

american society for adolescent psychiatry

P.O. Box 570218 • Dallas, Texas 75357-0218 • (972) 613-0985 • Fax (972) 613-5532

Roxanne Lewin, M.D., Editor

Summer 2015

ASAP Officers

| | |
|---------------------------|--|
| President: | Gregory P. Barclay |
| President-Elect: | Manuel Lopez-Leon |
| Vice President: | Jesse Raley |
| Treasurer: | Eric Williams |
| Secretary: | April Carpenter Richardson |
| Members at Large: | Lois T. Flaherty Roxanne Lewin Frank Tedeschi |
| Immediate Past President: | Sheldon Glass |
| Past President: | R. Gregg Dwyer |
| Newsletter Editor: | Roxanne Lewin |
| Journal Editor: | Lois T. Flaherty |

In This Issue . . .

| | |
|-------------------------------------|--------|
| From the President | pg. 1 |
| Welcome New Members..... | pg. 2 |
| APA Doings | pg. 3 |
| In Memoriam | pg. 5 |
| PRMS | pg. 6 |
| A Review of K2..... | pg. 9 |
| Emerging Adults..... | pg. 10 |
| Pharmacology Corner | pg. 11 |
| ADHD Diagnosis..... | pg. 12 |
| Highlights ISAP/ASAP Conference.... | pg. 13 |
| 2015 Governing Board | pg. 15 |
| PRMS Ad..... | pg. 17 |

FROM THE PRESIDENT GREGORY BARCLAY, M.D.

Summer greetings from The American Society for Adolescent Psychiatry! As the only professional society of mental health professionals devoted exclusively to advocating for the needs of teenagers, now is an exciting time to renew membership or join ASAP. Our 2015 annual meeting, held in March in New York and co-hosted for the first time by the International Society for Adolescent Psychiatry and Psychology, was a great success with almost 300 professionals in attendance. Participants earned up to 27 CME credits attending the many workshops, lectures, poster sessions, and symposia over 4 days. For those of you who were unable to attend some of the presentations or the meeting, we have posted most of the presentation power point slides on our website, so please visit <http://adolescent-psychiatry.org/news-events/presentations>.



In addition to the varying presentations and CME, for the first time in 10 years, we sponsored the certification examination in adolescent psychiatry at our 2015 annual meeting in New York. We have made the organizational commitment to resume this board certification opportunity for psychiatrists working with adolescents and their families as an *exclusive ASAP member benefit*. Further information regarding the 2016 certification exam and procedures can be found on our organizational website, <http://adolescent-psychiatry.org/public-resources/board-certification>. We have also established additional new member benefits, including identification on our website as a specialist in adolescent psychiatry, and subscription to our quarterly peer-reviewed journal "Adolescent Psychiatry".

Plans are currently in progress for next year's annual meeting, to be held March 18-20, 2016 in New York. This meeting will be a truly unique opportunity for our members as well as many others interested in the field of adolescent psychiatry. It will be a 3-day review course covering the depth and breadth of adolescent psychiatry, and is designed particularly to prepare members to pass our certification examination to become board certified experts in the field. We would also like to invite residents, fellows, and other professionals to attend this course, which will cover the gamut from normal adolescent development through new and specific evidence-based psychotherapy

Continued on pg. 2

ASAP Web Site: <http://www.adolescent-psychiatry.com> • e-mail: adpsych@aol.com

Mark Your Calender

The 2016 ASAP Annual Meeting will take place in New York, New York March 18-20, 2016. The theme of the 3-day conference will be "Adolescent Psychiatry: Past, Present and Future".

Manuel Lopez-Leon 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 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.

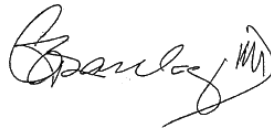
For drop-in ads, rates are as follows: Underwriting a complete issue, \$1500. This entitles the advertiser to exclusive advertising rights in that issue, with two full pages of advertising. Full page ad: \$350; one-half page ad: \$250; one-quarter page ad: \$150.

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.

and pharmacotherapy for specific adolescent disturbances. We are offering a one-time incentive for any diplomates certified by the former American Board of Adolescent Psychiatry (now subsumed by ASAP) whose certification has lapsed or are due for recertification this year: Attend the 2016 Annual Meeting Review Course and you will be recertified without any other requirements! Therefore, make plans now to attend the 2016 annual meeting, which will be organized and directed by ASAP President-Elect, Manuel Lopez-Leon, M.D.

Your officers and governing board have been particularly busy this year working to increase awareness of ASAP on the web as well as in various training programs and other professional organizations in order to build new members and keep our organization vibrant and successful. To do this, we need a strong member base to begin with and you will help us by renewing your membership immediately when you receive your dues notice this coming fall. Every member is important, and every member counts! Please let me or any member of the ASAP governing board hear your ideas about what ASAP might be able to do for you or prospective members and I hope to see you in New York next March!



Gregory Barclay, M.D.
ASAP President

Welcome New Members:

Laura Ballarè, Ph.D.
David Bowman, M.D.
Marta Brana, M.D.
Laura De Rosa, M.D.
Pamela Foelsch, M.D.
Bryant Gaddy, M.D.
M. Frampton Gwynette, M.D.
Mfon Inyang, M.D.

Arahcana Kathpal, M.D.
Aaron Krasner, M.D.
Tarun Kumar, M.D.
Raj Loungani, M.D.
Matthew Neltner, M.D.
Anna E. Odom, Ph.D.
Rashmi Parmar, M.D.
Enrique Vargas, M.D.

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>

APA DOINGS... Notes from the 168th Meeting of the American Psychiatric Association, Toronto, CA May 15-21, 2015

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

Once again, greetings, ASAPers from your representative from ASAP to the APA Assembly. I have been back from Toronto for several weeks trying to figure out why I have been so delayed in reporting on the business side of this APA meeting. I can only conclude that among other things it was the absence of real hot-button issues this time around, insofar as we were not debating gay marriage or limitations on abortion clinics or any other issue that divides liberal and conservative psychiatrists, just as they do the general public.

First, as to the APA itself, the organization seems healthier now than at various times in the past few years. Under the new CEO/Medical Director, Saul Levin, there have been a number of key personnel changes and new initiatives and an improvement in the financial health and membership rolls. In particular, Treasurer Frank Brown reported \$5 million in revenue over the past year, still significantly due to sales of DSM 5, but according to him, investment income also increased significantly, to \$4.2 million. Membership has reversed its decline and now exceeds 35,000. Expectations are that the Toronto meeting will do well financially as well.

For the rank and file, the APA Staff Directory has now been posted online (login required), and the APPI website has been upgraded for ease in book shopping. We are also posting a new website to help direct people to our colleagues in their communities, called www.findapsychiatrist.org. You should check it out to see what it looks like, but one does need to sign up to be included. If there are no proper instructions for doing so on the site, it is suggested you email Jon Fanning at jfanning@psych.org. This should hopefully steer more patients to those of us who are listed on the site.

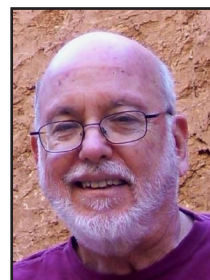
Also of note, the APA has at length produced a new overall branding strategy, one aspect of which is to have replaced the various APA logos, which have grown in number haphazardly over the years as different APA components have been created, with a unified one for all APA functions and entities. If you haven't already

seen it, look for it on your next APA communication. Those of us who sat around patiently for this year's convocation of fellows were treated to its unveiling for the first time and, even better, were given mugs with the logo imprinted for our troubles.

As you may know, Dr. Summergrad stepped down as APA President to be replaced by my old friend, Renee Binder, a well-respected forensic psychiatrist whose pedigree includes teaching at UCSF and being past president of the American Academy of Psychiatry and Law. Her slogan seems timely: *No Health Care without Mental Health Care*, which will keynote her efforts to advance the cause of improved access to mental health and addiction services as well as furthering the push for parity for mental health providers.

If there was a hot button issue, it was the recurring one of MOC. There remains a good deal of ferment regarding this issue and in order to hear her side, we invited Lois Nora, MD, President and CEO of ABMS (American Board of Medical Specialties) to speak to the Assembly. She acknowledged widespread unhappiness with things as they are but also stood up for the concept of recertification, and stated that there was "some evidence" that MOC 'improves outcomes' in patient care (something that nearly all of the critics find doubtful at best), but accepted that 'more study' is needed. She did recognize that the part of MOC, part 4, regarding quality improvement, was being looked at so as to apply sensibly to smaller medical practices. We'll see. She did not promise any significant changes, however, except that they aim to make the recertification exams less expensive and onerous by, among other things, researching the possibility that the exams can be taken at home.

Some years back as a result of the various financial crashes, APA, in crisis mode, cut back on many of its expenditures. However, now it is cautiously expanding



Continued on pg. 4

some of its benefits involving governance. Among other things, this led to the Assembly passing a reorganization plan that will allow a somewhat extended and more equal representation for smaller district branches and state associations. It is somewhat inside baseball for us, except that for the first time ever it accepted responsibility for covering the costs of attending the fall Assembly meeting for representatives of affiliated organizations (read: me). While everyone pays for their expenses at the annual meeting on the assumption that they are there anyway, or should be, for the scientific portion, the fall meeting is strictly business: it gives no CME or any similar incentive to come. It is always in Washington, DC, which is one reason I have represented ASAP for so long: I live here and have, in essence, no expenses. However, this development opens up the possibility that another member of ASAP can consider applying for my job without the burden of having to finance his or her travel to the fall meeting.

Also, just so you know: those of us from affiliated organizations (us, forensic, group, emergency psychiatry, and others) have heretofore constituted what has been called the Assembly Affiliated Organizations Liaison (AAOL). Now, however, because a couple of other organizations that could not be characterized as affiliated organizations (the APA Senior Physicians, for example) the name of the group has been changed to The Assembly Committee of Representatives of Subspecialties and Sections (ACROSS).

Any of you who happened to know colleagues Prakesh Desai, MD, a past speaker of the Assembly, and Herb Peyser, MD, an 'iconic' presence at the Assembly for many years from New York City, will be saddened to hear of their deaths.

Among the various action papers offered and approved by the Assembly, notable ones included: encouraging state and national governments to enable psychiatrists to use 'effective systems of immediate payment to insurance paneled psychiatrists or the patients of those who have opted out' using secure card or mobile technology; taking various steps to remedy

the scandalous fact that rape test kits have piled up in various jurisdictions and have not actually been analyzed, sometimes for years; approving a position statement in favor of assisted outpatient treatment (AOT—also known as outpatient commitment) so as to have its voice heard as the Murphy bill progresses through Congress; encouraging psychiatrists to develop a 'basic level of military cultural knowledge' in order better to treat veterans and their families; working to influence all jurisdictions to 'eliminate conditions contributing to emergency boarding of individuals with psychiatric disorders'; approving a work group including senior psychiatrists to explore ways to 'best meet the needs of these members within the APA'; taking further steps to deal with insurance companies that 'continue to fail to be in compliance with ACA and the Mental Health Parity Act; and creating and adopting a position statement "addressing the mental health impact of extreme weather events and natural disasters resulting from global climate change."

All of these recommendations now go to the Board of Trustees directly or the Joint Reference Committee (joint because it includes Trustees and Assembly executives) for further action.

That pretty much sums it up. There were some impressive scientific advances noted, including that one neuroscientist has been somehow able to take a brain, dissolve out the structural elements and replace them with a clear gel, allowing one to observe all of the tracts with never before seen clarity. Many scientists have started using this for their own research, and lots of fascinating discoveries are likely on the way.

Toronto is a clean, lovely town, with good restaurants, music, the space needle, and, of course, friendly people. Sitting through two days of meetings is a stiff price to pay, but worth it for time spent dining and schmoozing with old friends from all over that one may only see twice a year.

In any case, God willing and the crick don't rise, you will be hearing from me again in December.



In Memoriam

Dr. Max Sugar

Dr. Max Sugar of Denver, CO. 89, Formerly of New Orleans, passed away June 22, 2014. Husband of the late Barbara. Father of Mike, David (Linda), Melissa, Roxanne Sugar. Services were held at the Hebrew Educational Alliance, with his burial at Golden Hill Cemetery. Dr. Max Sugar was a past president of The American Society for Adolescent Psychiatry and served on the editorial board of Adolescent Psychiatry. He was an Emeritus Professor at LSU. Dr. Sugar was also an accomplished artist. Contributions in his memory may be made to: Dr. Max Sugar Professorship in Child/Adolescent Psychiatry at LSU School of Medicine, C/O LSU Health Science Foundation New Orleans, LA 70112 or the American Cancer Society.



Dr. Virgil M. Cox, Jr.

Dr. Virgil M. Cox, Jr. died on May 1, 2015 at his home. Dr. Cox was born in Hattiesburg, Mississippi on August 10, 1931. The family moved to Houston when he was five where he was raised. His pre-med education was at Baylor University and University of Houston. In 1956, he received his M.D. from University of Texas Medical Branch in Galveston. In 1957, he completed an internship at Methodist Hospital in Dallas. He was called to two-years active duty in the United States Air Force as a general medical officer at Ernest Harmon Air Force Base in Stephenville, Newfoundland. While there he functioned as the base psychiatrist. It was there that he began to develop his avocational interest in theater, writing, directing and acting in an officers' revue and starred in a production by a local theater group. He completed his residency at Duke University Medical Center in 1962. While in Durham he met and married his wife of 53 years Barbara McSwain. From Durham the couple came to Fort Worth where Dr. Cox started his practice in 1962 with an emphasis on child and adolescent psychiatry. He took great pride in winning the Herman Staples Award for service to the Society of Adolescent Psychiatry. He was a member of the Tarrant County Medical Society, the American Medical Association and had a lifetime fellowship in the American Psychiatric Association. Gifts in his memory may be made to Ridglea Presbyterian Church; or to a charity of your choice.



INDEPENDENT EVALUATIONS IN CHILD CUSTODY DISPUTES

Although performing independent evaluations is typically a low-risk area for the child and adolescent psychiatrist, we do occasionally see claims resulting from such work. These cases typically involve common missteps. Accordingly, if you are contemplating entering this area of practice you may want to consider the following observations and suggestions.

1. Treating clinicians are often asked to assume, or are pressured into assuming, the additional role of performing independent evaluations for child custody disputes. If both treatment and evaluation roles are assumed, the clinician will almost certainly be faced with conflicting demands that ultimately impact negatively upon the treatment relationship.
2. Once you determine that there are no conflicts, and agree to perform a custody evaluation, it is important for the side that is retaining you to clearly define your role as evaluator and the type of evaluation being requested. Do not accept an assignment where the retaining party attempts to influence the integrity of the evaluation. For example, if you will be acting on behalf of one party to a custody dispute, you should not profess, at the retaining party's urging, to be impartial or to be in a position to give an unbiased opinion about the overall custody determination or evaluation.
3. It may be a violation of a state's licensing laws to perform an examination in a state where one is not licensed to practice. If approached to do such an evaluation, confirm with that state's physicians' licensing body that there are not statutory or regulatory proscriptions.
4. The retaining party should supply the information and materials needed to conduct a careful and reasoned assessment. At a minimum, this may consist of prior medical/mental health treatment records (including any hospital admissions), school reports, and psychological raw data, as well as pertinent legal documents. If the retaining party withholds relevant information, consider refusing the assignment. Limited access to information has the potential to adversely affect the quality of the evaluation.
5. Before performing an evaluation and rendering an opinion, ascertain who has the legal authority to consent to the evaluation of the child. The legally authorized party should give written consent for the specific purpose of the evaluation. The legally authorized party should also sign an authorization form prior to the examination that includes permission to disseminate the report to the appropriate parties and to permit your testimony at deposition and/or trial, if required. Note that HIPAA's Privacy Rule allows providers performing independent evaluations to condition services (i.e., the evaluation) upon receipt of an authorization for the release of protected health information.

Continued on pg. 7

6. Clarify who will own or have access to any reports, notes, or records of the evaluation once the assignment is complete. Discuss this with the evaluatee (or the legally authorized representative) and document that conversation.
7. Clarify the nature of the relationship with the evaluatee (or the legally authorized representative), provide information about the purpose and limits of the evaluation, and document that discussion. You must make it clear that you are not an evaluatee's "treatment provider" but have been retained solely to evaluate and give an opinion.
8. If the evaluation is court ordered and the evaluatee (or legally authorized representative) refuses to participate or cooperate adequately, the report should be prepared advising of the failure to participate. It may not be possible to provide a complete opinion in this instance. In such cases, it may be appropriate to report that limited conclusions or no conclusions were reached due to the failure to cooperate.
9. The written report is a pivotal piece of information in an independent evaluation. When preparing a report include at least the following:
 - Who requested the examination/evaluation
 - Reasons for the consultation
 - Issues you were asked to address or questions you were asked to answer
 - List all material that has been reviewed as part of the evaluation and opinion, including the evaluatees' records, school reports, legal documents, etc.
 - Document all elements of the evaluation(s) that are relevant to the issues
 - Document who was evaluated, interviewed, contacted, telephoned, etc., for the report; include dates when seen/interviewed and the time spent in the session
 - Identify the clinicians/treating facility responsible for follow-up and treatment (if any)
 - Prepare a clear, succinct conclusion
10. The data in the report should be comprehensive enough to support the conclusions and recommendations.
11. Remember that testimony in a deposition or in court may take place months after an evaluation. Thus, the final report should be comprehensive enough that relevant information can be conveyed even months after the evaluation is completed.
12. If a deposition is requested, be well-prepared for it. The attorneys will question the report and its conclusions, sometimes quite vigorously. If you are a frequent expert witness in similar cases, the attorneys involved will often have transcripts from testimony in prior cases, and prior testimony can be used to attack your credibility.

Continued on pg. 8

Consider similar cases and whether testimony in the current case is consistent with testimony in prior cases. If not, be very clear on the distinctions.

13. Expert testimony may be subject to peer review. Accordingly, know and follow the applicable standards governing forensic practice, such as documenting examinations, identifying personal opinions as such, identifying material relied on in reaching conclusions pursuant to the evaluation, etc. Some states have statutory requirements about the necessary qualifications for professionals who give forensic testimony.

14. A mental health provider agreeing to perform an independent evaluation should have the appropriate knowledge, training, and skills before conducting a forensic evaluation. Several professional organizations have published guidelines about conducting child custody evaluations.

Compliments of:



| | |
|----------|--|
| Call | (800) 245-3333 |
| Email | TheProgram@prms.com |
| Visit us | www.psychprogram.com |
| Twitter | @PsychProgram |

The content of this article ("Content") is for informational purposes only. The Content is not intended to be a substitute for professional legal advice or judgment, or for other professional advice. Always seek the advice of your attorney with any questions you may have regarding the Content. Never disregard professional legal advice or delay in seeking it because of the Content.

©2015 Professional Risk Management Services, Inc. (PRMS). All rights reserved.

Synthetic Cannabinoids – A Review of K2

By: Roxanne Lewin, M.D.

K2 is a mixture of herbs, spices or shredded plant material that is typically sprayed with various synthetic cannabinoids. JWH-018, JWH-073, JWH-200, CP-47,497 and cannabicyclohexanol are the most well-known examples of synthetic cannabinoids (SCBs) contained in K2. The uneven distribution of those substances within the plant material can lead to accumulation of drug in “hot spots” and increase the risk of overdose. K2 – named after the world’s highest mountain – is a commonly used name but synthetic cannabinoid products are sold under various names, such as “Spice, herbal incense, fake weed, Yucatan Fire, Skunk, Moon Rocks”. The package is often unlabeled or wrongly labeled and subject to frequent composition changes without notice to buyers.

Spice products are popular among young people. Of the illicit drugs most used by high-school seniors, they are second only to marijuana. They are more popular among boys than girls — in 2012, nearly twice as many male 12th graders reported past-year use of synthetic marijuana compared to females in the same age group. Easy access and the misperception that Spice products are “natural” and therefore harmless have contributed to their popularity.

Like marijuana, K2 products are usually smoked in joints or pipes and some users make it into a tea. The increased use of e-cigarettes, vape pens and hookah pens especially in high schools and universities have now made the liquid form of K2 a growing trend.

Synthetic cannabinoids are full agonists at the two endogenous cannabinoid receptors, CB1 and CB2. Although chemically related to delta 9-tetrahydrocannabinol (THC), the main psychoactive agent in *Cannabis sativa* (marijuana), their effect is more intense than THC. Synthetic cannabinoid receptor agonists have a significantly higher potency that leads to an exaggerated psychoactive state – a greater high.



The acute psychoactive effects include changes in mood, perception, thinking, memory, and attention – similar to marijuana. Adverse events necessitating intervention by Poison Control Centers, law enforcement, emergency responders, and hospitals are increasing. K2 has been associated with many severe adverse effects that are

not commonly observed with marijuana use such as tachycardia, hypertension, nausea, vomiting, convulsions, agitation, hallucinations, psychosis, rhabdomyolysis, renal failure, respiratory depression, and acute myocardial infarction.

The onset of action this drug is 3-5 minutes, and the duration of the high is 1-8 hours. The variable duration of action is explained by the many active metabolites of SCBs.

For many years, K2 products have been easy to purchase, at low cost, in head shops, gas stations and on the internet. Because the chemicals used in K2 have a high potential for abuse and no medical benefit, the Drug Enforcement Administration (DEA) has designated the five active chemicals most frequently found in the drug as Schedule I controlled substances, making it illegal to sell, buy, or possess them.

Synthetic cannabinoids are not detectable by standard urine drug screens. This is another reason why K2 products have become attractive to users. However, the presence of many SCBs can now be detected through gas and liquid chromatography combined with tandem mass spectrometry.

The struggle to quell the rise of synthetic cannabinoids has been difficult. The manufacturers of K2 products attempt to evade legal restrictions by substituting different chemicals in their mixtures. However the DEA continues to monitor the situation and evaluate the need for updating the list of banned cannabinoids.

Engaging Emerging Adults Using a Developmental Perspective

By: Dominic Ferro, M.D.

At the Annual Meeting, Lynn Ponton, M.D. spoke about the developmental issues involved in treating young people in the range of 17-25 years old. Dr. Ponton described these as “the most volitional years” of development, because they have the autonomy of adulthood, but many of the choices that will define their adult lives are yet to be made. Although it is the age of emerging mental illness, the rate of dropping out of treatment is two to five times more frequent than for adolescents. In many ways, this stage is more challenging to treat than adolescence.

The tasks of emerging adulthood are an extension of the tasks of adolescence, but with greater complexity. Separation and individuation from parents continues. The presence of mental illness makes it more likely that young adults will live with their parents, but separation and individuation must be negotiated even while living together. Identity formation, developing the sense of who they would like to be, is another important task.

Establishing intimate relationships is one more challenge of this age, and is an area of experimentation. In general, developing a sense of confidence and mastery through healthy risk taking is important. The brain development during these years is such that centers involved in motivation, desire and impulse control are still developing. The emerging adult is trying to understand themselves and to find a healthy manner of living. During this period of experimentation, the risk of exposure to trauma is increased, and coping with trauma can be part of this developmental phase. This includes vicarious trauma through exposure in the varied media to which young adults are connected.

The practitioner treating emerging adults should have sensitivity to society’s changing cultural and economic conditions. The trend toward decreasing connectedness in families as they are spread across greater geographical distances is one such factor. Others are the rising costs of living and increase in global competition for employment. Presently emerging adults are aware that they may not be as successful financially as previous generations, which can undermine the sense of self-efficacy. Increasingly,

they are pressed into unpaid internships as a means of achieving employment.

Cultural changes have created key subgroups within the present generation of emerging adults. Many are living independently, but 22% live in their family home, which is the highest percentage since 1950. More young people are attending college, but as many as 50% may not complete undergraduate education. Significant subgroups are serving, or have served, in the military, and another subgroup has been incarcerated. Homelessness among young adults has increased. Seriously mentally ill and substance abusing subgroups also present for treatment.

The emerging adult who presents for therapy will require special attention to these issues. Although no longer adolescents, they still will require the therapist to engage them in a warm manner. The therapist should facilitate the client identifying their own treatment goals. Role-playing areas of choice and compromise can be useful, particularly with regard to conflict with their families. Trouble-shooting is indicated as they face life transitions and decide how to meet societal expectations. Validating their experience of change and facilitating positive change is an important aspect of therapy.

Emerging adults with mental illness face all of these developmental tasks, in addition to learning to manage their illness. The developmental issues will affect their compliance with treatment, and attention must be paid to how they view the risks and benefits of treatment. The young person will benefit from accepting that the diagnosis is part of who they are, but that it need not define them. Young people may require more direction in accessing needed services.

Dr. Ponton spoke about the importance of developing a frame of treatment. She identified five useful perspectives that inform this frame.

The first is relational-dynamic, which incorporates traditional dynamic principles with greater attention



Continued on pg. 11

to the therapeutic relationship. As with adolescents, more self-disclosure might be appropriate.

The second perspective is family and cultural. Individual therapy with the youth might involve meeting with the parents with or without the patient present. At the least, an awareness of the family dynamics is important, and facilitating effective communication with their family is an important target.

The third perspective is a CBT and symptom-based approach. With cognitive skills continuing to develop, the identification of automatic thoughts and false beliefs is a valuable skill. DBT mindfulness practices are often useful, as well.

The fourth perspective, meaning making, mirrors CBT. Their sense of identity and purpose are important areas of cognition. Spiritual, philosophical and existential questions are being viewed anew by the emerging adult.

The final perspective is biological. Undermining the sense of mind-body dualism remains a challenge for our profession, as well as for our patients. Understanding the biological basis for psychiatric disorder, as well as for attachment, trauma and impulsivity, is valuable to young people, who are trying to understand themselves.

The treatment of emerging adults presents unique challenges. The therapist must find a balance between being directive, as with adolescents, and assuming self-determination, as with adults. The chemistry with the therapist is important, and the therapeutic alliance must be reassessed throughout. The young person's sense of emerging independence might require periodic breaks from treatment. However, the work can be rewarding, as adult patterns of behavior are being shaped, and the impact of effective interventions can be dramatic.

Pharmacology Corner

Featured Drug: Vayarin

The diagnosis of ADHD for some is a heavy one and parents often ask about alternatives to stimulants. Here comes Vayarin, a "medical food", containing Phosphatidylserine (PS) in conjunction with the omega-3 fatty acids DHA and EPA. Research suggests that ADHD may be associated with lower levels of those substances. Omega-3 fatty acids have an anti-inflammatory effect and may influence neurotransmitter levels while PS is said to improve the uptake of DHA and EPA in the brain. As a medical food, Vayarin does not have to undergo FDA approval and is not subject to FDA regulations pertaining to drugs. The same FDA regulations that apply to other foods apply to medical foods as well in terms of standards of processing, labeling etcetera. Medical foods are "designed to be consumed under the supervision of a health care provider". Although a medical food does not need to be prescribed by a physician, Vaya Pharma, the maker of Vayarin, does require a prescription.

Does it work? A systematic review by Bloch et al. published in the Journal of the American Academy of Child and Adolescent Psychiatry in 2011 ("Omega-3 fatty acid supplementation for the treatment of children with attention-deficit/hyperactivity disorder symptomatology: systematic review and meta-analysis") concluded Omega-3 fatty acid supplementation, particularly with higher doses of EPA, was modestly effective in the treatment of ADHD. The relative efficacy of omega-3 fatty acid supplementation was only modest compared to currently available ADHD medications such as the stimulants or Atomoxetine. Based on the benign side effect profile of omega-3 fatty acids, the authors recommended its use as an add-on treatment to traditional pharmacological interventions or for families who decline other psychopharmacological options.

A study conducted on 200 children with ADHD randomized to either Vayarin or placebo found improvements in the parent Conner rating scale for ADHD after 3 months of treatment. Patients take 2 capsules daily, the capsules can be opened and sprinkled onto food. Treatment effects are expected to appear after 30-90 days. Prescription and pharmacy information is available on the company's website. This medical food may not be the solution to everyone's symptoms but it adds to the options we can give our patients.

ADHD in the DSM-5: Good News for Adolescent Doctors

By: Julia Holtmann, M.D.

Attention Deficit Hyperactivity Disorder (ADHD) is a chronic, persisting neuropsychiatric disorder that affects children and adults in varying degrees. The disorder is characterized by inattention, hyperactivity and impulsivity. Previously thought to be a disorder of childhood, it has been found that symptoms may persist in 65 % of cases to adulthood. Untreated ADHD may have significant negative impact on an individual's academic, occupational and social functioning. Youngsters with ADHD are at risk for social rejection and poor school performance. Adults with untreated ADHD have been found to have higher divorce rates, a greater number of car accidents and hold lower position jobs when compared to individuals whose ADHD symptoms were treated in childhood.

The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders Fifth Edition) made no changes to the symptoms of inattention and hyperactivity/ impulsivity listed in DSM-IV. It does introduce changes in two areas particularly relevant to adolescent and adult patients.

DSM-5 recognizes the difficulty of retrospectively establishing the onset of ADHD symptoms in early childhood, therefore, symptom onset now needs to be documented before age 12 years, as compared to 7 years of age in DSM-IV.

Also, ADHD symptoms may manifest differently, based on age and developmental stage. The DSM-5 elaborates further by giving helpful examples. A hyperactive preschooler may be swinging from the chandelier, while the hyperactive adolescent may describe a feeling of restlessness and the young adult be perceived as being difficult to keep up with in meetings. An impulsive 7 year old runs onto a street without looking, the adolescent/ young adult is prone to making hasty decisions without considering long-term consequences. Inattention may be less noticeable in a college-setting as compared to an elementary school classroom. For all those reasons, individuals 17 years and older now have to meet only 5 of the nine criteria in each symptom cluster. Patients younger than 17 years still require 6 of nine symptoms of hyperactivity/ impulsivity and/or inattention to be considered for the diagnosis.

As physicians dealing with adolescent mental health, we know all too well how mental health problems can affect the already fragile state of growing up. The DSM-5 changes are useful. They help us ask the right questions and facilitate a better understanding of this disorder that can potentially lead to significant negative consequences if left untreated.

Mentors Needed

Do you want to make a difference by strengthening ASAP's new and resident/fellow Membership? The ASAP membership committee is organizing a registry of ASAP general members interested in serving as mentors to new and resident/fellow members and invites you to consider participating. If this opportunity interests you, please contact ASAP's Executive Director, Frances Bell (frd1@airmail.com) or Membership Committee Chair Jesse Raley, M.D. (raleyjesse@gmail.com).

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 Jesse Raley, M.D., Book Review Editor, raleyjesse@gmail.com, with your contact information and interest areas.

Highlights from the 2015 ISAPP/ASAP Joint Conference



Drs. Sheldon Glass, Lois Flaherty, Richard Ratner and Gregory Barclay



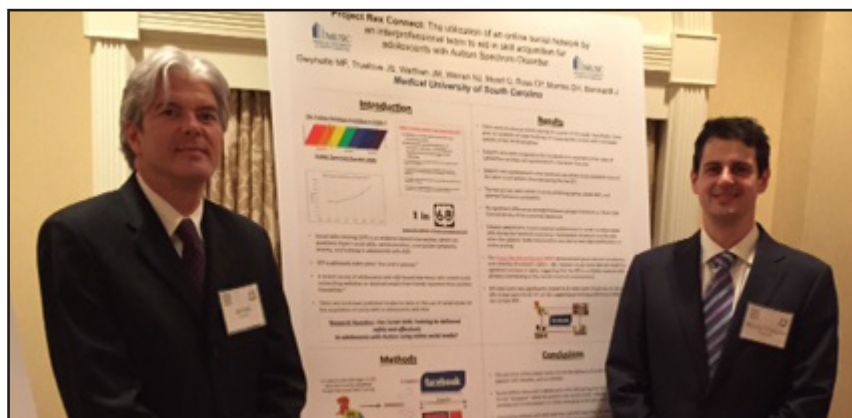
Drs. Lois Flaherty, Jennifer Bowman and David Bowman



ASAP Fellows: Drs. Ahmed Faheem, Dean De Crisce, Stephen Billick and Gregory Barclay



Drs. Sheldon Glass, and Gregory Barclay



James Truelove, MSW and Dr. M. Frampton Gwynette

Highlights from the 2015 ISAPP/ASAP Joint Conference



Dr. Gregory Barclay presenting the Staples Award to Dr. Lois Flaherty



Dr. Sheldon Glass presenting the Schonfeld Award to Dr. Efrain Bleiberg

“On the Lighter Side”



ASAP GOVERNING BOARD

PRESIDENT

Gregory P. Barclay, M.D.
1303 Delaware, #1005
Wilmington, DE 19806
O: 515-292-3023
Fax: 515-292-3053
Email: drb@drbarclay.com
March 2015 - March 2016

PRESIDENT ELECT

Manuel Lopez-Leon, M.D.
169 East 74th Street, Garden Level
New York, NY 10021
O: 212-260-1438
FAX: 212-228-3290
Email: rlopezleonasap@gmail.com
March 2015 - March 2016

VICE PRESIDENT

Jesse Raley, M.D.
Associate Clinical Professor, Dept. of
Neuropsychiatry
Univ. of So. Carolina School of Medicine
125 Alpine Circle
Columbia, SC 29223
O: 803-779-3548
FAX: 803-779-7055
Email: raleyjesse@gmail.com
March 2015 - March 2016

TREASURER

Eric Williams, M.D.
708 Cottontail Ct, S
Columbia, SC 29229-9485
Email: willier9@sc.rr.com
March 2015 - 2017

SECRETARY

April Carpenter Richardson, M.D.
Medical Director at Springbrook
Behavioral Health
111 Melville Avenue
Greenville, SC 29605
O: 803-434-4237
Email: carpe104@gmail.com
March 2014 - March 2016

AT LARGE

Lois Flaherty, M.D.
Editor-in-chief, Adolescent Psychiatry, the
official journal of the American Society
for Adolescent Psychiatry
9 Saint Mary Road
Cambridge, MA 02139-1220
Phone: 215-478-3568
FAX: 267-657-1341
Email: lflaher770@aol.com
March 2014 - March 2016

Roxanne Lewin, M.D.
6050 East Palisade Avenue, Suite 2-282
Englewood Cliffs, NJ 07632
Email: rl Lewinmd@gmail.com
March 2014 - March 2016

Frank Tedeschi, M.D.
221 East 11th Street, Apt. #1A
New York, NY 10003
Email: Frank.Tedeschi@nyumc.org
March 2015 - March 2017

MIT Representative

Ryan Leahy, M.D.
99 N. Main Street, Apt. 1302
Memphis, TN 38103
Email: rleahy1@uthsc.edu
March 2014 - March 2016

Andrea Brandon, M.D.
321 E. 48th Street, 11L
New York, NY 10017
Phone: 646-712-2719
Email: andrea.brandon@nyumc.org
May 2015 - March 2017

IMMEDIATE PAST PRESIDENT

Sheldon Glass, M.D.
National Medical Director, MedMark, Inc.
Assistant Professor of Psychiatry, Johns
Hopkins School of Medicine
Ste. 405, 3635 Old Court Road
Pikesville, MD 21208-3908
O: (410) 484-2700
FAX: 410-484-1949
Email: sheldonglass7@gmail.com
March 2015 - March 2016

PAST PRESIDENT

R. Gregg Dwyer, M.D., Ed.D.,
Associate Professor
Director, Community and Public Safety
Psychiatry Division
Dept. of Psychiatry & Behavioral Sciences
Medical University of South Carolina
29-C Leinbach Drive
Charleston, SC 29407
O: 843-792-1461
Email: dwyer@musc.edu
March 2014 - March 2015

HONORARY PAST PRESIDENT

Perry B. Bach, M.D., FASAP
12620 Old Pueblo Road
Fountain, CO 80817-3717
O: 719-382-6667 FAX: 719-546-4770
Email: perrybbach@aol.com

NEWSLETTER EDITOR

Roxanne Lewin, M.D.
6050 East Palisade Avenue, Suite 2-282
Englewood Cliffs, NJ 07632
Email: rl Lewinmd@gmail.com
Appointed: March 2014

COUNCIL ON CERTIFICATION

Co-Chairs:

Dominic Ferro, M.D.,

Email: drferro@optonline.net and

Richard A. Ratner, M.D.,

Email: raratner@ratner.com

Members: Gregory Barclay, Lois Flaherty,
Sheldon Glass, Anne LaForte

CENTRAL OFFICE

Frances Roton Bell

PO Box 570218

Dallas, TX 75357-0218

O: 972-613-0985

FAX: 972-613-5532

Email: frda1@airmail.net

COMMITTEE CHAIRS:**Committee on Administration**

Manuel Lopez-Leon, M.D.

Email: drlopezleonasap@gmail.com

Committee on Bylaws

Dominic Ferro, M.D.

Email: drferro@optonline.net

Committee on Finance

Eric Williams, M.D.

Email: willier9@sc.rr.com

Committee on Membership

Jesse Raley, M.D.

Email: raleyjesse@gmail.com

Members: R. Gregg Dwyer, April
Richardson, Eric Williams

Committee on Program

Manuel Lopez-Leon, M.D.

Email: drlopezleonasap@gmail.com

Committee on Publications

Lois Flaherty, M.D.

Email: lflaher770@aol.com

APA Assembly & AAOL Representative

Richard A. Ratner, M.D.

Email: raratner@ratner.com

LIAISON TO AAPL/AAFS/ASAM

Richard Rosner, M.D.

Email: rosner01@nyumc.org

CME Officer

Glen T. Pearson, M.D.

Email: Glentpearson@gmail.com

SOCIETY REPRESENTATIVES:**Honorary-at-Large Representative**

Phillip Katz, M.D.

Email: pkatz@cc.umanitoba.ca

New York

Richard Rosner, M.D.

Email: rosner01@nyumc.org

Email for ASAP: adpsych@aol.com

Web site:

www.Adolescent-Psychiatry.com

List serve addresses:

All ASAP Members with email:

asap@mailman.srv.ualberta.ca

March 2015

YOU CAN COUNT ON US.

// We have underwritten more than 20,000 psychiatrists since 1986. This psychiatric-specific expertise allows our knowledgeable and relevant approach to underwriting, assuring a secure source of coverage so you can count on us to be there when you need us most.

Jackie Palumbo
Executive Vice President,
Chief Underwriting Officer



In California, d/b/a Transatlantic Professional Risk Management and Insurance Services

(800) 245-3333

| TheProgram@prms.com

| PsychProgram.com/InfoRequest

More than an insurance policy



Actual terms, coverages, conditions and exclusions may vary by state. Insurance coverage provided by Fair American Insurance and Reinsurance Company (NAIC 35157). FAIRCO is an authorized carrier in California, ID number 3175-7. www.fairco.com