



April 2018

e-Newsletter



Photo by Fred Seligman, MD

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Laughing Matters In Therapy

Jokes from John McCarthy, MD

- 1. A Dentist and a manicurist married. They fought tooth and nail.*
- 2. Police were summoned to a daycare center where a three-year-old was resisting a rest.*
- 3. He had a photographic memory which was never developed.*
- 4. Acupuncture is a job well done. That's the point of it.*
- 5. Those who get too big for their britches will be totally exposed in the end.*

Joke from Perry Bach, MD

Many years ago, I was seeing a six year old boy because of his hyperactivity. (At the time his diagnosis was actually "Minimal Brain Damage.") He was also blind in one eye due to brain damage sustained when he was an infant and his father threw him against a wall. We were playing with little dolls identified as a family. After the family ate breakfast, he took the father doll and put him on a small airplane. He then flew the plane and the father around the office, finally setting them down on one of the broad leaves of a small rubber tree in a corner of the office. I asked him where the father went. He told me, "He went to work at the plant."

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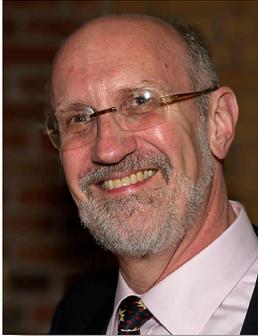
*Get involved -
submit articles for the
Owl Newsletter!*

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 June 15.

Martin Drell, MD



A New Owl Talks about Ageism: Now Is The Age Of My Discontent



Martin Drell, MD

In 1984, seventy-three-year-old Ronald Reagan was asked during his presidential debate with Walter Mondale if he were too old to run for President. Ronald Reagan answered, “I will not make age an issue in this Presidential Campaign. I am not going to exploit, for political purposes, my opponent’s youth and

inexperience.” This one clever remark dealt effectively with the claims and fears of ageism regarding Reagan. It also points out that ageism not only deals with discrimination against the old, but against the young, the latter of which child psychiatrists are painfully aware. Both ends of the age spectrum are prone to discrimination.

The topic of ageism has been on my mind and was on my list to write about in the future. It moved to the top of my list after many events that came to my attention over a short time period. One was Dr. R. Larry Schmitt’s wondering in his article titled “From Tofranil to Telepsychiatry,” why so few organizations responded positively to his requests to volunteer. The second was a friend’s remark that he regretted retiring to optimize his pension, as he felt that people were now treating him differently.

This friend related that he had been hearing of many peers who were suddenly being relieved of their duties despite illustrious careers. It seemed that these happenings were more than coincidence, although I wondered if I was not paying more attention to these issues as I aged into a period when I was more and more vulnerable to the same.

Everything coalesced suddenly when I ran across a wonderful activist TED talk by Ashton Applewhite on

ageism. She claims that ageism, like all “isms,” is a socially constructed idea that pits one group versus another. This “otherism” feeds on denial and is also fueled by our capitalist society, which sets up a young vs. old dichotomy that is good “for business.”

Ageism starts early on and converts being old into a disease, or many diseases, many of which are advertised in order to promote treatments for them. She gives six examples such as low T, the cosmetic industry, plastic surgery, the hair loss industry, and mild cognitive impairment to name just a few.

Applewhite points out that the process works so well that older people internalize these false claims and are left afraid, bewildered, and ashamed. The normal physical and emotional change processes of aging are transformed into diseases that must be challenged, fought, or denied.

She points out that the fear of aging is the “true” epidemic and that in many cases, it is worse than the physiological reality. She notes that only 4% of the population are living in nursing homes and that most “senior moments” are not signs of impending dementia. Do adolescents have “adolescent moments?”

She emphasizes that it is ludicrous to talk about the elderly as one great lump of poorly functioning protoplasm during a developmental process that spans decades and which seems to be expanding thanks to the wonders of modern medicine. She proposes that the concept of a “spectrum” is preferable to the present dichotomy of young and old.

The Owls already speak of young and old Owls. In addition, we all know that individuals have varying qualities that differentiate them from their peers. Are there not young people that act like old people? Oops, there I go, stereotyping again!



A New Owl Talks about Ageism: Now Is The Age Of My Discontent

As I listened to Applewhite, I realized that I avoid my growing older by a mix of projection, denial, and a sense of humor based on my fears of death and disability. “Isn’t that person really old? Why do old men walk that way? That will never happen to me!”

I recently watched a one man show with Ed Asner, age eighty-eight years, called “A Man and His Prostate.” Mr. Asner who has suffered a stroke, walks painfully slowly with a cane, sits for the majority of the performance that lasts slightly over an hour, and reads from notes.

He is still very funny and was plugging a book he has just written. He’s a neat old guy. (Oops, there I go again!!) I really liked that it was a short performance due to “me and my prostate.” (Oops, there I go again!)

More reading on the subject showed that the term “ageism” was coined by Robert Neil Butler in 1969. He defined it as “a combination of three connected elements. Among them were prejudicial attitudes towards older people, old age, and the aging process; discriminatory practices against older people; and institutional practices and policies that perpetuate stereotypes about elderly people.”

An official definition from Iverson, Larsen, & Solem in 2009 is defined as “negative or positive stereotypes, prejudice and/or discrimination against (or to the advantage of) elderly people on the basis of their chronological age or on the basis of a perception of them as being ‘old’ or ‘elderly’. Ageism can be implicit or explicit and can be expressed on a micro-, meso- or macro-level.”

I was fascinated to find that age discrimination is covered in the Federal Age Discrimination Employment Act of 1967 (ADEA). The age at which people can make a claim is age forty years.

It is covered by the Equal Employment Opportunity Commission (EEOC), which has had trouble discriminating the criteria for what is discriminatory as the protections have increased over time (n.b., probably into a spectrum of offenses).

The EEOC was noted to have a large back log. To further complicate matters, each state has its own age discrimination laws.

Articles have identified a harmful process which stereotypically lumps large groups, such as the Millennials (75 million) and the Baby Boomers (75 million), and pits them against each other.

Several articles pointed out that there are many “aging” persons in their thirties in Silicon Valley who are afraid, as younger “digital natives” compete for their jobs.

Other societal issues have been identified which conspire to inflame these issues. These include:

- Gender-based discrimination in which women receive less money than men for the same work - this also includes societal differences in how older women vs. men are viewed (also known as the “male gaze”) which translates into fewer roles in the media and films, especially for older women.



A New Owl Talks about Ageism: Now Is The Age Of My Discontent

The stereotype that men grow more distinguished with age while women don't is part of the problem

- Race-based discrimination
- Concerns about the stability of Medicare, Medicaid, and pension plan funding
- Lower percentage rates in the growth rate of the U.S. economy
- Relative stagnation in wages over the past decades
- Increasing costs in college education and the accrual of large educational debts which impact job preferences
- Aging of our population and the uncertainty over healthcare coverage with its increasing costs
- Globalization of many jobs
- Replacement of jobs due to technological advances

It is sadly noted that being old does not protect you from other "isms" that are often co-morbid with one another. To be poor, black, female, and old is a potent "quadruple whammy."

The perception that the societal pie is not increasing is leading to competition for what is perceived as a set number, or a decreasing pool, of jobs.

When these factors get added to the uncertainty as to when one will die, people start

postponing retirement. This, in turn, makes matters worse, especially for younger generations vying for the same jobs.

As my accountant joked, "You can retire now if you like dog food or if you'll only live five more years." Many a truth or anxiety is said in jest.

Statistics show that, in a very short time, there will be two billion people over age sixty years in the world.

Thus, the issues will, if anything, increase in the following years. In a macabre twist, the literature notes that ageism, with its anxieties and stresses, can actually decrease one's lifespan. Perhaps this will moderate what seems to be an never ending vicious cycle.

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Chair Column



Richard L. Gross, MD

Here I am, sitting at my desk, looking out my window; it's the first day of Spring, and snow is falling, prediction of three to six inches. Fortunately, we missed most of the three previous "Northeasters" that hit Philadelphia, New York,

and New England and their environs. I hope our colleagues north of DC have survived the rains, snows, and winds of early 2018.

In reviewing an earlier editorial in the Owl Newsletter by my co-chair, Cynthia Pfeffer, MD, she pondered "reviewing one's life" while attending a family wedding. I had the occasion to similarly "ponder my life" following my Acute Myocardial Infarction and triple by-pass surgery last June. Besides the love, care, and attention I received from my wife, children, and grandchildren, I was completely overwhelmed by the outpouring from my colleagues in the community and from AACAP and the Owls.

I am most appreciative, and I thank all of you. We are a small and caring community. I was well enough to be able to attend our last Annual Meeting fortunately in Washington, DC, our home, in October. I was completely overwhelmed by all the attention and good wishes that I received there.

This leads me to pondering the lifetime of the Owls. The organization has prospered since its beginnings in 2010 and the original leaders are getting older and many have retired. There is a need to get younger Life Members involved

in order for the Owls to continue to do the good work that has been done until now and continues to be done. We supported 13 medical students and 17 residents to be able to attend the recent Annual Meeting, and there were over 100 of them at the Mentoring Program at which Life Members met with the medical students and residents in order to provide mentorship. In addition, the grantees were feted at a dinner with the Life Members. The letters of appreciation were extraordinary.

This gets me to my next (and last) ponder about the life of the Owls. It is through your contributions that we have been able to provide these grants so that the medical students, residents, and fellows can attend, learn from the meeting, and be mentored. Among the letters of appreciation were comments like, "a wonderful week," "networking and learning," "meeting experts," "I developed connections with multiple Life Members," "I can't express how thankful I am," "learned about future research directions in Autism," etc. We would like to do more and to support more potential child and adolescent psychiatrists. To do that, we need to hear from you.

We are a more diverse group than you may be aware. It is an important attribute that I fear is unrecognized. The diversity to which I am referring is that Lifers are NOT all retirees. Many are not retired, and we NEED younger Owls to be involved. There are Lifers in active practice. There are Owls still in full-time Academia. There are Lifers who are semi-retired (teaching and/or consulting or part-time practice). There are Lifers who



Chair Column

are retired. There are younger, middle-road, and older Owls. We need all of you, and we need new, younger Owls to be certain that the Lifers continue to exist as a thriving organization to continue this tradition of grants for really young, future child and adolescent psychiatrists to attend our Annual Meeting and go on to be members and leaders of AACAP.

All too often when my wife, Carol, and I were editors of this Newsletter, I was told when I asked a Lifer to write something, "I am still working; I'm not really a Lifer." Yes, you are a Lifer, and we need you. We want to hear from all of you Lifers, and we want you to be involved, not just the retired! We need young, active Owls, not just the old geezers!

We need feedback. We need an active group of Owls – younger, older, retired, semi-retired, active, less active. We need you for your leadership, your mentorship, and for your support in helping to finance grants to young future child and adolescent psychiatrists. Since 2010 (when the Owls started), our Life Members Fund has made an investment of 78 medical students and 92 residents/fellows – a total of 170.

That's impressive!!!

Richard L. Gross, MD





From Tofranil to Telepsychiatry



"If you live long enough, what you experience, especially as a physician, will be amazing."

Tofranil appeared just before I trained at the Karl Menninger School of Psychiatry from 1965-69. Family psychotherapy had come on the scene and appealed to me. It required that I obtain supervision on my own.

R. Larry Schmitt, MD

I completed one family psychotherapy case with Arthur Mandelbaum, LCSW. Family therapy caught me. Due to the impact at that time of more traditional treatments, a decade passed before I began frequently using it with my young patients, their siblings, and parents. The more I used it the more I was convinced of its efficiency and sustained positive changes for families.

After my fellowship came the excitement and pleasure of supervising. I enjoyed years of opportunities to teach child psychiatry fellows how to fit it all together. Consultation-liaison psychiatry clearly was my niche. My father ran a fine general practice in a small northern Wisconsin village. That experience increased my own comfort dealing with physicians outside of my specialty as well as families experiencing physical issues associated with emotional ones. My very satisfying experience doing consultation-liaison at a pediatric hospital in my early private practice years was short-lived.

Unfortunately, I had to leave it in order to make a living. As a trusted colleague stated at that time, "When hospital physicians request a psychiatric consultation, they consider it similar to calling a religious counselor, anticipating there will be no charge." Fortunately, times have changed and now insurance generally pays for the required time and skills.

I was disappointed but not discouraged.

During my first four years of private practice in San Diego, I combined hospital and outpatient work. That proved an inefficient use of time as my office was too distant from the hospital.

I worked, at my office, with hundreds of young patients and their families before retiring in 2005.

Anticipating retirement caused some brief anxiety, mostly concerns as to how I would use my time and whether my funds would last. That anxiety was unnecessary.

A surprise came when I contacted more than twenty NPOs offering to assist them pro bono with their children and families. Only two accepted my offer. I have yet figure out why a pro bono psychiatrist for children, costing \$350 per hour in the free market, was not welcomed. One possibility is there are so few child psychiatrists that we suffer from bias and fear of the unknown, (i.e. what does a child psychiatrist really do?). Perhaps people anticipate that I would aggressively push to alter how they deal with children. Maybe it is ageism? Maybe it is fear of lawsuits? If so, the Federal Trade Commission provides the finest professional liability protection for professional volunteers at NGOs, that requires minimal paper work each year. The complainant must sue the government, not the professional.

I finally chose to work for a large organization for the homeless that wanted my assistance in their learning center. That position rapidly confirmed, for me, that I could be useful. This went well until a new director of that learning center did not seek my support in spite of my useful presence at their team meetings. I resigned after three years with high praise for their team's work. A few months passed before the Medical Alumni Volunteer Expert Network (MAVEN) contacted me in August 2016. More on this later.

A year prior to retirement, I began a 15-year relationship with the UCSD pre-med mentor program that allows pre-med students to interview physicians in various areas of medicine and surgery. For psychiatry it is a win-win situation.

They choose who to interview and for how long, one to six sessions or more. Since they may request once or twice a month contact, I can take up to five a semester. In case you have not had this gratifying experience, psychiatry mentoring at this level provides a ripple effect.



From Tofranil to Telepsychiatry

For those pre-meds who interview us and later do not choose psychiatry, they have been partially inoculated against future medical professionals they encounter who exude a negative bias toward the mentally ill and their caretakers. Few readers need a reminder that such biases and stigma continue. It may have abated from the time of our training, yet more remains to be done in our medical schools.

Three years ago, I started to advocate the use of adverse childhood experiences (ACE) surveys to all with whom I consulted including my premed mentees. The solid and extensive research was completed by 2000. Dr. Vincent Felitti created ten questions for patients to answer yes or no regarding events before their nineteenth birthday. These questions concern childhood trauma that many physicians are reluctant to explore. Opening these areas for discussion often provides great and unexpected help to the patient. It has been accepted and used by many non-medical groups across the United States. In schools and juvenile courts, it is often referred to under the rubric of “trauma- focused” care. Medicine continues to slowly appreciate how useful such questions are for many patients. A score of four or more out of ten predicts that such a patient will have a shortened life caused by physical maladies. Just opening such topics can start the patient on a road to resilience in the vulnerable areas. I retired before using ACE, but I now take every opportunity to inform physicians of its healing and money saving potential when taking histories.

In 2016, MAVEN contacted me with a request to do telepsychiatry for children. Dr. Laurie Green, OB/GYN, from San Francisco created MAVEN in 2014. To be accepted, one is required to provide documents that reminded me of applying for hospital privileges in the seventies.

Bingo - this new opportunity returned me to consultation/liaison psychiatry, my favorite niche. Once accepted, I used my desktop computer and a ZOOM telemedicine link to work with 12 families in two clinics in northern California. At the start, I was anxious concerning my staleness in psychopharmacology and the acuity of my third ear.

For me, these first dozen cases were like a bracing double tonic! I proved useful in each case. Most of the time I needed less than the allowed hour, unless an interpret-

er was required. On two occasions when the ZOOM link failed, I completed the interviews over the telephone, again with clear success. Psychotropic meds were not an issue, and my third ear proved up to the task.

In most cases I sent in a brief encoded written summary to the clinics. In two cases, the attending MD came into the ZOOM room after the family departed. We discussed my impressions and recommendations. My discussion with the attending was very efficient especially as it minimized any possibility of misunderstanding.

I was struck how often the primary care MDs did not ask key questions concerning the psychiatric history. So much of my understanding and assistance in those initial MAVEN cases came from asking, “When and where did your problem begin?” Have societal forces pushed the frontline physicians to over-focus on the presenting complaint with hope for a quick fix so that they no longer take an adequate history from their more complex or unresponsive patients? My best example: A 14-year-old girl who had been treated for bipolar disorder including unhelpful medications since age eight. Her symptoms began when she and her sister were temporarily removed from mother’s care by child protection. Both she and her sister were fortunate to be placed in different yet fine foster care for a short time. This girl’s symptoms began when she returned home. The mother, the sister, and the “patient” reported that no professional since that time had explored their memories of that disruptive event until my consultation.

Recently, MAVEN linked me with American Indian Clinics east of Los Angeles, allowing me to continue my clinical usefulness.

Through all of this, I have yet to volunteer enough. It has fluctuated from four hours per week to the more common one hour or less. I seek more volunteer opportunities. The reluctance mentioned earlier continues.

Child psychiatry has provided a long and splendid trip for me, filled with truly enriching experiences including during my retirement years.

In the last 50 years from Tofranil to telepsychiatry, there has been great progress in our field.

R. Larry Schmitt, MD



First Owl to Be President-Elect of AACAP



Diane K. Shrier, MD

Though there are numerous Past Presidents, past members of the Executive Committee, and past members of Council who are Owls, Gabrielle (Gaye) Carlson, MD, will be the first Owl to serve as President of AACAP. Of course, for the next two

years she will serve an “apprenticeship” as President-Elect. This article focuses on how the Owls could be helpful to Gaye and what suggestions she might have for the Owls during the time period she is President-Elect and President.

Gaye feels she was always a late bloomer, so the experience of becoming President-Elect/President at the “Owl” stage of development is nothing new for her. Gaye has been a full-time tenure-track academic for her entire career – teaching, doing clinical research, and seeing patients. Her CV summarizes the usual academic activities - editorial board of numerous academic journals, author/co-author of innumerable articles, and a highly regarded speaker at professional meetings. From 1985 to the present, she has been Professor of Psychiatry (and since 1988 also Professor of Pediatrics) at Stony Brook University School of Medicine. From 1985 to 2013, Gaye served as Director of the Division of Child and Adolescent Psychiatry, building a highly regarded program from scratch.

We spoke briefly about what led Gaye to run for AACAP President. She said it was a convergence of two career pathways: positive experiences at AACAP and major changes in

her career at Stony Brook following the hiring of a new Chair of Psychiatry who de-emphasized the role of child and adolescent psychiatry, at least at the beginning of his tenure. Regarding AACAP, when Larry Greenhill, MD, was President, he asked Gaye to serve as Chair of the Program Committee, which she did for four years (2011-2014). He predicted she would enjoy the job, and she really did – not just the program development but working with AACAP staff and members.

As a result, she became more interested in working with the organization when her Program Chair term was up. She served on AACAP Council as Councilor-at-Large and then became interested in serving on the Executive Committee. She was selected to run for President and was elected. Regarding her career at Stony Brook, Gaye continues to remain a very active academic as a tenured Professor and to use her considerable organizational and strategic skills to benefit AACAP and conversely to use the advantages of being an AACAP resource to benefit Stony Brook’s child psychiatry division.

Once she became AACAP President-Elect, she (and her husband who is an Endocrinology professor and chaired that Division at Stony Brook) went to 60% time. In her husband’s words, that means working full time and getting paid part time. In reality, it allows for more flexible use of time and also allows them to do more of the things they WANT to do without being forced to do the things younger faculty in medical schools unfortunately HAVE to do.

Regarding projects with and for the Owls, Gaye, who serves on the Life Members Com-



First Owl to Be President-Elect of AACAP

mittee, was interested in knowing how well the fundraising by the Owls fulfilled its goal of getting young people interested in becoming child and adolescent psychiatrists and in joining AACAP, i.e. what was the return on investment (ROI).

With Cordelia Ross, MD, a PGY2 from Massachusetts General Hospital who had received funding previously for attending the Owl dinner, mentoring by Owls, and AACAP's Annual Meeting, the Life Members Committee developed a survey for former recipients of these awards. Dr. Ross wrote up the detailed findings, but the bottom line is that the fundraising gives us a very good ROI. Hopefully, this information will be used to further increase the funds generated by the Life Members for recruitment, mentoring, and the Owl dinner.

We discussed more about Gaye's relationship with the Owls and what roles the Owls might play in her Presidency. Gaye has sought the input of several former Presidents who are currently Owls, as well as other Owls, for their advice and guidance.

For instance, she talked to Past Presidents Tom Anders, MD, and Marty Drell, MD, when she was deciding whether or not to run for AACAP President, and they had strongly encouraged her to do so. She respects the wisdom and experiences of the Owls and welcomes their advice and suggestions over the coming four years as she serves as President-Elect and President of AACAP.

We welcome Gaye as the first Owl to serve as AACAP President-Elect and President and look forward to continuing and growing collaboration and input to her Presidency and to



Gabrielle Carlson, MD



Gabrielle Carlson, MD, and Heidi B. Ford



Owl Mentorship Program: Follow-Up of AACAP's Life Members Fund Awardees

the Owls. Given that Gaye sees herself as a “late bloomer,” rather than being in the Eriksonian eighth stage of Wisdom, she is still in the seventh stage of Generativity. She plans to put her considerable energies to work in the continued service of youth and of AACAP! “If I have seen further it is by standing on the shoulders of giants.” — Isaac Newton

Mentorship has been described as a two-way gift exchange, simultaneously humbling the wise and experienced, while inspiring leaders of the future. As such, mentorship has been a fundamental aspect of AACAP, particularly among the Life Members.

In fact, it has been one of the Owls' cornerstone missions, in order to enhance the field of child and adolescent psychiatry (CAP). At AACAP's Life Members Committee meeting at the annual AACAP meeting in October 2017, Gaye Carlson, MD, proposed doing a follow up of medical students, residents, and child and adolescent psychiatry fellows to find out how many had entered or stayed in the field and were members of AACAP. This report highlights salient findings of that brief study.

In the span of five years (2011-2016), the Owls provided funding of over \$150,000 to support 158 trainees in attending AACAP's Annual Meeting. In this period of time, the Owls granted 76 AACAP Life Members Mentorship Grants for Medical Students; of these, 59 (77.6%) are current AACAP members. Similarly, the Owls granted 82 Educational Outreach Program awards for general psychiatry residents and CAP residents; of these, 76 (92.7%) are active members.

To obtain more detailed data on the results

of our mentorship programs, we decided to focus on surveying the 76 medical students who received awards from 2011-2016 given their undifferentiated career status at the time. We used Survey Monkey to obtain our data.

Due to limited contact information, we were able to contact a total of 66 (66.0%) former medical students who received an AACAP Life Members award between the years 2011-2016. Fifty-one (77.0%) individuals responded, and their current status includes 40 (78%) trainees and 11 (22%) early career psychiatrists. The trainees' current status includes 20 (50%) residents, 10 (25%) CAP fellows, and 7 (18%) medical students.

Notable findings about medical students who received awards from 2011-2016 include the following:

- 96% of survey respondents are current AACAP members.
- 15% of respondents are board certified in CAP; 29% are board certified in general psychiatry, and 69% are not yet certified because they are still in training.
- 88% of respondents found the award to be helpful for networking.
- 79% found the award helpful for gaining mentorship.
- Award recipients also found the award to be helpful for learning about training opportunities (40%), career/job opportunities (17%), and research opportunities (12%). It was helpful for increasing one's interest in CAP/ AACAP and getting involved with an AACAP committee.
- Respondents noted that they greatly enjoyed meeting Owls, particularly at the annual Life Members dinner. They enjoyed receiving



Owl Mentorship Program: Follow-Up of AACAP's Life Members Fund Awardees

advice from seasoned child psychiatrists, those at the other end of the career trajectory, and found it inspiring to hear about their career progression. Several described the dinner as “the best part of this award.” One award recipient eloquently wrote, “My favorite event! The location was beautiful and the impact of the Life Members was deeply conveyed. I had wonderful conversations and even went on a walk in the rain uptown with esteemed members of the field. It was an evening I will always remember.”

This survey had several limitations. First, our findings are limited and likely inflated by self-report bias, as those for whom we had contact information and those who responded to our survey may be more likely to be actively engaged in AACAP. Second, we did not survey those who were residents or CAP fellows at the time of award, but expect that even more are current AACAP members, as suggested by data from the 158 total award recipients above.

Nevertheless, these results are particularly important given that medical students and residents are in their formative years deciding career trajectories – to choose psychiatry or not, and to pursue further training in CAP or not. This is critical given the well-documented severe mismatch between demand for CAP providers and the actual number of practicing clinicians, with AACAP projecting a shortage of more than 4,000 CAP physicians by 2020.

Early exposure to the field of CAP through attendance at AACAP's Annual Meeting provides medical students with unique educational, research, and clinical opportunities and valuable social and professional connections. This not only encourages them to pursue a career in CAP but also ultimately helps

to combat the dire workforce shortage that our field faces, particularly in underserved areas. In addition to merit- and experience-based qualifications, preference is given to award applicants who live in those underserved areas with limited CAP services.

I (Cordelia) am fortunate to have received three awards from the Life Members and AACAP's Endowment Fund. I attended my first Annual Meeting as a third-year medical student, where I was struck by the sheer volume of speakers, workshops, and social events squeezed into a five-day conference. The experience was formative. It was at my first Annual Meeting that I realized I had found my people – passionate trainees and child psychiatrists who shared my enthusiasm for promoting children's mental health.

I joined the Committee on Medical Students and Residents (MSR) and began to co-chair events myself, including a mentorship breakfast for trainees since 2015 and the “Meet the Life Members” mentorship event in 2017. I have been learning how to become a clinician educator, in hopes of one day serving as a mentor myself. AACAP's valuable mentorship and educational events will undoubtedly provide the support to help me achieve this. I look forward to improving my teaching skills and funneling my clinical interests towards sustainable projects to serve children and families.

Mentorship has played a pivotal role in my training thus far and will undeniably remain an important aspect of my life. I am proud to be a five-year member of an organization that emphasizes mentorship and encourages trainees of all levels to become involved in programming and decision-making.



Owl Mentorship Program: Follow-Up of AACAP's Life Members Fund Awardees

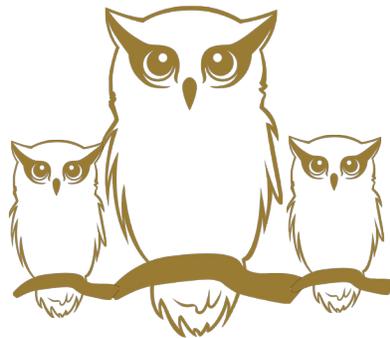
While continuing to seek mentorship for myself, I have also worked to create similar opportunities for others. Through my involvement with the MSR Committee, I hope to help expose trainees to the many perks of CAP, encourage more students to pursue CAP, and foster connections among those with similar interests, as my peers and mentors have done for me.

We thank Anneke Archer, AACAP's Program Manager of Training & Education, for her assistance in tabulating the data and for her work with trainees. We also thank those members of AACAP's MSR Committee who volunteered to assist in the selection of Life Members award recipients. This is exactly the kind of involvement and participation that mentorship in AACAP fosters.

Lastly, we hope that our survey findings highlighted the important and lasting effects that the Life Members awards and opportunity to attend AACAP's Annual Meetings had on trainees, particularly those at early and undifferentiated stages of their careers. We also hope that our findings will encourage our readers to consider contributing to the cause and supporting future generations of child and adolescent psychiatrists.

Note: Cordelia Ross, MD, is currently a PGY2 at the MGH/McLean Adult Psychiatry Training program affiliated with Harvard Medical School; she is in the program's five-year child and adolescent psychiatry track. She has been an AACAP member since 2013 and has served on the Committee on Medical Students and Residents for the past three years.

Cordelia Ross, MD
Gabrielle Carlson, MD



Life Member Attendance at Annual Meeting Statistics

Total number of Life Members as of December 2017: 1,100

<i>Annual Meeting Year</i>	<i>Total Life Members at Meeting</i>	<i>Total Attendance at Meeting</i>	<i>Percentage of Life Members to Total Attendance</i>	<i>Percentage of all Life Members as of December 2017</i>
<i>2017 (Washington, DC)</i>	<i>164</i>	<i>4,279</i>	<i>3.8%</i>	<i>14.9%</i>
<i>2016 (New York, NY)</i>	<i>185</i>	<i>5,430</i>	<i>3.4%</i>	<i>16.8%</i>
<i>2015 (San Antonio, TX)</i>	<i>143</i>	<i>3,646</i>	<i>3.9%</i>	<i>13.0%</i>
<i>2014 (San Diego, CA)</i>	<i>144</i>	<i>3,958</i>	<i>3.6%</i>	<i>13.1%</i>
<i>2013 (Orlando, FL)</i>	<i>148</i>	<i>3,676</i>	<i>4.0%</i>	<i>13.5%</i>

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The Owls continue to demonstrate their long-term commitment to AACAP and to supporting the next generation of child and adolescent psychiatrists. Owls make a difference in the lives of other AACAP members as mentors, advisors, and friends. AACAP is thankful to the following Life Members for their generous donations. As part of their commitment to AACAP, more than 90 donors raised over \$18,000 between January 1, 2018 and March 31, 2018 to AACAP's Life Members Fund.

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Every effort was made to list names correctly. If you find an error, please accept our apologies and contact the Development Department at development@aacap.org or 202.966.7300, ext. 130.

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In Memoriam

Frank Gilbert Buckman, MD, died on February 18, 2018. He was 93 years old. Frank was one of the unsung pioneers of our discipline.

In 1957, he completed his two years of training in Boston under the tutelage of Drs. Eveoleen Rexford and Susan Van Amerongen at the Douglas Thom Clinic. Later that year, he was appointed Director of the newly formed Children's Clinic at the Institute of Living in Hartford.

Almost singlehandedly, and painstakingly, by 1960, he proceeded to gain acceptance for his clinic as a bona fide psychiatric clinic for children by the American Association of Psychiatric Clinics for Children (AAPCC).

The AAPCC was at that time the only official body for approving such clinics and also for approving their training programs for child psychiatry fellows.

Indeed by 1961, again by his indefatigable efforts, he obtained such approval for the Institute of Living's Child Psychiatry Training Program. In doing all this, he was fully supported by his boss, Francis Braceland, MD, Psychiatrist-in-Chief at the Institute.

By 1967, he was one of the founders of the Connecticut Council of Child Psychiatrists, which was to become the Academy's regional branch for Connecticut.

Throughout those early years, he inspired those of us who worked with him by his devotion to teaching and research. He founded in the Clinic one of the nation's first nursery treatment schools for autistic children and received federal grants for research in the clinic's programs.

When Frank retired from the Clinic in 1974, he moved on to become a civilian physician volunteer serving our armed forces stationed in Germany.

In 2005, when the Clinic was celebrating its 50th anniversary, Frank wrote:

"Now, 50 years later, we can see ourselves as pioneers in the field. Looking back does give a different perspective to our work. In the midst of it, it seemed humdrum and every day, but seen from this perspective it is amazing."

Paul Ned Graffagnino, MD

In Memoriam

**Frank Buckman, MD
G. Thomas, MD**

From January - March 2018



Throughout the Years...

