LifeMember
OWL NEWSLETTER

August | September 2022 e-Newsletter

Welcome to the Fall Edition of the Owl News!

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

Kindness & Caring Quotes

"Human kindness has never weakened the stamina or softened the fiber of a free people. A nation does not have to be cruel to be tough."

— Franklin D. Roosevelt

"Kindness is the only service that will stand the storm of life and not wash out. It will wear well and will be remembered long after the prism of politeness or the complexion of courtesy has faded away."

— Abraham Lincoln

"If you want to lift yourself up, lift someone else up."

— Booker T. Washington

"Never believe that a few caring people can't change the world. For, indeed, that's all who ever have."

— Margaret Mead

"To the world you may be one person, but to one person you may be the world."

— Dr. Seuss

"If you see someone without a smile, give them yours."

— Dolly Parton

"Kindness is the language which the deaf can hear and the blind can see"

— Mark Twain

COMMITTEE

Marilyn B. Benoit, MD

Cynthia R. Pfeffer, MD

Perry B. Bach, MD

Martin Drell, MD
Editor

John E. Dunne, MD

Joseph J. Jankowski, MD

Allen Mark Josephson, MD

Paramjit Toor Joshi, MD

Douglas A. Kramer, MD, MS

John Schowalter, MD

Ellen H. Sholevar, MD

John B. Sikorski, MD

Rob Grant
Managing Editor

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 communications@aacap.org
The deadline for the next issue is **December 1, 2022.**

IN THIS ISSUE

Transitions: Important Moments of Life 04
By Cynthia Pfeffer, MD

An Impostor's Take on Impostor Syndrome 07
By Martin J. Drell, MD

A Retired Psychiatrist's Handbook to Writing Fiction Part One: From Inception to Conception 11
By Peter Cohen, MD

Roe Who? Remembering When 14
By Stewart Teal

Palindromes That Will Make Your Head Hurt 16
Thanks, John McCarthy

Poetry Corner 17

Donors to AACAP's Life Member's Fund 18

AACAP Policy Statement on Autism & Vaccines 19

Member Photos 20

COVER CREDIT:

In early 2020. NAMI and the University of Pittsburgh put together a virtual art gallery called, *"Putting Mind into Matter: An Art Exhibit on Mental Health & Creativity"* showcasing pieces that visualized mental health and mental illness. Rose Leaonard, Student, University of Pittsburgh

october 17–22
20AACAP
22CACAP
annual meeting | toronto

Visit www.aacap.org/AnnualMeeting-2022 for the latest information!

Save the Dates

Early Bird Registration Deadline:
September 15, 2022

On-Demand Content Available:
October 3–November 30, 2022

CAP@Home Virtual Experience also available. See website for more details.

James J. McGough, MD
Program Chair

Barbara J. Coffey, MD, MS
Deputy Program Chair

John Teshima BSc, M.Ed, MD, FRCPC
Local Arrangements Chair

Mark Hanson, MD, M.Ed, FRCPC
Local Arrangements Chair

American Academy of Child & Adolescent Psychiatry
WWW.AACAP.ORG

Canadian Academy of Child & Adolescent Psychiatry
Académie canadienne de psychiatrie de l'enfant et de l'adolescent

Transitions: Important Moments of Life

By Cynthia Pfeffer, MD

Cynthia Pfeffer, MD

Throughout time, changes mark the significance of life.

From the time a baby emerges from a mother's womb, hopefully with a resounding crying noise that signals "I'm here to take my place in the world of human existence" a most significant event has occurred: exit from internal to entry into external life experiences. Any neonatal pediatrician can attest that the complexity of childbirth changes a family's equilibrium by the quality of acceptance of a stranger into the family. This ability to seamlessly receive a newborn into a family is a key element for harmonious interactions during human developmental life trajectories. Child Psychiatrists are often called upon to help new parents with their transitions from childless family life to caring for a newborn family member. New parents often are beset with anxiety when interacting with and caring for their infant. Many programs exist to help parents transition to develop skills and alleviate worries in caring for their newborns. By the time toddlers exhibit language skills, complex motility, willfulness, determination, and displays of joy, fear, anger, and oppositional behavior, parents have been initiated into the complexities of toddlers and the importance of exhibiting skills to foster healthy independent behavior of their child.

Preschool years offer the potential to learn social skills, express creativity, interact with peers, begin to read and write, and express kindness towards peers. During this time, children achieve the ability to exhibit early leadership skills and ability to cope with disappointments. Parents too exhibit more complex skills in caring for their children and aiding improvements in cognitive functioning and social interactions. Entry into elementary school fosters significant experiences of independence, cognitive development, social skills and peer relationships, community awareness, and ability to cope with achievements and disappointments. During teenage years and entry into high school, independence is a hallmark of one's social and academic development. Teens express strong opinions, exhibit creative abilities in the arts and music, delve into high level academic learning, participate in and observe sports competitions, experience intense peer relations, consider experimenting with problematic activities such as drug abuse, experience peer tensions and fears about future experiences. Toward the last years of high school, adolescents begin to consider options for their college or work opportunities. These subsequent years provide the processes for advancing learning and career activities and more independent socialization. The extensive life transitions in childhood and adolescence ready young adults to focus on independent living, higher level education and work opportunities, social interactions that promote formation of social bonding leading toward marriage and other social relatedness. Children and adolescents, like young, middle, and older adults, experience life transitions that shape every person's cognitive and emotional attributes of "who they are" as their unique personal profile.

The word "transition" is defined as "the process or period of changing from one state or condition to another." As I will retire from my post as AACAP Life Members Committee Co-Chairperson in October 2022, I'm pleased that our

Transitions: Important Moments of Life

Life Members Committee has evolved markedly in the last few years. We have weathered the COVID19 pandemic by transitioning to Virtual Communication which has been successful in communicating broadly among Life Members and providing trainees with opportunities to benefit from the teaching and wisdom of Life Members. We had our successful virtually presented national AACAP meeting in October 2021 and subsequentially offered three Life Members Committee virtual teaching forums. One forum held virtually at the AACAP 2021 annual meeting was overseen by Joseph J. Jankowski, MD and Ellen H. Sholevar, MD This forum involved small groups of trainees who met for approximately 20 minutes with two Child and Adolescent Psychiatrists to discuss issues posed by the trainees regarding their plans for becoming Child and Adolescent Psychiatrists.

This process was repeated two more times with the trainees rotating to meet with other Child and Adolescent Psychiatrists. Two similar Life Members teaching forums were scheduled for 2022 to be held virtually in June 2022 and August 2022. Marilyn Benoit, MD, Martin J. Drell, MD and John Dunne, MD are the leaders of these programs.

Because our meeting was held virtually in 2021, the Life Members Fund grew to a grand total of $147,299.00 by April 2022. As a result, the Life Members Committee will sponsor 15 medical students, 15 general Psychiatry residents, 8 child and adolescent Psychiatry fellows, and 2 Pediatric residents (triple board residents) for a total of 40 trainees to attend the 2022 AACAP Annual Meeting.

This year at the 2022 AACAP Annual Meeting, Life Members Committee Co- Chairperson Marilyn Benoit, MD and Life Members Committee member Allan M. Josephson, MD will lead the AACAP teaching program (Life Members Wisdom Program) entitled "A Lifetime of Lessons Learned: Careers in Child and Adolescent Psychiatry".

This meeting will be chaired by Allan Josephson, MD
The speakers and titles of their talks are:

- **Marilyn Benoit, MD: "Interrupting Transgenerational Trauma."**
- **Martin Drell, MD: "Looking Backward and Forward on a Career";**
- **J. Michael Houston, MD: "Understanding Career Choice and Trajectory Through the Lens of a Personal Narrative;"**
- **Bonnie Zima, MD: Striving to Improve the Quality of Child Mental Health Care Through Teaching, Clinical Care, and Research." The discussant is David L. Kaye, MD**

It's pleasing to note that in 2021-2022 excellent articles were published in the AACAP Owl Newsletter, edited by Martin Drell, MD Life Members are encouraged to contact Dr. Drell to discuss articles that a Life Member may wish to publish in the Owl Newsletter, which is an especially important venue to disseminate a variety of publications including descriptions of new concepts, activities, history, poetry. and drawings. Dr. Drell welcomes speaking with any Child and Adolescent Psychiatrist or trainee who wishes to consider publishing in the Owl Newsletter!

There is no doubt that significant transitions occurred successfully for the Life Members Committee in 2021-2022. Kudos to AACAP staff working with the Life Members to develop fine productions and activities in 2021-2022!

They include (in alphabetical order):

- **Anneke Archer, Training & Education Manager**
- **Jill Z. Brafford, MTA, CMP, Staff Liaison: Meeting & CME Director**
- **Rob Grant, Director, Communications, Member & WEB Services**
- **Carmen Thornton, MPH, CHES, Director Research, Grants & Workforce.**

There have been many sad newsworthy events this year that cause concern among our population, especially communities that experienced gun violence. A recent Centers for Disease Control and Prevention (CDC) statistical evaluation indicated that gun violence is the leading cause of death for children and teens and that states with the most robust gun laws have lower gun-related deaths. From 2019 to 2020, the rates of homicide in the U.S. involving guns rose by 34%, which was the highest rate in more than 25 years; making this a major public health problem.

Specifically, the number of firearm homicides increased from 14,392 in 2019 to 19,350 in 2020 and the highest rates of firearm murder occurred among people 10 to 44 years old. The highest prevalence of gun murder rates was among Black men, who were 10 to 44 years old. Specifically, more than half of all Black teens (age 15-19 years old) who died in

2020 (52%) were killed by gun violence. One explanation for this higher rate of firearm homicide may be that the COVID19 pandemic affected populations already at high risk for health and financial disparities. Grief is rampant especially affecting families whose deaths were due to COVID19 illness or for children, adolescents, and adults who were killed by gunshot. It is essential to transition to utilize successful means of stabilizing the safety of our population. In the late 1990's, I developed a Childhood Bereavement Program that focused on enabling grieving children, adolescents, and their parents to gain support and use of empirical methods to cope with their grieving process.

At that time, understanding childhood grief and utilization of standard empirical means to enable children and adolescents to cope with death of a close relative was rarely available. Empirical treatment methods are required to prevent homicide or suicide of children, adolescents, and adults by use of guns. Methods within communities to evaluate, treat, and follow-up on emotional problems and other stresses must be utilized to create successful reduction of gun violence. As Child and Adolescent Psychiatrists, we must generate and disseminate knowledge among Child and Adolescent Trainees and seasoned Child and Adolescent Psychiatrists to use viable, empirical methods to lower components of risk for human gun related deaths and develop empirically sound methods to cope with the grieving and psychiatric sequelae of gun related homicide/suicide.

COVID continues to be an epidemiological problem but thankfully due to the development of COVID vaccines, the rate of deaths related to COVID infection is lowered and the recovery among those treated with COVID vaccines have greater recovery from COVID infection. Young children are now able to be inoculated with a COVID vaccine so that such children are better protected against suffering COVID infection. Attention continues to be a needed focus on people's motivation to decrease their resistance to treatment with empirical COVID interventions.

Recent laws were passed to eliminate a pregnant woman's legal rights to obtain an abortion. This issue causes great anxiety, fear, and a sense of helplessness in coping with plans for pregnancy and plans to abort a fetus due to medical or social concerns. Such laws abolish basic freedoms for women to cope with medically legal abortion of a fetus. Much needs to be evaluated about the Supreme Court rational for the approval of abolishment of woman's rights to abortion. Sequelae of this law may significantly impact emotional and physical wellbeing of people of all ages. Child and Adolescent Psychiatrists may be significantly needed to help families cope with the outcome of this law. As Child and Adolescent Psychiatrists, we need to be aware of the legal, social, physical, and emotional effects of this law and be able to successfully help families cope with the sequelae of this new law. Notably, the issues of gun violence, rights of women to have a legal abortion, and conquering the emotional and physical ravages of COVID infections are significant current issues to be addressed by the work of Child and Adolescent Psychiatrists.

As I transition to complete my term as Co-Chairperson of the Life Members Committee, I'm confident that our committee is steering us in a fine direction in teaching those who wish to become Child and Adolescent Psychiatrists, promoting activities of Life Members, and developing new ideas for aiding healthy development and promotion of social advocacy for the welfare of children and adolescents.

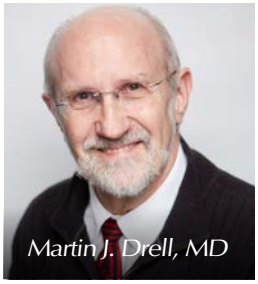
Over my 47 years as a practicing Child and Adolescent Psychiatrist, I highly value my work with colleagues and students to lend innovative ideas to our work as Child and Adolescent Psychiatrists, my aims to foster education of Child and Adolescent Psychiatry students and colleagues, and to promote wellbeing of children and adolescents. I wish my colleagues on the Life Members Committee and those Child and Adolescent Psychiatrists at lodge good fortune, continued contributions to Child and Adolescent Psychiatry, and focus on well-being of children, adolescents, and their families. I plan to continue my involvement as a Child and Adolescent Psychiatrist.

"If ever there is a tomorrow where we're not together, there is something you must remember.
You are braver than you believe, stronger than you seem, and smarter than you think. But the most important thing is, even if we're apart… I'll always be with you."

— Winnie the Pooh and Piglet. AA Milne (1926) ■

An Impostor's Take on Impostor Syndrome

By Martin J. Drell, MD


Martin J. Drell, MD

A young entrepreneur I see for therapy had been the COO of a successful startup and moved on to start her own company. Soon after the start, she talked about her trouble returning emails that she routinely and effortless did in her previous position. She was upset with herself and told me she felt like an "imposter." As the phrase came out of her mouth, I realized that she was one of several of my patients who had lately accused themselves of the exact same feelings. I noted that there seemed some sort of "trend" going on that seemed useful in capturing how they were feeling. I knew what to do in therapy. I asked for her to tell me more about her feeling of being an impostor with the goal of trying to understand what was going on. Despite this, I made a note to myself to read up on impostor syndrome and see what others have thought about it.

There turned out to be an abundance of information in the form of academic journals, magazines, websites, and blogs. It is indeed a well-known phenomenon. Most authors agreed that phenomena was coined by Pauline Clance and Suzanne Imes in the 1978 article titled, "The impostor Syndrome in High Achieving Women: Dynamics and Therapeutics." The authors report that the concept has slowly gained recognition and relevance in popular culture. Clance and Imes noted that these women do not experience an internal sense of success despite being objectively successful as judged by awards and promotions. The "competent" women they described had an ongoing internal sense of self doubt that translated into a sense of being "frauds" that would inevitably be "found out" and exposed. When asked how they had been so successful to that point, their women subjects said it was due to luck or compensatory overwork on their part. Their sense was that if they didn't overwork that their deficiencies would be discovered with subsequent bad consequences. Melody Wilding laughingly refers to the syndrome as a "hot mess of harmfulness."

Valerie Young, PhD, in her book, "The Secret Thoughts of Successful Women: Why Capable People Suffer from the Impostor Syndrome and How to Thrive in Spite of it, breaks those with the syndrome into five very interrelated and overlapping subgroups. These are:
The Perfectionists: This group sets excessively high goals and pays the price for not meeting them. These perfectionists are seldom satisfied and may project their expectations onto those who work for them with subsequent micromanagement and problematic delegations. They don't realize that not all efforts need to be 100%. I often remind such persons that a 93% is still an "A." They seldom agree and are equally skeptical of Winnicott's concept of being "good enough." They are not able to have "radical compassion" for themselves.

The Superwomen: This group compensates for their sense of incompetence by pushing themselves to work longer and harder. They become super "workaholics" with few outside interests. They are on a treadmill of their own making that has its incline and speed settings constantly increased. They are "good" girls working for external validation.

The Natural Geniuses: This group feels that they need to be or are raised to believe they are "geniuses" who should "effortlessly" succeed. When they don't succeed, they feel deep shame. This category reminds me of the work of Carol Dweck that describes two mindsets depending on where people feel their abilities come from along a nature-nurture continuum. At the nature end of the continuum are those with a "fixed mindset" who feel their success is due to innate ability while at the nurture end of the continuum are those with a more flexible "growth mindset." Dweck's research shows that those with "fixed mindsets" often do poorer, as they want to look smart and avoid challenges that might challenge their genius status. Dweck favors a parenting style that validates flexible efforts that promotes a growth mindset.

Upon reading her work, I couldn't help but to associate to a few, quite intelligent medical school classmates of mine who, after getting straight A's their entire lives, found themselves competing with others in medical school of equal, if not better standing, and promptly academically crashed and burned."

The Soloists: This group feels that asking for help will reveal their deficiencies and therefore, condemn themselves to doing things on their own. I used to joke that I always studied alone because if I felt the person I was studying with was smarter than I, I'd feel bad and if I felt they were dumber than I, then what would I gain.

The Experts: This group bases their sense of competence on what they know and can do. They are constantly driven to learn more and more, not for the joy of learning, competence, or

helping others, but for fear of not being found to be lacking. As Satchel Paige said, "Don't look back. Something might be gaining on you."

Each of these 5 subtypes appear to represent different strategies for dealing with the pain of feeling inadequate. One can see that each of these subtypes sets in motion dynamic cycles of defensive/coping mechanisms that in turn cause new problems that must in turn be dealt with - - on and on, ad infinitum. These strategies are driven by the double bind of having to deal both with the consequences of failure as well as of success. These strategies translate into behaviors that are all too familiar to therapists, administrators, parents, and friends. They include perfectionism, procrastination, problems in prioritizing, collaboration, communication and delegation, cheating, sensitivity to criticism, self-criticism, scapegoating of others, a sense that one is constantly being monitored, various forms of self-sabotage (n.b., "shooting yourself in the foot"), not asking for raises or promotions, or quitting one's job for fear you are about to be fired. It also includes many signs and symptoms of burnout that are associated with psychiatric distress, especially depression and anxiety.

Research on Impostor Syndrome since 1978 has clarified that this is not just an affliction of women and extends to men. The research shows a steady increase over time in those thought to have impostor syndrome to a whopping estimate of 70% in the U.S. An article by Felder humorously titled "Impostors Everywhere" nicely highlights this burgeoning trend.

Theories about the etiology of Impostor Syndrome are multiple. This list of usual "nature-nurture" suspects identified are:

- **Biological risk factors for anxiety and depression.**
- **Early family dynamics and parenting.**
- **An introjection of problematic societal sex role stereotypes.**

A parallel inculcation of our societies values with regards to what is valuable and worth striving for. Capitalism is certainly up for scrutiny with its focus on money, success, and power. I often exemplify this with what I call the "Hollywood" mentality that focuses on what you've done lately and the adage that you are "only as good as your last movie – and its gross."

Persons with dynamic therapy training can certainly see a cavalcade of ego defenses in action trying to deal with the numerous underlying conflicts involved. They would also highlight the linkages to problematic development, parenting techniques, and fragile narcissism.

Many articles on the topic suggest a plethora of ways to address "Impostor Syndrome." They include calling attention to the syndrome (n.b., self-awareness) and educating people that they are not alone in either their feelings or their actions (n.b., misery is helped by company). Presentations on the topic and support groups have been suggested as helpful. As expected, this has been a focus of CBT techniques that attempt to clarify the extent of the problem, what the person has tried so far, differentiating feeling incompetent and actually being incompetent, identifying faulty attributions and perceptions and their subsequent actions, challenging the validity of the attributions, trying new activities, tracking the success of these new activities, the repetition of successful efforts (as I say, "then do it a thousand more times!"), and an intimate knowledge of the Serenity Prayer. Aspects of positive psychology, which has been increasingly subsumed under the ever-enlarging tent of CBT, are often mentioned. These include taking care of yourself, deep breathing and other relaxation strategies, mindfulness exercises, and compassion for yourself ("quit beating yourself up!") and others ("Be kind, as everyone is carrying a heavy load").

If these therapeutic strategies don't work, I would suggest other psychodynamically informed therapies that might be helpful in understanding the etiologies of this syndrome, especially if they are out of the awareness of the person. I note that this phenomenon is familiar to most psychodynamic therapists who have their own names for it whether this be neurosis, ABD – All but Dissertation syndrome, those wrecked by success (Fenechel), narcissism, poor self-esteem, etc.

Seritan and Mehta, in their excellent article, "Thorney Laurels: The Impostor Phenomenon in Academic Psychiatry," focuses on the individual strategies listed above, but add specific strategies for academic institutions. Their list suggests that academic institutions should:

- **Provide educational workshops on impostor phenomenon for faculty and staff.**
- **Develop mentorship programs, in general.**
- **Design specific, targeted support and mentorship programs for international medical graduates and underrepresented minorities in medicine.**

- **Offer leadership training and coaching.**
- **Foster a "growth" mindset culture that does not punish mistakes.**
- **Factor aspects of Impostor Syndrome into the academic processes of promotion and remediation.**
- **Factor aspects of Impostor Syndrome into Employee Assistant Programs.**
- **Factor aspects of Impostor Syndrome into existing programs addressing burnout and wellness especially for faculty new to their positions and/or in transition.**

As my target audience is child and adolescent psychiatrists, I will end with a note on parenting, which is a potential prevention strategy. Several authors focus on parenting specifically. They point out that parents with Impostor Syndrome are likely to spawn a next generation of Impostors. To reduce the possibility of such, the parents should be aware of the syndrome and use the individual strategies above to help themselves and, therefore, subsequently help their children. The parents should be aware of the messages they send out as far as what they value and expect. They should promote Dweck's "growth mindset" and be careful of what they criticize and validate. They should avoid the idea of "you are no good unless you're good," styles of parenting, which lead to overly obedient children who are afraid to talk about their feelings even if those cases when they actually know what they are. Winnicott's concepts of being "good enough" (vs. perfect) and the "false self" would seem to factor into any formulation.

The parents should generally praise their children for specific positive achievements and do so frequently. They should pay attention to their actions with the knowledge that their children are looking to them as role models. Children should be raised by their parents to know that the parents are not perfect, can make mistakes, and can apologize. Parents should help their children make decisions and to accept the consequences of them. Similarly, they should teach that some problems do not have great solutions and that some may have none. This allows children to internalize the concept of being "good enough" developmentally as well as an appropriate sense of their limitations. Finally, parents should be aware of helicoptering which involves doing things for their children that the children can do for themselves. This act of enabling robs their children of opportunities to practice and master valuable skills and, at the same time, sends the message to their children that they don't have the skills to do things themselves. Helicoptering is a process by which parents try to reduce the anxiety in their children. It works well in the short run, as it temporarily avoids and reduces anxiety, but is harmful in the long run as it tends to leave children feeling incompetent and potentially sets them up for a future life as an impostor. More insidious is the reality that the parent's actions are often based on their own anxiety, which creates a mutually reinforcing process that reduces anxiety in both parties. Such parent and child interactions has been suggested as the etiology for some of the problem's millennials are accused of having (See Simon Sinek), even though impostor syndrome as an entity long predates the much talked about and often maligned generation of millennials. ■

REFERENCES:

Buchannan, L. & Young, V. (15 Apr. 2020) The impostor syndrome: Why do so many successful entrepreneurs feel like fakes? Inc.com. Retrieved from: https://www.inc.com/magazine/20060901/handson-leadership.html

Dweck, C.S. (2016). Mindset: The New Psychology of Success, New York, NY: Penguin Random House, LLC.

Escalante, A. (23 Oct 2019) How to prevent impostor syndrome in your child: The culture of perfectionism makes our kids feel that they can never measure up. Psychology Today. Retrieved from: https://www.psychologytoday.com/us/blog/shouldstorm/201910/how-prevent-impostor-syndrome-in-your-child

Fenichel, O. (1943). The Psychoanalytic Theory of Neurosis, New York, NY: Norton (reviewed 1972, Felder, R. Impostor's Everywhere, In Chem. Engr. Education, 22(4):168-169 (Fall 1988).

Impostor Syndrome. Retrieved from: https://en.wikipedia.org/wiki/Impostor_syndrome

Molinsky, A., et al. (7 Jul 2016). Everyone suffers from impostor syndrome – Here's how to handle it. Harvard Business Review. Retrieved from: https://hbr.org/2016/07/everyone-suffers-from-imposter-syndrome-heres-how-to-handle-it.

Sinek, S. (10/29/16) Simon Sinek on Millennials in the Workplace. YouTube. Retrieved from: https://www.youtube.com/watch?v=hER0Qp6QJNU

Soeiro, L. (22 Aug 2019). How to cope with impostor syndrome. What is impostor syndrome, why does it occur, and what can you do about it? Psychology Today. Retrieved from: https://www.psychologytoday.com/us/blog/i-hear-you/201908/how-cope-impostor-syndrome

Wilding, M. (5-18-17). The five types of impostor syndrome and how to beat them. Retrieved from: https://www.fastcompany.com/40421352/the-five-types-of-impostor-syndrome-and-how-to-beat-them

Seritan, AL & Mehta, MM (2016). Thorny Laurels: The Impostor Phenomenon. Academic Psychiatry, 40(3):418-21.

Young, V. (2011). The secret thoughts of successful women. Why Capable People Suffer from the Impostor Syndrome and How to Thrive in Spite of It. New York, NY: Crown Publishing Group. A Division of Random House, Inc.

DON'T MISS LIFE MEMBER EVENTS at the AACAP/CACAP 2022 ANNUAL MEETING!

The Life Member's Committee is very excited to be together again in **TORONTO!**

While we know that there are still many challenges to travel, we hope that those of you who will be in Toronto will participate in all of the Life Member programs and events.

Meet Life Members at the 2022 Annual Meeting

Tuesday, October 18
4:45 pm-6:15 pm

This is a premier opportunity for medical students and residents to meet with the most senior members in child and adolescent psychiatry for career advise and mentorship. If you are interested in being a mentor, please email ellensholevar@hotmail.com by September 15.

Clinical Perspectives 47: Life Members Wisdom
Clinical Perspectives: A Lifetime of Lessons Learned: Careers in Child and Adolescent Psychiatry

Thursday, October 20
2:30 pm-4:30 pm

Hear from top members in the field about their career trajectories and why they chose child and adolescent psychiatry.

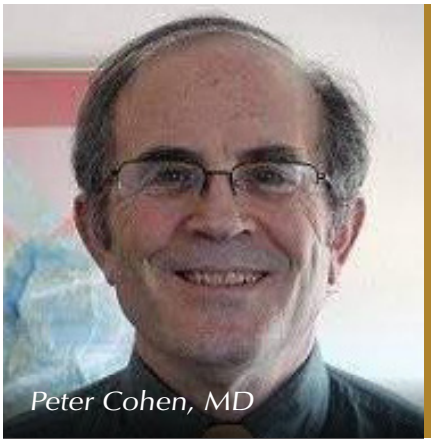
Life Members Reception and Dinner

Thursday, October 20
6:30 pm-9:00 pm
Fairmont Royal York

Join us for this memorable event for Life Members to enjoy the company of friends and colleagues while mentoring our young award winners as they start their careers in child and adolescent psychiatry.

Tickets are required and available when you register for the meeting.

If you've already registered and would like to buy a ticket, please email registrar@aacap.org or call 202.966.7300, ext. 2005.


Peter Cohen, MD

A Retired Psychiatrist's Handbook to Writing Fiction

Part One: From Inception to Conception

By Peter Cohen, MD

Nothing's simple in life, including the workings of our noble profession. Add writing and publishing a book to that list. My novel, a coming-of-age comedy, demanded ten years spanning my late career into retirement. At that non-prolific rate of speed, Stephen King lapped me at least nine times.

My guide about penning a novel will take the form of a two-part self-interview. In Part One, I'll describe how the reception of one book under intense criticism can turn into a vastly different full-length novel. In Part Two, I'll outline the process for penning something that is hopefully half decent.

The book's title is "The Boys and Girls Guide to Relativity." Here's a summary:

Jonah Isaacs runs away on the night of his high school graduation party: from over-doting parents, a double-crossing girlfriend, a triple-crossing best buddy, and his reputation as a people-pleaser, too anxious to assert himself when it counts. Before he summons up the moxie to hightail it to New York City on a free-wheeling caper, his Great Uncle Max shows up at his bedroom door without an invite. The problem is Max croaked earlier that day. He claims, however, he's only "relatively" dead and alive enough to offer his nephew the opportunity to learn a thing or three about the opposite sex and life in general. Suspicious but intrigued, Jonah hops into his uncle's Olds, not knowing he'll travel back 24 years, from '66 to '42, to the Hudson, his uncle's burlesque house in New Jersey. For starters, Max will coerce him into performing in the theater's midnight benefit to support the war effort. But that's for starters. The kid will play in skits lampooning his sorry love life, he'll fall for his dance partner, Laura, a "triple-threat" performer, and he'll dodge a gangster stalking him at gunpoint. And to take the cake, a young couple—his newly engaged parents—will be seated in the audience. By evening's end, this 18 year old must answer three critical questions about his life's direction. Should he escape from the past with his dignity and body intact? Or should he remain there and defy the cosmic laws of time, all for a woman whose charms, smarts, and wise cracks soften him up, then whack him on his emotional kneecaps? And, lest we forget,

what else is Uncle Max hiding up his sleeve?

Now, the Q&A.

1. What inspired you to write this book?

My book pays tribute to Lewis Carroll's conceit of climbing through the looking glass to discover an alternative world. This phenomenon is a fitting metaphor for creating a novel as well as replacing one idea with another. Here's some details:

In the early 2000's, I engaged in a ritual required of every fledgling writer: to rid oneself of an over-long, navel-gazing, semi-autographical novel. My book was an alternative personal history: What if I was drafted in 1970 and the USofA shipped me over to Vietnam, where I wound up on the jungle floor shot full of holes? I lugged this 500+ pager for feedback at a week-end conference called "Fiction Writing for Physicians." The most fruitful experience was learning the art of composition from two successful doctor-novelists, Tess Gerritsen and Michael Palmer. The most intimidating component was pitching the book to agents in a noisy hall.

My first prospect was a quick-thinking New York-born sourpuss. Half-way through my first polished sentence, he wagged his head. Though his rudeness was off-putting, I refused to pick a fight. He had credibility adapting books into film. I asked him, "How come the strong 'no?'" He said, "Nobody wants to read another Vietnam book. Anything else you got?"

Dejected, I phoned my wife about the thumbs down. Without a beat, she said, "Sorry, but he could be right despite his personality. Think about x-ing the Vietnam part, but keep Jonah. He's basically you and your protagonist. And make Max the burlesque owner your antagonist. He's incidental to the war story but very funny."

I let my thoughts spin, first about the tragedy that we can't advise our younger selves about growing up. So, place Jonah in a quandary to where he is comes of age via time-travel. Third, make the venue a burlesque house from the 40's.

I returned to the hall and pitched my new idea to an agent. She liked the concept, wasn't offended by the burlesque element, and asked how long before I could send out a copy. She suggested I contact her about the new book as soon as possible. After two years of rewrites, I sent her the standard pitch and mentioned our meeting at the conference. She sent back a courteous "thank you, but I can't put my heart behind what you want to express."

Post note: After the conference, I read "Matterhorn," a superbly written Vietnam war novel. At the author's book promotion in DC, he thanked his young enthusiastic agents (again, women), who transferred the printing rights from a small publisher to a larger one. It became a bestseller. So much for one agent's opinion.

2. What do you owe the real people upon whom you based your characters?

Empathy. I luckily met Richard Russo, whose laugh-aloud masterpiece "Nobody's Fool" depicts characters who are lovable in spite of themselves, like Sully, who is patterned after the author's grandfather.

In my novel, Max is a blend of two relatives. One, my great uncle Sam, a legendary Jersey burlesque manager, who booked greats like Gypsy Rose Lee and Abbott and Costello. He kept mobsters at bay, paying them off without breaking his bank. He was also a generous employer and family member. With one exception. Tickets. Nobody got a freebie. His cheapness provoked his audiences into ribbing him with chants of "Sam the Horse Thief!" whenever entered the theater. It turns out that Damon Runyon took a liking to him, and featured him as an incorrigible character in several of his short stories.

Two, my father-in-law, who was a self-taught, devoted family man and recovered gambler. His Polish accent was so unintelligible, at get-togethers I had to translate his English into English. He was also a Holocaust survivor who testified against Nazis. And as an opera buff, he'd take a lunch break from his food market job to attend Lincoln Center rehearsals, where he'd tender advice to the director about how to play Verdi right.

3. What about your protagonist Jonah?

Temperamentally, he is slow to warm up, self-conscious, filled to the gills with anger, over-doted upon by his parents, and cowed by peers and relatives. How do you encourage readers to root for such a non-assertive, angry boy? Make him a smart aleck and surround him with folks who prod him to show initiative, figure out what he wants, firm up his identity so he's on the road to intimacy.

4. So he's you.

Except he plays baseball way better than I did.

5. I'm serious here. Why wouldn't you put him in therapy in your book?

Leave that to Salinger and John Green. I'm more interested in how a young person can grow despite himself into a better adult by hanging around smart, empathic, overbearing people.

6. What are you trying to work through in your life by writing this novel?

Keep in mind, this novel is not a "true confession." It is a metaphor and an attempt through character and story to resolve my lifelong perturbed perplexity about the quirky sexual and intimate goings-on between adults. In truth, I'm still confounded. I think we need novels that highlight the human condition but they're no substitute for therapy. Especially relatives, friends and ne'er-do-wells, who as rotten models of mature behavior upstaged me as a youngster.

7. What research did you do for the book?

I studied the history of burlesque and had the fortune to discuss my project with Karen Abbott, the author of a superb Gypsy Rose Lee biography. Plus, I searched reputable internet sites to verify facts about the 40's. The music and movies, WWII, the lingo, and the writing style. That led me to write the summary in a breezy conversational style reminiscent of the era.

8. Why the burlesque house?

It is no different from today's on-line, subscription, magazines, and club scenes, but without the jokes. As the French say, "Plus ça change, plus c'est la même chose."

It rose out of vaudeville when the public flocked instead to movies. In response, the owners kept the comics, sketches, and musical acts. Then they cut the kiddy and dog-and-pony acts and replaced them with stripteasers. At its heyday, burly-q was still a breeding ground for a generation of funny men and women, who later became movie, TV and night-club stars. Like Bert Lahr, Fanny Brice, and Red Skeleton. The audiences were also far from just "lonely old men." Upper crusties and intellectuals came to witness Gypsy wax on wittily about sex and politics all the while demonstrating the art of disrobing. Women paid the fare to eye the latest bedroom fashions, before Victoria's Secret. The hoi polloi feasted their eyes on feminine, masculine, and other forms on the continuum, coupled with sense a humor in a venue where no one shamed them. I'll have more to say about this underlying subtext and issues of objectification of women in the second part. ■

Stewart Teal

Roe Who? Remembering When

By Stewart Teal

As an old but still practicing Psychiatrist certain thoughts, patients and situations still haunt my dreams. Recently, I find both sadness and anger triggered by the recent Supreme Court decision to reverse Roe vs Wade. Women and some men are marching and finding some consolation in the strength of their numbers and the truth of their message:

"I own my body, it does not belong to some paternalistic politician."

I need to share some of my anguish over old times because it is different having actually been there than just reading about the bad, ancient days when ending a pregnancy was legally almost impossible. I think the anger over the injustice keeps the faces of these women still so strongly in my mind and the flame burning in my gut.

In 1968 I was assigned as a senior Psychiatric Resident to the University of Michigan's Medical Center Abortion Committee. The function of the committee was to decide if a woman applying for an abortion would be able to get it done. My job, I gathered, was to give input to the five senior obstetricians on the emotional state of the applicant. I only attended one meeting. The young woman was a student nurse who had been raped at a party while passed out, drunk. She had no financial resources and was desperately afraid her family would disown her. She had no idea who the father might be. I informed the committee of five men that having to proceed with the pregnancy would be of great emotional damage to her.

The five men conferred for about five minutes and denied the abortion. They stated since it was her own fault for getting drunk she should have to bear the consequences. The men were smug, condescending, and joking over their coffee. Two of these men had been my respected professors in medical school. They ranged in age from young to very old, black beards and grey beards. How could they not see the pallor of this girl's skin, the trembling of her jaw, her shaking hands and the fear in her eyes as she sat before them? I never found out what happened to this poor young woman. I knew I could never come back to this kangaroo court.

"No, no doctor, not a needle, I'm scared to death of needles."

The fifteen year old girl was bleeding to death following a back alley abortion attempt with a knitting needle. Her eyes were round in terror the whites visible all the way around; like a doe caught in the headlights of an onrushing truck. Unless we could get an I-V in quick we might lose her. I was an intern at Philadelphia General Hospital working the emergency room; it was 1964. I recalled from my undergrad psych classes the power of suggestion.

WE WANT TO HEAR FROM YOU!

We're requesting articles, film reviews, book reviews, documentary review – and suggestions!

In addition, have you seen or heard a TED Talk recently that set your hair on fire? If so, we want to know!

Please send interesting articles, book/film reviews – anything you think the Owl Community would benefit from knowing about to communications@aacap.org.

"Honey, I'm going to give you a pill that will take away all your pain, you won't even know a needle went into your arm."

I gave her a single aspirin with a sip of water. I told her to close her eyes and slipped the needle into her vein without even a wiggle.

"Did you do it yet doc?"

"Yep, you're going to be fine."

I didn't tell her that in all likelihood she would have to have a hysterectomy to stop the bleeding and she would never be able to have children.

The next day I went up to the GYN floor to see my new patient, a thirty five year old policewoman. She had come in with a raging fever following a septic abortion. She was a beautiful but stern looking lady with I-V's going with massive amounts of Penicillin going in her veins in one and saline solution in another for rehydration. She was on the ward with ten other PID (pelvic inflammatory disease) patients.

"Doctor, how am I doing?"

"You're doing fine, the fever has come down from 105 degrees to 101, so the antibiotic is working well. How's your stomach feeling?"

"Still hurts like hell but better than yesterday."

"What did you do?"

I asked.

"Sorry, doc, I really can't tell you about it."

Her face turned stony, and the anger was reflected in her gritted teeth.

"Will I have any problems after the infection clears up?"

"Well, I won't lie to you. You may get chronic infection with recurrent pain and need for treatment. It's also possible your fallopian tubes, the ones that carry eggs from your ovaries will be scarred and won't be able to function."

"Does that mean I won't be able to get pregnant?"

"It's one of the possible complications of your infection. I recommend that you see an OB-GYN specialist after you get out of here."

She pulled the sheet up over her face.

"Thanks doc," she mumbled from under the cover.

All of this went away after Roe vs Wade. Well, it's back. It wasn't pretty then and it's devastating now. ■

John McCarthy, MD

Palindromes That Will Make Your Head Hurt

Thanks to John McCarthy, MD for both finding and submitting these!

Palindrome: are words or sentences that read the same backwards or forward (not counting punctuations)

- **Racecar (1 word, 7 letters)** Comment: NASCAR fans would like this one.

- **Dammit, I'm mad! (3 words, 11 letters)** Comment: A pure expression of frustration.

- **Never odd or even (4 words, 14 letters)** Comment: Might send one down and existential tangent.

- **Satan, oscillate my metallic sonatas. (5 words, 31 letters)** Comment: Are metallic sonatas a metaphor?

- **Marge lets Norah see Sharon's telegram. (6 words, 21 letters)** Comment: Is Marge betraying Sharon but letting Norah in on the gossip?

- **Doc, note: I dissent. A fast never prevents a fatness. I diet on cod. (14 words, 52 letters)** Comment: This is interesting dietary advice from a patient who has taken nutrition into his/her own hands.

- **Dennis, Nell, Edna, Leon, Nedra, Anita, Rolf, Nora, Alice, Carol, Leo, Jane, Reed, Dave, Denny, Lena, Ida, Bernadette, Ben, Ray, Lila, Nina, Jo, Ira, Mara, Sara, Mario, Jan, Ina, Lily, Arne, Bette, Dan, Reba, Diane, Lynn, Ed, Del, Rena, Joel, Lara, Cecil, Aaron, Flora, Tina, Arden, Noel, and Ellen sinned. (63 words, 263 letters)** Comment: Sounds like a good party. It might look like a simple list of people who have sinned BUT IT IS INDEED A PALINDROME! ■

POETRY CORNER

The Words Written Within the Water

By Kieran Darragh O'Malley MD

I Can you read the sand script
as it appeas
figures crafted
invisibly,
catching coming winds
palm trees gentle swing,
inscribe unspoken thoughts,
The water sounds,sing,
clearly,
unsaid words.

II A language
for those who know much
yet cannot speak such
once seenheard
Then, understood.

III As tides age water
trace shades on. sand-shore,
and briefly leave them,
evanescence memories
for our transient stories.

LEAVES

A poem by John Dunne

Leaves
Old leaves fall
Leaving branches bare
For new leaves.

Donors to AACAP's Life Members Fund

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.

$2000 to $1000

Joseph J. Jankowski, MD
McDermott Family Charitable Fund

$999 to $250

Marilyn B. Benoit, MD
Anthony A. Bottone, MD
Lawrence Brain, MD
Martha Collins, MD, MPH
in memory of Carol Jankowski
Charles Hart Enzer, MD
Theodore John Gaensbauer, MD
Ralph Gemelli, MD
in memory of Helen Ross, Psychoanalyst
Steven Jaffe, MD
Alan D. Megibow, MD
Sonia B. Yballe, MD

$10 to $249

Patrick Butterfield, MD
Peter R. Cohen, MD
E. Gerald Dabbs, MD
Ralph Gemelli, MD
Anthony H. Jackson, MD
Eric and Valerie Leifer
in honor of Joel Ganz, MD
John Lingas, MD
James A. Margolis, MD
W. Peter Metz, MD
Nirmalam Nagulendran, MD
Steven L. Nickman, MD
Ruth Noel, MD
in memory of Joseph Afterman, MD
Kent Ravenscroft, MD
Howard Rudominer, MD
Sam Tyano, MD
George L. Wing, MD
Margaret J. Zwerling, MD

1953 Society

Anonymous (5)
Steve & Babette Cuffe
Samuel Glernter, MD
Catherine DeAngelis, MD, MPH
Paramjit T. Joshi, MD
Dr. Michael Maloney &
Dr. Marta Pisarska
Sally McDermott
Patricia A. McKnight, MD
Scott M. Palyo, MD
The Frank A. Roberto, MD, Family
Diane H. Schetky, MD
Gabrielle Shapiro, MD
Diane K. Shrier, MD &
Adam Louis Shrier, DEng, JD

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.**

Donations made between February 11, 2022 - August 31, 2022

AACAP Policy Statement on Autism and Vaccines

Vaccines work with the immune system to prevent infectious diseases such as polio, measles, diphtheria, and whooping cough. Hence, vaccines are one of the greatest success stories in all of medicine. Unfortunately, immunization rates have dropped in recent years in part because of concerns about whether some vaccines may be associated with the development of autism spectrum disorder (ASD). Multiple studies conducted in several different countries have demonstrated that there is no causal association between vaccines or their preservatives and ASD. Further, vaccines do not change the timing of the onset of ASD symptoms, nor do they affect the severity of ASD symptoms. Even in families who have a greater risk for ASD, such as those who already have a child with ASD, there is no increased likelihood that the second child will have ASD if vaccinated.

Twin and family studies over the last few decades have consistently demonstrated that ASD has a strong genetic basis. Recent studies have demonstrated that brain changes associated with ASD risk most likely occur before birth and well before any immunizations are ever administered. Some environmental risk factors, such as maternal valproate use during pregnancy, are linked to ASD. Other environmental factors may also increase risk for ASD in those who are genetically vulnerable, though more research is needed on these factors. Childhood vaccination is not one of these environmental risk factors.

The consequences of measles, diphtheria, whooping cough, severe Covid-19 and other preventable infectious diseases can be catastrophic to an individual or a population and lead to death and long-term disability (as evidenced by recent outbreaks of measles in several countries). Research indicates that the lower the immunization rate in a population, the greater the risk of these preventable infections.

Vaccine hesitancy among parents and healthcare providers persists and appears to be on the rise in recent years. Internet searches regarding ASD and vaccines are increasingly frequent. Parents and some providers cite that concerns about ASD may contribute to this hesitancy despite the lack of supporting evidence in the peer-reviewed literature. Parents of children with ASD have higher rates of vaccine hesitancy, are less likely to have their children vaccinated, and are more likely to attribute their child's ASD to vaccines compared to parents of children who do not have ASD. Thus, vaccine hesitancy is present despite robust evidence indicating that primarily genetic factors and possibly some environmental factors play a role in the pathogenesis of ASD.

To ensure that all children receive appropriate immunizations, the American Academy of Child and Adolescent Psychiatry recommends:

- **All children and adolescents receive routine immunizations according to the current U.S. Centers for Disease Control and Prevention Advisory Committee on Immunization Practices Recommended Child and Adolescent Immunization Schedule, unless medically contraindicated.**

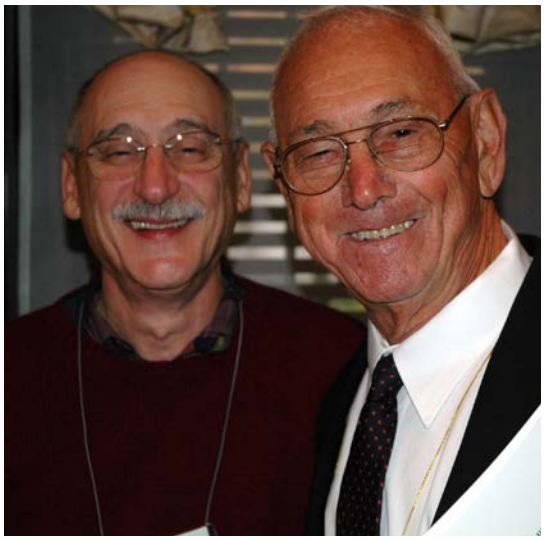
- **Prioritizing research on the potential causes of ASD, including possible environmental risk factors.**

- **Public education campaigns on the safety and efficacy of routine vaccinations and lack of evidence supporting any relationship between routine vaccines and the development of ASD.**

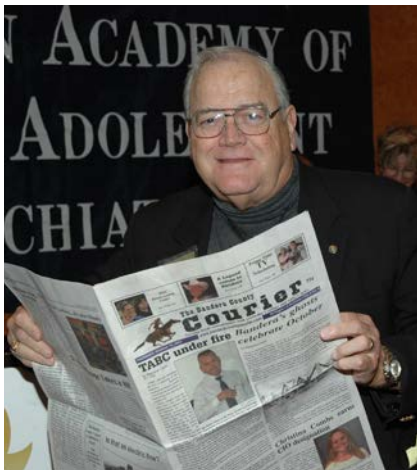
The American Academy of Child and Adolescent Psychiatry promotes the healthy development of children, adolescents, and families through advocacy, education, and research. Child and adolescent psychiatrists are the leading physician authority on children's mental health. ■

Approved by Council March 2016
Revised June 2022

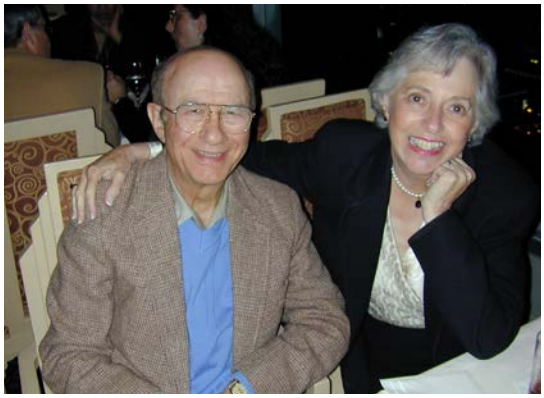
Member Photos

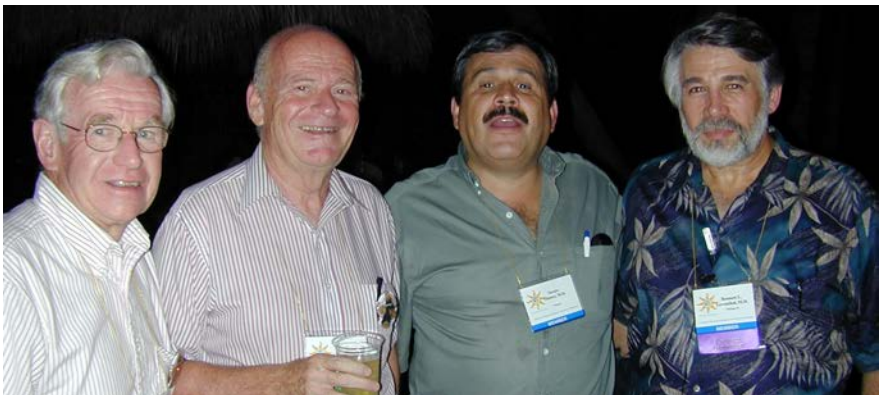


Member Photos



Member Photos





Member Photos

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

WWW.AACAP.ORG

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016-3007

Phone: 202.966.7300
Fax: 202.464.0131

aacap.org