychiatric evaluation'. The latter, for example, in conjunction with the new CPT codes, could require some kind of inquiry and documentation of a patient's physical status at each visit. Catch me at the next ASAP meeting, and I will explain how the unholy alliance of CPT changes, the electronic medical record, and these practice guidelines are gradually gutting the ability of us and our colleagues to practice psychodynamic psychiatry.

CPT, ETC.

Speaking of CPT codes, I unfortunately missed the Assembly's expert on the subject, Ron Burd, MD, give his update. But my trusty colleague, Roger Peele, summarized as follows: the so-called SGR

'fix' could be on its way after many a year, but in its place may come new restrictions and requirements, including various new forms of payment including 'capitation', ever more documentation of fulfillment of the E/M codes, more scrutiny of submissions which can result in our being accused of upcoding and asked to refund payments, and other ugly possibilities. As is clear, we are all being pressured into adopting EHR, even though they are absurdly expensive, fragmented among providers, and only marginally able to capture what actually goes on in a typical psychiatric session. Pertinent to this mess was an action paper the Assembly passed asking the APA to explore the notion of finding or developing a more psychiatry friendly EHR that members might be able to purchase, possibly at lower cost, and use.

ELECTIONS

APA announced that the candidates for president-elect for 2015-16 will be an old-timer and a young Turk: Bart Blinder, MD, from California and Maria Oquendo, MD, from New York, respectively. Both are very qualified, and we will expect each to discuss their aspirations and priority. Renee Binder, MD, will be the incoming president in May; if anyone has some interest to bring to her attention, let me know, as I know her better than many previous APA presidents, including Dr. Summergrad, whom I don't know personally at all.

ACTION PAPERS

Some of the other papers that passed including one to explore whether controlled substances can be e-prescribed if requisite safeguards are in place; one opposing direct to consumer advertising by drug companies of any psychiatric medication; one requesting that APA develop a definition of 'telepsychiatry' and of suggested standards, guidelines and regulations; one requesting APA to work together with the national nurse practitioner group to 'standardize nurse-practitioner training; one requesting APA look into the rather miserable level of compensation of psychiatrists working in federal correctional institutions, which helps to explain the significant shortage of our colleagues who work there; and a position paper on Firearm Access,

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which passed when one of the recommendations related specifically to the availability of automatic weapons was deleted as being an intrusion into an area specific to law enforcement.

Various existing position papers were either retained or retired, mostly via the consent calendar, which is where issues where there is no real debate get voted in the recommended direction.

A number of other issues came up and were discussed, but the above represents the major developments. Your representative wishes every ASAP colleague a safe and happy holiday season. If not before, you should each be hearing from me again in the spring when the Assembly meets in conjunction with the APA's annual scientific meeting. The meeting, in May, will be in Toronto, a great city.

The Diagnosis and Treatment of Narcolepsy in Children and Adolescents

By Julia K. Holtmann, M.D.

Do you remember the last time you gave your little talk on sleep hygiene? You probably sat across from a droopy-eyed teenager who looked increasingly alarmed as he imagined a night unplugged from all his devices. Being the good practitioner, you asked the pertinent questions and figured out the problem.

Improper sleep hygiene is a major issue in adolescents and the most common reason for excessive daytime sleepiness in this group. The advent of social media has transformed bedrooms across the nation into communication hubs where screens flash blue light all night. Posting a Facebook comment after 3 am means one's cool factor is bound to rise significantly. Which is why this seemingly simple problem is so difficult to remedy. Talking to patients about the advantages of adequate sleep should be on every clinician's to-do list.

Most sleep disorders often go undiagnosed for years. My patient David is a good example - He was sixteen when his pediatrician upon the insistence of his mother referred him for a sleep study. Since age nine years, David has been falling asleep at school in his classes, on the bus, while doing homework and at the dinner table. His naps would last several hours but still left him tired. He went to bed early and slept all night. He made mostly C's in school and had few friends as he spent his time nodding. David's mother repeatedly exclaimed that she knew something was wrong with her son.

David's overnight polysomnogram showed more

than four **sleep-onset** REM periods (SOREMPs).

During normal sleep, REM periods generally occur after 90 minutes of sleep and SOREMPs are suggestive of narcolepsy. A multiple sleep latency test (MSLT) is the diagnostic test of choice, which was used to confirm David's diagnosis. This test is performed in a sleep lab where the patient is asked to take several short naps while their sleep is recorded. Unlike in adult narcolepsy, there are no set diagnostic MSLT criteria for the diagnosis in children and adolescents, but most specialists diagnose narcolepsy when the MSLT shows the onset of REM sleep within 8 minutes after falling asleep.

David's narcolepsy manifested solely with excessive daytime sleepiness. This is typical for many pediatric cases and one reason for the delay in diagnosis.

There can be other manifestations of disordered REM sleep in narcolepsy. REM sleep - just to recap - is this paradoxical state of sleep during which people experience rapid eye movements (hence the name), a brain wave pattern similar to wakefulness and an increase in respirations while the muscles of the body become paralyzed. Dreams occur during REM sleep.

Cataplexy - sudden isolated or repetitive drop attacks - signifies the intrusion of REM sleep atonia into wakefulness. In its' most subtle form, cataplexy can manifest with as little as a drop of the jaw or

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sudden involuntary drop of the eyelids. They can be distinguished from seizures by their preservation of consciousness. Cataplectic attacks last only seconds and are typically preceded by positive emotions such as laughing about a joke. They are less common in adults but occur in up to 75% of pediatric cases. Excessive daytime sleepiness can precede the onset of cataplexy by several years.

Hypnagogic and hypnopompic hallucinations are believed to be dream content spilling over into wakefulness. They are experienced by up to 50% of narcoleptic children and adolescents but are not exclusive to narcolepsy. Other etiologies are drugs, especially sedatives, insomnia and depression.

In contrast to adults, children have “friendly” hallucinations in the form of colors, shapes and images of people or animals. Narcoleptic hallucinations are mostly visual and exclusively associated with waking up or going to sleep.

Affected individuals often experience another phenomenon of REM sleep intrusion during those hallucinations – sleep paralysis. This is a state of persisting REM sleep atonia with preserved eye movements and breathing immediately after awakening. The spell can be broken by being touched or being spoken to. This happens to 30-60 % of children, who are often unable to explain what happened to them. Most patients also experience sleep disturbances at night such as frequent awakenings, vivid dreams and nightmares.

The pathophysiology of narcolepsy has not been fully elucidated but is known to involve hypothalamic dysfunction of sleep regulation and in cases of narcolepsy-cataplexy comes with deficiency

in orexin, or hypocretin, an excitatory hypothalamic neuropeptide.

The most effective treatment consists of a combination of sleep hygiene, scheduled naps and medication to promote wakefulness. Napping at lunchtime and in the afternoon enhances alertness and academic performance. So does regular exercise. Excessive daytime sleepiness responds to stimulants and Modafinil. Adderall is the only FDA approved medication in children. Usually, the stimulant used is Methylphenidate. Sodium oxybate is used for daytime sleepiness, fragmented nighttime sleep and cataplexy. Venlafaxine, Fluoxetine and Clomipramine have been shown to be effective in the treatment of cataplexy as well.

In children with narcolepsy, significantly higher rates of depression and behavioral problems are seen. The impact of the disease on quality of life and educational progress is tremendous.

The diagnosis and treatment can restore the affected individual’s functioning.

David’s life has improved since his symptoms are controlled. David once told me he never realized the extent of his impairments until he was treated. He is now doing well academically and generally finds life more fulfilling. So next time you give your sleep talk, remember you may be doing more than improving a nights’ rest.

Julia Holtmann is a Pediatric Neurologist in Brooklyn, NY. She evaluates and treats neurologic patients at Maimonides Infants and Children’s Hospital and The Brooklyn Hospital Center.

Member Updates:

Gregory Barclay was voted as a Distinguished Fellow of the APA

Damian Kim was voted Doctor of the Year 2014 by the New York City Health and Hospital Corporation

Adam Raff was voted Castle & Connolly’s Westchester Top Doctor 2014

Congratulations to Dean De Crisce, M.D. on elevation to Fellow Member



In Memoriam

HENSCHEL--Dr. Leonard P., 85, of Kew Gardens, N.Y. passed away peacefully on December 18, 2014 after a brief illness. Dr. Henschel was born in Washington, D.C. to the late Joseph and Leah (Cooper) Henschel. He graduated from Syracuse University and obtained his MD degree at the University of New York, Upstate. He completed his residency at the University of Michigan. Dr. Henschel was a psychiatrist specializing in adolescent development and maintained a thriving practice well into his 70's. His other interests included a love of books, travel and a passionate interest in horticulture. Dr. Henschel was an active member of the Greater Orchid Society of New York. He maintained an extensive orchid collection and enjoyed giving impromptu tours of his greenhouse. Dr. Henschel is survived by his sister, Shirley Henschel, his brother Herbert Henschel (Marilyn), his nephews, Dr. Marc Henschel (Deborah), Stephen Henschel (Jocelyn) and Eric Henschel (Laurie), three great nephews, a great niece and his lifelong friend, Mario Silva.



Published in The New York Times from Dec. 20 to Dec. 21, 2014

Why Taking Career Advice From A 2-Year-Old May Not Be A Bad Idea

By Gregory Lewin, Human Resources Specialist

If my 2-year-old were a dish, she would be sweet and sour something. One minute she's an angel and the very next she's bouncing off the walls like a racquet ball. Yet, I wouldn't have her any other way. Truth is, I find too much of either side equally terrifying. Being pulled into her frenetic little world by whatever limb she can wrap her fingers around is to be on a roller-coaster ride of laughter and terror.

I have two little girls. I know. Lucky guy. They are my ying and my yang. My older daughter (7-years-old) is my timekeeper. She makes sure my calendar is kept up to date with all of her activities which sometimes spares me from her rambunctious little sister. Then there is my 2-year-old, who teaches me how to be a better person. My first lesson is in patience and I'm being tested every single day. Apart from that, my world would be off-kilter without my girls. Watching them grow into these little people is my personal dosage of chicken soup for the soul.

It's the parent who should teach but oftentimes it is the child that teaches the parent and who keeps

them in line. I have learned and am still learning a lot from my kids and have become a better professional and human being because of those lessons.

Here are a few of the lessons from my 2-year-old.
Lesson 1: Don't take myself too seriously...

Take breaks and laugh at yourself sometimes. My daughter doesn't nap. She takes a string of short breaks throughout the day. That's usually all she needs to recharge and return to terror. You can be just as effective (minus the terror, of course) if you take small breaks from your work every now and then to recharge and refocus.

Lesson 2: Enjoy learning new things

Most of the things a child learns in the first few years are self-taught. Sure, we teach them a lot but they pick up some of the technical (and naughty) stuff all on their own. You can blame your foul-mouthed neighbor all you want for your child's brand new

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vocabulary but their perfect usage is a matter of pure genius. The point is as professionals you should continuously seek out areas for improvement and not wait around for it to show up on your performance appraisal. In that case, you may just be a day late and a dollar short. Success is self-taught.

Lesson 3: Celebrate the small victories

Why wait for the big win when you can celebrate along the way. My 2-year-old celebrates everything. Her favorite two phrases are “I did it” and “I win,” punctuated by a massive double fist pump. The lesson here is all accomplishments whether big or small deserve a little celebration.

Lesson 4: Don't be afraid to ask for help

Children ask for help instinctively. This is how they learn. The problem with getting older is we develop all kinds of fears and insecurities that keep us from learning what others know and are willing to share if we just ask.

Lesson 5: Be persistent

If you have ever had the pleasure of watching a baby learn how to walk then you'll understand what I mean by being persistent. I remember watching my daughters take their first steps and they were moments mixed with happiness and pain because every time their little bums would hit the floor I was already in flight to help them up. But my rescue missions were futile because once they were back on their feet, they were back at it again. The minute a child learns how to walk, they want to run. Be persistent at your career goals. You may fall hard but get up and run. No statue has ever been erected in honor of man sitting someplace.

Lesson 6: Always willing to pitch in and help

My 2-year-old is my little elf. No matter what I'm doing, I'll be sure to hear the familiar rhythm of her little feet rapidly approaching with an even more eager vow to serve or to destroy, “I'll help you, Daddy.” And even though her idea of helping is more often like un-helping, she does it with so much

excitement that it's hard for me to tell her no, twice. The climb up the career ladder is competitive but I find that the folks who do get to the top are the ones who hold the elevator so others can get aboard. Be unselfish. Sharing what you know won't hurt you.

Lesson 7: Always seek things out of your reach

Toddlers are always on their tippy toes trying to reach something that has been moved out the way of their super extendable little arms. The closer their little fiddling fingers get to the object, the higher they seem to levitate. The desire to reach a goal can give you supernatural powers. The thing about that is you don't always hit your target but you will certainly move from where you started if you give it all you've got. Stay reaching and remember to celebrate the small accomplishments.

Lesson 8: Let others know they are appreciated

Here's the reason being a parent (of young children) is the best job in the world, you get paid in hugs and kisses for just showing up and doing your best. Your losses are not held against you because it's your attempts that are counted. I believe the panacea for high employee turnover rates is a little dose of appreciation. But you can hold the hugs and kisses and save HR the headache of dealing with harassment charges.

Lesson 9: Be willing to follow the leader but know where you want to go

A child is a loyal follower. They will go wherever you lead them, most of the time. But they may be resistant to sudden movements that digress from their desired course. Allow your leaders to lead but the onus is on you to know how their movement is aligned with your career interests. If you and your boss are heading in divergent paths then this is the point where you let go, drop and roll. No, you know better. Instead, sit and have a discussion about your future at the company.

Lesson 10: Be yourself

Enough said.

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Is It Time to Become an ASAP Fellow?

By Gregory P. Barclay, M.D., ASAP President-Elect

The American Society of Adolescent Psychiatry honors long-standing members who have shown evidence of outstanding contributions to the field of adolescent psychiatry. ASAP's organizational by-laws outlines the following criteria for fellowship:



“To be a candidate for the honor of being an ASAP Fellow, the member must have been a member of the American Society for Adolescent Psychiatry (ASAP) for a minimum of eight years, and must have been actively involved in the affairs of ASAP, nationally or locally, through a constituent society or as a member-at-large.

*“Active and Life Members may be honored by election to Fellowship. A candidate for ASAP Fellowship shall be **evaluated** on five parameters:*

- a. Certification by the American Board of Psychiatry and Neurology, the Royal College of Physicians and Surgeons of Canada, the American Board of Adolescent Psychiatry, or their equivalent.*
- b. Active participation in the affairs of the community, particularly with reference to the psychiatric needs of youth.*
- c. Outstanding clinical and administrative contributions to mental health services, particularly those serving the needs of youth.*
- d. Outstanding contributions to the teaching programs of a hospital, clinical, medical school, or other academic institution, including aspects of adolescent psychiatry.*
- e. Contributions to psychiatric research and/or publications.*

“A candidate for ASAP Fellowship may be recommended by a constituent society, by members of the Governing Board, or upon recommendation of three ASAP Fellows.

- a. Nomination by a constituent society: The local society must thoroughly evaluate the candidate's credentials, including satisfactory completion of the Nomination for Fellowship Form and supporting letters. If the local society determines that the candidate qualifies to be a Fellow, all supporting material should be sent to the ASAP Membership Committee.*
- b. Nomination by a member of the Governing Board: The Board member should be personally familiar with the candidate's credentials, and whether he meets the criteria for fellowship, including satisfactory completion of the Nomination for Fellowship Form. If so, the Board member shall send all supporting material to the ASAP Membership Committee*
- c. An ASAP member in good standing who believes that he may meet the criteria for fellowship shall complete the Nomination for Fellowship Form, obtain letters of recommendation from at least three ASAP Fellows, and submit the Nomination for Fellowship Form, the recommendation letters, and any other supporting data to the ASAP Membership Committee.*
- d. If a nominee is a member of a constituent society, the Membership Committee shall ask the constituent society for its recommendation, and that recommendation will be taken into account in the Membership Committee deliberations.*
- e. In all cases, the Membership Committee will review the credentials and make a recommendation at the next Governing Board Meeting. Election to Fellowship shall be made by a two-thirds majority vote of the Governing Board.”*

Continued on pg. 16

If you fulfill these criteria, or desire to nominate an ASAP member who fulfills Fellow status criteria, we are interested in hearing from you! Our membership committee plans to review applications and nominations this fall for inclusion at our annual meeting in New York in March, 2015. Please address any nominations or inquiries to our Executive Director, Frances Bell, at frda1@airmail.net or by regular mail at our central office.

Report from the Nominating Committee

The Nominating Committee is pleased to announce the slate of officers for election at the ASAP Member Business Meeting. The position of Representative at Large is open for nomination, including self nomination. If you have a nomination, please send the information to Frances in the Central Office at: frda1@airmail.net

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President-Elect: Manuel Lopez Leon, M.D.

Vice President: Jesse Raley, M.D.

Treasurer: Eric Williams, M.D.

Representative at Large: Open for nomination

MIT Representative: Frank Tedeschi, M.D.

R. Gregg Dwyer, M.D., Chair of the Nominating Committee