# american society for adolescent psychiatry

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**Gregory P. Barclay, M.D., Editor** **Summer 2009**



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## FROM THE PRESIDENT ADAM N. RAFF, M.D.

Dear Friends,

We had a great conference this past March hosted at DayTop Village here in New York. The two day conference, meant to provide the most updated scientific data on several major disorders and other clinically relevant topics, was a success on different levels. Apart from the consistently high quality of presentations, the modification of this program's venue and length also underscored this organization's need and capacity to adapt to our own fiscal limits while continuing to provide our current and prospective members with educational meetings. Despite the meeting's shorter overall length and fewer luxuries, the quality of the scientific presentations combined with lower registration fees were, in addition to its necessity, a welcome change to many attendees.

Some of the highlights of the meeting included:

- Presentations of the Alexander Gralnick Research Award to Katherine Halmi M.D. for her seminal contributions to work in eating disorders.
- The William Schoenfeld Award presented to Cynthia Pfeffer, M.D. for her widely recognized work in the assessment of adolescents for suicide and post traumatic stress disorder.
- Finally, no guest lecturer received higher praises at this or any other meeting in recent memory than Dolores Malaspina, M.D. Her presentation on the risks for schizophrenia and autism associated with advancing paternal age and research on the role of epigenetics truly captured the attention of everyone in attendance.

Now more than ever, our work promoting mental health treatment for adolescents faces numerous challenges both on organizational and political levels. With continued decreasing numbers, we are again charged with trying to find ways to increase our membership. As previous presidents of ASAP have remarked, it is incumbent on us to reach out to our own professional communities of residents and trainees in order to educate them about adolescent psychiatry, and the benefits of joining ASAP. Also, with recent changes in our own by-laws we should be able to progressively focus our efforts to recruiting members from other mental health disciplines.

But remaining a viable and active community of professionals goes beyond our own society's internal issues, and speaks to the nation's critical need for adolescent specialists. Only recently was The Child Health Care Crisis Relief Act, a bill meant to provide federal support and incentive to those mental health professionals interested in working within child and adolescent health care, introduced in the House of Representatives. It is an important piece of potential legislation that only reveals just how critical a need exists for mental health professionals able to

For Your Calender

ASAP Fall Business Meeting
October 24, 2009
Dallas, TX

ASAP 2010 Annual Meeting
March 6-7, 2010
Los Angeles, CA

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work with adolescents.

Next year's 2010 Annual Meeting is to be held in Los Angeles, California on March 6-7, with our own Dr. Joe Kenan as its Program Director. Please make every effort to support ASAP's mission, especially during these times of economic hardship, by attending this meeting. While we depend significantly upon the educational material presented at these meetings, it is the personal relationships within our society that ultimately make these gatherings meaningful for our future as a professional community. I look forward to seeing you all in Los Angeles!

All the best,

Adam N. Raff, M.D

## From the Editor

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

This edition of our semi-annual newsletter features summaries written by our own members and pictures taken by our Executive Director, Frances Bell and former newsletter editor, Len Henschel, from our 2009 scientific meeting held in New York this past March. It was particularly gratifying for me to assemble these summaries and pictures since I was not able to attend the meeting and therefore had to depend on others for these tasks. For a control freak, that is tantamount to being asked to quit breathing! Not that I didn't plan to attend the meeting. Like many, I made plane reservations several months before the meeting to secure good rates and flight times. Having learned from past experience, I also thought I had gotten seat assignments on all my flights. As the saying goes, "one without a seat assignment is one without a ticket". In my haste, as the departure date approached and distracted with other matters, I overlooked one detail. My flight from Des Moines to New York, organized so that I would miss a minimal amount of work and still make it to the Friday night Governing Board meeting, no longer listed my seat assignment but instead the message "seats to be given out at the gate". Anyone who flies regularly knows what I did not – that message is code for "we've oversold the flight, so it is first come, first served". Along with several other latecomers who did not know this code, I was summarily bumped from the flight!

One of the down sides to living and working in Iowa is that there aren't too many flights to or from New York (or anywhere else, for that matter) in or out of Des Moines, so after retrieving my luggage from the plane, there was no way I could fly to New York Friday evening. So, I went home to my rather perplexed family and gave it a try again the next day, as airline representatives told me to return to the airport early and possibly get routed to New York on stand-by. However, since it was spring break week and every flight was overbooked, my chances were considered quite slim. So, after spending all day Saturday at the Des Moines airport without success, I finally concluded that this was the ASAP meeting that "wasn't meant to happen", and I went home again to my bewildered fam-

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ily. I am still fighting with the airline company over my ticket refund and reimbursement for my non-refundable hotel room in New York, but I am not holding my breath. Who would? After phoning and conveying my situation to colleagues, everyone jumped in to help me out. I have special thanks for the efforts of Frances Bell, Len Henschel, Dom Ferro, and Lois Flaherty who stepped in to assist me!

In addition to the two clinical summaries from our annual meeting, this edition of the newsletter contains a timely update from Dr. Richard Ratner, who faithfully represents ASAP at APA functions, regarding the APA Assembly meeting last month in San Francisco. We are indeed fortunate to have a dedicated representative like Richard Ratner who participates at his own expense on our behalf at APA functions. Thank you, Dick!

Please take note of the fact that our next Annual Meeting is scheduled for the weekend of March 6-7, 2010 in Los Angeles. I do plan to attend that one, and will make sure I do have seat assignments that time around! I hope you, also, will plan to join us for what is shaping up to be a unique conference in terms of its depth and appeal to providers of varying disciplines and professional interests. I look forward to seeing you there!

# APA Doings - November 10, 2008

Richard Ratner, MD

Once again your stalwart representative attended the American Psychiatric Association Assembly meeting at the annual APA meeting in May. You will recall that we are one of the so-called Affiliated Organizations (there are maybe 19 of us but only about 7-12 attend with any regularity), including groups organized around psychoanalysis, group therapy, psychiatric administration, child psychiatry, forensic, consultation-liaison, etc.). This year, a larger than usual number of reps showed up, perhaps because everyone loves San Francisco.

In the past an ongoing issue was whether the Assembly believed that having our group as part of it was of any value, and we were unendingly audited and evaluated by its various subcommittees. We, of course, wanted to have our expenses paid, at least the one time a year that the Assembly meets outside the scientific meeting, which would have added a noticeable chunk to the APA's expenses. However, all of that is ancient history as much larger changes are in store.

I suppose it was a combination of the recession and the current dustup regarding how pharmaceutical companies generate much of APA's revenue, an issue that has personally entangled the incoming APA President, Dr. Alan Schatzberg. However, dramatic surgical cuts are being made across the board of APA governance. Drs. Stotland, Schatzberg, and their advisors have taken a scalpel to the entire components system, cutting both committees and councils and collapsing others into each other. Since the entire components structure is part of the "executive" branch of the APA, decisions regarding its future are fully in the hands of the Board of Trustees, a body that has itself downsized in the name of efficiency and cost saving. The components, which typically meet in Washington in September, will be doing so on a very attenuated schedule this fall.

In San Francisco, the Assembly had somewhat of a debate about whether to do its usual job of evaluating, and then passing or failing to pass the usual action papers presented by members and district branches, or instead to put all the work aside to comment upon various plans for revising its role in a changed APA. A number of action papers with this common theme were proposed by Area II (New York), and while they were somewhat debated, the bulk of the time ended up being used on the usual Assembly business.

Among many other things, the Assembly voted to push the APA into:

- opposing lifetime incarceration without the possibility of release for children under the age of 18
- preparing a position statement on children and guns
- once again revising the website, which though recently revised remains difficult to read and difficult to use
- exploring the meaning of equity with respect to psychiatric patients
- adopting a formal statement of the responsibilities of training programs to their residents
- reviewing the dues structure with an eye to lowering the dues of those who have retired and/or have no further income
- working with other medical organizations to advocate for the idea that time spent by physicians satisfying the needs and requirements of insurance companies and other parasites should be compensated by those companies
- supporting telepsychiatry by both developing educational materials and by addressing the various financial and legal hurdles involved in this kind of practice
- endorsing the reinstatement of the Committee on Psychiatric Dimensions of Disasters, which the Board has ordered sunsetted and its functions to be taken over by another Council.

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A good deal of time both in and outside the sessions was devoted to the report of a work group headed by Paul Appelbaum, former APA President and well-known ethicist, regarding recommended changes in relationships between us and the "pharmaceutical and medical device industries". The Institute of Medicine has already promulgated much of it in a report, and the drug companies themselves have already implemented some of the recommended changes. The report covers both large issues, such as disclosing researcher financial relationships and payment for the conduct of research studies; and the smallest issues of contact between individual psychiatrists and drug reps who buy lunch in order to have some access time to the physician. The report recommends that no food be accepted at all and that a careful eye is kept on the supply of drug samples so that they serve only for the benefit of one's patients.

For the moment the report is of a workgroup and has not yet been granted the status of recommendations. Dr. Appelbaum was fairly quick to point out that these guidelines are not about to assume the status of ethics rules but will instead remain only as "recommendations", once passed by the Board of Trustees. This will probably mean that the APA has covered itself while at the same time not trying to stuff some of the more unpopular (and most of us would say ridiculous) recommendations down psychiatrists' throats. The full text of this workgroup report should be available on the APA website.

Finally, the financial problems mentioned above have brought forth the notion of a radical restructuring that could lead to what is called a "unicameral" deliberative body. In pure form this would involve paring down the Assembly dramatically and somehow conflating it with the Board of Trustees. If this happens, it is unclear what exactly will become of the Assembly, the various areas, and representatives from affiliated organizations. As it is, ASAP's representation in the APA is a good deal less than I would wish, as a result of our small size and few members who have the time, name recognition and ability to uphold our interests. Any ASAP member who has an interest in getting involved in APA governance, perhaps through his or her local district branch, is hereby encouraged to get involved. I would like to see an ASAP caucus of sorts at the APA meetings (we've had them before), rather than walking around largely on my own.

And that's all 'til next fall.

# From the 2009 Annual Meeting in New York . . .

## Jennifer Harris, M.D. – "Update on Juvenile Bipolar Disorder: Struggles in Diagnosis and Treatment"

**Summarized by Lois T. Flaherty, M.D.**

Is bipolar disorder over-diagnosed in children and adolescents? Is it true, as one of the audience participants at this presentation commented, "Every time a kid gets angry there is a rush to give a diagnosis of bipolar disorder?" A People magazine article titled "Murder by Medication" gave details of a Massachusetts case in which parents charged with murder in the Clonidine overdose death of their young child. Their defense was that the child's psychiatrist had recommended this medication to treat the child's bipolar disorder.

Dr. Harris illustrated the difficulties faced by clinicians by presenting two challenging cases from her practice. Both of these youngsters had been previously given a diagnosis of juvenile bipolar disorder. In one case, the youngster had other reasons for his behavior problems. In the other, the confirmation of bipolar disorder only emerged over time as medication was tapered. She then went on to review the discrepancies among criteria used by various researchers, and the pressures brought to bear by third party payers, drug company marketing, and parents who see the diagnosis as an explanation for severe behavioral problems in their children.

The first case was of a 13 year old boy with explosive and aggressive behavior, who was brought by his father who said he was about to get custody after a long custody battle. The parents had divorced when the child was age 3, and his mother had been getting Social Security Disability payments based on his disability. The father believed there was nothing wrong with the child, and that his problems were all related to poor parenting by the mother. This child had a history of developmental delays and learning difficulties in addition to behavioral problems. Although the diagnosis was not at all clear at the outset, he improved after moving to his father's home and placement in a special educational setting, and eventually was taken off all medications and remained stable.

A second case involved at 13 year old girl who had developed polycystic ovaries on Divalproex Sodium, which had been prescribed for her presumed bipolar disorder. She had been switched to lithium, but was anxious to discontinue medication. Her mother had a history of post-partum psychosis. She came to appointments sometimes garishly and provocatively dressed, wearing poorly applied makeup, and at times was hard to follow. Wondering if perhaps the pa-

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tient was "just bad at putting on make-up," or that she was just having a hard time following her, Dr. Harris agreed to taper her medication. With this she got worse, and improved when the dose was raised.

Pointing out that these two cases represent either ends of the spectrum with respect to bipolar disorder – in the first case, over-diagnosis, and in the second, failure to recognize it—Dr. Harris went on to review the areas of disagreement among experts with regard to diagnostic criteria. She commented, "Researchers all say they are using DSM criteria, but you have to look at what they are actually doing."

Most of the disagreement, she said, has to do with Category A symptoms—especially the requirement for a "distinct period" of elevated mood. The main arguments are whether or not mood must be different from baseline and whether to accept irritability as well as euphoria as a mood symptom. Researchers basically divide into three camps. Those who argue for a narrow phenotype are exemplified in the Course and Outcomes of Bipolar Youth (COBY) study at NIMH, which used very strict criteria, including a distinct change, with mood changes part of the distinct change. This criterion is also endorsed by the AACAP Practice Parameter for Bipolar Disorder.

At the other end of the spectrum, Joseph Biederman and colleagues have expanded the criteria to include chronic irritability, and do not consider grandiosity or euphoria necessary. Finally, Barbara Geller takes a middle position –believing that euphoria must be present (a cardinal symptom); but that there can be brief frequent cycles. She believes that children with bipolar disorder have distinct periods but also describes ultradian cycling, or many cycles per day.

Despite these opposing points of view, Dr. Harris believes that a consensus is developing – that there are different manifestations of bipolar disorder in kids. Some do meet adult criteria. There is also a group of bipolar disorder not otherwise specified (BP NOS), and there is a third group for whom the term severe mood dysregulation (SMD) is emerging as a category, as described by Ellen Leibenluft at NIMH. F-MRI studies are showing differences in response to frustration between the narrow phenotype group and the group with SMD. They also differ with respect to family history of BP. At the same time, in adult research, an increasing acceptance of "spectrum" disorders is emerging.

Epidemiological studies that use strict criteria, such as The Great Smoky Mountain Study (one of the best longitudinal studies) indicate that BP is very rare. Prospective studies have found that  a lot of adolescents" look a little manic;"and those who might be considered to have subsyndromal BP as teenagers do not have BP as adults, although they do have impaired functioning.

Psychopharmacology data are very disappointing -- there are NO gold standard studies (using PCT=placebo controlled trials) showing benefit, although there is some evidence from other studies.  This doesn't mean there is no benefit, rather that the studies just haven't been done. In response to a question about lamotrigine – Dr. Harris stated there is not a lot to support the use of it in BP, but one participant reported it seems to helpful in patients with a strong depressive component. Others felt it is a dangerous drug to use because of the risk of Stevens-Johnson syndrome. The fact that lithium seems to have a non-specific effect on aggression—based on a study of prison inmates who had a dramatic response to it—means a good response to it doesn't prove a diagnosis of BP.

Audience participants offered their opinions about why BP is over-diagnosed. "We fail to recognize our biases in favor of diagnoses du jour." One participant mentioned being told by a reviewer at a managed care company – "here are 3 codes – you have to choose one to get approval." Others commented on a decrease in psychotherapy by psychiatrists, and failure to recognize trauma, PTSD, and borderline psychopathology. Others cited the role of drug companies in promoting off-label uses of medications and widening diagnostic criteria. "These are really challenging kids to treat," concluded Dr. Harris, an instructor at Harvard Medical School. No one disagreed.

## THE AMERICAN BOARD OF ADOLESCENT PSYCHIATRY

At press time, we've learned that Sidney Weissman, M.D., has resigned from his position as President of the American Board of Adolescent Psychiatry (ABAP). The ABAP Board has elected Richard Ratner, M.D., to be its new President. We anticipate that the long awaited merger of ASAP and ABAP will take place in the near future. ABAP and ASAP are finalizing the arrangements to continue the ABAP responsibilities for recertification of Diplomates in Adolescent Psychiatry. At the same time, ASAP is beginning to work on a new process to certify adolescent psychiatrists. Information will be released as soon as the organizational changes are final. In the interim, any questions may be addressed to the ASAP Executive Director, Frances Roton Bell.

# Katherine Halmi, M.D. - “The Diagnosis and Treatment of Adolescents with Eating Disorders”

## Summarized by Dominic Ferro, M.D.

Dr. Halmi addressed the meeting after receiving the Alexander Gralnick Research Award for fostering research in adolescent psychiatry. Dr. Halmi expressed a deep sense of appreciation, saying that recognition has grown more significant to her as she approaches retirement.

Dr. Halmi began her presentation by discussing the risk factors for eating disorders. Risk is derived from a wide range of variables: from genes to personality to culture. Individual factors include being overweight and experiencing early menarche. Individual psychological style is also important: perfectionistic and obsessive styles increase risk, as does low self esteem and a sense of personal ineffectiveness. Behavioral patterns also affect risk, as youngsters who diet, and especially those are involved in vocations or avocations which demand weight control, such as wrestlers, dancers, jockeys and actors, are at increased risk. Individuals with childhood feeding problems are also at increased risk. Finally, individual psychopathology affects risk: mood disorders are associated with eating disorders and substance use disorders are associated with bingeing and purging.

Risk factors also lurk beyond the individual. Stressful events, such as the death of a close relative or friend, or being victimized by sexual abuse, increase the risk of eating disorders. Familial factors are significant. Both anorexia and bulimia run in families. Also, the incidence is increased in children with a family history of depression or substance use disorders. The larger culture also has an impact. Cultures that emphasize thinness as a component of beauty create greater risk, as does the epidemic of obesity with its corollary of obsessive dieting. Living in an industrialized country is a risk factor. This was shown conclusively with a study that found that the rate of eating disorders in Taiwan was the same as in Western societies, while rural, Mainland China had none.

Finally, larger forces affect risk by fostering the development of a sense of personal independence. One survey of eating disordered patients found they had spent less time away from family. Dr. Halmi shared an anecdote in which she wondered aloud with an African American friend why the rates of eating disorders are so much lower in the African American community. Her friend said that parenting in the African American community anticipates many challenges in life and focuses on teaching children how to take care of themselves in world. Dr. Halmi reported that the research supports that a sense of personal and social effectiveness is protective. Even high achieving individuals who have a sense of low effectiveness can have poor self esteem and be at risk for developing eating disorders.

Dr. Halmi described the best model available to understand the pathogenesis of eating disorders: dieting meets predisposition. People with the biopsychosocial risk factors described above start to diet. Weight loss is self-reinforcing, as are the psychophysiological effects of starvation. The sense of success and self efficacy stemming from restricting decreases thoughts of inadequacy. This constitutes a vicious cycle of negative reinforcement. In addition, starvation causes the release of hormones that suppress appetite and provide positive reinforcement as weight loss proceeds. The effects of starvation necessitate re-feeding as a vital aspect of treatment; while starving, the patient lacks the capacity to choose to participate in treatment.

Similarly, the bingeing and purging establish a self-reinforcing cycle. Bingeing on tasty foods feels good, and can distract from boredom and tension. The act of vomiting is a mixed bag; although it is repulsive, the patient experiences “a high.” The release of dopamine and serotonin has been measured in association with vomiting, in a pattern similar to that found in substance abusers. Cross dependence between substance use disorders and binge/purge behaviors is not uncommon.

Dr. Halmi warned that these patients rarely seek treatment at their own motivation, and even if they are willing, secretiveness and shame remain barriers. Many patients know the signs and symptoms better than the psychiatrist and become expert at concealing them. Some warning signs that an adolescent is developing an eating disorder are weight fluctuations; a diet of a restricted range of foods, usually low in fat; rituals around eating, especially eating in isolation; preoccupation with food; immaturity, depression and poor concentration; obsessiveness and insecurity; excessive exercise and high activity levels; and preoccupation with body image, as evidenced by looking in the mirror, weighing self frequently, and calorie counting. In bulimia, evidence of purging may be noticed, such as finding laxatives, diuretics and enemas. If vomiting is frequently, parotid glands might become swollen. Relationship turmoil and poor self esteem are also frequently present.

Eating disorders have high comorbidity with other psychiatric disorders. In a sample of 105 eating disorder patients, 63% had affective disorders, 37% had anxiety disorders and 37% had substance use disorders. Fully 68% met criteria for a personality disorder. 30% of both anorexia and bulimia met criteria for a Cluster C Personality Disorder. Interestingly, none of the patients with the restricting type

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of anorexia met criteria for a Cluster B Personality Disorder.

Medical comorbidities are also common. Osteoporosis and alopecia can be sequelae of anorexia. Endocrine abnormalities, such as decreased LH, FSH and estrogen, increased CRH and a slight decrease of T3, tend to normalize with nutrition. Patients with bulimia are at risk for tooth erosion, poor gum hygiene, swollen parotid glands and abrasions on hand. All eating disorder patients are at risk for substance abuse disorders; those who restrict are more likely to use cocaine and other stimulants, caffeine, alcohol, nicotine and prescription drugs. Purging causes a number of laboratory abnormalities. Elevated amylase is the most useful diagnostically, but a hypokalemic alkalosis and hypo- or hypernatremia can also be found. Patients can normalize potassium, sodium and acid balance by drinking juice or soda before blood is drawn.

Dr. Halmi concluded by speaking about treatment. She acknowledged that the evidence base remains lacking, largely because many eating disorder patients are unwilling participants in treatment. Those that do enroll in studies often drop out of treatment or have to be dropped from the study due to medical complications. Dr. Halmi recommended the APA guidelines to treatment of eating disorders as a comprehensive resource. She emphasized that outpatient treatment teams must be competent at assessing medical risks. Inpatient settings must also be experienced at re-feeding with careful medical monitoring and psychosocial intervention. Counseling about healthy dieting is needed. Antidepressant medications are adjuncts for depression and anxiety, and antipsychotic are used for overwhelming anxiety and hyperactivity.

For children and adolescents with eating disorders, family interventions are also needed. The studies with the best follow up have been the studies of family therapy. Three controlled studies of the Maudsley family therapy method have shown that children under 19 did significantly better with family therapy, both at the end of treatment and in 5 years. In a study by Le Grange, et al., family behavioral therapy resulted in 39% abstinence as opposed to 18% in a supportive therapy arm of the study. It is not surprising that family interventions are helpful as family issues are often found to contribute to the development and maintenance of eating disorders.

A number of family issues are often present and can serve as targets of family based interventions. The families of Bulimia Nervosa patients often show low family cohesion. Frequently, the parents of eating disordered patients also have, or have had, eating problems. They are often preoccupied with the weight and appearance of the patients. Often, fathers are compulsive about exercise. Mothers are often remote, and patients show signs of insecure attachment. Parents have a tendency to be critical, intrusive and overly controlling. This tendency to be controlling is intensified once the eating disorder has developed as the risk of starvation and death looms over the family. Sometimes marital conflict intensifies, especially if parents' approaches to the disorder differ.

Family intervention approaches differ, but in general, the approaches involve bringing the family together in understanding the disorder and in deciding how to address it. As the crisis diminishes, the focus shifts to fostering better boundaries and establishing a family dynamic that fosters mastery and maintains the gains. A study of the treatment of Bulimia Nervosa in adolescents showed that family therapy was superior to individual therapy. The treatment was focused on eating behaviors; it acknowledged the tendency toward secretiveness, guilt and shame; and it focused on comorbid illnesses.

Finally, Dr. Halmi discussed the role of pharmacotherapy in the treatment of eating disorders. She was clear that at this point pharmacotherapy only serves a role as an adjunct therapy. She noted that cyproheptadine facilitates weight gain, perhaps through histaminic effects. Dosing up to 24 mgs per day may be required. Some antidepressant may have beneficial effects. SSRI's may create anxiety and hyperactivity in the underweight patient, however once the patient has been re-fed to 90% of the target weight, SSRI's can help with obsessive and social anxiety. The use of major tranquilizers is limited to severely obsessional and ill children. A recent study of olanzapine showed that it facilitated weight gain and reduced anxiety. Discontinuation should be considered after two months of weight stability. In Bulimia Nervosa, Fluoxetine up to 60 mg/d has been beneficial. However, studies show only a 36% abstinence rate and CBT is still treatment of choice.

## Slides from 2009 Meeting Now on Website

The slide presentations from many of the speakers at the 2009 Annual Meeting in New York are now on the ASAP website. They are in PDF format.

# From the 2009 ISAPP Meeting in New York…

## Running Away to Join the Circus—A New Therapeutic Approach?

Summarized by Lois Flaherty, M.D.

Patricia Garel, MD, the President of the International Society of Adolescent Psychiatry and Psychology (ISAPP), Director of the Neuro-Sciences - Genetic - Psychiatry program in Ste-Justine Hospital (Montreal), and Chief of the Department Psychiatry and Associate Professor of Psychiatry at the University of Montreal, gave a presentation on "Adolescent Social Rehabilitation After Intensive Psychiatric Treatment," which focused on a planned adaptation of the Cirque du Soleil's worldwide youth programs to adolescents discharged from psychiatric inpatient treatment.

Dr. Garel described a new project beginning in September in Montreal that will involve a partnership with her institution and the Cirque du Soleil, which will be a new direction in the work of the Cirque with at risk young people. The program will work with adolescents discharged from inpatient care into the community. The hope is that this project will engage many teenagers who are reluctant to be involved in anything labeled "mental health" or "psychiatric," and thus avoid follow-up treatment. Although the Cirque, which traces its origins to a group of young street performers, has had a long standing interest in working with at risk youth, this project represents a totally new direction. Dr. Garel discussed the work of The Cirque du Monde, in partnership with an NGO, Jeunesse du Monde, with street youth throughout the world. This work, which has been going on since 1995, involves training youth in circus activities, as a way to build self esteem and promote prosocial behavior such as leadership and teamwork. They term the work they do "social circus," which has the goal "to support the development of children, young people, teenagers and others who are at risk or excluded from society." Dr. Garel pointed out that the Cirque capitalizes on the romantic appeal that the fantasy of running away to join the circus has to youngsters. The Cirque trainers work together with social workers and others who are already involved in youth programs. One of their goals is to train future trainers who will be able to carry on the programs after they leave, and there is a follow-up component, in which the Cirque staff return at intervals. According to the website for the Cirque du Monde,

> The pedagogical approach of Cirque du Monde is founded on the crossroads of circus arts and social intervention. At that nexus we create a training curriculum centered on respect, safety and pleasure. At the same time we set incremental, proportioned challenges in circus training techniques for young people. This develops better physical conditioning and opens up avenues of expression and personal growth.

Heretofore, the project has not ostensibly involved teens with identified psychiatric disorders (although many of the youth it has served are homeless and addicted to drugs and undoubtedly have high rates of psychiatric illness) and it involved much discussion and careful planning to develop this new direction. Dr. Garel showed several video clips that illustrate the work of Cirque du Monde, including an introduction, and stories from youths in the Netherlands and South Africa. To see them, go to http://www.cirquedusoleil.com/en/about/global-citizenship/community/social-circus/circus-for-life/aspx.

For more information about the work of the Cirque du Soleil, go to http://www.cirquedusoleil.com/en/about/global-citizenship/community/social-circus/cirque-du-monde.aspx.

## Welcome New Members!

**Asif Habib, M.D.**
Granite City, IL

**Didier Jutras-Aswad, M.D.**
New York, NY

**Eileen Kaloudis, PsyD.**
New York, NY

**Christopher Myers, M.D.**
New York, NY

**Sonya Owley, M.D.**
Bronz, NY

# Photo Gallery

Marty Fine, M.D.,
Claudia and Jim Gilfoil, M.D.

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John Flaherty, M.D.,
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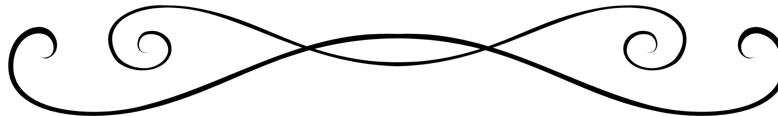
June 2009



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ASAP 2010 Annual Meeting
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