LifeMember
OWL NEWSLETTER

Spring Edition 2025 e-Newsletter

Welcome to the Spring Edition of the Owl News!

American Academy of Child & Adolescent Psychiatry
www.aacap.org

Quotes On Spring & Hope

"Spring will come and so will happiness. Hold on. Life will get warmer."

— **Anita Krizzan**

"The deep roots never doubt spring will come."

— **Marty Rubin**

"With the coming of spring, I am calm again."

— **Gustav Mahler**

"Hope is the thing with feathers that perches in the soul—And sings the tune without the words—And never stops at all."

— **Emily Dickinson**

"Spring is nature's way of saying, 'Let's party!"

— **Robin Williams**

"To plant a garden is to believe in tomorrow."

— **Audrey Hepburn**

"No matter how long the winter, spring is sure to follow."

— **Proverb**

"You can cut all the flowers, but you cannot keep spring from coming."

— **Pablo Neruda**

"Every child is born a naturalist. Their eyes are, by nature, open to the glories of spring."

— **Rachael Carson**

"What a lonely place it would be to have a world without a wildflower!"

— **Roland R. Kemler**

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COVER ART:

The Spring Owl, nestled among vibrant wildflowers, serves as a gentle reminder of nature's renewal and the quiet magic of the season. With its wise, watchful eyes and peaceful presence, it symbolizes the return of life, color, and possibility—ushering in spring's promise of hope and new beginnings.

AACAP Leadership: Standing With You in Uncertain Times

By Tami Benton, MD

Tami Benton , MD

Washington DC - February 14, 2025: As the political landscape continues to evolve, the American Academy of Child and Adolescent Psychiatry (AACAP) remains steadfast in our commitment to protecting and advancing the mental health and well-being of children, adolescents, and families. Our mission has not changed, nor will our focus on science, clinical excellence, and advocacy for child and adolescent mental health. We recognize that recent policy proposals and executive actions may bring uncertainty and concern about their impact on our profession and the patients we serve. Our mission has not changed, nor will our focus on science, clinical excellence, and advocacy for child and adolescent mental health. You are not alone—AACAP stands with you, offering the guidance, advocacy, and support necessary to navigate these challenges.

AACAP leadership is actively communicating with our Assembly, committees, caucuses, resource groups, and task forces to assess emerging developments and their potential impact on our field. Together, we are reviewing new information as it becomes available. We are monitoring developments, engaging with policymakers, allied organizations, and our international colleagues to ensure that the voices of child and adolescent psychiatrists—and the children and families we serve—are represented and protected.

Despite these uncertainties, AACAP is fully engaged in advancing our mission and supporting our members. We remain committed to Capture Belonging and Bringing the Village to the Children. We are well-resourced and will continue with all initiatives and priorities as intended. Recently, we hosted the AACAP/CACAP Pediatric Psychopharmacology Update Institute, a successful collaboration with the Canadian Academy of Child and Adolescent Psychiatry, reinforcing our commitment to international partnerships. AACAP leadership also celebrated the 50th Anniversary Meeting of the Asociación Mexicana de Psiquiatría Infantil (AMPI) in Oaxaca, Mexico, further strengthening our global engagement in child and adolescent psychiatry.

At the same time, we continue to look ahead. Our Call for Papers for the 2025 Annual Meeting received an incredible response—the highest number of submissions to date—demonstrating our community's commitment to advancing critical research and clinical insights that shape the future of child and adolescent psychiatry. Additionally, our 2025 AACAP Legislative Conference, scheduled for May 5-6 in Washington, DC offers a critical opportunity for members to engage with policymakers and advocate for children's mental health. Through all of this, AACAP remains a steady, active presence, ensuring that our profession continues to move forward while addressing the challenges of today's political landscape.

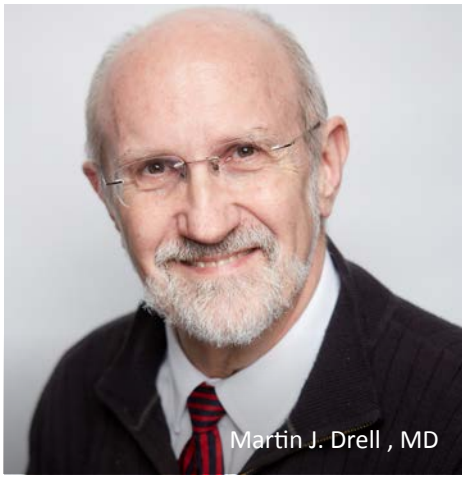
Thank you for your continued dedication to the mental health of children and adolescents. Together, we will navigate these challenges, strengthen our profession, and ensure that the mental health needs of children and adolescents remain a priority.

With sincere appreciation,

Tami D. Benton, MD
President, AACAP

Critical Thinking About My So-Called Concierge Practice

by Martin Drell, MD


Martin J. Drell , MD

I was having dinner with my friend, a child psychiatrist. We had eaten and settled down to watch a movie when my phone rang. It was one of my patients in crisis. I asked my friend if I could use her office, where she conducts remote sessions, to talk to my patient. She agreed, though her expression made me wonder if she was irritated that my attention had shifted elsewhere.

The call was a crisis by any definition. It took me an hour to assess and calm the situation. As I walked back into the living room, my friend said, "When I grow up, I want you to be my doctor." I was irritated by this remark and immediately asked why. "I am amazed that you take calls after hours. Nobody does that anymore."

"Well, I do?" I responded, perhaps too sharply. I wondered why I reacted that way. Had I made my friend feel guilty? Did she take my response as an indication that I considered myself a better doctor than her? That thought, in turn, made me feel guilty and in need of apologizing. God forbid anyone suggest I am a few points too high on the narcissism scale! But this was how I was taught; it was part of my sense of professionalism.

I trained in a community mental health center. We did home visits. My father, also a psychiatrist, was one of only two in a city of 100,000. He saw patients until 9 p.m. most nights and often handled crises. His office was in the basement of our home, so, in essence, his patients made home visits to us. There was a tiny waiting room right off our kitchen. I could see them arriving through the window. As Rockford was a small city, I recognized many of them—some were my doctors, some were my teachers, and some were people I knew from the newspaper. My father often ran late, so my mother would offer the waiting patients coffee and chat with them. My sister and I would shuffle in, eager to see who had captured our mother's attention.

By this point, I realized my explanation was getting too long. I was now explaining it to myself. My friend simply replied, "But most psychiatrists wouldn't."

I answered automatically, "But they have medication practices, and I do therapy! I have a different contract with my patients." Then, I felt bad, realizing my friend primarily conducted med checks. I reminded myself that I also did med checks. Did I treat those patients differently? No. But for the sake of this one-sided argument with myself, I continued, "My med check patients all have my phone number, too—especially since COVID, as I did virtual meetings. They called me with crises and problems, particularly during the extended stimulant shortage."

> My friend repeated, "But most psychiatrists don't give out their phone numbers or handle crises."

That was enough to keep things going: "I'm biopsychosocial," I said, though even I realized that wasn't exactly relevant. I thought to myself: Wouldn't most child psychiatrists claim to be

biopsychosocial too, even if they emphasized the biological side during med checks due to time constraints? In reality, I knew I didn't conduct therapy the same way during med checks. Another partial blind alley. I then thought about my therapy training, which was deeply psychodynamic. Some have told me I was lucky to be trained during the "heyday" of psychodynamics. After my training, though, it was clear the field was shifting.

I recalled a patient I had seen during my psychodynamic training who had been traumatized when a burglar broke into her house and raped her. I made a home visit, only to be told by my supervisor that I shouldn't have. I disagreed with the idea that neutrality should override my humanitarian instincts, particularly given my training in crisis home visits and my father's example.

At this point, it became clear that I was just arguing with myself. I turned my attention back to the movie. Unfortunately, my mind was now in overdrive, catastrophizing about why our field was narrowing its scope to primarily med checks. I understood the capitalistic argument—med checks paid better—but what about the many other disciplines that could also perform med checks? Might they expand their market share by offering services at a lower price and later raising their rates? I tried to focus on the movie and my friend, but before I could stop myself, I snarkily blurted out, "I guess I have a concierge practice!" My humor, once again, came to my rescue.

Ironically, after returning home, I was watching another movie when I received a 10:45 p.m. call from another patient's mother. Her son was having a panic attack and felt like he was dying. She was headed to the ER, anticipating a long wait, and hoped a call to me might help. I spoke with him, and he immediately calmed down. I felt gratified, even more so when his mother texted me afterward to thank me. She said he relaxed the moment we started talking. She was relieved to have avoided the ordeal and cost of an ER visit.

I felt very good about my crisis interventions—both of them. It had been years since I had two emergency calls in one night. I was exhausted after the first call and even more so after the second. But I went to sleep with the narcissistic satisfaction that I was perhaps practicing, as they say, "at the top of my license."

In my newly coined "concierge" practice, I slept well but wondered if I was just an ivory-tower elitist. Years ago, a mentor reassured me after I had been called "elitist." He smiled and asked, "Is that so bad—especially for someone in academics?" The next day, I shared my thoughts with my brother, a general psychiatrist in private practice who primarily does med checks and TMS. He noted that I did not, in fact, have a concierge practice—because if I did, I would be charging more for enhanced access.

I was left with the realization that I am an elitist, a very bad capitalist, and someone with a significant work-life balance problem. ■

A Celebratory Gathering: 2024 Life Members Lunch

By Marilyn Benoit, MD

Marilyn B. Benoit, MD

The 2024 Life Members Lunch, held during AACAP's Annual Meeting in Seattle this October, was a resounding success and a heartfelt celebration of our vibrant Life Member community. This cherished event brought together esteemed colleagues to honor legacies, share wisdom, and strengthen bonds while looking ahead to a promising future for child and adolescent psychiatry.

Set in the heart of downtown Seattle, the lunch was a perfect blend of camaraderie and reflection. Life Members enjoyed reconnecting with long-time friends, welcoming newer members, and celebrating the collective impact of their contributions to AACAP and the field at large.

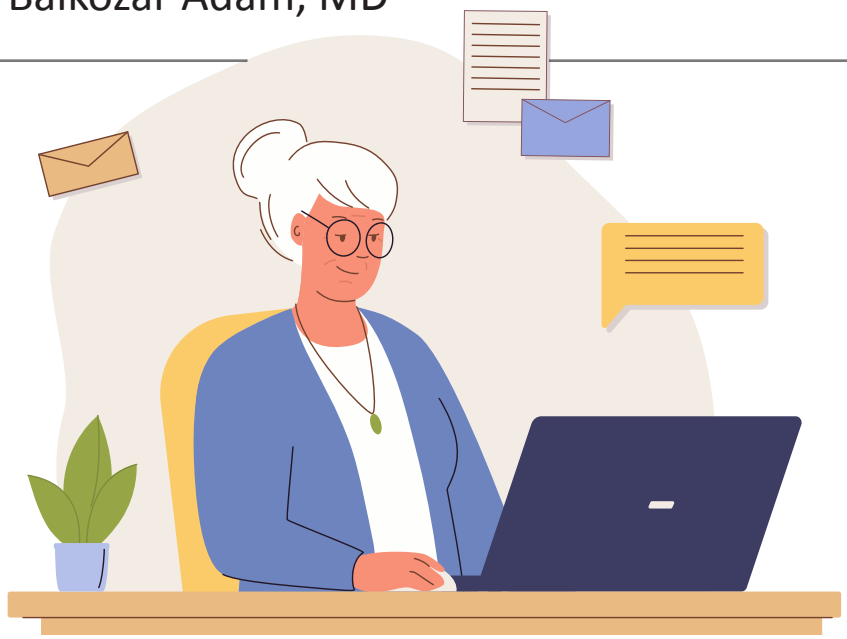
One of the most moving moments of the lunch was the tribute to two giants in our field and cherished members of our AACAP family, John Schowalter, MD, and Joe Jankowski, MD, who are no longer with us. Stirring tributes, delivered by Ginger Anthony, AACAP Past Executive Director and honorary Owl, and Margery Johnson, MD, Owl Committee member, celebrated their leadership, friendship, and lasting impact on child psychiatry and our Owl community.

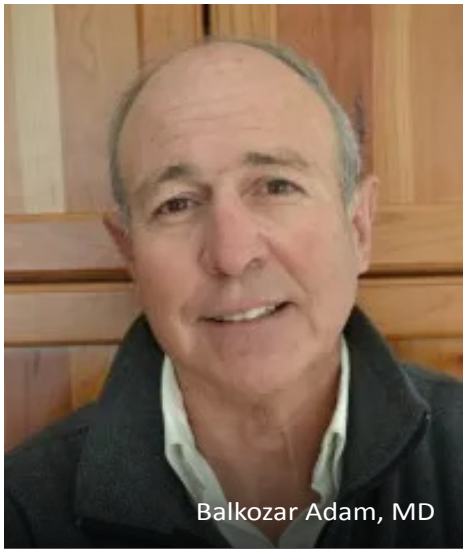
The event also highlighted future of our profession through AACAP's Educational Outreach Program (EOP) for Child and Adolescent Psychiatry Residents, supported by AACAP's Life Members Fund. Residents seated alongside Life Members at each table engaged in meaningful conversations that blended insight, wisdom, and laughter. This interaction is a highlight of the lunch, fostering connections that enrich both residents and Life Members alike.

The 2024 Life Members Lunch exemplified the enduring legacy, connection, and shared purpose of our Life Member community. It was a glorious time to celebrate milestones, honor contributions, and build bridges for the future. Thank you to everyone who made this event unforgettable. We look forward to continuing this cherished tradition and building on its success in the years to come. ■

A Post Retirement Activity Survey: Development, Distribution, and Data

By Balkozar Adam, MD





My involvement in a survey of post-retirement activities for child and adolescent psychiatrist was highly colored by my academic career. In 1981 I arrived at the National Institute of Mental Health in Bethesda for what was to be a two-year fellowship. I ended up leaving 30 years later in 2011. Following the NIMH, I provided clinical care at Walter Reed National Naval Hospital, Fort Meade Outpatient Psychiatry Clinic, and a small private ADHD clinic. Currently I am a solo practitioner in a part-time private practice, facing my mid-70's.

By coincidence I became a mentor for a PGY 1 psychiatry resident who was interested in child, adolescent psychiatry and research. We met at a mentoring evening meeting (Life Members Virtual Mentoring Program) sponsored by AACAP's Life Member Committee. The ancestry of this fellow originated in Southeast Asia, and she had an interest in "wisdom" as part of her cultural heritage. I proposed a survey on post-retirement opportunities, gathering insights from senior AACAP members. In part, this was a self-serving way to explore my own future options—seeking ways to remain active in the field without the demands of full-time or part-time practice and the responsibilities of patient care. She immediately accepted the idea of the project.

Under my mentorship, the PGY 1 resident created the survey. The survey went through the AACAP's approval processes and was distributed to all AACAP Life Members.

The goal of the survey was to identify opportunities that child and adolescent psychiatrists who are retiring or seeking to transition to retirement, could participate. As a bonus, ongoing participation might also help to address that gap of the child and adolescent provider population partially exacerbated by of the COVID pandemic.

Survey Results

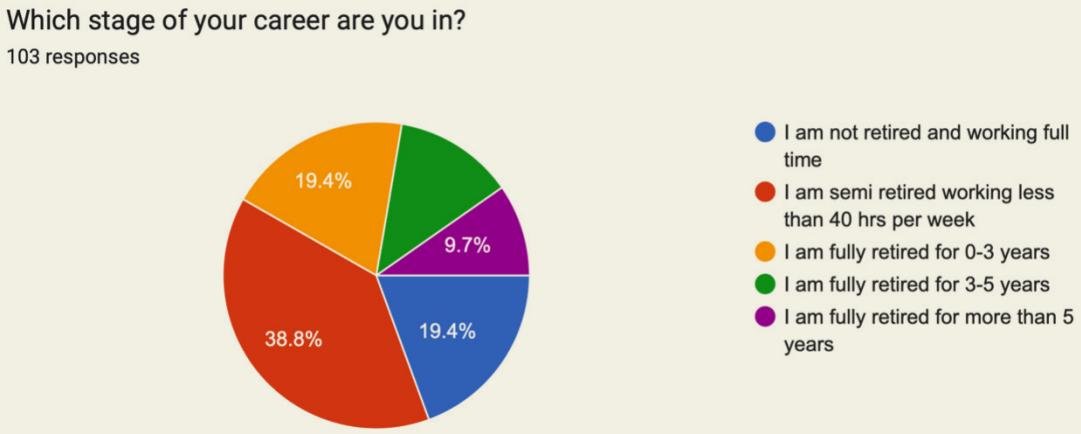
Several hundred life members were invited to participate in the survey, and 103 responded, yielding a response rate of approximately 30%.

Among respondents, 20% reported working full-time, while about 40% worked fewer than 40 hours per week. Another 20% had been fully retired for up to three years. Additionally, 10% had been retired for more than three but fewer than five years, and 10% had been fully retired for more than five years.

There were approximately 20 commonly mentioned post-retirement activities, many of which were logical and frequently repeated. Several required maintaining a state medical license and medical malpractice insurance, which emerged as a significant issue for post-retirement pursuits.

Notably, three or four particularly interesting and unconventional activities stood out. I would like to highlight these first in this article, as they are highly unique and unusual. Their inclusion made the effort involved in conducting the survey especially worthwhile.

A Post Retirement Activity Survey: Development, Distribution, and Data



Unusual and Thought-Provoking Ideas for Post Retirement Activities:

- "Wisconsin State Law exempts retired physicians from liability if they provide clinical services in a free clinic. I have malpractice insurance for my consultation work with the Department of State though it may not be necessary as one consults with other providers about clinical care they are rendering but I do not provide direct care myself. The decision to purchase malpractice coverage is closely linked, I think, to level of risk tolerance, a subjective factor."
- "Working in the state prison system" – "most gratifying job I ever had."
- (Requirement of liability insurance unclear)
- "I moved to Florida after retirement. All activities including volunteer work require Florida License"
- "Consult in collaborative care; consult at juvenile detention."
- "I've volunteered to be on the admissions committee for medical school applicants"
- Retrain in a related field like Forensic Psychiatry
- Consider volunteering in Ukraine or Gaza.

Commonly Cited (i.e., less unusual) - Survey Results
Post practice/career Activities that are available for child and adolescent psychiatrists:

- Telepsychiatry, locum tenants settings
- Part time opportunities at county mental health clinics, community clinics, private groups
- Teaching, mentoring and volunteering
- Committee work, public advocacy

What type of child/adolescent related activities do you currently participate in?

- Collaborative care projects
- PRN coverage
- Board of directors
- Private practice
- Committees
- Advocacy, teaching, mentoring

Are you aware of anyone (either you or someone else) who has been a volunteer to provide clinical services for free?

- Pro bono private patient long term
- Volunteers in medicine organization
- Evaluating asylum evals, patients at the border, refugee work
- Community program
- State prescription monitoring review

Conclusion / Future Directions

In summary, the survey was an excellent research experience for a PGY 1 as well as gathering interesting ideas for myself personally in the field of post-retirement activities, as I would like to stay involved and help providers fill gaps in this field. Other states

(like Florida) could be encouraged to facilitate post-retirement contribution for child and adolescent psychiatrists by changing statutes to align with those more like Wisconsin, i.e., no liability if providing free care.

The example of Wisconsin (that protects providers from liability if they provide free care) was noted although many providers will continue to choose to have malpractice coverage.

Another future direction would be to encourage Malpractice Providers to offer inexpensive (backup coverage) for senior clinicians. These clinicians have already spent in their lifetime perhaps a quarter of a million dollars in premiums. By tailoring a policy to "non-direct patient care," more clinicians might be willing to help in the field.

There are a lot of different opportunities that are available but the requirement of the different opportunities often depends on active medical licenses or malpractice insurance.

Two Final Points in Conclusion

Although this endeavor straddles the line between biomedical and sociological research, a seasoned biomedical librarian could help conduct a thorough review of existing literature in this field—not only in psychiatry but in medicine more broadly, as well as in social work. After all, it's not just child psychiatrists who retire or scale back their work.

A brief review of the literature on "activity" and "retirement" reveals a substantial body of research confirming that physical activity, as well as intellectual and social stimulation, are strongly associated with improved outcomes later in life.

The second and final point occurred to me quite late in this project. Contributing to the efforts to lengthen the "shelf life" of child and adolescent psychiatrists by doing research, mentoring students and trainees, and on the state and federal level by both educating and lobbying lawmakers and advocacy groups for psychiatry organizations (AACAP and APA among many others) is IN ITSELF an important and valuable post-retirement activity! Who knew? ■

THE SURVEY

First Name: _____

Last Name: _____

Questions:

1. Bridgement opportunities are defined as activities that are between the phase from active clinical work and retirement. This could range from part-time opportunities to volunteer activities. What are some bridgement opportunities that you have heard are available for child and adolescent psychiatrists?
2. What settings have you worked in previously? (i.e., research, industry, academia, etc.)
3. Which stage of your career are you in?
4. If you are retired, what barriers have prevented you from participating in CAP post-retirement? (please answer N/A if this question does not apply to you)
5. What type of child/adolescent related activities do you currently participate in (please answer N/A if this question does not apply to you)
6. Are you aware of anyone (either you or someone else) who has been a volunteer to provide clinical services for free? (like lawyers do with pro bono services or the IRS with free tax assistance) . Please specify if yes and describe the services that are provided
7. What are some ways that you or your colleagues have remained involved in CAP and how has that changed over the years? (this could include volunteering, teaching, supervision, etc.)
8. Do you have any ideas on how child and adolescent psychiatrists can contribute as they transition from clinical practice to retirement?
9. Of the ideas that were listed above, which of the opportunities would require malpractice insurance?
10. Of the ideas that were listed above, which of the opportunities would require an active medical license?
11. What are some barriers (if any) that you know of that can be challenges to doing anything in retirement?
12. have not heard of any bridgement opportunities

Reflections on Retirement

By John Dunne, MD

John Dunne, MD

During my first year of psychiatry training at the University of Washinton, one of my professors, Dr. Holmes, discussed the findings of his study on the differing patterns of retirement between blue-collar workers and white-collar professionals. For whatever reason, his words stayed with me while so much else slipped through the cracks in my memory. Blue-collar workers tend to be very active during their first post-retirement year. They often buy an expensive RV and travel the country. After that year of frenetic activity, the RV would get parked and they would become relatively inactive, often spending much of their day watching TV or tinkering around the house. Many find ways to volunteer their time. They tend to die younger than white-collar workers, perhaps because of their more physically demanding jobs. White-collar professionals, in contrast, would often be inactive during their first post-retirement year, sometimes falling into a depressive funk. Gradually they would emerge, as they slowly developed new interests that held meaning for them. Of course, there are many variations on those themes, one of which is continuing with diminished professional roles and identity.

Now that I have been retired for five years, Dr. Holmes' study prompts me to reflect on my own experience with this transition. Immediately after retirement, I organized a Zoom meeting of the child psychiatrists in Whatcom County, where I had relocated four years prior to retiring. Those Zoom meetings died out about three years ago when interest and participation waned. After COVID broke out, I volunteered to be a contact tracer for the county Health Department. That "new career," which I wrote about in the August 2020 issue of the Owl Newsletter, stopped after officials realized that contact tracing was not altering the local course of the pandemic. I was also recruited for the Board of the NW Washington Medical Society because they needed

a representative from psychiatry. My contributions to that Board have been minimal. I think it would be fair to say that my professional identity and involvement have progressively faded, although not completely gone (otherwise, why would I be writing this article for my fellow Owls?). I played trombone in two orchestras, joined Rotary, rode with a weekly road bike group, played bridge with my friends and enjoyed time with our two grandkids. I never became depressed or disheartened but there was clearly a lack of a coherent meaning and direction to my life. Marilyn Benoit, MD, in the Spring/Summer 2024 edition of the Owl Newsletter, quoted Thomas Insel, MD, former director of NIMH, who noted that "people, place, and purpose" were necessary for good mental health. Nathaniel Donson, MD, in the April 2019 issue of the Owl Newsletter described how he combined both people and purpose. I was short on purpose.

I am a naturally curious individual

and have never been interested in TV entertainment (OK, MASH was the one exception). My pleasure comes from doing things that add to my fund of knowledge or challenge my mind and ingenuity; my pleasure in playing bridge is a good example. One of the wonderful things about practicing psychiatry is that we become comfortable talking with anyone, regardless of their mental state (the exception for me was dealing with an

abusive father who had become enraged and threatening because he was upset with the changes in his wife and son during therapy). In Bellingham, as in most of the country, there has been a surge of homeless people during the last decade. Society tends to hold these people in very low esteem: they are viewed as criminals, druggies, crazy, and shoplifters, society's dregs and rejects. I was certain that they did not represent the threat that others perceived. About three years ago I began striking up conversations, sometimes very brief ones, with homeless people I encountered. Many quickly recognized that I was being respectful of their basic humanity and would readily talk about themselves. I discovered that I really enjoyed the freedom of hearing about lives that were so different from mine without the responsibility of trying to help them, although I did occasionally offer suggestions. I began writing articles about some of the individuals I encountered for a local, low circulation online newspaper. Some of the articles drew a lot of positive feedback and the editors encouraged me to do more. I accompanied the Homeless Outreach Team, part of a local non-profit, as they made their rounds. The team leader was instrumental in helping to identify people willing to be interviewed and photographed for an article. Unfortunately, that team leader "moved on" and his replacement was not at all receptive.

The editors recommended a series of articles about organizations that house the homeless, such as tiny home villages. The editors have been very accommodating to my pace of one article per month. That pace has been temporarily interrupted by a ruptured anterior tibial tendon. As I have gotten more involved with documenting the operations of homeless organizations, I have begun to understand the complexity of how these organizations and agencies work together (or not), their diverse funding sources and the gaps in services, particularly housing and treatment for those homeless with chronic mental illnesses. However, my aim remains the same: to humanize the homeless and to help the public understand that homeless people are still people and not that much different from you and me. Regardless of their difficulties, we have our basic humanity in common.

I really enjoy talking to these people, whether they are homeless or part of an organization that works with the homeless. They all have interesting stories. Of course, nothing is ever entirely wine and roses. Lurking in the background is the risk of boredom. Retirement has been a time of gradual searching, largely unconsciously, for a new meaning in life, one that I have accidently stumbled upon. As I am sure you have surmised by now, this endeavor has given me a new and unexpected meaning, even though I don't know how long this will last or where it will lead me. But Dr. Holmes was certainly right about the white-collar pattern when reflecting on my own retirement. ■

The Drive to Use Opiates

By Steven Jaffe, MD

A grieving mother who had just lost her young adult child to an overdose of fentanyl/heroin asked me whether her daughter knew that she loved her at the time of her overdose and whether, if she had just done "this or that," it would have prevented her death. I assured her that her child certainly knew she was loved. I then shared my understanding of the experience of using opiates, hoping this might help relieve some of her guilt and help her better comprehend why all the love in the world and our best therapeutic approaches sometimes cannot counteract the drive to use.

As one individual with a substance use disorder said, "When I use, it's like the angels from heaven come down and wrap me in a warm blanket." The drug has become God—a higher power with great strength. The drug does not represent God but is God, and when using, the individual becomes part of that God.

This can be understood through the concept of a transitional object, which developmentally occurs at around one year of age. Here, a blanket or special object exists in that transitional space where the child experiences it as if it is the mother, not just a representation of her. This is depicted with Linus and his blanket in the "Peanuts" cartoons.

Thus, when using, the individual feels a profound sense of happiness and love,

as if they have found meaning in their life. During this experience, issues of connections to family and friends, anger and anxiety, disappointments and trauma, as well as the love of family and friends, no longer exist. The individual has entered a different world of bliss.

Families need to understand that an overdose is not a rejection of them but results from changes in the individual's brain and an enormous pull to enter this seemingly God-like state. I believe this is what makes treating individuals with opiate use disorders so difficult.

Medications and therapies lead to many successes, but we still face the sadness of numerous overdose deaths each year. I hope that this brief description of what we face in treating opiate use disorders helps ease the burden and guilt that grieving families experience. ■

Donors to AACAP's Life Members Fund

AACAP is committed to the promotion of mentally healthy children, adolescents, and families through research, training, prevention, comprehensive diagnosis and treatment, peer support, and collaboration. We are deeply grateful to the following donors for their generous financial support of our mission. **Donations for August 20 to December 4, 2024.**

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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.**

Thank you for supporting AACAP!

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