American Academy of Child & Adolescent Psychiatry
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LifeMember Owl Newsletter

April 2014 e-Newsletter

Photo by Fred Seligman, MD

Inside...

Thoughts from the New Editors of the Life Members Newsletter

Dick and Carol Gross

It takes two people to replace one larger than life editor of this newsletter, Ginger Q. Anthony. It is not possible for one person to step into Ginger's shoes; therefore…there are two of us! We hope that we can achieve the levels of editorship of those who have come before. We are neighbors and close friends of Ginger and James; therefore, we took this job knowing that Ginger is nearby.

With new editors come changes. We think that you will be pleased to know that there will be a new format for the publication of The Owl Newsletter. Formerly, one had to click on and pull up each article separately. Now, you can click on The Owl Newsletter, scroll down through it and print it if you wish. Please let us know if you have any difficulty accessing this newsletter in its new format. Our goal is to make The Owl Newsletter as "user friendly" as possible.

We need to hear from you. We *want* and *need* articles from all of you!! Send ideas, articles, likes or suggestions to: **rlgrossmd@gmail.com**. This newsletter is for *all* Life Members, those still working, those semi-retired, and those retired. Older psychiatrists don't fade away, they take on new activities! Write to us about who you are, what you are doing, and what you or others have done. You can e-mail to us or mail your thoughts to Rob Grant, Director of Communications and Member Services at AACAP (**rgrant@aacap.org**).

"We need to hear from you. We *want* and *need* articles from all of you!! Send ideas, articles, likes or suggestions to: **rlgrossmd@gmail.com**. This newsletter is for *all* Life Members; those still working, those semi-retired, and those retired."

We are very pleased that in this edition are articles from old friends: one via e-mail from Australia, by a friend from Boston training days, Barry Nurcombe and another via snail mail from an old colleague from early Washington Council days, Larry Silver. We welcome more from all over the world.

Please find below a message, I, Dick, received from a medical student recipient of an Outreach Award from our Life Members' Fund to attend the 2013 AACAP Meeting in Orlando; I had told him about The Awards at The Advocacy Day last May.

We Owls have a lot to offer and it is nice to hear there are grateful recipients of our wisdom. We look forward to hearing from all of you.

Dick and Carol Gross

Mentorship Thanks

Bud Vana

To: Richard Gross

Tue, Nov 26, 2013 at 7:05 PM

Dear Dr. Gross,

It was great to see you again at AACAP in Orlando and thank you for your help getting there through the Life Members Mentorship Grant. I hope that your wife is recuperating well.

I look forward to seeing you at many more AACAP events. This annual meeting really confirmed for me that child psychiatrists were my kind of people.

Best wishes,

Bud

George (Bud) Vana
UVM Medical Student, Class of 2014

The Owlets Mature

The concept of formally forming a group for older Academy members came from David Herzog, the Chair of the AACAP Development Committee, in 2010. He arranged for a Life Member Group to become a Development Committee subcommittee and asked me to chair it. The subcommittee began meeting and this *e-Newsletter* began publishing in 2011. In a relatively brief time, much has happened. We have established an annual *Wisdom Perspective* presentation and an extremely popular Life Member Dinner at the AACAP Annual Meetings; we raise more money each year to provide more and more travel grants for medical students and residents to attend the Meetings, and we have won the AACAP *Catchers in the Rye* Award in appreciation for these efforts.

The above certainly can be said to represent a "fast track." However, since December, things have speeded up. During the subcommittee's December conference call, three important decisions were made.

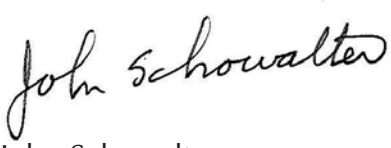
1. We addressed an issue mentioned by me in the previous newsletter. Some who attended the Orlando Owl Dinner expressed hope that its cost ($150 per person) could be kept constant for a third year in San Diego. This request was approved.

2. Ginger Anthony proposed that Dick & Carol Gross replace her as *e-Newsletter* editor(s), and this occurs now. *Welcome Grosses!*

3. Lastly, and most importantly, it was voted unanimously that we grow up to become a full Committee and therefore find a new home or nest. (After all, we represent more than 1,000 Academy members).

Our request was supported by AACAP President Paramjit Joshi and Executive Director Heidi Fordi. I believe we have won the lottery! We are now a full Committee under the auspices of the Meetings Department and its Director, Jill Brafford. Since the Annual Meeting is where we Owls meet face-to-face, it's wonderful to have our Mom in charge. As a bonus, Rob Grant, the Director for the Communications & Members' Services Department, has agreed to work with the Grosses to make our *e-Newsletter* the best it can be!

We Owlets are now all grown up and have much to be thankful for. Let the spring flowers begin to bloom!



John Schowalter

I was supported financially in my medical course at The University of Queensland by the State Government to whom I was indentured after graduation (in 1955) for seven years. I wanted to become a pathologist but the State made me a medical officer in a psychiatric hospital, in a job nobody else wanted. I found psychiatry interesting but disliked mental hospital work, so in 1960 I took the opportunity to enter a new Child Guidance Clinic, temporarily I thought. I liked it so much that I have never left the field. I had trained in adult psychiatry in Melbourne, but there were no training programs in child psychiatry: my colleagues and I were essentially amateurs coming to grips with diagnosis and treatment of dysfunctional families.

In those days, most Australian physicians went to the UK for postgraduate training. However, I was not happy with the approach that prevailed there, at that time. Most of the scientific papers I respected came from the U.S. So I applied for and was awarded a Fellowship of the Commonwealth Fund of New York, a philanthropy that had been set up by Stephen Harkness, Rockefeller's silent partner. I did not realize then that the Commonwealth Fund had been intimately involved in establishing child guidance centers in the U.S. and Great Britain.

So in the fall of 1963, leaving behind my wife and three children, I set off for America, the Judge Baker Guidance Center, and the Children's Hospital Medical Center, Boston. I was a raw recruit from an egalitarian country, newly affluent but still emerging from the Great Depression and World War II. Negative thinking abounded, particularly in Queensland which had paranoid attitudes toward the more wealthy southern States. I had come to an enormously wealthy, thrusting, individualistic country, egalitarian in regard to opportunity, but without the social supports that were available in Australia. The air was electric. There was a sense that, with good will, talent, and hard work, the country could tackle any problem, a heady approach embodied in an exciting young President and his sparkling wife.

On the morning of November 22, 1963, I was with a patient in my office at Judge Baker Children's Center. A friend telephoned to say that President Kennedy had been shot. I went into the corridor where people were weeping. Later that day, my friend and I went to

a tavern where angry Boston Irish working men watched the TV as their champion's body returned to Washington, D.C.

In Boston, there were long waiting lists. All families got the same treatment, for a year or longer. The parents were treated by a social worker trainee, and the children by the psychology or psychiatry fellows. Psychotherapy was intensive, devoted, and well supervised, with regular team conferences. The theoretical model was unabashedly and exclusively psychoanalytic. Medication was never used. Family therapy happened only in outlandish places like California. Civilization stopped at the Massachusetts's border within. This was an example of psychological reductionism, a mirror image of the narrow biomedical approach. I knew that it would not be accepted in Australia, but the style of analytic thinking involved has never left me, and has become integral in my diagnostic and therapeutic technique.

At the end of my training, I was obligated to go back to Australia, but not happy to do so. If I had remained, I would have undertaken training as a psychoanalyst. As it was, I went to the University of New South Wales to learn to be an academic research psychiatrist with an interest in early preventative intervention.

When I returned to the United States in 1976, the country was different. Biological psychiatry had swept psychoanalysis from academia. Child and adolescent psychiatry was becoming dominated by malign trickle-down effects from the DSM, and psychiatrists were abandoning psychotherapy to behavior therapists. The funding system soon determined that psychiatrists should be prescription-writers. Leon Eisenberg (who had much to do with the change) famously complained that psychiatry used to be brainless but had now become mindless.

I will be speaking on this matter in San Diego – the unscientific, reductionist split between body and mind, and the dysfunctional separation of biological psychiatry from the psychotherapies. If we don't change this historical trajectory it is difficult to see how the profession can survive. Accountancy has decreed that there is no time or money for comprehensive psychiatry.

Who influenced me most in my career? The people who come to mind are Freud, Sullivan, Rogers, Bowlby, Wolff, Rutter, Piaget, Anthony, Slater and Engel. In 1977 Engel articulated a biopsychosocial model designed to overcome the dualistic split I have criticized. Is this model defunct? If so, why did it fail? Are the causes of failure inherent in the model or has the model been squeezed out by extraneous forces? The future of our profession hangs on this question.

Barry Nurcombe, MD
Emeritus Professor of Child & Adolescent Psychiatry
Vanderbilt University & The University of Queensland

Adjusting and Coping with Retirement

I completed my training in General Psychiatry and then in Child and Adolescent Psychiatry in 1967. In 1965, when I started my training in Child and Adolescent Psychiatry, I joined the American Academy of Child Psychiatry (now the American Academy of Child and Adolescent Psychiatry) as a trainee member. I have been an active member of the Academy since 1965.

I knew I wanted an academic career and was delighted to be offered a position at the Rutgers University School of Medicine (now the Robert E. Wood School of Medicine). Over the next twelve years, I was busy within the Medical Center, teaching medical students and later residents in General Psychiatry, Child Psychiatry, and Pediatrics and within the Community Mental Health Center as the Coordinator of Child and Adolescent Services. My clinical research in the areas of Learning Disabilities and attention disorders was productive. These were busy and exciting years. By 1980, I was Professor of Psychiatry and Professor of Pediatrics within the Department of Psychiatry and Coordinator of Child and Adolescent Services within the Community Mental Health Center.

Then, an opportunity came up that was too good to refuse. In 1980, a good friend and colleague was appointed as the Director of the National Institute of Mental Health. He asked if I would accept a position within the Institute. I did. After a period of time I became the deputy director.

Then, when he left, I became the Acting Director of NIMH. About this time, there was a new Administration in Washington and with this change in leadership within the Department of Health and Human Services, Public Health Service, and NIMH it was clear that it was time for me to leave.

I wanted to return to an academic position. But, my kids were in college or graduate school. My wife had her career. We were settled in the Washington, D.C. area. There were academic opportunities around the country but not in the Washington area. We did not want to move again. The compromise was to accept a half-time position at one of the Medical Centers in the area and to do a part-time private practice. With a change in academic leadership and in the direction of the Department of Psychiatry, I found myself in full-time practice with a few hours a week of teaching. Not what I thought I would be doing toward the end of my career, but, reality was reality.

Private practice can be very isolating. I needed something more than full-time clinical practice. So, I contacted a few of my previous Residents in Child and Adolescent Psychiatry who were now in private practice in the area and asked if they might like to meet once a month to discuss/problem solve clinical issues in their practice. They were very interested. Each asked a few of their colleagues. A group of ten of us, all Child and Adolescent

Psychiatrists, began to meet once a month for two plus hours to discuss clinical issues. As we became a group, the topic often shifted to the feelings and struggles experienced when working with such difficult patients and their families. Now, three plus years later, we are a blend of a clinical discussion group and a support group.

Two years ago I retired from clinical practice; however I continue to remain a clinician within this group. Now, when I listen to my colleagues discuss the emotional stress that goes with treating very sick children and adolescents and their family, I find myself thinking, "You know, retirement isn't so bad."

Larry B. Silver, MD
Distinguished Life Fellow
American Academy of Child and
Adolescent Psychiatry

Celebrating Our Owls!

For more photos visit:
www.aacapphotos.com/life_members_2013/

Detection, Prevention and Treatment of Bullying Related Morbidity: Rediscovering the Syndrome of Maltreatment

For the past decade, I have been passionately involved in raising awareness about the nature and toxicity of bullying. I was driven into this issue by the growing number of news reports on deaths associated with it, as well as a 2002 AMA position statement urging physicians to detect, prevent and treat bullying-related morbidity.

I started to routinely ask all my patients whether they were bullied, bullying others and/or witnessing others being bullied, and if so, whether it occurred at home, school, work, dating relations, cyberspace, and /or any other milieu.

Through analysis of data derived from a national health survey I became aware that one in ten US adolescents experienced frequently occurring physical and emotional symptoms associated with their participation in bullying as victims and or perpetrators. Furthermore, this group of youngsters was eight times more likely to hurt themselves purposely, as compared to their peers who were not involved in bullying.

I have been challenged by the task of applying and adjusting the significant body of knowledge about the nature, ecology and prevention of school bullying—based on three years of non-clinical research pioneered by Dan Olweus—to the reality of a clinic population.

I am faced with a continuously evolving understanding that bullying is a multifaceted form of maltreatment, prevalent across social settings, along the human lifespan and across the world. At the same time, an exponentially increasing number of published studies are documenting a very significant association of participation in bullying with a wide array of serious public health risks.

Very soon I realized that the prevention, detection, and treatment of bullying related morbidity requires the active participation of all segments of society through the development of coalitions committed to the prevention of bullying across social settings. Within such a context health practitioners could play a pivotal role in promoting public awareness about the nature and impact of bullying by supporting the development of prevention programs to enhance mutual respect, sensitivity and support for others, tolerance to diversity in all social settings, and fostering the public health need to report incidents of bullying in order to ensure deterrence of further episodes. There is a need for health practitioners to provide detection and monitoring of ongoing bullying episodes, encouragement of school intervention through school counselors or nurses to protect and support students who are being bullied, as well as counseling for perpetrators about the harm inflicted.

Above all there is a need for the community to support the notion of health referrals for victims and perpetrators who experience physical and psychological symptoms linked to bullying to ensure medical evaluation and treatment.

The developmental link between school bullying and its occurrence in adulthood has challenged me to extend my interest in bullying prevention efforts through college and into the workplace. Bullying encompasses different aspects of the wide spectrum of maltreatment from abuse, violence, and aggression, through harassment and intimidation, to exclusion, neglect and rejection. The medical recognition of the nature and toxicity of bullying leads us to a renaissance of our interest in the spectrum of maltreatment as it was first cited half a century ago by Kempe, in his seminal work of the Battered Child Syndrome.

Jorge C. Srabstein, MD
AACAP Distinguished Life Member
Medical Director
Clinic for Health Problems Related to Bullying
Children's National Medical Center

Celebrating Our Owls!

For more photos visit:
www.aacapphotos.com/life_members_2013/

Donors to the Life Members Fund

AACAP sincerely thanks the following Life Members for their generous contributions. Remember, donors who contribute $400 or more (the equivalent of an Owl's excused membership dues) to the Life Members Fund between *November 1st, 2013 and October 31st, 2014* will receive a limited edition **61st Anniversary Life Members Owl Pin!**

Donations from December 1st, 2013 through February 28th, 2014

To ensure you receive your limited edition commemorative pin, donate today: Click here!

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Special Announcements

AACAP Congratulates Bill and Mary Alice on their Marriage

Dr. Bill Clotworthy was the first chairman of the House Committee of the then newly acquired headquarters of AACAP on Wisconsin Avenue in Washington, D.C.

Bill is a former President of what is now called the Child and Adolescent Psychiatry of Greater Washington and a former member of the Assembly for many years as well as many other prominent positions in AACAP. Bill shares a love of gardening with his Mary Alice, who holds a masters degree in international law.

In Memoriam

David M. Ellis, MD
Lafayette Hill, PA
March 17, 2014

If you know of a colleague who has passed away, or would like to send condolences to the loved ones of a recently deceased Life Member, please contact Membership at **membership@aacap.org**.