American Academy of Child & Adolescent Psychiatry
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LifeMember

Owl Newsletter

October 2019 e-Newsletter

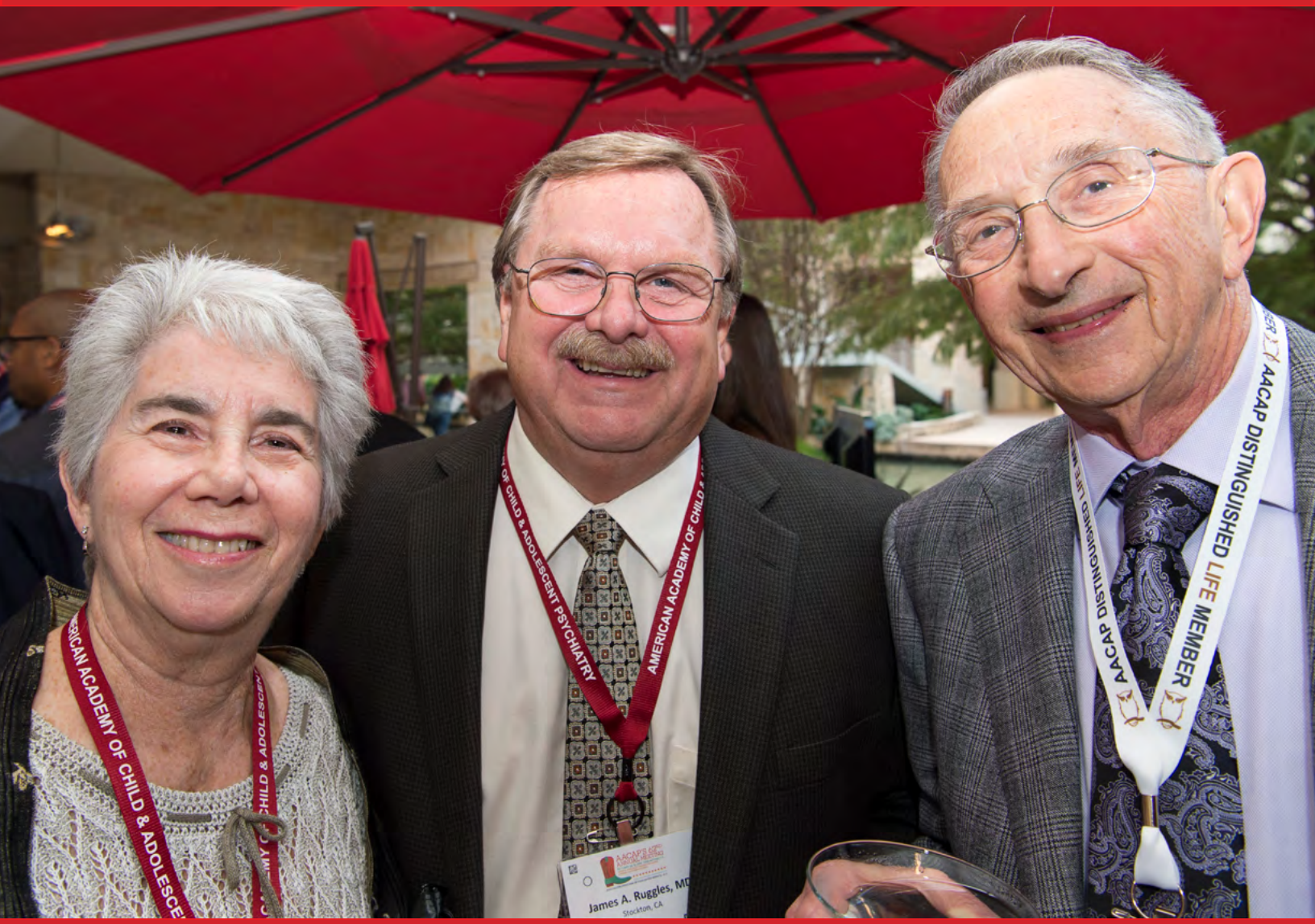

Photo by Fred Seligman, MD

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Theodore Roosevelt Quotes

In reading the third volume of Edmund Morris' trilogy on Teddy entitled Colonel Roosevelt, I was struck by the number of phrases, quotes, and expressions he coined or popularized that are still used today

- Martin Drell, MD

- *Lunatic fringe –referred to "the members of unusual political or social movements espousing extreme eccentric or fanatic views." He used the phrase with regards to the Armory Show in 1913 that introduced avant-garde art (Cubism, Futurism, Neo-Impressionists) to the United States.*
- *Bully pulpit – refers to a conspicuous position that provides an opportunity to speak out and be listened to, like his office as President of the United States.*
- *Nailing jelly to the wall – referring to an impossible job.*
- *Weasel words – referring to soft and ambiguous language.*
- *Square deal – a fair agreement.*
- *Molly coddle – defined as weak and cowardly.*
- *Strong as a bull moose – to have immense and formidable strength. He was the candidate for President in 1912 for the "Third Party" Progressive Movement which was also called the Bull Moose Party in honor of Teddy. His candidacy split the Republican vote and gave the Presidency to Woodrow Wilson.*
- *Muckraker – refers to a journalist that reports dishonorable tactics used by politicians.*
- *Pussyfooting – to shirk from a commitment.*
- *Hat in the ring – refers to the beginning of a campaign.*
- *Speak softly and carry a big stick – referred to Roosevelt's foreign policy which stressed diplomacy and peaceful negotiating, but made it clear that physical force would be used if necessary.*
- *The man in the arena – from a speech entitled "Citizenship In A Republic," delivered on April 23, 1910 at the Sorbonne in Paris, France.*

Get involved - submit articles for the Owl Newsletter!

Get involved - submit articles for the Owl Newsletter! We want to hear from you! Let us know what you are up to, how you're doing, and more! Please send materials to mdrell@lsuhsc.edu. The deadline for the next issue is **December 15**.

Martin Drell, MD

Painful Meanderings on the Differences Between Child and General Psychiatry

Martin Drell, MD

Martin Drell, MD

Many years ago, someone at a meeting asked what the difference between adult and child psychiatry was. I was not sure what I thought was the correct answer, and was loathe to answer, lest it was a trick question. I prevaricated and let the questioner answer his own question, which he seemed burning to do. "The difference," he proclaimed, "was a belief in development." I thought it was a very good answer!

Over the past decades, I have returned every once and a while to this question. The last time I thought about this, I was absolutely sure the differences between general and child psychiatry were widening, leading to the sense of different tribes. As I approach the subject now, the question remains a valid one, but deciding what constitutes the difference seems harder for me to answer. One of the differences I had thought about in the past was the use of medications by general psychiatrists, but child psychiatry has embraced medicines so fully that we are often portrayed by the public as "pill pushers". The news speaks daily of polypharmacy and the overmedication of children, especially young children. So I don't think the use of medications are an adequate answer, as child psychiatrists seem, in this regard, to be more like and not less like general psychiatry.

While thinking this through, I couldn't stop thinking of Stephen Sharfstein's oft quoted remark that the "Biopsychosocial Model" seems to have been replaced by the "bio bio bio model." Perhaps, the answer is that general psychiatry focuses more on biology than child psychiatry, but surely no modern child psychiatrist would disavow the importance of biology in this age of neuroscience, brain scans, medications, and genomics.

After more discussions with myself, I ended up doing an uncomfortable "flip flop" and wondered if the differences between general and child psychiatry were not widening but were actually narrowing. This led me to envisioning a time when one would ask what the difference between general and child psychiatry are and the answer would be "none." This did not seem right to me! Perhaps I have been blinded and biased by my anger at the general demise of psychotherapy training in general psychiatry, which I have written and talked about over the years. Could it be that I am a victim of "assortative mating" in that most of my professional friends are "therapy enthusiasts" who reinforce my unconscious and conscious biases towards training in psychotherapy. If I lift my blinders, isn't it the reality that child psychiatry is following general psychiatry in its de-emphasis on training in psychotherapy and that this difference seems gone also? — (Much to my dismay). I ask myself over and over why would general or child psychiatry knowingly narrow their scope of practice?

Returning to the original question, I then wonder whether child psychiatry was also losing its traditional focus on development. My "therapy enthusiast" friends surely agree with this and frequently ask me, "Does anyone read Mahler anymore?" or "What happened to the psychosexual stages, you know, like oral, anal, oedipal, latency, adolescence, or the psychosocial stages of Erik Erikson? Have these been lost to civilization like the art of embalming that was perfected by the Egyptians?"

At this point, I found myself becoming anxious and then defensively flippant. I repeat, with hyperbolic disdain, a frequent remark of mine is that the "newer generations" do indeed have a sense of development: iPhone 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 or DSM 1, 2, 3, 4, 4TR, and 5. In reality, few younger child psychiatrists have ever seen DSM I, II, or & III. I appear like an ancient book seller as I share with them my dusty

copies of I, II, & III to show what changes have occurred in our field over the past decades ("Look how skinny they are!" "Look how few diagnoses there are!").

After such "flights into flippancy," I reestablish a serious tone and return to thinking about the "lack of a developmental perspective" in general and child psychiatry. In my experience, when I discuss development with people, the conversation invariably leads to whether there are any recent "good" textbooks on development. Does this mean that they have not been keeping up with this area that they say is so important? At this point, it is amazing how often my contemporaries lovingly harken back to Mel Lewis' venerable developmental book Clinical Aspects of Child Development. They seldom get the title correct, but usually are able to describe the colors on the cover (depending on their age; orange and blue, which is the 1981 2nd edition, or orange and white, which is the original 1971 paperback edition). My personal 1971 copy got waterlogged when my ice cooler leaked into a box of books in my car while I moved from my residency in Boston to my first job at Baylor in 1979.

I personally cannot fathom the world of child and adolescent psychiatry or general psychiatry without some sort of developmental perspective to help understand the vast differences between infants, preschoolers, middle childhood, adolescents (younger and older), transition age youth, and adults (younger and older). To check my bearings, I recently asked a general psychiatrist who works at a mental health center what development theories he uses. He paused for a very long time before responding, "I'm not sure... perhaps Erikson?"
I am not a purest who demands faithful allegiance to the psychosexual stages. In fact, I never felt that they were enough to fully explain the cases I was seeing and don't directly use them as much these days. They were, however, an academic starting point for me, especially after David Freeman, MD, (a psychoanalyst and general psychiatrist at Baylor) in the 80s, informed me that Freud's theories were imperfect, but the most comprehensive models concerning normal development, the development of psychopathology, and therapy available. He fascinated me by pointing out that these Freudian developmental insights were constantly being interpreted and re-interpreted and that even the most eloquent of formulations did not guarantee that Freudian therapy would "cure" the problems identified, or even be the treatment of choice. These were important distinctions for me at the time and remain so today.

My work with infant's validated my problems with the psychosexual stages. Calling an infant "oral" doesn't help very much. To help with this population, I needed the assistance of latter developmental theorists, most of them psychoanalysts, such as Piaget, Spitz, Emde, Sanders, Sameroff, Mahler, Klein, Winnicott, and the object relation theorists. Each of these theorists added differing perspectives on development, some of which were more useful and understandable than the others. I sadly admit to still struggling with the Ruth and Pre-Ruth stages of Winnicott.

At around the same time, in the early 80s, I took an ongoing interest in George Engel's "developmentally influenced and system's informed biopsychosocial model" as an overarching model which seemed to inclusively accommodate all the theories that I read about and juggled in my mind.

Over time, I have continued to add new developmental theories to Engel's model to better explain differing time periods of the lifespan. To me, these theories are like looking at the same microscope

Painful Meanderings on the Differences Between Child and General Psychiatry
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slide with differing powered lens. Mahler certainly helped me focus more in-depth and to better figure out the toddler period of the "anal phase." Similarly, there are times when a "wider angle" lens has proven helpful, like the addition of the psychosocial foci of Erik Erikson, family-systems theory, and the family life cycle that are so helpful in couples, parenting, and family work.

In keeping with the best of Engel's model, you should not be surprised that I have been an advocate for the addition of brain development and the neurosciences to the child training curricula. Information on these topics is developing apace and will be more and more necessary for future child psychiatrists. Unfortunately, I have to learn the subject matter before I can teach it. To that end, I have gone to several American Association of Directors of Psychiatry Residency Training (AADPRT) Brain Institutes that try and show how one can teach the neurosciences. I find it daunting! At these institutes, I find that I am not alone in my feelings. My favorite "honest" presenter on the subject of teaching the neurosciences, at a recent institute, said that he wasn't quite sure how to teach this material in an acceptable and digestible manner, but that we all needed to attempt it to do so. His advice was to "just do it."

I suspect many training programs are doing too little with regards to the neurosciences and brain development, and some are doing too much. I think often of the Three Little Bears and Goldilocks story. What is the "baby bear" approach that is "just right?" I find the neuroscience literature interesting. I especially love the anecdotes that condense years and years of pain-staking research into usable sound bites of information. Despite my love, I have trouble finding how it can be helpful with the patients I see other than adding immeasurably my abilities to provide fancier and more cogent scientific psychoeducational explanations to the people I see in my clinical work.

Many patients and their parents especially enjoy and can relate to my seemingly scientific explanations, especially when I use "top down" and "bottoms up" metaphors, although my "inner" flippant, defensive self can't help but note that the bottom up seems awfully like the id, while the top down is not unlike the ego/superego. Am I missing something when it seems to me that all the brain scans always point to the "top down" frontal lobe? I suspect Jonathan Cole, an early psychopharmacologist, thought similarly when years ago, he humorously and perhaps flippantly chastised psychopharmacologists for chastising psychoanalysts for explaining "everything" with the trilogy of the id, ego, and super ego. "After all" said Cole, "don't you pharmacologists explain everything with the trilogy of serotonin, norepinephrine, and dopamine!"
We all start with the models we are taught and do the best we can with them. Hopefully, we add to them or replace them with newer models that we determine more helpful in our overall clinical work.

I suspect that some feel that I do not practice what I preach. I know that I have been accused of being "reactionary" due to my love of therapy. Indeed, I have been told more than once to my face that I do not prescribe meds. This is simply not true! In my defensiveness. I usually direct my accusers to read my "Clinical Vignettes" column which often mentions that my patients are prescribed medications by me. I then add proudly that I am a State Consultant to foster care for polypharmacy and boast of being an "early adopter" of SSRIs. In truth, the latter act was mostly due to my anxiety concerning the lethality of the tricyclic antidepressants that I used before SSRIs came out. I love avoiding anxiety of that sort almost as much as I love being able to help my patients. If my accusers persist, I then mention that I was orchestrating chloripramine treatment for an adolescent patient of mine

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with severe OCD in the early 80s. At that time, the meds were secured from Canada by the family, as they were not as yet approved or distributed in the United States. Why do my accusers think I can't walk and chew gum at the same time and force me to say which of the two practices (psychotherapy or pharmacology) I prefer? Can't I "prefer" both even if, in reality, I prefer one treatment modality (psychotherapy) more than the other? Is this more tribe-like behavior?

As the Decade of the Brain in the 90s was initiated 29 years ago, I know we are in a long and slow launch sequence that will definitely lead to the neurosciences being more and more helpful to our patients. As this eventuates, I know that whatever discoveries are made will fit nicely into Engel's overarching systems model, which incorporates a developmental biopsychosocial perspective. I sincerely hope that the answer to the question of the difference between adult and child psychiatry will end up being answered as "none," as they both encompass all the best system's informed, developmental and biopsychosocial information and skills we have and will, in the future, have available to us in pursuit of quality patient care. The acquisition of new information and skills should be a "this and" and not an "either or" proposal that favors inclusiveness vs. exclusiveness. It will hopefully include diagnosis and formulation, as well as psychopharmacology and biological treatments, plus a range of therapies in its training curricula. Meanwhile, I will continue my learning, questioning, and thinking, exciting and painful as these meanderings may be.

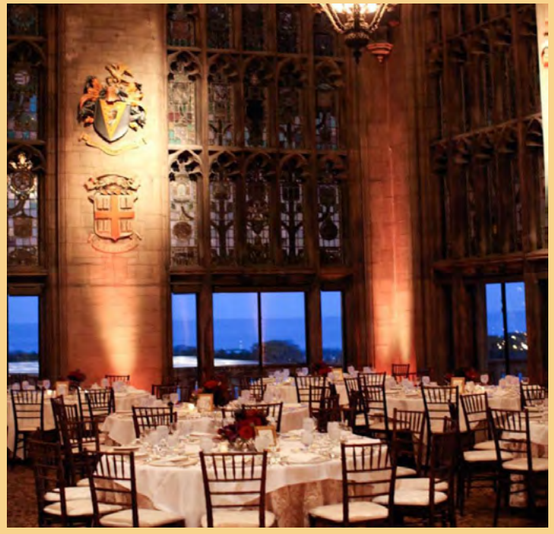
Life Members Reception & Dinner

Mark your calendars and make plans to attend, **Thursday, October 17** at **6:30 pm,** at the elegant and lovely *University Club of Chicago*

Enjoy the company of long-time friends, colleagues, and celebrate our young award winners! It's Not only a great night for nostalgia, but also plays a key role in moving our specialty forward

Tickets are required, and available for purchase at the Registration Desk at AACAP's 66th Annual Meeting

You Don't Want to Miss It!



Chicago: City of Culture and the 2019 AACAP Annual Meeting

Cynthia R. Pfeffer, MD

Cynthia R. Pfeffer, MD

It is time to review what Life Members have done in 2019 and describe plans for the 2019 AACAP Annual Meeting in Chicago, Illinois. In my last co-chair's column, I focused on historical elements of pop culture. My column ended with a prescient quote, "Hakuna Matata," meaning "no worries," which is a repeated statement in the movie "The Lion King." Recently, a third version of this spectacular pop-culture tale of parenting, challenges, loss, and victory opened in movie theaters with a star-studded voice acting cast of favored pop-culture icons and a wonderful technological advance that depicted the story's animated lions and other animals to look very realistic.

Doubtlessly, pop culture has burgeoned as we move to enter the third decade of the 21st century. Additionally, on July 20, 2019, the United States celebrated the 50th anniversary of the first manned United States space craft, Apollo 11, landing on the moon with astronauts Neil Armstrong and Edwin "Buzz" Aldrin aboard; Astronaut Michael Collins remained aboard the command module. A human marvel occurred when Neil Armstrong stepped out of Apollo 11, placed his foot on the moon, and stated "That's one small step for man, one giant leap for mankind." The excitement of considering future human space voyages became a reality.

Soon, AACAP will open its 66th Annual Meeting in Chicago, one of my favorite US cities. It is a city that exudes evidence of haute culture and pop culture. Consider the variety of art, music, architecture, colleges and universities, extensive health care facilities, vibrant financial activities, as well as its diverse population. At 2.74 million, Chicago has the third largest populous in the United States. AACAP expects this meeting to have one of the largest attendances of AACAP Annual Meetings. Of note is Albert Camus' comment: "Autumn is a second spring when every leave is a flower." I hope you enjoy autumn in Chicago.

AACAP's life members are entering this vibrant city's sphere in October 2019 with a fierce energy that may produce some of our finest programming since the inception of the Life Membership! The life members, in general, have made their mark this year via their donations to the Life Members Fund to the extent that we are able to continue to invite and finance a total of 30 medical students and residents to receive travel awards to come to the 2019 AACAP Annual Meeting. It is praiseworthy that during 2019, an increased number of life members donated to the Life Members Fund. The Life Members Committee thanks you for your generous contributions!

Special news is that if we can maintain an increased flow of donations to the Life Members Fund, we will be able to increase the number of trainees that the Life Members Fund sponsors for travel grants to the 2020 AACAP Annual Meeting. This is a new life members mandate for 2020. Notably, we constructed a spring and fall appeal for life members to donate to the Life Members Fund. Please contribute an increased contribution to the 2020 Life Members Fund Appeals. The focus of attention needs to be on promoting medical students and general psychiatry residents to choose child and adolescent psychiatry as their career path.

This year, the Life Members Committee has readjusted the proportion of medical students and residents who will receive Life Members Fund awards. We will sponsor a larger proportion of medical student to resident awardees. Our concept and aims are to engage students earlier in their training trajectories to seriously consider their future work specializing in child and adolescent psychiatry. The shortage of child and adolescent psychiatrists has increased; we need to solve this people-power dilemma of a burgeoning shortage

of Child and adolescent psychiatrists. While many approaches for overcoming this dilemma may be considered, it is necessary to increase the number of practicing child and adolescent psychiatrists. AACAP is united on this important front of improving psychiatric health care for children and adolescents.

Mentoring is a hallmark of the life members' work and very prominent at every AACAP Annual Meeting. The Life Members Committee works very diligently between Annual Meetings to review and construct means of providing active mentoring at the AACAP Annual Meeting. A cherished highlight is the Life Members Dinner for life members to gather with each other and meet with the Life Members Awardees. This year, it will be held at the University Club of Chicago.

The Life Members Dinner is the last of the formal life members programs at the Annual Meeting. Social interactions between the attendees have been rated very highly. The life members not only enjoy the company of their colleagues but are very stimulated talking, guiding, and learning from the medical student and resident awardees. This is a unique phenomenon because it is near the end of the Annual Meeting and offers time to reflect on the valuable experiences that the Meeting offers. It stimulated the life members to be inquisitive about the life experiences hoped for the new awardees who speak about their dreams for their professional experiences, achievements, and practical issues in favor of our specialty. The medical student and resident awardees have consistently highly rated the Life Members Dinner as providing a relaxing social venue to probe for information about the personal experiences of the life members and to understand more about the processes of life as a child and adolescent psychiatrist whether one is a child and adolescent psychiatrist academician or practitioner.

The University Club of Chicago, established in 1887 by a small group of college graduates, is contained in a historic landmark gothic skyscraper designed by renowned architect, Martin Rocher. The ambiance is spectacular. It is a wonderful place to hold our special evening event, the Life Members Dinner. Please be sure to register for the Life Members Dinner!

The life members' programmatic functions at the 2019 AACAP Annual Meeting begin on Tuesday afternoon with the mentor-mentee forum entitled "Medical Students, Residents and Fellows — Meet Life Member Mentors at the 2019 AACAP Annual Meeting." It is co-chaired by Joseph Jankowski, MD, and Ellen Sholevar, MD, from the Life Members Committee, child and adolescent psychiatry residents Cordelia Ross, MD, and Krysti Vo, MD, from Massachusetts General Hospital in Boston Massachusetts And from Mount Sinai Hospital Icahn School of Medicine in New York City, New York, respectively. In addition to the Life Members Committee, this forum is co-sponsored by the following AACAP committees: Committee on Medical Students and Residents, Training Committee, and the Membership Committee. At this program, child and adolescent psychiatrist mentors meet with medical students and residents in small groups to discuss and help these trainees with their wishes to enhance their knowledge about our profession and planning for residency training in our specialty. An array of topics are discussed including regional training programs, how to plan location of training, features of various training programs, and planning future work after training. This mentor-mentee forum promotes a collegial alliance between the trainees and child and adolescent psychiatrists. It becomes a basis for mentees to maintain contact with their mentors and paves the way for planning future discussions with the child and adolescent psychiatrists at the Annual Meeting and beyond.

After the Annual Meeting, the life members solicit information from the trainees and mentors about their experiences at this program. Of particular interest is learning how the program helped shape the mentees'

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Cynthia R. Pfeffer, MD

plans for their career goals. Also, it is a means for the life members to prospectively follow up on the mentees' professional development.

Each year the Life Members Committee presents the Clinical Perspectives Program, which is presented on Thursday afternoon this year. The title is "The Physician-Patient Relationship in Child Psychiatry: Four Unique Perspectives." The Chairman of the Clinical Perspectives Program is Douglas A. Kramer, MD, MS, from the University of Wisconsin School of Medicine and Public Health in Middleton, Wisconsin. Over the years, Doug has consistently developed an outstanding Clinical Perspectives Program for the life members. The discussant is Margaret Cary, MD, MPH, from the Department of Community and Human Service in Seattle, Washington. An aim of this Clinical Perspectives is to provide a developmental focus on the evolution of work as a Child and adolescent psychiatrist by connecting concepts about child and adolescent psychiatry work at one's early and later career stages. Therefore, two presenters are more seasoned child and adolescent psychiatrists and two are in their early career stages. All speakers will reflect on the physician-patient relationship from various vantage points.

Nancy Rappaport, MD, from Harvard Medical School in Cambridge Massachusetts, will identify influences of creativity, derived from being a mother, wife, teacher, author, and patient, which may facilitate the doctor-patient relationship. Erin L. Belfort, MD, from Maine Medical Center in Cape Elizabeth, Maine, will describe how she incorporates family therapy concepts to facilitate the doctor-patient relationship alliance. Peter M. Lake, MD, from the Rogers Memorial Hospital in Oconomowoc, Wisconsin, will emphasize developing a healthy physician-patient relationship and a strong therapeutic alliance before consideration of medication and other therapies in his work and adolescents with OCD in a residential treatment program. Ayesha I. Mian, MD, from the Aga Khan University in Karachi, Pakistan, considers that the doctor-patient relationship involves a four-way conversation involving the cultures and identities of the physician and patient; she highlights the universal experience of the treatment alliance across all cultures. Dr, Cary will integrate issues that may influence the physician-patient relationship and cause distress and burnout in the physician.

A significant ongoing feature of the Life Members Committee is to offer a constant forum for life members to communicate with each other. We have achieved a fine means of doing this by publishing the life members "Owl Newsletter." The current editor, Martin Drell, MD. Has very successfully fostered the expansion of this publication and has enlisted fine feature articles written by our life members. The Owl Newsletter is published online each year in January, April, July, and October. Please submit articles of your choice that are relevant to life members' professional, personal, retirement, and other activities. If you have questions about a topic for submission, please contact Martin Drell.

Through the establishment of the AACAP Life Members Designation, AACAP has achieved a major developmental benefit for child and adolescent psychiatry. As child and adolescent psychiatrists enter retirement age, they can continue to actively contribute to AACAP for the betterment of our field of child and adolescent psychiatry. The life members' wisdom, innovative ideas, and mentoring activities are apparent in AACAP in a major nurturing way. Life members have a significant and defined purpose of maintaining our specialty as a vibrant force that promotes child and adolescent psychiatry "from one generation to the next!"

"The greatest good you can do for another is not just to share your riches but to reveal to him his own." – Benjamin Disraeli

Cordially,

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

Dear Life Member,

We hope you're planning to join us at AACAP's 66th Annual Meeting. As a long time AACAP member, you know the value of the Annual Meeting, and we want to see you there to share your wisdom and mentor aspiring child and adolescent psychiatrists.

Be sure that the Life Members Dinner is on your agenda! The Dinner enables Life Members to reminisce with each other and mentor the medical students and residents who were awarded travel grants to attend the AACAP Annual Meeting. It's great fun and an excellent way to support the future of our field. The cost is $145/person and spouses are welcome to join us as well. **The Life Members Reception and Dinner** will take place on **Thursday, October 17 from 6:30 pm-9:00 pm** at the University Club of Chicago.

Remember to donate at least $450 to the Life Members Fund in order to get your limited edition 66th Annual Meeting Owl Pin. Remember why your donation matters: 20 Medical Students and 10 Residents are attending this years' Annual Meeting because they applied for and received scholarships. The Life Members' aim is to enable these trainees to experience first-hand interactions with AACAP members and become integrated into our profession in advance of their completing their training. Your Life Members Fund makes this investment.

Below are some events just for owls:

Tuesday, October 15
4:00 pm – 5:30 pm (open)
Medical Students, Residents, and Fellows: Meet Life Member Mentors at the 2019 AACAP Annual Meeting
Sponsored by the Life Members Committee, the Committee on Medical Students and Residents, and the Training and Education Committee

Thursday, October 17
1:30 pm – 4:00 pm (open)
Clinical Perspectives 38: Life Members' Wisdom Clinical Perspectives: Four Unique Perspectives on the Physician-Patient Relationship in Child Psychiatry
Sponsored by the Life Members Committee and the Family Committee

Thursday, October 17
6:30 pm – 9:00 pm (ticket)
Life Members Reception and Dinner
University Club of Chicago
Sponsored by the Life Members Committee

Friday, October 18
11:15 am – 12:45 pm
Life Members Committee Meeting

We look forward to seeing you in Chicago!

Kind regards,
Cynthia R. Pfeffer, MD and *Richard L. Gross, MD*
Chairs, Life Members Committee

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Please consider a **Monthly Hope Maker Gift**

- You will be investing in the next generation of child psychiatrists, who will lead in innovative research, training, and treatment.
- Your recurring monthly gift will allow us to plan ahead with confidence and maintain a consistently excellent level of programing throughout the year.
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It's easy to sign up: just visit www.aacap.org/donate or give us a call at 202-966-7300 ext. 140.


Peter R. Cohen, MD

Author's Note: The July 2019 issue featured the first of a four-part fictional story about psychiatrist Jack Gilliam's inability to decide whether or not to retire. He sought advice from his great uncle and mentor, the legendary emeritus psychiatrist and recluse Reginald Shropshire MD. At the acme of his career, "Reg" was revered by colleagues for his singularly understated interpersonal manner complimented by his succinct but pointed psychiatric formulations. Though Reg remained mute during the three one-hour sessions with Jack, he surprised his great nephew by producing an unexpectedly lengthy document in the form of a psychiatric evaluation.

Alas, this relatively long tale has had to bow to publishing limits, requiring its being spread over four issues. The previous issue focused on Dr. Gilliam's history of presenting illness. This issue reports his Review of Symptoms and Past History. The next issue will feature his Mental Status Evaluation and his great uncle's Formulation, while the final issue will include Recommendations, Responses and Followup.

Thank you for your ability to delay gratification. As a consolation, I believe there is sufficient clinical material in each part of this story to foster analytical digestion, assimilation, rejection and/or reflection.

And with that brief reorientation and apology concluded, the story continues:

SESSION TWO, PART 1: Review of Symptoms and Past History, as recorded by Reginald Shropshire, MD

Jack Gilliam, here. During the second of my three hour-long sessions with Uncle Reg, I fretted frequently about his physical condition. Firmly ensconced in his Queen Mary's chair, he appeared to drop off repeatedly into dreamland. This presumed state was supported by his fits of snoring, the volume of which, unlike his reputation for understatement, was definitely out of character. Had he perchance taken ill or was he simply bored with my rambling narrative? It seemed neither. Though he seemed to sit Buddha-like with eyes shut and Beethoven-like with ears non-functional, he never lost track of the details of my disclosures. The report below is proof of his promise to see and hear me out attentively and thoroughly. Who among us can match the magical, yet eccentric quality residing in the cerebrum of one so devoted to the service of truth?

Yet, on an ethical note, after the last session I also began to fret about what I got myself into. Would I resort to a similar psychiatric conceit of observation and analysis to tend to a loved one more distant than a parent, sibling spouse, child or grandchild? Should one deny one's expertise and knowledge as long as it's restricted to insight and advice but not treatment? And why was Reg applying this conceit? Was he giving me a little tweak, something that resembled the adage, "Physician, Heal Thyself?"

But without further ado-save a smidgen of hesitation and potential embarrassment-I submit the next section of Reg's report:

Review of Symptoms: Generally intact, highlighted by a hearty appetite (and the opportunistic propensity to crack one-liners). The sole exceptions are as follows:

Sleep:

a. Early insomnia and sleep continuity distubance, erratic in frequency and periodicity
b. Recurrent but infrequent, aggravating dreams about failing to master a complex, whirring machine that consistently shut off in the middle of its assigned task.

This "gizmo" seemed to alter its shape and physiognomy with each dream, but always representing one of the pioneers in the history of psychiatry. Dr. Gilliam has succumbed so far to the machinations of Sigmund and Anna Freud, Carl Jung, Erik Erikson, Heinz Kohut and Fritz Perls.

Emotionality:

On workday mornings, he customarily sighed at his image in the mirror and:

a. attempted to bolster his spirits by exclaiming "It's showtime!" accompanied by the display of "jazz hands."
b. brooded about the upcoming day's paperwork.
c. bemoaned his thinning hair, which refuses to hold its own—a "sad state of being" reinforced whenever he glimpsed at his balding pate on a store's surveillance TV.

Medical History:

"My father put it best: 'Getting old is like working at a deli. The customers are your diseases. They stand in line, each one waiting its turn to take a whack at you.'"

"Over the last ten years, while working in this deli of doom, I've survived cancer and a mitral valve repair. One more malady and I hit the trifecta, but who says it stops at three?"

"Thank heavens there's an effervescent, optimistic, obliviousness built into twenty-somethings. It's a dandy protective mechanism to prevent their realizing that by 70 they too will begin the ritual of setting aside 15 minutes a week, packing a dozen prescribed and OTC meds into AM and PM containers. And why should they worry about the inevitable signs of aging? There's a slew of adventures, love affairs, and obligations up ahead, such as changing your baby's wet, smelly diapers. There's years before they face the fact that the primary purpose of evidence-based medical preparations is to keep one propped up vertically until the body finally cries out, "enough is enough, let the decline begin!"

Psychiatric History:

"In my early 20s, there was nothing more invigorating than spending an hour on a snowy, bone-chilling day in a Midwest town, expressing my infantile rage and managing anxiety by pounding on a pillow while my Gestalt therapist cheered me on. And at the moment I thought I was reaching transcendence without words, my shrink suggested I should have a conversation with the pillow. Yikes! In other words, I should talk to whoever was bugging me, which more than half the time was me. To put it another way: it took successive tidal waves of professional prodding and "suggestions" to stop my behaving like an adolescent, railing against an indifferent universe and fighting for validation. Eventually I learned to feel more content in viewing adversity as a creative opportunity rather than obsessing on the tragic state of the human condition. So, if you give me the choice between a musical comedy about scam artists & Nazis (aka "The Producers") versus a mind-tangled novel about an obsessively detached suicidal outsider (aka Steppenwolf), I'll take Mel Brooks over Herman Hesse any day."

"It's taken a lot of hard work to manage my inattention and disorganization, but with the recent increase in slip-ups at home and work, I think I must have always been a camper pitching his tent on the border of the ADHD spectrum."

"I dabbled briefly in some stuff, but no acid, coke, opiates, bromides or absinthe. Drug use was a peer-pressured rite of passage for baby boomers, and I think more wrong than right. As for pot, sure, it can spark creativity, insight, and wacky hilarity, but as Dr. Andrew Weil advocated back then, you can reach those states

of non-ordinary reality chemically-free—and not lose your license. Plus its downside are potential effects of creeping paranoia, dysphoria and dissociation—not a good combination if you're intent on helping someone in trouble, including me.'"

Social History:

"My dear parents? They were 'good enough,' the model for tolerating high dramatics, eccentric hi-jinx and rowdy roughhouse to varying degrees in their daughter and four boys. They civilized us enough to stop before we reached the edge of mutual annihilation. They were also the model of intolerance about challenging their authority. We rarely goaded mom and dad—that was a bridge too far. Otherwise we were free to do whatever a five-ring circus of kids was destined to do—provoke, annoy, and tease each other when we weren't busy doing homework, hanging out with friends, or pursuing extra- and ultra-curricular activities."

"After the hell my dad witnessed fighting in the Pacific during WWII and my mom suffered on the home front combating her crushingly opinionated and tactless family, I can understand my parent's wish to maintain family peace. But that implicit expectation had to be punctuated by frequent declarations that children will live longer if they are 'seen but not heard.'"

"It's been a hoot shepherding three children and four grandchildren with our wits still intact. Despite the brilliance, creativity and utter adorability of children, they are prone on an annual basis to do some 'lame-brain, pathetic, what-in-god's-name-were-you-thinking, did you even stop yourself for a second, not even I can protect you from your mother or father for the knuckle-headed thing you just did.'"

"Now that our three children are too old to be sent to their room for miscreant behavior and mendacity—hell, they're married with children, successful at work, and kind and charitable while managing to stay out of prison—my wife and I consign ourselves to be on call to help their distraught kids pull themselves together, and just as critical, prevent their parents from acting on their revenge fantasies."

"My wife and I prefer to spend our remaining days on earth reading books, seeing movies, traveling, dining out with friends, and reviewing the grandkids' latest exploits. We've also agreed to laugh at each other's loathsome quirks instead of throwing knives and plates."

Interests:

"You don't need a cruise-ship social director to give you a list of things to do during retirement. Like the things I just mentioned, as well as writing, gardening, sailing, cooking, playing guitar, taking a mid-afternoon 10-minute nap, complaining to my legislative representatives, attending Saturday AM Torah study without dozing off, and most important, meeting a grandchild at his or her favorite restaurant so I can listen to his or her most recent gripe about the parents."

Family History:

Psychiatric:

a. Illness- and stress-related depressive moods.
b. Social and generalized anxieties.
c. ADHD, inattentive type, and
d. Learning disabilities, predominantly reading input and processing challenges

"In my family, it was difficult to differentiate between what were or weren't valid psychiatric diagnoses, what with my parents over-reading their kid's quirks and all seven of us discovering innovative methods to annoy the crap out of each other."

Somatic:Essential hypertension, heart disease and hyperlipidemia: "The three banes of East European Ashkenazic Jews who live for and die for creamed herring and corned beef."

THE CURIOUS CASE OF THE AMBIVALENT PSYCHIATRIST
Peter R. Cohen, MD

Developmental History:

Milestones are predominantly within normal limits, though he complains, "In my youth, I aspired to run like Jim Brown and leap like Nureyev. My body refused to cooperate."

Temperament: slow-to-warm up. His parents attested that from infancy he approached and adapted to everything slowly. His quiet and subdued manner prompted visitors to ask if the mother had actually borne another child into this world. She'd respond by saying that as a fetus, he lollygagged so long about leaving the womb, the doctor had to yank him out.

He was a "slow reader" moderately responding to psycho-educational remediation. "But not my handwriting. It was so illegible, I had to stop penning love letters after my first real girlfriend couldn't decipher my scratchings and thought I was breaking up with her. She still dropped me even though promised to sign up for typing class."

Professional History:

"During a very busy and taxing medical internship I also completed an independent three-year training program in Gestalt Therapy. Flash forward to my psychiatric residency. Our beloved training director wasn't enamored with my burning interest in the therapy. He vowed to rescue me from it. I think he worried my answers to all human woes was Gestalt. Not so, but the only way you can subdue the fervor of a recently initiated behavioral existentialist is with a dart gun. So, we compromised. I agreed to learn everything else psychiatric and practice the therapy without flaunting it or getting into insulting arguments with Freudian aficionados. Out of that compromise, I discovered a big secret: in practice, the most accomplished psychoanalytic and behaviorally bent clinicians are as here and now as hell. So much for orthodox ideology. In other words, based on psychotherapy research, it you want to hedge your bets about what essential factor will most likely help your patients, it's the relationship, stupid."

"I was lucky that a junior faculty member rejected my application for a chief residency in family therapy. Talk about a bad fit: me, a peripatetic kid whose idolized the Marx Brothers versus a smart, competent, diligent but dour, abrupt and essentially uptight supervisor. Instead, I became the chief resident in community psychiatry. This opportunity eventually led to three dream jobs as a medical director: for my county's behavioral health services, my state's substance abuse administration, and a regional hospital."

"During my career I've witnessed enough dedicated professionals who enthusiastically began working for a behavioral health treatment center, hospital system—you name it—only to have their idealism crushed by a harsh reality: too many of these programs proclaimed that they treated teens with respect, but their default mode was systematic browbeating and bullying. It's daunting and oft times impossible to turn that organizational mindset around."

"We know how to do better by kids and families. That means creating coherent systems of care supported by levels-of-care criteria, and infused with evidence-based treatment, valid outcome measurements, and precise, empathic supervision. So why do we so often fall short of putting into all that in operation? Blame it on unenlightened or insufficiently talented administrators under financial pressure to make ends meet. And dwindling reimbursements. And a paucity of support by insurance companies. And the lack of a critical mass of employees who believe in the mission and have the will to follow it through. So instead, we once again default to a lowest common denominator. How does this affect us psychiatrists? They hire us to see patients for no more than 15-minute med checks, then document and bill at an effective rate to cover our salaries. No wonder modern psychiatric care can become distorted, forcing dedicated professionals through a narrow strait that berates our

training, capabilities, and talents. Ask a psychiatrist what's wrong and you may hear she or he rightfully complain about 'treating the paper, not the patient' and 'diagnosing for dollars,' where the only goal is 'stabilizing kids through better chemistry.'"

"I've left a couple of great jobs that sadly went sour, because the administrators devalued professional psychiatric expertise, while believing that anyone could do what a psychiatrist does. But here's the event that really tipped my cow over: The higher-ups at the state level didn't want to announce their decision about a proposed policy before they formally asked for opinions from all the important underlings in the department. So, while recovering at home from recent abdominal surgery, I composed an earnest critique, couched in politically correct language. In essence I said that the policy stunk, because the potential lack of oversight would put our consumers at high risk. When I returned to work all patched up and ready to go, my new boss then called me into the office, not to thank me for my thoughts but to berate me for responding to the request when I shouldn't have responded at all—and then called me a renegade. Didn't I know I wasn't being a "team player?" Well, that was the last straw. I was too shocked and too slow to counter with a Groucho Marxism: 'Don't look now... but there's one person too many in this room, and I think it's you.' Instead I told my boss that I must have been too naive and idealistic to realize that honesty is never the best policy. Then I had to phone my old boss—the guy who originally hired me. He had been fired when he rightfully but politically ruffled the feathers of a bunch of judges—but that's a story for another day. Well, I told him I was now being called a 'renegade.' He laughed and said, 'That's why I hired you.'"

"So, I learned a tough lesson about work. A healthy organization takes all types, but don't work in one that hates your type."

"I've also learned three hard-earned clinical lessons:

- You can't help teenagers until you come to terms with what makes them so damned annoying.
- When a teeny-bopper insults you, take a deep breath and remember the last line of the movie Casablanca: 'I think this is the beginning of a beautiful friendship.' And if the adolescent finally asks for your help in that typically adorable, uniquely awkward and indirect manner, be grateful. The two of you might be on the way to the merry old land of Oz.
- A lot of what helps a kid turn around boils down to what Mr. Rogers used to say to youngsters. 'You are a special and good person. You don't have to prove that to anyone.' I would humbly add, 'But think about being nice to yourself and others. It never hurts.'"

"To paraphrase GB Shaw, it's a shame grandparenthood is wasted on the old. When we were newbie shrinks-in-training, our supervisors would urge our assuming the grandparent stance with our patients. I'm not referring to the stereotype of an old codger who progressive slouches to the point of being bent over and complains about every ache and pain. In formal terms, I mean controlling one's counter-transference while embodying a Yoda-like presence, topped with a humorous sense of the absurd—but that is way, way easier said than done. Sadly, a T-bond matures faster than it's taken me to keep my composure when a patient, child, or grandchild freaks out."

"Finally, putting off retiring has got nothing to do with waiting till we burn the mortgage. Fortunately, savings and investments have put us in decent financial shape. But then again, that's what Wall Street said the day before the Great Depression."

"I don't think avoidance of either conflict or ambivalence is prolonging my current indecision. That would be true if I refused to humble myself to therapy, reasonably sane friends, the absence of high-test street drugs and marrying someone who survived the streets of New

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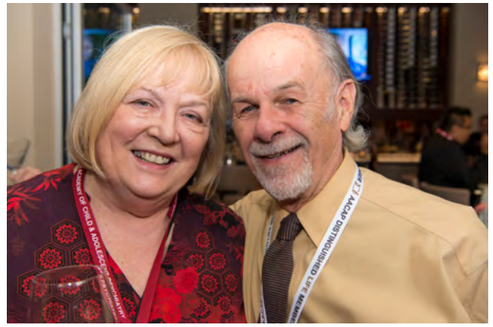
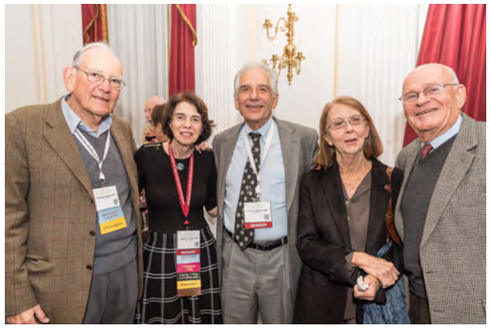
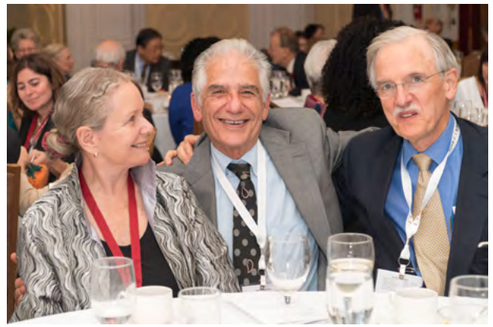
York City and refused to back down from adversity.

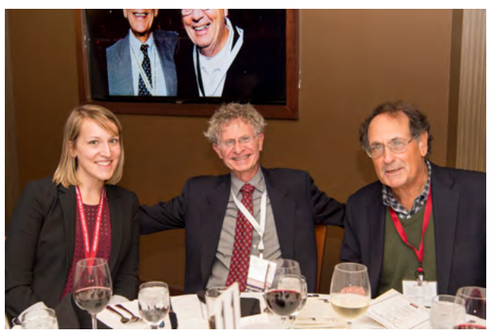
"On retirement, who wouldn't miss witnessing one's patients' upward trajectories? Right now, most of them still seem to need me, but they won't if my foibles start turning into fumbles."

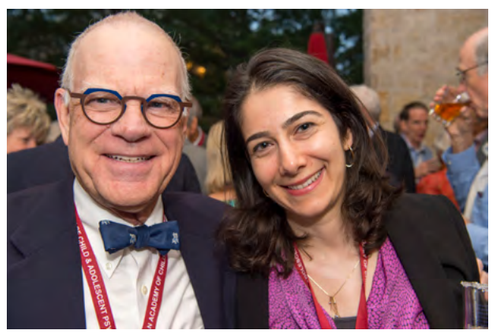
"So in the end, I'm left with three questions: Has my career been good enough to stop working? Have I done enough good and undone enough of my bone-headed well-meaning gaffes with patients to forgive myself and finish my career? And what do you have to do to find some good ice cream in this town?"











Kim Masters, MD

Editor's note: This letter to the Editor evolved out of an email exchange I had with Dr. Masters in response to my column entitled "Fluffiness and Why This Follow-up Column to my Previous Column on Burnout is Not On Wellness as I Promised.' "It included the sharing of new articles on the subject. At some point, I suggested that Dr. Master's convey these thoughts to the Owls in the form of a Letter to the Editor. The letter printed represents an example of editorship that Dr. Master's felt seemed, at points, was more of a collaboration. My position is that all editors collaborate with their contributors towards a goal of improved clarity and impact.

Dr. Drell's commentary on burnout is a thoughtful beginning to a dialogue about its causes. It is somewhat strange for some of us who are no longer practicing in the demand-heavy environments that are catalysts for "burnout" to be commenting about it. Nonetheless, having experience with these issues in practice in the past may make my comments somewhat useful.

Much can be said about the complex causation of "burnout" and about the way it can interfere with our daily practice of Child Psychiatry. Additional factors to those presented in Dr. Drell's article that promote "burnout" can include substance use issues as either promoters or sustainers; financial burden, and by student debt or excess demands on what we earn.
In addition, recent articles[1,2,3,4] on wellness and resilience programs to combat "burnout" suggest that they may complicate matters by shifting the responsibility for systemic and societal problems to the physician. In effect, these programs oblige doctors to compromise moral and ethical standards, especially those relating to beneficence (doing what is right for the patient) and fiduciary responsibility, (putting the patient's interested first), thus creating moral injury. A Medscape commentary has labeled this as "healthcare organization gas lighting," because it sells "practitioner self-help burnout recovery programs as a substitute and even a distraction from addressing regulatory over-reach and an outsized commitment to making money." One might be disposed to consider this the George Orwell, Animal Farm approach to "burnout"

The way out of this moral dilemma would be to quit. However, the "Catch 22" result would be financially and socially crippling. It is possible that these issues lead some Child Psychiatrists into private practice, and others into managed care roles, and medical administration, but these may have other moral dilemmas, like not accepting Medicaid patients because insured patients pay more, becoming invested in the profit-driven algorithms that limit care, and promoting the well-being of the institution over the well-being of its patients.

Probably, for some, 'burnout' is an isolated work phenomenon, but for others, perhaps, it is a reflection of what our achievement in becoming a Child Psychiatrist means to our changing personal assessment of how well or poorly we are doing. Do we mean 'burnout' at work, or 'burnout' at life, when we use the term? If the former, then the discussion that Dr. Drell has started provides us with materials for deepening our understanding about it. If the latter, perhaps, Viktor Frankl's, "Man's Search for Meaning," (meaning men and women) offers a way forward. Admittedly, this may seem a simplistic sop to something much more complex. For some Child Psychiatrists the practice is their life and its meaning. However, I am not addressing those who thrive in this way, but those lives who feel that the 'burnout' is not limited to work related issues, but to a change in the perspective about life; its meaning, goals, ambitions etc. Maybe it results from the conflicts within Erikson's developmental trajectory of the life stages of "generativity vs stagnation," a reawakening of previous life stage spectrum issues of "intimacy vs. isolation," or the

Letter to the Editor: Burnout
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anticipation of the final stage of "integrity vs despair." Maybe the development of "the burnout life" is the result of illness, or of loss or other factors that promote a personal re-appraisal and nothing good comes up? Possibly in these situations, "burnout" repair at work is insufficient to restore a personal sense of direction. The reflection on Frankl's achievement, that he found meaning in the horrors of the concentration camp, might be an inspiration for continuing one's own search for life meaning.

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2. Sepah, T. The Problem with Calling Physician Burnout a human rights violation or moral injury. Physician. 19 June 2019
3. Wible, P. Not 'Burnout', Not 'Moral Injury'…Human Rights Violation. Medscape 20 March 2019
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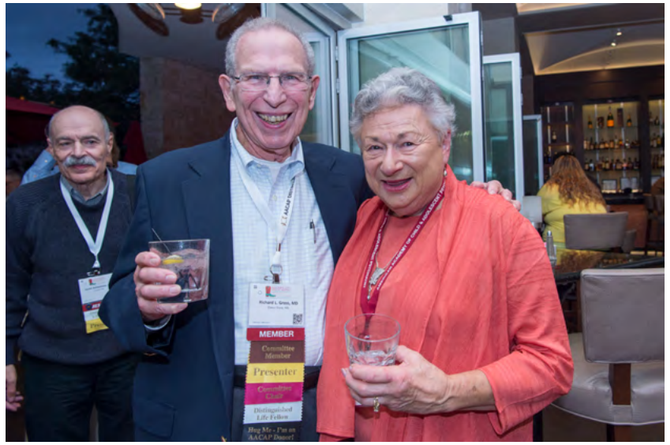

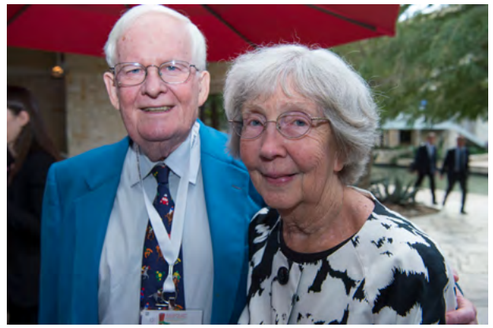

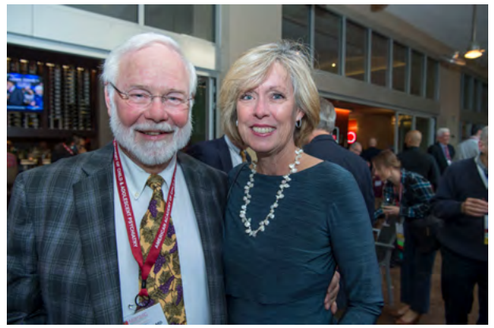

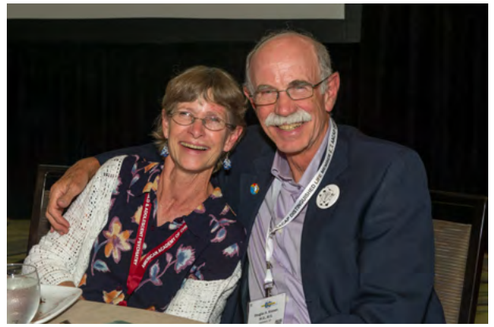

Life's Footprints

What are Roots?

do they have unique footprints,

do these footprints change through generations,

can the durations of generations erase them,

or will they always find some way to re-appear

invariably becoming the Ghosts of yesteryear,

who still walk with us;

and are only waiting to be

re-claimed

re-captured

re-imagined

and journeyed once more;

creating footfalls on

the canvas of life.

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