



# Newsletter



Dominic Ferro, ASAP President-Elect, organizer of the ASAP Annual Meeting.

**The 2006 Annual Meeting in Miami Beach at the Eden Roc Resort from March 16 to March 19 is on schedule.** Reservations are being made

and the syllabus is being compiled. The annual meeting serves important functions for our organization. First, it provides education in the much understudied field of adolescent psychiatry. Our adolescent patients rely on us to make the most of what research is available, as well as the benefits of clinic experience. Our meeting provides an educational experience concentrated on adolescent mental health. The 2006 meeting will focus on psychotherapeutic and psychopharmacologic interventions for several adolescent populations: substance abusing, self injuring and sexually

offending.

Second, the annual meeting provides an opportunity for our members to gather. The collegial, supportive atmosphere of our meetings supports the growth and development of the careers of professionals interested in the care of adolescents with psychiatric and emotional problems. The diverse areas of interest reflected in the presentations at this year's meeting are indicative of broad range of clinical and research interests represented and supported by our organization in our efforts to provide care to adolescents. Adolescence is a developmental phase encompassing a range of sociological, biological and psychological challenges, and our organization has proven open and inclusive to an equally broad range of academic and clinical interests.

Reaching out to new potential members is important to the health of our organization. The annual meeting is a great opportunity to approach colleagues who are interested in adolescent mental health. I hope that as many members as possible will be in Miami, and that they will bring along potential members, as well. Dominic Ferro. \*\*\*

## Gilfoil



James Gilfoil, Programs & Meetings Council.

**M**iami Beach in March! Can it get any better than that? Well, maybe South Beach you say. Hold on just a minute. ASAP will be at the historic and fabled Eden Roc—in the 60s the “Sands of the South.” This is where the Rat Pack hung out. Yeah, that Rat Pack. Morris Lapidus designed, the Eden Roc has undergone a \$35 million facelift over the last five years, so even though the 50s décor remains as some say “borderline tacky,” “the Roc” is still a great place to stay and is only a short ride from South Beach. It’s also right next to the Fontainebleau, another Lapidus creation, and, as he put it, “the world’s most pretentious hotel. I wanted people to walk in and drop dead.” Lapidus’ memoirs are titled, unsurprisingly, *Too Much Is Not Enough*. So, in case you were wondering, we’re not in Mies Van der Rohe country here. Speaking of hotels, there are a slew of new chic, hip—the only two overused adjectives worth using here—hotels in South Beach, many with some superb restaurants featuring excellent food and even better eye candy. And you absolutely must do the Art Deco architectural tour, before turning your mind to

**ASAP’s Annual Meeting  
The Eden Roc  
Resort**

**Miami Beach,  
March 16-19**

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## For Your Calendar

ASAP Business Meeting, October 14, 2006, Dallas, TX

**APA Annual Meeting, Toronto, Canada, 5/20-25/06.**

International Child-Adolescent Meeting, ISAP, ICAPAP, WAIMH, November, 2006. Rio de Janeiro, Brazil.

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Exec. Director, Frances Roton,  
ASAP  
P.O. Box 570218, Dallas, TX 75357  
(972) 686-6166 Fax (972) 613-5532:

**Web Site: <http://www.adolpsych.org>  
ASAP's email address is:  
[adolpsych@aol.com](mailto:adolpsych@aol.com)**

**Newsletter Editor  
[lhenschel@nyc.rr.com](mailto:lhenschel@nyc.rr.com)**

**Topical Studies Council:  
[chuffine@uwashington.edu](mailto:chuffine@uwashington.edu)**

**Book Review & Annals Editor: Lois  
Flaherty  
[lflaher770@aol.com](mailto:lflaher770@aol.com)**

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the aforementioned restaurants.

My absolute favorite restaurant in all of South Beach is Pacific Time. Located in the Lincoln Road Mall—an outdoor promenade, superchef Jonathan Eismann has been wowing diners, with his take on Pacific Rim cuisine, a fusion of Chinese, Japanese, and Thai, for ten years and he's still going strong. If you've got time for only one special meal, this is the place.

Second on my list is the unpretentious, (a word seldom used while discussing South Beach,) Wish, in the Todd Oldham designed The Hotel. Just off Ocean Drive, the garden at Wish is wonderfully calm and serene, though it may "suffer" from a lack of the attitude that you find in so many restaurants here. You know, that certain "you're so fortunate I'm your waiter (maitre d', etc.)" thing. Michael Reidt wows with his Brazilian and French influenced Continental menu. However influenced it is, his slightly understated style and understated prices—it's a veritable steal by South Beach standards. Wish is special.

My third option would be Mark Militello's Mark's South Beach in the Hotel Nash. Mark apparently was hesitant to lend his name to a restaurant in "a locale where restaurants are judged by those who eat there than by what is eaten." Exactly the problem. Despite his reservations, he made a good decision for us. Like other celebrity chef restaurants, Mark's South Beach has someone else as the actual chef—in this case executive chef Tim Andriola. Make no mistake, Andriola, if he's still there, is damn good, if a bit overwrought with some of his creations. His take on Militello's "New World Cuisine" is terrific. So, if you're a talented chef with ambition, you've got to come up with some title for your own special cuisine, then you can farm your name out to restaurants all over the country, or world for that matter, and you've got it made. It's a good gig if you can do it, but we diners need to be discriminating. That's where I come in. I will happily be your personal restaurant consultant for a very reasonable fee, considering my expertise. I will be passing out my card at my booth at the convention. Just stop by!

A case in point for my above rant would be Emeril's Miami Beach in the

Loews' hotel. Do we really need another Emeril's? Hell, I went back to the original in New Orleans (R.I.P.) a couple of years ago, and I wouldn't go back, even if it does come back. Another CIP (case in point) is Nobu in the very au courant Shore Club Hotel. Here you've got not only the celebrity chef, but the celebrity backer, i.e., Robert de Niro. Nobu is celebrity central, or at least it was last week. Check with the concierge. Oh, by the way, the food is quite good. Or you could do Blue Door, Madonna's restaurant in Ian Schrager's Philippe Starck designed Delano hotel. (This name dropping is tough on my typing.) Thankfully, Madonna is not in the kitchen, but culinary guru Claude Troisgros is "in charge." Anyway, the food is superb, if overpriced. You pay for all those names, which is what makes Pacific Time and Wish the exceptions that prove the rule.

Another serious consideration is Barton G the Restaurant. The menu is funky and fun, and, all in all, very good. Think of it as "updated American classic with a twist." You can get truffled macaroni and cheese with white and green asparagus, popcorn shrimp in a popcorn box, "Kentucky Fried Chicken," and for dessert, what else, cotton candy. I know it doesn't sound like it could be, but this place is hot. For Italian, try Casa Tua, which has a beautiful garden, Osteria del Teatro, or Spiga in the wonderful Hotel Impala—where Floridians stay when they don't go to Europe. A definitely down-scale choice is Tap Tap. Named for the colorful Haitian taxis, this is a good inexpensive option that will make you feel like you're in the Caribbean.

Two of the best restaurants in Miami aren't in South Beach. If you're up for a long cab ride, consider Norman's in Coral Gables, where one of the true culinary stars of the US practices, Norman van Aken. Or you might try his more casual Mundo. A much shorter cab ride will take you to the Mandarin Oriental Hotel and the much acclaimed Azul. The original chef recently left, but the restaurant is still getting rave reviews.

And last but not least, for an enlightening cultural experience, don't miss the Jewish Museum of Florida.

See you in Miami. It promises to be quite a trip.\*\*\*

## Book Review Corner

Regional Identity and Behavior  
by Max Sugar, M.D.

Kluwer Academic/Plenum Publishers  
reviewed by Philip Katz.

[Max Sugar is a Past-President of  
ASAP-Ed.]

This most interesting and intriguing book focuses on the topic of "Regional Identity," its composition and its significance. Dr. Sugar builds the case for regional identity by selecting four groups of immigrants who left England in the 1600s and founded colonies in America: the Puritans who settled Massachusetts, the Quakers who settled Pennsylvania, aristocrats who settled the Chesapeake Bay area, and the "back country" immigrants from the border area near Scotland who settled in Appalachia. He studies each of these disparate groups from the number of vantage points – history, family values, marriage, child-rearing, gender and sexual attitudes, education, work and freedom, developing a portrait of a regional identity. Each of these colonies was isolated and separate, made their own rules, and were free of outside influences for a number of generations.

The author then explores the contribution of those regional cultures 300-400 years later, to current personality expressions in each of those regions by looking at child development, acceptable personality traits, attitudes to education, unwed mothers, STDs, alcoholism, violence, and sexual and physical abuse of children.

What emerges is a striking picture of the regional culture's powerful influence on, and permeation of, the lives of the descendants of those colonists and the later immigrants to those areas. An exploration of the present status of the descendants of those groups that had remained in England shows a significant similarity to those of their relatives who emigrated to America.

Dr. Sugar then considers the role of Regional Identities in the practice of psychiatry, demonstrating how some areas of behavior, e.g., teenage pregnancy, would be considered quite acceptable in some regions, but would be disapproved of in others, with implications of rebelliousness

and antisocial behavior.

Regional Identity and Behavior is a valuable contribution to Psychiatry, especially Adolescent Psychiatry. Dr. Sugar makes the case for psychiatrists having to be aware of a patient's cultural background, and suggests ways that the knowledge can be used in treatment.

Philip Katz, M.D.

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Separation Anxiety in Children and  
Adolescents

by Andrew R. Eisen, Ph.D. and Charles  
E. Schaefer, Ph.D.

(Guilford, 2005), 298 pp., \$35.00

reviewed by Gregory Barclay

This is an excellent book, especially for therapists desiring a strong cognitive-behavioral approach to this common condition. It is of particular benefit to less experienced therapists since it offers specific strategies targeted to behavioral problems manifesting from separation anxiety. The authors also present strategies to deal with other co-existing problems such as Obsessive-Compulsive Disorder and Panic Disorder in children and teens.

The book is divided into six sections. The first is an overview of the condition, stressing the roles of temperament and attachment in its etiology. The second portion is dedicated to assessment, with strong emphasis placed on the use of rating scales and other psychometric measurements, an approach consistent with the authors' orientation as behavioral psychologists. The third section addresses child coping skills, including the essential importance of progressive relaxation training. Identification and replacement of cognitive distortions with supportive self-talk, the use of exposure, and learning self-control skills are also addressed in this section. Part four is devoted to parent skill training, specifically the negative impact of blaming, assuming, and over-protective maintenance parenting behaviors. The authors suggest that therapists coach parents in the targeted use of rewards and incentives, contracts, and negotiation. The fifth section speaks to consultation room strategies utilized by the therapist. Case examples facilitate the review of specific interventions for target-

ed problems, including abandonment/separation fears and school refusal. The final section is devoted to management of relapses and the difficulties presented by common comorbid conditions, frequently another anxiety disorder.

This is an excellent resource for the office-based practitioner working with anxious youth and their parents. Refreshingly, the authors do not embrace the medical model, and place a higher value on skill acquisition and problem mastery than on symptom relief using medications. While they recognize the benefits of medications in certain circumstances, their review of the research supports the reality that they have an adjunctive benefit at best. This perspective only enhances the book's value as a necessary resource for practitioners.

Gregory Barclay

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### ISAPP

The International Society for Adolescent Psychiatry and Psychology (ISAPP) announces the release of the 3rd Volume of ISAPP Publications which is available online in the website at (<http://www.isapp.org/publication.php?IDNUM=3>)

VOLUME No 3, 01/02/2006. Treatment in adolescence. Developments in Clinical Work., Selected papers, presented at the 6th International Congress of the ISAPP. Rome, June, 2003.

Among the papers are:

Clinical Dynamics during Adolescence: psychoanalytic and attachment perspective, Massimo Ammaniti. The conceptual framework of attachment has given an important contribution to the psychoanalytical theory of the infantile development shifting the emphasis from the drive model of the infants psychic functioning to the relational one.

In the shadow of grandfather. Peter Breuendl. The complex developmental task to accept one's inborn mortality and one's life being limited by birth and death thereby simultaneously propelling procreative strivings can be mastered for the first time in adolescence.

Insecure attachment, self-regulatory difficulties and self-cutting in adolescence, Shelley R. Doctors. In this paper I focus on self-cutting as a self-regulatory behav-

ISAPP, con't on Page 7

## From Our members

Got Ink or Steel? Why Ask?:  
Adolescents with Tattoos and Piercings  
by R. Gregg Dwyer, M.D., Ed.D. and  
Fabian M. Saleh, M.D.

Except for women's pierced earlobes and some tattooed members of the military, tattoos and piercings were once infrequent in the United States and when seen were typically associated with the fringe of society to include the criminal underworld. They are now found across the social strata and range of ages to include adolescents.<sup>1-6</sup> When discovered on our adolescent patients, what significance, further inquiry or action should we consider? Although visible body art would likely at least be noted mentally if not charted by most of us, should we specifically ask every adolescent client whether or not they possess any? Are assumptions made about adolescents because of their body art? This article addresses these questions with a brief overview of tattooing and piercing among youths with attention to the psychiatric relevance. Although there are obvious potential infectious disease, dermatological and in some cases dental and genitourological complications, these are not the focus of this article.

How common is body art among adolescents? In a study of 79 females 15 to 18 years old in a nonresidential program for high school girls with truancy and absenteeism problems, 37% (29) had piercings and 20% (16) had tattoos.<sup>7</sup> A study of 210 teens aged 14 to 18 years old enrolled in a substance use study at an urban children's hospital adolescent clinic revealed 42% (90) with piercings other than earlobes in females and 10% (22) with tattoos.<sup>8</sup> Braithwaite et al's study of detainees age 11 to 18 years found 71.2% (594/834) had ever had a body piercing and 28.9% (245/847) had ever had a tattoo.<sup>1</sup> Houghton et al studied 464 high school students age 13 to 18 years in Perth, Australia discovering 13.6% (63) had tattoos.<sup>4</sup> Carroll et al's survey of 484 12 to 22 year olds from a Naval Medical Center adolescent clinic in San Diego, CA revealed 26.9% (130) had body piercings other than earlobes in their lifetimes and

13.2% (63) had tattoos.<sup>9</sup> Roberts and Ryan analyzed data from the National Longitudinal Study of Adolescent Health which surveyed 11 to 21 year olds from a sample of junior and senior high school students.<sup>10</sup> The data was collected in two waves two years apart (1995 & 1996). Wave one reported 4.6% (270/5837) and the second wave reported 3.0% (131/4379) with tattoos. Armstrong and Murphy's survey data from 2,101 junior and senior high schools from eight states revealed 10% (213) with tattoos.<sup>11</sup>

Why and where do they get them? The reasons vary, like most risk taking behaviors, but common themes were noted to include peer pressure or acceptance,<sup>5,7</sup> fashion,<sup>1,3,5,7</sup> self identify/expression,<sup>5,7,11</sup> love and relationships,<sup>9</sup> source of "permanence",<sup>5</sup> self-mutilation,<sup>4,5,7</sup> and gang affiliation.<sup>1,9</sup> Modeling idols from the entertainment industry<sup>2,3</sup> and sports<sup>3</sup> is another possibility given the prevalence of body art among those artists. Obviously, there is no single reason and likely there is a combination of factors

for any given adolescent to get a tattoo or non-traditional piercing. When looking to identify their presence, remember they are not always visible. Locations for piercings include the ears, tongue, lips, nose, eyebrows, navel, nipples and genitalia.<sup>1,2,7,9</sup> Reported tattoo locations included arms, legs, shoulder,<sup>7,8</sup> hand, stomach, breast,<sup>7</sup> groin, buttocks and head.<sup>8</sup> As with our observations of other physical and behavior traits, the key is

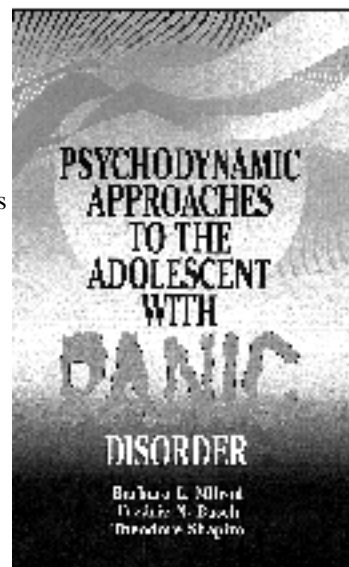
to be open and objective with the goal of understanding.

What, if any, actual connections exist between body art and psychosocial issues? The Armstrong and Murphy study found the majority of tattooed adolescents reported positive experiences with their tattoos leading to improved self-esteem.<sup>11</sup> Brooks et al found similar results with 75% of subjects possessing some form of body art (their sample also included scarring and branding) reporting positive experiences, only 9% reporting negative ones and the remaining 55% were neutral.<sup>8</sup> On the other hand, Armstrong and Murphy noted that amateur tattoos, those often made by peers with "household instruments", carry psychosocial risks because they are of their poor quality in appearance which is generally on an exposed body area.<sup>11</sup> Additionally, amateur tattoos are linked by many with gangs and having served jail or prison time where amateur tattoos are the only option. Carroll et al echoed

Got Ink,

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## NOW AVAILABLE



by Barbara L. Milrod, Fredric N. Busch, & Theodore Shapiro  
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this concern based on their literature review in which amateur tattoos were found to be associated with poor academic functioning and behavioral problems.<sup>9</sup> The Armstrong and Murphy study revealed that adolescents experienced embarrassment and decreased self-esteem suffered when others saw their tattoos.<sup>11</sup> Carroll and Anderson found that the more tattoos and piercings, the more negative the owner's attitude toward her body.<sup>7</sup> It is interesting to note that until early adolescence, youths viewed tattoos negatively based on a study of 80 primary through high school students age 6 to 16 years in Perth, Australia.<sup>3</sup> Females in particular became more accepting as they entered adolescence.

What interpretations may be relevant to the presence of body art? Martin advised that arguments about body art between adolescents and their families may actually be deeper issues such as the youths' separation from their families of origin.<sup>5</sup> He also noted that for some, piercings and tattoos offer the opportunity to reclaim control of their bodies during a time of great change and to afford a sense of uniqueness. The tattoo can serve as a means of assimilating, owning and making permanent a relationship, a person or an ideal. This perspective lends itself to an object relations approach.<sup>5</sup> Illustrating a connection to others, such as gangs, or to memorialize an event can lead to getting tattoos as well.<sup>5</sup> It is obvious how knowing something of the context in which adolescents obtained their body art will further understanding of the adolescents psychosocially and aid therapy focus when necessary. Like other controversial issues, we should be sure to know our own attitudes about tattoos and piercings. A study of attitudes among health care professionals to include physicians, registered nurses, licensed vocational nurses and students of medicine and nursing from 22 states revealed that adolescents were generally viewed more negatively when tattooed and more so than tattooed adults although the students were overall less critical.<sup>6</sup> Such an attitude will potentially restrict the honesty and forthrightness of adolescent patients.<sup>6</sup>

The presence of tattoos or piercing can help alert us to the need to screen for certain risky behaviors. The Carroll et al study (2002) revealed that persons with tattoos or piercings were associated with

more marijuana, alcohol and cigarette involvement and greater suicide risk than those without body art and this risk increased as age decreased except when it reached ten years or younger.<sup>9</sup> The lower age range had a lower risk of both gateway drug use and suicide risk. Being female and having a tattoo increased suicide risk in this study. The more piercings, the greater the chance of drug abuse to include cocaine, crystal methamphetamine and ecstasy. Males with tattoos and females with piercings had more involvement in violence related behaviors than those without. Carroll and Anderson's study of female adolescences found that the more tattoos or piercings, the greater the chance of anger reactions and of verbal anger.<sup>7</sup> The possession of a tattoo or piercing increased the chance of being sexually active, but no relationship was found between quantity or age of first tattoo acquisition. The Roberts and Ryan study had similar findings with tattooed adolescents at higher risk for marijuana use, physical violence, sexual intercourse, school truancy and gang involvement.<sup>10</sup> Houghton et al also noted greater school problems for those with tattoos and hypothesized that tattoos could either be signs of underlying problems or be triggering negative reactions from others or personal shame that worsens an already poor fit in school.<sup>4</sup> Braithwaite et al found a significant correlation between tattoos and alcohol, tranquilizers, "speed" and "downers" after controlling for gender, age, race and gang affiliation and only a "marginally significant" association between piercings and alcohol use with controls for age, race and gender.<sup>1</sup>

Although Brooks et al reported that when controlled for age, adolescents with body art had a 3 times greater odds of self-reported problem substance use, they added that over 50% of those with body art were at low risk for such use while 20% of non-body modified adolescents were at risk.<sup>8</sup> They recommended screening but not automatic assumptions regarding substance abuse.

We don't want to

imply that you should interpret the mere presence of a tattoo or piercing on one of your adolescent clients as an indication of psychopathology. Clearly, this is not the case based on the literature to date we have cited herein. What we are encouraging is that you identify adolescents with such body modifications so that you can explore of the context in which they obtained their body art and their current thoughts about their choices as these impact on their biopsychosocial functioning and potential for risky behaviors.

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Got Ink,

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## Involuntary Interventions in Adolescents: a Breach of the Alliance?

by Nancy Byatt and Fabian Saleh.

As a general adult psychiatry resident I am struck by legal and ethical dilemmas one faces when working with adolescent patients. The following case of Maria captures such quandaries precisely. In this report, specific information about the case has been modified in order to disguise the details of the case, yet the clinical factors remain illustrative of the difficulties encountered when working with adolescent patients. Maria is a 16-year-old Hispanic female who was referred by an attending psychiatrist for psychotherapy treatment. After leaving a message with Maria to set up an appointment I received a frantic voicemail from Maria's uncle requesting I call him immediately. In speaking with Maria's uncle, Uncle D, I was informed of Maria's increasingly concerning symptoms of suicidal ideation, insomnia and depressed mood. I had yet to meet Maria and was concerned that these symptoms may put her in danger. After discussion with Uncle D and the referring psychiatrist, I felt assured that Maria was safe yet needed urgent treatment and evaluation.

During the initial evaluation I discovered Maria was indeed suffering from depression, suicidal thoughts and insomnia in the context of a tumultuous family situation involving physical abuse and unstable relationships. Maria also reported anger to the extent of feeling homicidal. Faced with the responsibility of working with a suicidal and homicidal adolescent who was enduring physical and emotional abuse brought to mind three responsibilities: the duties to warn, report abuse and protect Maria from herself. Upon questioning her further, I felt assured that there was no intent or plan for homicide or suicide. It was clear however, that the abuse must be reported Department of Social Services (DSS).

This young woman was fighting to stay afloat in the context of worsening academic decline, physical abuse and a family dynamic that was exacerbating her already conflicting emotions and tenuous stability. I was also struck by Maria's tenacity: she was managing at a very challenging school, continuing competitive sports and maintaining her solid ideals, even in the midst of seven months of

tremendously challenging life events. My challenge was to establish and maintain an alliance with Maria while trying to protect her from herself and her family.

After frequent visits over the next few weeks, Maria seemed to improve. Her suicidal thoughts decreased in frequency and severity, as did her insomnia. I felt confident that a crisis had been averted and that I had managed to maintain an alliance with Maria thus far. One week later, Maria was late for an appointment. The front desk informed me that Uncle D was downstairs without Maria. Uncle D came to my office reporting that prior to leaving for the appointment Maria and Uncle D had an argument. During the dispute, Maria jumped out of a second story window of the house. As per Uncle D, Maria was angry, refused to come back in the house and ran away. Maria had not stated any suicidal thoughts. I immediately called the police to try to locate her. I contacted Maria's mother, Mrs. H, who reported Maria was fine and hung up the phone. Within two hours the police found Maria and took her to the emergency room.

Realizing that at this point, I was the only person involved who thought Maria needed to be hospitalized led me to review my decisions. I repeatedly asked myself: what I would do if Maria were my own daughter? This was an invaluable gauge to monitor my own countertransference and how it might interfere with my judgment. As the Hippocratic Oath states, my goal was to use my skills "for the benefit of the sick according to my ability and judgment; [so] I will keep them from harm..." The psychiatric emergency room also wanted to discharge Maria, yet agreed to hospitalize her upon hearing my strong recommendation for hospitalization.

The case of Maria posed a multitude of legal, ethical and treatment challenges. Where was my alliance with Maria at this point? Could she still trust me after I reported her family to DSS and committed her to the hospital involuntarily? Maria's family was livid that she was hospitalized and demanded her immediate discharge. Seven days later, after a vociferous family meeting on the inpatient unit, Maria was discharged against medical advice and brought home by her family. The referring psychiatrist, Dr. S then received a voicemail from Mrs. H reporting Maria needed an urgent appointment

as Maria no longer trusted me. Dr. S informed Mrs. H that I was still Maria's psychiatrist and she should call me to set up an appointment.

I met with Maria and her family the day after her discharge. Mrs. H was agitated, argumentative and guarded. Convinced I was conspiring against her daughter with Uncle D, she fiercely stated that I was "sadly mistaken" in hospitalizing her daughter. Surprisingly Maria defended me, reporting, "Dr. B was concerned about my safety." Still, I had reached an impasse with Maria's family. Mrs. H then asked, "Would you do this to you own daughter?!" In honesty, I answered, "Absolutely, I would." After Mrs. H absorbed my answer, she softened, reporting that my statement meant a lot to her. Mrs. H seemed to understand maternalistic involuntary treatment of her daughter, allowing the alliance with both Maria and her family to be forged.

As this case progressed I asked myself continually if I should have hospitalized Maria as it was clear that doing so angered all the family members involved. When in a clinical conundrum, the family member gauge is invaluable on many levels. It allowed me to assess my judgment and countertransference, maintain the confidence of Mrs. H, quell my own anxiety during the crises and possibly even maintain my alliance with Maria. The fact that I would have wanted my own daughter hospitalized guided me through the crises and my own anxiety.

This case provides an objective lesson in both the difficulties encountered when treating high-risk adolescent patients and the conundrums and ethical and legal issues involved in the issue of involuntarily hospitalizing adolescent patients. The duties to warn, report abuse and protect our patients are critical in this process. Equally essential is the establishment and maintenance of a therapeutic alliance. During such challenges, the most precious tool we have is our ability to reassess and confirm that the decisions we make for our patients will help "keep them from harm."

Address correspondence to Nancy Byatt, D.O., M.B.A., Dept of Psychiatry, University of Massachusetts Medical School, 55 Lake Ave North, Worcester, MA, 01655; byattn@umhc.org;

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Changing Trains. Clinical Implications of Crisis Management in Adolescence.

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### About Our Members

Dr. John Meeks of Rockville, MD, is the coauthor with Debbie Riley, MSW, of a new book: *Beneath The Mask: Understanding the Adopted Adolescent.*

Dr. Jonathan Bauman of Katonah, NY, was awarded the Nancy C.A. Roeske, MD, Certificate of Excellence in Medical School Education at the 2005 APA Annual Meeting.

Dr. R. Taylor King has been recognized as a Distinguished Life Fellow of APA.

Dr. Irv. Berkovitz of Los Angeles, CA, is recovering from cardiac bypass surgery.

Dr. Daniel Offer is writing a book coauthored with his wife Marjorie and daughter, Susan Offer Szatic, titled *Dialysis Without Fear* to be published in 2007.

Dr. T.C.R. Wilkes of Calgary, Canada, is a member of the Canadian Academy of Child & Adolescent Psychiatry and now a recognized specialist in Britain and the European Community.

The David Dean Brockman, M.D. (of Chicago IL) award given annually to distinguished psychoanalysts was given in 2005 to Dr. Harold Blum.

Dr. Morton Silverman of Chicago, IL, has a new book published, coauthored with others, titled, *Adolescent Suicide: Assessment and Intervention.*

Dr. Judith Jorgensen of La Jolla, Ca, a Distinguished Fellow of APA.

### From The President

Many people ask me why there is an organization like ASAP. It is an easy answer. Psychiatrists are trained in their general psychiatry residency to treat adolescents and adults, and have some exposure to the treatment of children. Child and adolescent psychiatrists are too few to treat all of the juveniles in the country who are in need of assessments and therapy. General psychiatrists should avail themselves of the opportunity to enhance their skills in caring for adolescents. Not only will they help an underserved population in need of mental health care, but the psychiatrist will increase his referral base and enhance his practice opportunities. ASAP is the best of both worlds: practice expansion as well as helping young needy patients. Encourage your colleagues to consider extending their referral base by coming to ASAP's Annual Meeting in Miami Beach.

ASAP has a new resident/fellow paper award. Any trainee in psychiatry is eligible to submit a paper concerning adolescent psychiatry for consideration. Submissions should be sent to ASAP Central Office, c/o Frances Roton. The winner will have their paper presented at our Miami Beach Annual Meeting and receive expenses for hotel, meeting registration and travel (up to \$1,000). Please encourage trainees whom you know to submit a paper for consideration.

ASAP is strong and wonderful. I encourage you all to participate. Please let me know if any of you would like to be more active joining councils, starting committees or presenting at our meetings. Stephen Billick \*\*\*

ior and try to explain how infant research concept helps us to understand adolescent cutters.

The Alien Body and The Attracting Glance. Claudio Fabbri

From Rhythm to Words: The Initial Treatment of a Narcissistic Adolescent. Angela Gesue

Since its origins, especially in Freud's work and later in that of several other authors with different theoretical orientations, psychoanalysis has focused on the study of psychosis and the possibility for its successful treatment through the therapeutic process.

Stress on Parents with Developmentally Delayed Adolescents. Jill Savege-Scharff

The task of parenting an adolescent is even harder than usual when the adolescent has developmental delays. The parent, especially the mother, has a harder time separating from that child than from her other children because she remains responsive to his needs.

Antisocial Adolescents Treatments in Juvenile Justice Services. Aldo Maggolini

An Adolescent Treatment Process: Jonathan Cohen.



Jeff Stahler  
The Columbus Dispatch  
United Media



# In Our Mail



The American Psychological Association reports a new edition of the book, *What Therapists Don't Talk About and Why: Understanding*

*Taboos That Hurt Us and Our Clients.*

The softcover edition (256 pages) can be ordered online at

<http://www.apa.org/books/4317105.html>

From the publisher's blurbs: a compendium of questions and issues that have been avoided by directors of training programs...a guide to help recognize and respond to unacknowledged taboos, secrets, and uncomfortable feelings as therapists...a practical book on boundaries

and ethics... for trainees to seasoned practitioners.

Helping Gay and Lesbian Youth: New Policies, New Programs, New Practice. by Teresa DeCrescenzo, MSW editor. Huntington Park Press, 186 pp. \$19.95

(from the publisher's blurbs:) Rich in insights into how gay and lesbian adolescents develop and learn to cope with problems attendant on growing up different . . . Ground-breaking work describes what has been done with child welfare departments, law enforcement, the public schools, and mental health agencies in

educating them to the special needs of the community.

Sexual Abuse and Residential Treatment, edited by Wander de Braga, MD and Raymond Schimmer, 122 pp, \$14.95. The Haworth Press.

...with the growing number of sexually abused youth being referred for residential care, this book is an important resource for administrators and workers. It provides a useful framework, relevant literature and provocative questions for discussion and reflection.

## CLASSIFIED AND DROP-IN ADVERTISING AVAILABLE

Ads must be received at the ASAP office by the following deadlines: Summer issue — July 30; Fall issue — September 30 and Winter issue — December 1st. Copy should be typed and double-spaced.

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.

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### ASAP NEWSLETTER

P.O. Box 570218, Dallas, TX 75357-0218

(972) 686-6166 Fax (972) 613-5532

email:adpsych@aol.com

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Editor: Leonard Henschel, M.D., 80-49 Park Lane, Kew Gardens, NY 11415. Phone/Fax: (718) 849-6339. E-Mail Address: lhenschel@nyc.rr.com