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Roundtable for New Division Directors: Things to Think About and Comments for New Heads of Child and Adolescent Psychiatry Divisions

"The times they are a changing," *Bob Dylan* (2016 Noble Prize winner!)

"It is not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change." *Charles Darwin*

"Piss poor preparation predicts piss poor performance," *My Director of Nursing's Father*

"Once you've seen one Child Division, you've seen one Child Division," *Martin J. Drell, MD*

"For every complex problem, there is an answer that is clear, simple, and wrong," H.L. Mencken

Mega Question: Are you a leader or a manager or neither or both?

- "Leaders do the right things. Managers do things right." *Warren Bennis*

Mega Question: Are you systemic and able to see the forest and the trees? Being systemic is a talent that many don't have. One of the difficulties, especially in this time of decreasing resources and increasing change, is being systemic and dealing with all parts of your system and the larger system it is embedded in. Those in the system may not be systemic and will tend to take care of their own interests. One should vigilantly look for conflicts of interest (COI) which need to be managed.

Question: Did you really want to be a Division Head? What are your motivations for doing so? Do you have the temperament/drive/social and cognitive skills to effectively do so? Is your Division the right fit for your skills? For your age/stage of development? To start a Division from scratch is much different than inheriting one to maintain. To maintain a Division with a major research focus is different than one with a major clinical focus. A Division in the private sector is different than one in the public sector. To be a director during times of change is a different and difficult skill. Is there a "goodness of fit between what you are good at and what is needed?"

Note: (Concept of Situational Leadership.) Being a leader post-Katrina is different than Pre-Katrina. Rebuilding is different than building or maintaining or reconfiguring a Division (n.b., as I had to do secondary to our primary clinical site, the New Orleans Adolescent Hospital and Community System of Care, being closed by Governor Jindal as part of his efforts to privatize the public sector). This necessitated many changes in our clinical sites, our stipending, and our faculty. (See section: More comments on Public vs. Private for more details and a case study).

Comment: To be a Head means you may not be able to do other things you might feel are more interesting or important to you. It may impede or kill a research career.

This may, in turn, impede one's ability to be promoted (depending on what tracks your medical school has). There are few quadruple threats—clinical, research, training, and administration.

Comment: The job may not be compatible with your developmental stage (n.b., Think Erik Erikson's life cycle here) in life or your academic developmental stage. It may not be a position for the old or the young. You may; in fact, developmentally grow out of your wish to be a Head... or grow into it.

Example: I once considered a move after Katrina, but it was a bad time to move as my children were all doing well, had friends, and didn't want their lives disrupted.

Example: The closure of our main clinical site where I was Clinical Director impacted my jobs and salary. That it occurred at age 60 and during a nationwide recession presented me with interesting dilemmas and decisions. Age and ageism are alive and well.

Example: Now at an age when I could retire, and as a new grandfather (x4), and as an ex-President of the AACAP, and Head of Child Division. Before not being the Head, the fantasized pleasures of pre-retirement (resting on one's laurels) and retirement increase in proportion to increased administrative B.S. and the vestiges of aging. There is something about being able to retire, which my financial advisors assure me I can, that changes the equation of the work/life balance (Am I becoming a millennial?). Having fewer administrative duties has made it so that I have more time to pursue scholarly activities in a more focused way. It's like having a half time sabbatical (in place). I find (or rationalize) that I prefer getting things done than being the boss. I still have lots of projects.

Quote: "As I get older, it is harder and harder to do the things I never wanted to do in the first place." *Martin J. Drell, MD*

Question: If the job is not for you, why stay in it and torture yourself and others?

- The status quo and homeostasis and prestige (real and/or perceived) are powerful forces to stay in your position.

- "Golden Handcuffs" – When one's salary is such that it impedes ones wish to change.

Quote: "Many can rise to the occasion, but few know when to sit down."

Oops! It's too late for this question to be of help. Perhaps you can use this information the next time you look for a job: Did you negotiate properly before becoming the Head? Did you know what to ask for? What can you do if you didn't? Can you ever make up from a poor starting package? Did you ask for an organizational chart? Did you ask for a job description? What should you have asked for (n.b., monies for key change agents to improve your organization.

Note: An internal candidate maybe at a disadvantage in asking for an attractive "staring package."

Note: You never have as much leverage as when you're being courted.
Quote: "Once you sign on the dotted line, you're just another piece of slime." *Martin J. Drell, MD*

Note: When entering systems, it is a good time to ask for advice and perhaps to ask for a lawyer's input to check your contract. I note that non-compete clauses in contracts are being challenged more in courts, especially due to the impact of large hospital systems and their large hospital systems.

I will use Covey's 7 Habits of Effective People to Organize the Next Part of my Presentation

7 Habits

The 7 Habits of Effective People by Stephen Covey, NY: Firestone (Simon & Schuster), 1989.

1. Be proactive.
2. Begin with end of mind (Missions and Goals).
3. Put first things first (prioritize).
4. Think win-win.
5. Seek first to understand, then to be understood.
6. Synergize (creative cooperation).
7. Sharpen the saw (reading, experience, and renewal).

Habit: Sharpen the Saw

Question: How much do you know about Leadership, Administration, and Management? (Being a Head of a Child Division is an administrative position). You're a "middleman" in between faculty, trainees, and the head of psychiatry and the higher echelons of the Medical School/Health Services System. This, by definition, creates conflicts of interest.

Answer: Most residency training programs have little to no teaching, training, or supervision with regards to administration/management.

- Dorothy Stubbe's (JAACAP, Feb. 2002) article on preparation for practice showed that recently graduated CAP's lacked skills in the areas of administration.

- Quote: "You have no idea what you will end up doing in your future. Whatever you do, you will be a leader even if it involves your administrative staff in your private practice. Because of this, the true issue is whether you will be an effective leader or an ineffective one." *Martin J. Drell, MD*

Question: If you didn't learn these skills during your training, then you might want to learn these skills after graduation? The good news is that you can learn these skills after training and while on the job.

- How much have you read about leadership, administration, and management?
- If not, a good starting place is the handouts by Victor Fornari, MD, Meg Benningfield, and myself that are on the website.
- Another good starting point might be Stephen Covey's book, which I have based my handout.

Other book/articles/opportunities to consider that I have found valuable from teaching and personal use:

1. Barron, J. (2019). The Visual MBA. New York, NY. Houghton Muffin Harcourt.

2. Bhugra, D., Ruiz, P., & Gupta, S. (2013). Leadership in Psychiatry. Hoboken, NJ. Wiley Blackwell.

3. Bossidy, L & Charan, R. (2002) Execution: The discipline of getting things done. New York, NY. Crown Books.

4. Bryant, A (2011). The corner office: Indispensable and unexpected lessons from CEO's on how to lead and succeed. New York, NY. Times Books.

5. Buller, J. (2012). The Essential Department Chair: A Comprehensive Desk Reference. (2nd Ed.). San Francisco, CA. John Wiley & Sons. (Note: The Department Chair has submitted job to you, just one level up.)

6. Buller, J. (2015). The Essential Academic Dean or Provost: A Comprehensive Desk Reference (Jossey-Bass Resources for Department Chairs). (2nd Ed.) San Francisco, CA. Jossey Bass: A Wiley Brand. (Note: Dr. Buller appears a man heading upwards in the hierarchy.)

7. Drucker, P. *The Effective Executive*, NY: Harper & Row, 1967.

8. Eble, K., *The Art of Administration: A Guide for Academic Administrators*, San Francisco: Jossey-Bass, 1978.

9. Hill, L. (1993). Becoming a Manager. New York, NY. Penguin Books.

10. Jeffrey L. Houpt, J.L., Gilkey, R.W., & Ehringhaus, S.H. (2015). Learning to Lead in the Academic Medical Center: A Practical Guide. (1st Ed.), New York, Springer, New York, NY.
11. Jenkins, R. (2017). The Millennial Manual: The Complete How-To Guide To Manage, Develop, and Engage Millennials At Work Paperback , Atlanta, GA. Ryan Jenkins, LLC.

12. Numerous universities offer Leadership Development Seminars/courses (online or otherwise).

13. Oncken, W. & Wass, D. (Nov/Dec 1999) Management time: Who's Got The Monkey. An analogy that underscores the value of assigning, delegating and controlling. Harvard Business Review Classic.

14. Sanfilippo, J.S. (6/27/02). MBA For Healthcare. J.S. Sanfilippo, Thomas E. Nolan, & Bates H. Whiteside (Eds) Parthenon Publishing.
15. Seuss, T. (1953). The Sneetches and Other Stories. New York, NY. Random House. (Note: I add this classic Dr. Seuss book to warn people of the dangers of assuming "we" are the best sneetches on the beach.
16. Simon Sinek on "Millennials in the Workplace" – YouTube, October 29,2016

17. Talbott, J & Hales, R (2001) Textbook of administrative psychiatry, (2nd Ed.), Washington, DC. APA Press.

18. The best business books ever: The 100 most influential management books you'll never have time to read. Cambridge, MA. Perseus Books, 2003. ISBN: 0738208493. (Note: Short summaries of key points of many classic books.)

19. The Physicians Essential MBA: What Every Physician Leader Needs to Know. (1999). (1st Ed.), Michael J. Stahl (Editor), Peter J. Dean (Editor). An Aspen Publication. Jones & Bartlett Learning (Publisher).

20. Tuff, C. & James, M. (5/3/2019). *The Millennial Whisperer: The Practical, Profit-Focused Playbook for Working with and Motivating the World's Largest Generation*.

Example: Each year, Harvard puts on a leadership forum: Leadership Development for Physicians in Academic Health Centers, Harvard T.H. Chan School of Public Health, Boston, MA.

- Idea: Ask to attend for such a program as part of your hiring entry package.

21. Soundview Executive Book Summaries (http://www.summary.com/ or 1-800-776-6279).

Note: Knowing is not enough! To know what to do is not the same as doing it in the real world. It's easier to talk the talk than walk the walk! If things are not going well, check which of Covey's 7 Habits you are not attending to.

Habit: Seek first to understand: Do you know your system?

- Do you know your boss? Do you get along? Is your style a good fit for the leader's style? Do your values coincide? Many would say that your relationship with your boss is the number one thing to look for. Is he/she a mentor or a tormentor? Does your boss give you constructive criticism? Is your boss available to you? How often do you meet formally? Is your boss available informally? What communication style does your boss have? What does he tell you about what's going on that effects you? Note that just as you may change over time, so can your boss. This can lead to mismatches that were not there earlier.

- What are the goals for your department? If so, who made them? What are your boss's goals for your Child Division? Do your boss's plans coincide with your plans? Do you know your boss's plans? Do you know your

plans? Is child and adolescent psychiatry a high priority? Note that "stuff happens" and this stuff may mean a change in your bosses and your goals.

- I believe that a gigantic compounding/confounding factor is where you think our field is headed. What will be our perceived "scopes of practice" going forward, and who will define them for us? Who will pay us and at what rates? Will we be the heads of teams? Who is our competition? What impact will neuroscience research and achievements have on our field? Will it empower us, decenter us, or dethrone us?

As AACAP President, I attempted to answer some of these interesting and often vexing questions in *Back to Project Future: Plan for the Coming Decade*, which many of the questions are still important a decade later. (Retrieved from: https://www.google.com/search?ei=Z82bXMfVBdHUsAW08qqACg&q=Back+to+Project+Future+&oq=Back+to+Project+Future+&gs_l=psy-ab.3..0i22i30.2575.3283..4015...0.0..0.62.62.1.....0....1j2..gws-wiz.....0..0i71.f7n_DwP2uhA).

Another resource should be the AADCAP 2019 survey that gives us clues as to where our field is now as well as present and future trends.

Comment: Remember Maslow's Hierarchy of Needs. If child psychiatry isn't high on your boss's hierarchy, then what will happen when times get tough? In almost all cases, when push comes to shove, the needs of general psychiatry will generally trump the needs of child and adolescent psychiatry and medical needs trump psychiatric needs.

- Can you easily draw out an organizational chart for your department and Division? Could your faculty?

- Are the lines of responsibility and authority clear? Do child social workers, psychologists, nurses, and other staff report to you or not? Should they?

- Note: In this ever-changing world these disciplines are changing in their goals, ambitions, objectives, and their scopes of practice. In many cases, they may be competitors and will or not happy with their tradition positions in the Medical School, now called "Health Sciences Centers" (another indication that the MD's may not be in charge). The "Holy Trinity" of MD, psychology and social work is not what it used to be. In the "old days," the MD was invariably the Head of the Trinity. That is less clear in this day and age. And where do nurse practitioners, medical psychologists, physician's assistants, and other health care extenders fit in this?

- What are the goals and culture of your medical school? Public or Private makes a big difference. Both have their strengths and weaknesses.

    - Example: LSU is a State School. Its main mission is creating clinicians for the citizens of Louisiana. Creating a research empire would be harder at LSU than in some other places.

    - Note: The differences between public and private have blurred at many universities as more and more things are privatized.

- Note: Often the original missions linger on and have not been looked at in years to see if they still make sense. Do you need to tweak your mission statement to accommodate to the times?

- Do you have a monopoly in your city or are there other competing Departments/Divisions? This makes a big difference.

  - Note: If your program is in the State capital, this is a plus! One has easier access to those in power and a better chance you might get to know and influence someone that can assist you towards your goals.

- What is the history of your Division? Does it have a habit of falling apart or has it flourished? How embedded is your Child Division in the community?

  - Note: It is your job to embed your program in the community, as well as in your department and the medical school? Friends in high or the right places help in times of crisis, change, and need. Do you and your staff do media interviews and community service?

Habit: Begin with the end in mind: Do you have a 1 year, 3 year, 5 year plan for your Division?

- Have you figured out what combination of research, service, and training, and administration you wish your Division to have? This necessitates prioritizing.

  - Examples of endless number of things that need prioritizing: Equity, diversity, health care disparities, forensics, pediatrics and pediatric homes, research, rural, telemedicine, specialty clinics, psychopharmacology, neuroscience, genomics, grant writing, publishing, clinical service, training (who?). Traditionally, this has been the medical students, the general residents, and the child and adolescent psychiatry residents. Now you may want to add to the Nurse Practitioners, Medical Psychologists, the Legislators with more to evolve.

- Again, the specter of the "quadruple threat" (n.b., someone good at research, service, training, and administration) needs to be dealt with. I believe that it is more realistic to have the Division, in totality, be the quadruple threat, not all its individual members. This is especially true in smaller programs.

- Development Issues: Is your plan developmentally sensitive to where your Division is now? Research usually comes only after clinical services/populations are developed and the right people hired/trained, etc.

- Is your plan realistic? Do you have staff and resources to carry out your plan? Do you have the resources to recruit or train existing staff if you don't? To mentor and maintain them?

- Note: Research shows that writing down goals and objectives and showing them to another/others makes it 33% more likely that they will be accomplished.

- Is your plan written down? Is it done like a business plan with goals, costs, barriers to implementation, etc.? Is the plan systemic? Does it mention risks/benefits to Child Division and General Department? Note: The ACGME has implemented SWOT (Strengths, Weaknesses, Opportunities, and Threats) analyses of training programs prepared by the program director with ongoing written action plans. This is an interesting and effective way of planning! The Head of the Division should have a parallel plan. The plan should be top down and bottom up. The plan should be transparent.

    - Have you shown your plans to your Department Head? Discussed it with him/her? Have you got his/her buy in on it?
    - Have you shown your plans to your faculty and staff? Discussed it with them? Have you got their buy in on it?

Habit: Put First Things First: Could you tell me what you want as the next three major initiatives for your Division? This necessitates prioritizing. Prioritizing is painful! You very often need to not do things that you'd like to do or that deserve doing.

Quote: "A good idea is a good idea, but it may not be as good as other good idea." *Martin J. Drell, MD*

Note: A common problem with CQI (Continuing Quality Improvement), another JCAHO and ACGME favorite, is the tendency to attempt to improve too many things at once vs. prioritizing or staging the changes. Decide which improvements need to be implemented first or you will drive your faculty and staff crazy and burn them out.

Note: For those of you running or working in hospitals, JCAHO has many resources that can be accessed and used.

Note: The Next (and not so new) Accreditation System (NAS) seems very similar to JCAHO expectations for hospitals. The problem is that hospitals usually have more resources to comply with the requirements and the ability to "push back" than Academic Divisions have.

Habit: Be Proactive
Question: Are you proactive?

- "The best way to predict the future is to create it." ~ Dr. Alan Kay

- If you aren't proactive, someone else will be for you! (Nature abhors a vacuum!).

Question: Do you wait for your boss to run your Division or key aspects of it? (External locus of control vs. internal locus of control).

Question: Do you have enough time in your schedule to be able to be proactive due to increasing clinical demands? In these times in which one needs to earn more of one's salary by clinical work (n.b., The "kill what you eat" mentality, along with and the tyranny of administrative clinical demands for productivity – RVU's) or grants, one can find that they have no time to be proactive, much less to do things one values. You end up going from one crisis to the next.

Question: Do you function solely with the resources you were given or inherited upon your arrival? Many Division Chiefs never climb out of the small and restrictive boxes they were originally given, with lots of bitching and moaning about limited resources and being under-resourced and not loved by the boss (External locus of control). Did you inquire about these resources when you were being recruited? Is the limited resource a recent phenomenon? If recent, then why? Do you have a new boss with a different vision for the Child Division than your previous boss, or who wants to hire his own people, including for your position? Did something change in your area (n.b., like hurricanes, which are now due to climate change not just in the South) department funding due to numerous changes including recruitment, state budget cuts, department priorities, or department feelings about your leadership and/or your Division? Whose fault is that?

- Developmental Note: All large Divisions were small at one time! They do not leap forth full grown from the head of Zeus! How did they develop and expand?

- Is being bigger really better? Should your Division, at least at first, start with a specialty focus or should it be a "Jack of All Trades and Master of None?" (generalist focus?). Said another way, you should advertise whatever strengths your Division has?

- Quote: "The fox knows many things, but the hedgehog knows one big thing." ~ Isaiah Berlin

- I would add that child divisions usually have core duties that demand a certain number of faculty to cover them. A small or just beginning child division with very few faculty has a unique set of challenges, especially if they have a training program to manage. Often, clinical and training duties are prioritized.

- How rich is your community? Is there a tradition of giving to the medical school and/or your Department/Division? Are the community riches divided and directed to other competing Division's and programs?

More Comments on Public vs. Private: LSU is a public program. Many people assume they are already paying for public programs through their taxes. Thus, it is generally harder to get donations and there is less P.R. resources allocated. There is civil service to contend with. Are there unions? There also is tremendous overhead, which seems to increase as state budgets are cut and bureaucratic demands expand. The number of Deans and Associate Deans seems to increase exponentially. Most Medical Schools have recently added new Deans for equity and Title IX. This leads to higher overhead which makes academic personnel very expensive to hire. There are many differences/issues I never thought of when I was a young Division head.

It is becoming clearer and clearer that the culture, history, and standard operating procedures of public universities can disadvantage them from being successful in newer more business-like environments.

- What are the needs of your community? If you don't know what they are, how would you go about learning about them? Do you wish to meet these needs? Do you wish to meet some of them? If so, which ones? This necessitates further prioritization and pro-activeness.

- Who is the Governor greatly impacts public institutions. Republicans like to privatize, tighten budgets, and shrink the size of official government.

- The concept of public and private are blurring more and more over time. Think of the impact of the closing of State facilities to the public medical schools.

Habit: Be Proactive: Have you gone out and hustled up any new patients, grants, contracts, benefactors? Do you do any fundraising? Are you allowed to? Each medical school has their own rules about this. You will need to check these out.

Habit: Think win-win: Do you let anyone know that you're willing to help or want extra help? Remember, there's a CAP shortage in most places (law of supply and demand model). Note: The shortage statistics depend on what services and scope of practice CAP's are seen as performing, what they charge, and who else in the community is available to do the same services. Note: financial realities often trump quality issues (which are harder to quantify and quality).

Habit: Synergize: How involved are you in your communities? Do you know the key granting agencies for children/adolescents and their mental health in your area? Have you talked to their Executive Director and Board Members? Have you thought of having a community advisory board for support/advice/ connections for your Division? Are you on any community boards? Do you do any P.R.? Do you have anything worth advertising? Of course you do! Would you know how to do it? If someone asked you what you'd like money for, would you have a coherent answer/the elevator speech? Do you utilize social media? Have you checked your website? Do you have a Department Newsletter? Do you have the skills to create and/or improve a website or faculty (often younger) who do have these skills? That's what delegation is about (see attached handout on delegations).

Habit: Think Win-Win and Synergize: Do you have any collaborative initiatives? Think of using the Academy Advocacy and Collaboration Grants for AACAP Regional Organizations to further your goals.

- Often two heads or agencies are better than one.

- Granting agencies are in love with collaborations.

- Public-Academic and Private-Academic initiatives have been trendy for years!

Note: The new University Medical Center Hospital (that replaced Charity), is a public/private relationship and has more leverage than the prior Charity leadership

ever had as it was public and, therefore, mainly dependent on the State for funding and direction. The private partners can threaten and negotiate with the State in ways that Charity leadership couldn't.

Note: With collaborations come "conflicts of interest." Do you address these (transparency)? Conflicts of interest are becoming more and more important with each passing year. Remember: Conflicts of interest are inevitable and can't be totally stopped. However, they can and need to be identified and managed.

Habit: Seek First to Understand: Do you have the data you need to run your Division? One should think through the key data needed for each service. This should include what you want, as well as to know what the institution needs. This should include ACGME survey's, one's own survey's, feedback from child division meetings, meetings with individual faculty and institutional meetings. You should be able to answer questions given to you by your boss/bosses or to be able to get the answers quickly.

Quote: "The plural of anecdote is not data." Administrators, especially "bean counters," don't tend to respond to anecdotes. Can you validate what you want with data or what I call "the illusion of data?"

Question: Do you have a budget? Having a budget that you oversee is not always needed or desirable. If you get what you request from your department, then do you really need a budget? This system may be acceptable until money gets tight. There are always State budget adjustments, leadership changes, new sections that needs to be started and funded, or new "pet" or mandated projects that the Dean and the Department Head feel need implementing.

In reality, few child divisions truly have their own budgets and autonomy to do with them as they wish. What one usually has is an allotment of monies given to you after a "Top Down" process in which others (n.b., above you in the endless upwards hierarchy) define your priorities are and how they will be funded. Often you will be allowed certain autonomy (n.b., the illusion of autonomy) to deal with this pile of money (your allowance, so to speak). It would not be unusual for persons higher up in the hierarchy to impose or revise rules on what and how you can spend your money. I say higher ups, as there are many levels above your boss/department head, all the way up to the State and Federal Government. These rules proliferate and flow down from above "like manna from Heaven" and are usually less palatable and sustaining. It is not unusual for one level in the hierarchy to blame a higher level for changes.

In modern complex systems of care, you will often be involved in multiple such systems and their hierarchies. The leading candidates these days are Children's Hospitals. This means that you must learn the rules of the varying systems with their varying philosophies and priorities. The fact that insurance companies are so often involved further confuses, as does bad feelings between the various systems who seldom pay attention to past history, except for remembering all the bad things (n.b., the definition of Jewish Dementia: When you forget everything but the grudges).

My joke is that I never had a budget until something went wrong and I was suddenly in charge of fixing things. My bottom line has always been that if I am to have my own budget, I wish to have autonomy for its management and input into its construction (n.b., In reality, I wish to have the illusion or is that a delusion of control,

transparency, and a bottom-up approach). I am not stupid enough to ever think I truly have autonomy to do what I wish as child divisions are usually small entities in the larger overall systems.

Quote: "When the water buffalo's fight in the swamps, the frogs suffer," A Thai saying.

While setting guidelines of having "one's own budget," you are confronted by the reality that budgets are complex entities that you have not been taught how to do. The wish to know about budgets comes up every year in our Administrative Primer Sessions for New Heads of Child Psychiatry. Relax and take a few deep breaths. These are skills you can learn via reading *(see references)*, administrative courses, or on the job training with your department administrator if he or she is friendly, transparent, and wishes you to prosper. Some ambitious souls seek out MBA or Health Administrative degrees.

Regardless of one's anxiety dealing with budgets, they are "important and full of consequential details." One should confront the budget head-on rather than putting it off. A budget is one of those things it is best not to delegate away. It is an exercise like one's household budget that is often honored in the breach or delegated away. It shouldn't be. One needs to prioritize and make decisions as to what is necessary and what isn't. It is your spending plan. It is necessarily and helpful when dealing with the normal, self-interests of your faculty. Like your bosses, you will have to decide who to involve and how to involve them. Will your budget be done "Top Down" or "Bottom Up?" How much transparent will there be? How much will be allocated for the present and what will be allocated for the future investments or rainy-day funds? Can you have any surpluses roll over from year to year or does used monies return to the general budget or the Department, or the Medical School (use it or lose it)? How often and carefully will you track how things are going? All these decisions will be scrutinized by your faculty who, whether you like it or not, see you as a role model (for better or worse). Don't you want them to know your priorities and to be good stewards of their parts of the budgets?

As the budget process is, at minimum, a yearly exercise, you will need to decide how to add or subtract from the present budget. As it is easier to simply build on last year's budget and to change little (n.b., this causes bad feelings to those who get less than the previous year). I suggest that every once and a while you do <u>zero based budgeting</u> (n.b., I call it "etch a sketch" budgeting), which starts from zero and rebuilds the budget on the true realities of your system at that time. If not, you will be building in inefficiencies based on former priorities that may not be as important as the years go by. The zero-based budgeting process may be the time you especially want to involve your faculty in the process.

<u>Quote</u>: "I have some bad news and some good news. The bad news is that the State continues to cut its support to the Healthcare Center. The good news is that we have more money than ever, thanks to our faculties hard work in billable activities," *(the Dean)*. This quote led to a discussion of RVUs, their impact on well-being and promotion, what the goals of the medical school are, and why new entering faculty are getting more money than the more senior faculty.

Quote: "It's the system stupid." As I said earlier, a budget is not always needed, nor desirable. If you want a budget and get what you request from your department, do you have ample and adequate administrative support (administrative assistants, IT. equipment and support, offices, recruitment budget, etc.) to do it properly?

Note: <u>There is nothing more important than recruitment of faculty!</u> Have you worked out how you will go about recruitment? Are there adequate funds for such? How long will the recruitment/visit be? Will there be more than one visit? Who will be involved in the recruitment? How will the Department Chair be involved and at what points? Who will make the calls? Who will make the reservations? To which restaurants? Which hotel? Will there be a tour of the city? How extensive will be your background checks (n.b. If you don't make calls, you are looking for trouble -- "Act in haste: Repent at leisure." Did you Google the name of the recruit and see what comes up? Do you check social media? Have you checked out how their voicemail message sounds? How the recruit interacts with your administrative staff? How do you pay attention to the needs of the recruit's significant others/family? Moving expenses? Recruitment packages? Is there a job description? An organizational chart? If so, at what point is it presented to the recruit and is it then part of a negotiations?

- **<u>Note</u>:** Recruitment has been complicated by Covid, which has stopped "live" visits. This means that you will need to come up with a virtual equivalent that addresses all the issues already mentioned. It seemed clear that Covid will decrease the number of persons applying. Are you prepared for "live" interviewing again?

- It is my sense that Covid and political tensions has intensified regional tensions.

- Will recruits move to a Red State? To a state with low vaccination rates, anti-mask protests, or abortion bans.

- Will they move to a state or a city with a vastly higher standard of living?

- Just in case, why not check to see if there are parts of your state that qualify for national loan forgiveness. These are usually rural areas but can be for cities that have had natural disasters, such as hurricanes. New Orleans qualified for loan forgiveness after Katrina.

- **<u>Note</u>:** Can you hire someone to replace those that are leaving or is there a lag due to payment obligations to the former employee, (*<u>Examples</u>:* Often accrued leave time of the previous faculty needs to be exhausted before a new hire can start) or attrition related hiring freezes, or administration slowdowns to save money?

- **<u>Question:</u>** **"**Who will do the exiting faculty's work while they are on terminal leave? This usually means someone else needs to work harder, which is trickier these days due to work life balance issues and generational issues.

- Another problem exists in that many positions in Child Divisions are basically clinical positions that one most likely needs to fill locally (n.b., few will leave their current position in another city to work in a clinic or on an inpatient unit).

This especially effects smaller and more clinically focused Divisions and leads to only hiring local people, often one's graduates, which can lead very quickly to a lack of diversity in ideas (n.b., I joke that this inbreeding leads to weak chins and academic hemophilia) and can lead to gradual downward drift of research and scholarliness. **Note:** When you hire those you trained, you are hiring their transferences (good and bad) to you and your transferences to them! **Note:** The current downturn in recruitment into child psychiatry fellowships will hurt faculty recruitment for the future, especially for clinical positions that are so plentiful.

- Another factor impacting faculty wellness and recruitment is the reality that the ACGME and the medical schools are limiting the work that fellows formally did. This often shifts work to faculty. These changes pit the wellness of the trainees with those of the faculty!

- **Evaluating your Faculty:** Do you truly evaluate your faculty? Do you sit down on a regular basis with each faculty and highlight their strengths and weaknesses and what they should be focusing on for themselves, the Child Division, and your department? *(See attached "old" straight forward, user friendly LSU Faculty Review Form. It was replaced from above by a new more complicated version and process.)* **Note:** Most do not like to be evaluated. It makes them uncomfortable even if wedged in between positive remarks (n.b., the "sandwich method." I refer to it as the baloney sandwich method). Some younger faculty that was raised getting trophies and accolades for just showing up may be especially sensitive to evaluations.

- **Dilemma:** If you really cannot fire someone or have trouble hiring new people due to policies and procedures, real feedback can just make things more miserable for all. One needs to consider the consequences of your evaluations. The partial answer to this dilemma is to be a mentor (see attached handout) and focus on your relationship to the faculty, as well as strengths and areas of improvement vs. deficits. This takes social skills that I often lack, especially when I am stressed or angry (That damned amygdala of mine!) at the faculty member. I often remark that it seems I always need to finesse everything and "play the cards I have." Sometimes, I have been dealt lousy cards. (Note: I am a lousy poker player.)

- **Dilemma:** If you don't have evaluations that are truly transparent and reflect the strengths and weaknesses of your faculty, then evaluations often tend to be skewed to the positive. This causes dilemmas if you should ever need to or want to let someone go or not renew them. At that point, they will point out that they have had ten years of glowing reviews and accuse you of being biased against them or of having ulterior motives. In addition, your lack of feedback to your faculty may hamper their ability to work on areas they need to work on. The answer to this is to talk with HR about policies and procedures for dealing with problematic faculty before you have one or early on in the process when you do.

    - **Note:** The ACGME is demanding increasingly more "formalized" assessments of faculty and the program. I am especially concerned that "secret" surveys actually distort and complicate communications

and group dynamics, therefore making things worse (n.b., they can create vicious cycles). They assume there is mistrust and retaliation, which there often is, but not always. These are difficult times with much tension.

- **Quote:** "A friend stabs you in the front!"

- **Advice:** Training is so much more routinized, regulated, and computerized that you need to have a coordinator with enough time to handle the needs of your training director. Once you have one, be nice to and support them. A competent coordinator is now essential, despite their cost. They make for less grumpy training directors. Be nice to your program director. And to your institutional ACGME Dean and their delegated assistants.

- Do you have any say in your faculty's salaries and raises? Are salaries based on performance? If so, how is that performance measured? Or are your salaries standardized? Do some faculty get more money based on where they work (i.e., inpatient units generally pay more than outpatient clinics)? Inequality of pay can and will lead to faculty tensions.

  - **Question:** How transparent do you really wish to be? What problems do transparency bring about?

  - **Question:** How transparent do you really wish to be? What problems do transparency bring about.

  - **Quote:** "Never talk about your salary. You'll either find that someone makes more than you, which will be upsetting, or someone else will find out you make more than them, and they'll be upset with you." *Martin J. Drell, MD*. **Sub-quote:** "There are few secrets in academic facilities."

- **Communications:** Does your boss find out things before you do? Communication is something that is partially in your control! Do you tell your staff what information you want to know from them? I told my staff "I don't like surprises. I'd like to know anything that might impact the Division positively or negatively, especially rumors. Don't assume I know what you know. I am not a mind reader and often the last to know. What are the goals of such meetings? If you're giving me too much information or the wrong types of information, I'll let you know."

- How often do you meet with your staff? In what groupings? What are the goals of such meetings? To communicate what's going on, explicate goals, and facilitate implementation of these goals (synergize). When you meet, is there an agenda? Are there minutes? Who are the minutes distributed to? Is there a "To Do" list that is created at each meeting, which becomes part of the agenda for the next meeting?

  - **Note:** The closure of my hospital, which was the central location for many staff and activities, caused a diaspora of my staff to several distant sites with increased problems with holding meetings (how often

and where) and communication problems. It appears that many divisions have faculty at many different sites. Because of this, one needs to address how and where to have faculty meetings (Zoom, Skype, conference calls) and "get togethers."

Quote: I'd rather tell you what's going on and have you anxious than not tell you and have you paranoid." *Martin J. Drell, MD*

Question: Do you follow through on what you say you will? Poor execution is often a killer. It kills trust and undermines respect and integrity.

Question: Do you return your emails and calls in a timely manner? Can you afford not to? I tell my staff that if I have not responded back in three days to assume I didn't get it and they should re-contact me.

Quote: The reason that University politics is so vicious is because the stakes are so small. *Henty Kissinger*

Note: Do you pay attention to confidentiality and content issues of you and your faculties communications and the fact that what you say in your emails and via social media is easily transmitted and discoverable? Do you know that the Federal Government has ruled that your medical school's email system is owned by them and not you? Repeat of previous sub-quote: "There are few secrets in academic facilities."

Question: Do you ever ask for a consultation or help? Do you have a mentor (see attached)? **Note:** It is often lonely at the top, especially when you need to maintain boundaries. This often deprives you of people to talk with. Can you talk with your head? Someone else in the community? Why not call one of the members of the AADCAP? If you ask someone and they don't call back, call someone else who will. **Note:** Be on the lookout for a new mentor program that is currently being formulated by the Emeritus Committee. **Note:** Also consider using the AADCAP list serve to ask questions. I really value a small group of national friends, especially when things are going badly. You often just need someone to talk to. Come to meetings? Submit questions for the oft held (n.b. before the virtual meeting) consultation segment of the Annual meeting? Read the business literature (n.b., Covey's *Sharpen the Saw Habit*).

Repeated advice: When things are not going well, stop and go over the 7 Habits to see which of the habits you aren't performing. The propensity is to become mired in crises, trivia, busywork, meetings, timewasters, emails, non-priority issues, to micromanage, to have your personal life distract you, to not delegate properly, to do things yourself that others could do (enabling), to do more of the same, etc… and to neglect the basics.

ACTIVITY MATRIX

URGENT	NOT URGENT+
I Crises Pressing Problems Deadline-driven projects, meetings, preparations	II Preparation Prevention Values clarification Planning Relationship building True re-creation Empowerment
III Interruptions, some phone calls Some mail, some reports Some meetings Many proximate pressing matters Many popular activities	IV Trivia, busywork Some phone calls, Time wasters "Escape" activities Irrelevant mail Excessive TV

Note: Try and optimize box II *Covey, 1989*

Comment: Concerning the times: As one ages (and that occurs quickly), one needs to deal with accrued change within yourself (or lack of it), as well as changing expectations. A senior faculty is often interacting with two or three generations of faculty and trainees. An LSU faculty member is in a leadership position, stated that the medical schools didn't quite know what to do with the millennials. When he said this, in my mind I thought, "Yes, you do. You capitulate to them!" I would add that one should be systemic and add that the millennials, likewise, do not know how to deal with the senior faculty. Although it is ridiculous to stereotype and lump all millennials together (or any generation for that matter, including your own) it has been my experience that some younger faculty and trainees have trouble working within our existing systems, especially those that are hierarchical, like most medical schools. Add to this: political correctness, the concept of psychological safety (see below), the vicious political divide in our Nation, 1st Amendment (freedom of speech), rights in general, and specifically in academic settings, trigger warnings, invited speaker boycotts, implicit bias, work/life balance, racism, ageism (perhaps this is "No Country for Old Men), issues of diversity and inclusion, identity politics, the issue of "perceptions," the striving for equality/equity, white privilege and white fragility, Titles 7 & 9, the "me too" and Black Lives Matter movements, the fact that many medical school classes and fellowships are now majority female, social media, gaslighting, imposter syndrome, and the steady increase in bureaucracy with the help of computerization (see quote below), and you realize there are a dizzying array of potential issues to consider and deal with. The challenge is to be aware of these serious issues and create of psychologically safe culture in which they can be respectably discussed, acted upon, and worked through. I assume that younger Division Heads may have less troubles with many of these issues (especially ageism), but I doubt if they are totally immune. I assume also that with time, the younger

heads will quickly age out of their "younger" status, and in the future become involved in such issues that are part of the current academic life cycle, as well as their own family life cycle.

Quote: "Civilizations in decline are consistently characterized by a tendency towards standardization and uniformity." Arnold Toynbee, Historian (1889-1975).

Attachments:

1. Brief Biography
2. Maslow's Hierarchy of Needs
3. A Note on Psychological Safety
4. A CBT Interpretation of Covey's 7 Habits.
5. A Personal Case Study.
6. Entering Systems
7. Change
8. How to Run a Meeting.
9. Delegation
10. Mentor Column (Trying to be a Mentor Can Be Tormenting)
11. Implicit Bias (Parts 1& 2)
12. Curriculum Planning
13. Being Systemic.
14. Sneetches
15. Trending Issues: Burnout and Wellness (Part 1)
    Fluffiness and Why This Follow-up Column to My Previous Column on Burnout is Not on Wellness as was Promised (Part 2)
16. An Impostors Take on Impostor Syndrome
17. Gaslighting - Casting a Light on a Familiar Phenomenon
18. Say the Right Thing—Yoshino and Glaskow (Book Review: 2023 Owl's News
19. LSU Faculty Evaluation Form (Now replaced by a longer form)

Attachment 1: Brief Biography

Dr. Martin J. Drell is the Carl P. Adatto, M.D. Professor of Community Psychiatry at Louisiana State University (LSU) Health Sciences Center in New Orleans. He initiated the current Child and Adolescent Psychiatry Program at LSU in 1987 and was its Head until 2017. He has been a Training Director several times in his career spanning back to when he was at the Baylor College of Medicine in Houston. He is a Clinical Professor of Psychiatry. He is a past President of the American Academy of Child and Adolescent Psychiatry-AACAP [2013-2014], as well as past President of the Society of Professors of Child and Adolescent Psychiatry-SPCAP (now the American Association of Directors of Child and Adolescent Psychiatry-AADCAP [1996-1998], and the American Association of Directors of Psychiatric Residency Training-AADPRT [2001-2002]. For the last nine years, he has been a consultant to DCFS (Department of Family Services) and involved in issues of the diagnosis and polypharmacy in children/adolescents in foster care. He is currently editor of two Newsletters (for the AACAP Owls and for the AADCAP). He has lectured and written numerous articles on clinical issues, including infant psychiatry, ethics, consultation/liaison, and systems of care, polypharmacy and diagnosis in foster care, management of disasters, administration, and the teaching of psychotherapy. Newer projects concerning the teaching of psychodynamic psychotherapy include the AACAP Psychodynamic Faculty Training and Mentorship Initiative and the AACAP Leatherman-Drell-Ritvo Endowment Fund for the Advancement of Psychodynamic Understanding and Psychodynamically Informed Child Therapies both of which he helped initiate and which he continues to be a member of it's leadership Team.

Attachment 2: Maslow's Hierarchy of Needs

Attachment 3: A Note on Psychological Safety:

Timothy Clark in his 2020 book, *The 4 Stages of Psychological Safety*, which is written for industry, says that the goal is to create an environment in which people feel safe from embarrassment, marginalization, and/or punishment. He describes 4 progressive stages:

Stage 1: Inclusion Safety: Where people feel accepted and included.

Stage 2: Learner Safety: Where people feel safe to learn, interact, and ask questions without problems.

Stage 3: Contributor Safety: Where people feel safe to contribute as full-fledged members.

Stage 4: Challenger Safety: Where people feel safe to challenge the leadership, the team, and the status quo.

This book seems to answer the questions asked as to what to do with the changing times. It specifically addresses what leadership needs to do or what they can do to reduce tensions and increase productivity and innovation.

Attachment 4: CBT Interpretation of Covey's 7 Habits

From: The Great Courses course: Cognitive Behavioral Therapy: Techniques for Retraining your Brain. Jason Satterfield, PhD. 2015.

Habit 1: Be Proactive: Realize that your decisions are the primary determining factor for effectiveness in your life. Take responsibility for your choices and the consequences (i.e., have an internal locus of control).

Habit 2: Begin with the end in mind: Self-discover and clarify your deeply important character values and life goals. Envision the ideal characteristics for each of your various roles and relationships in life.

Habit 3: Put first things first: A manager must manage his or her own person. Managers should implement activities that aim to reach the second habit.

Habit 4: Think win-win: Have genuine feelings for mutually beneficial solutions or agreements in your relationships. Value and respect people by understanding that a "win" for all is ultimately a better long-term resolution.

Habit 5: Seek first to understand then to be understood: Use empathic listening to be genuinely influenced by a person, which compels them to reciprocate the listening and take an open mind to being influenced by you. This creates an atmosphere of caring and positive problem solving.

Habit 6: Synergize: Combine the strengths of people through positive teamwork to achieve goals no one person could have done alone.

Habit 7: Sharpen the saw: Balance and renew your resources, energy, and health to create a sustainable, long-term, effective lifestyle. It primarily emphasizes exercise for physical renewal, prayer (meditation, yoga, etc.), and good reading for mental renewal. It also mentions service to society for spiritual renewal.

Attachment 5: A Personal Case Study ("All politics are local" – Tip O'Neill)

Governor Bobby Jindal privatized all of the healthcare and mental health care in Louisiana. This led to massive chaos in medical schools that were predominantly focused on Charity Hospital for its clinical rotations and stipends. My Child Psychiatry Division's main facility, NOAH, was closed. In a short period of time, the State Office of Mental Health delegated its former mission to regional districts. Our District was just starting when Hurricane Katrina hit. Pre-Katrina, NOAH took care of public sector seriously and emotionally disturbed children and adolescents. Because of this, the District focused on adults. When NOAH closed after Katrina, the District did not pick up Child and Adolescent SED services, so the State Office of Mental Health took over those services temporarily. Shortly after, the State carved out Medicaid psychiatric services to Magellan. The District then took charge with the obligation of having to provide non-Medicaid (i.e., indigent) care, which is a small group of children and adolescents. There is now more competition for Medicaid population, a formerly not so attractive population in the eyes of many. Two years ago, the state announced that they are not renewing Magellan's services and are moving (un-carving) mental health services to the five existing previously privatized systems for Medicaid care. We are now in an uncomfortable transition period made even more uncomfortable by impending cuts due to continuing Louisiana's state deficits predicted for the next fiscal year. To further confuse, the new Democratic Governor has agreed to take Obamacare funds, which will increase healthcare monies.

During this time, I moved from being Clinical Director of NOAH (a 22-million-dollar facility) that was the core of my Division to not being Clinical Director and not having a core of my Division. This led to much broken field running. We transferred our inpatient rotations to Children's Hospital (a not-for-profit hospital, which has higher service expectations and is more business-like). My goal is to have a core continuum of care at Children's, like I had at NOAH, but this has been and remains a slow process. To complicate matters, at present I am now little involved at Children's. My faculty that was centralized at NOAH is now "all over" on multiple, often short-term contracts with more clinical expectations. There are now multiple allegiances and multiple bosses. While everyone is working harder and state funding decreases, the training standards increase. In the long run, the challenge will be to figure out how, at age sixty-nine, to find a new leadership style to deal with the new reality of constant changes (some good, some bad) while dealing with the narcissistic injury of not overseeing our core facility or President of the Academy. In the short run, a big concern is how I will get my faculty to attend my monthly Child Division meetings, which are more and more important, as they are the only time the faculty ever gets together.

On a positive note, there have been several changes at Children's Hospital, including leadership positions that have the hospital more interested in child psychiatry and mental health issues. This has led to several expansions in services that have allowed the Division to hire new faculty, which is delightful.

Comment: Post Katrina, I was constantly confronted with worthwhile federally funded projects that would be good for the children and adolescents of Louisiana. I could drive my Division and myself crazy pursuing them. When is enough enough? When does expansion endanger the "coreness" of your Division? There is a cost to expansion. I prioritize clinical programs and sites that meet the academic goals for

my Division, as identified in my formal and informal strategic planning. Despite this, there are some things you have to do for various reasons, including the wishes of the state, your medical school, and your boss.

It is even more complicated when you are in situations where you are tempted to do things for competitive reasons or are not so subtly threatened or played off against one's competitors (n.b., if you don't do this, we'll give it to your competitor).

- **Example:** Post-Katrina, we received monies from various sources to run clinics that saw "everyone" who needed it. After these grants ended, we were confronted with lots of existing patients, a "we take everyone" culture, and drastic cuts in resources to do these "good deeds." Altruism is a much easier if you are paid well for being altruistic!

Note: A post-Katrina problem occurred when projects pursued by the Department that involved child/adolescents clashed with Division initiatives (*Example:* at one-point, Post-Katrina, I had 9 outpatient clinics in existence that often used the same overlapping staff and residents).

Attachment 6: Entering Systems **Martin J. Drell, MD**

Preface: *Entering a system in a new role is an art. When I was about to take over as President of the AACAP, I wanted to convey my administrative aspirations to the senior staff. A special time was set aside for my meeting with them. The time included a time for Q & A. This handout was prepared for this meeting. As you can see, it was heavily influenced by my handout for the AADCAP Roundtable for New Directors. It was subsequently sent to all staff and given to new staff as they were hired.*

My Administrative Aspirations

As I embark on my Presidential years, I thought it might be helpful if I shared with you my administrative biases. What I will talk about is how I think I should act. This does not necessarily totally coincide with how I do act. Because of this discrepancy, I would like you to assist me to act more like how I think I should. I hope that you will keep me honest and as effective as I can be.

I believe that the job of an administrator is to get things done with and through other people. If asked how best to do this, I generally refer to Stephen Covey's 7 Habits of Effective People, NY: Firestone (Simon & Schuster), 1989. He proposes that to be effective, we should pay attention to the following 7 Habits:

- **Be proactive:** Take the initiative. Create one's future rather than have others create your future.

- **Begin with an end of mind:** Set goals of where one wants to be. To do so greatly assists one in planning what to do.

- **Put first things first:** Prioritize what one does.

- **Think win-win:** When working with others, think of strategies that allow all parties to gain. This is different than a "win-loss" model in which there is always a loser. Ronald Reagan said, "You can get anything you want as long as you are prepared to not take credit for it."

- **Seek first to understand, then to be understood:** Be an active listener/learner and pay attention to what other parties want and need. Take the time to gather the appropriate information needed concerning what you want done. Let others get their point across first. (Try to understand their point and their frame of reference.)

- **Synergize:** I believe that 2 heads are better than one and that cooperation and teamwork usually lead to better results. Valuing differences really drives synergy.

- **Sharpen the saw**: Take care of yourself and your physical, social/emotional, mental, spiritual and intellectual needs. Renew yourself and continue with life-long learning.

Having put these 7 Habits forth, anyone who knows me knows that I am better at some of these habits than others. In fact, few leaders are good at all of these. I try my best and compensate for my shortcomings by having the belief that it is the job of the entire leadership team to approximate the 7 Habits via people with other strengths complementing or making up for the weaknesses of others. The whole (of the executive team) should add up to more than the sum of its parts. There are many duties and certain activities that would be better for others to do besides me.

Covey also has a **Time Management Matrix**:

THE TIME MANAGEMENT MATRIX		
	URGENT	**NOT URGENT**
IMPORTANT	**I** **ACTIVITIES:** Crises Pressing Problems Deadline-driven projects	**II (The Key Box)** **ACTIVITIES:** Prevention, PC activities, relationship building, recognizing new opportunities, planning, recreation
NOT IMPORTANT	**III** **ACTIVITIES:** Interruptions, some calls, some mail, some reports, some meetings, proximate pressing matters, popular activities	**IV** **ACTIVITIES:** Trivia, busy work, some mail, some phone calls, time wasters, pleasant activities

Covey, 1989

This matrix suggests activities that leadership should focus on and prioritize. It also suggests activities that are "time drainers." It suggests that we should avoid the lure of never-ending crises management, interruptions, and focusing on low priority projects. If this is what we end up spending your time doing, then we need to think through what is going wrong.

Having said that, I will offer more individual and personal knowledge about my administrative biases:

1. I have a belief in the necessity and helpfulness of policies and procedures. They clarify how things should be done. To not have them promotes confusion and mischief, impedes training and orientation, promotes the creation of unique and often contradictory policies by staff, and leads to wasteful discussions and actions regarding how things should be done that are based on people's faulty memories or their self interests. Please note that there are chances for all the above problems to occur even with well written policies – just less chance.

2. I think that there should be serious thought to what the President does and doesn't do. I believe that there are things that absolutely necessitate the President's involvement; however, there are several things that the President is involved in that he/she doesn't need to be doing. Please be protective of the President's time and clear about his/her priorities. Ask: "Why is the President doing that?" Does he/she need to? Can someone else do it better than the President?

3. As much as possible, things need to be delegated to lower levels in the organization.

4. As much as possible, all activities proposed should be carried out by existing components. We should always think which components are in place that can and should be used to get something done before creating a new component to do it.

5. A good idea is a good idea, but it may not be as good as another good idea (i.e., the need to prioritize and be good stewards of our limited resources). We can't (and God knows we try to) do everything, especially in times of recession. Sometimes we need to say no to things or to prioritize. Not everything can be done at the same time.

6. Collaboration/cooperation is good. We can't afford not to collaborate/cooperate in this day and age. To have numerous components or organizations expending energies doing the same things may not be the best way to go. If someone else is doing the same things, think whether we should liaison with them and cooperate. I know that this doesn't work sometimes, but it is worth the effort. I also know that there are times when we need to do things ourselves, even if others are. That is fine. It is; however, important to at least ask the question and decide which things need to be done ourselves.

7. I think that we should constantly try to educate our members and ourselves about what we do. "One shot" education is often not as effective as multiple attempts. I believe that if things are going well, the administrator's job is mainly education.

8. I am generally in favor of transparency. I have been known to say, "I'd rather people know what's going on and anxious than not know and be paranoid." I believe that secrets are hard to keep and generally become known. Assume that it will become know. I would prefer that major issues be dealt with "on stage" vs. "backstage."

9. I am much better at identifying problems than solutions. Likewise, I am much better at asking questions than figuring out solutions. If I have a question, don't assume that I have an answer. But "a well stated problem is a problem half solved." Charles Kettering, inventor, and engineer, 1876-1955.

10. I believe that "the group" generally comes up with better answers than an individual (back to the importance of teamwork and teams).

11. I am a "gradualist" who tries to improve processes (continuing quality improvement). I am less good at making "bold moves."

12. I generally feel that it is the job of leadership to make sure the organization is prepared for what will occur. As the head nurse at my hospital said: "Piss poor preparation leads to piss poor performance." Another quote that comes to mind is "Act in haste. Repent at leisure."

13. My goal is to continue the tradition of having the vast majority of decisions decided by collegial discussion and consensus. I am not a big admirer of Robert's Rules of Order, which are not mandated in our bylaws. From my sense, Robert's Rules was created to deal with contentious groups and is set up so that minority opinions are listened to and not suppressed. If we get to the point where we need Robert's Rules of Order, or when people are yelling at each other. I believe it is time to slow down and figure out what is going on, especially as we are all psychiatrists. "When in doubt, do what you think mature people will do." I do not like it when discussions are high jacked by the person with the best grasp of the nuances of Robert's Rules, especially as there never seems to be a parliamentarian or member without a conflict or interest to arbitrate as to whether the rules are actually being followed. I believe that in such cases, the rules end up subverting their original mission.

14. Quality Improvement should always be part of all that we do. However, if we try to improve everything all at once, we will drive ourselves crazy. Thus, quality improvement projects need to be prioritized.

15. Strategic planning should always be part of all that we do. To only have strategic planning done as part of a specifically planned, every 5-10 years event is counterproductive. Such special plans should be carefully thought through and should add to the day-to-day strategic planning already being done.

16. Hiring consultants is fine in specific circumstances in which we do not have specific expertise and skills. The hiring of consultants should only be done after extended discussions of why we can't do it ourselves. To have a consultant do something we can do ourselves undermines morale and often is not as effective because we know our system better than the consultant. Consultants are costly.

17. If I know what I want to say, I am generally succinct and clear. If I am not succinct and clear, assume I am still working on the issue.

18. I think as I talk and often repeat myself. This is how I think things through. Do not assume that I am getting at something specific (note: per #13, if I know what I want, I'm usually clear with my request). Likewise, I think by writing emails and lists of questions.

19. I am not the best at not interrupting what people are saying. This is impolite, but I do it a lot (ADHD, narcissism, impulsivity, poorly myelinated frontal lobe, free association). Forgive me. You can always say you'd like to finish.

Generally, I am listening and will get back to the subject at hand. If I do get off track for longer than usual, redirect me.

20. If I'm being unclear, please tell me and ask questions. I have no wish to be unclear. Know also that I am often defensive and upset when confronted, but usually calm down. I would rather do right for the AACAP than do what I feel is right (especially if this is, in reality, wrong)

    Quote: "We should not write so that it is possible for the reader to understand us, but so that it is impossible for him to misunderstand us." Quintilian rhetorician in "De Institutione Oratoria" (c. 95 AD) Book VIII, 2, 24.

21. I am not the best at compliments. I try my best, but this part of my frontal lobe lacks myelination. Do not expect compliments and do not be upset by the lack of them. In general, no news is good news.

Attachment 7: Change

- **Quote:** "The trouble with the future is that it usually arrives before you're ready for it."

- Change is a part of everyday life and inevitable.

    - It is the basis for development. Development assumes change!

- **Quote:** "In a fight between you and the world, bet on the world." *Franz Kafka*.

- Need to consider change from the standpoint of the "changer" (leadership) and the "changed" (staff), although **all** are in the "changed" category. Good organizations need good leadership and good fellowship.

    - **Note:** Make sure that the change is necessary and that the outcomes outweigh the costs of staying the same. Change for change sake is **not** what we're talking about.

- If there is change, there will be resistance. This is a given and needs to be understood and dealt with.

- Resistance takes many forms and has many themes:

    - Change means giving something up.
    - People like the comfortable status quo (ostrich syndrome).
    - Change lead to glorification of the past.
    - Change introduces uncertainty and therefore anxiety.

- **Note:** Anxiety is not necessarily bad.

    - Some resist change out of personal or interpersonal issues.
    - Catastrophizing
    - Come legitimately feel change will be bad. Is this a rationalization to deal with anxiety?

- You will need to be patient, a good communicator, a good listener, understanding, and persistent.

- Change is a process.

- How has this process been conceptualized?

- **Who Moved the Cheese** – Spence Johnson, MD (1998)

    - Change happens
    - Anticipate change
    - Monitor change
    - Adapt to change quickly
    - Change
    - Enjoy change
    - Be ready to change again

- **Leading Change** – John P. Kotter (1996)

    - Establish a sense of urgency.
    - Create a guiding coalition team that can and will get the work done. Get their commitment and empower them.
    - Develop a vision and strategy. It needs to be imaginable, desirable, feasible, focused, flexible, and communicable. Write it down and distribute it. Break it down into small reasonable doable tasks. Be clear whose job it is to do what.
    - Communicate the change vision – over and over.
    - Empower employees for broad based action.
    - Generate short-term wins.

        - Deal with short term losses and resistance.

    - Consolidate gains and produce more change.
    - Anchor new approaches in the culture. Create a culture of change or acceptance of change. Create an entrepreneurial can do spirit.

        - **Quote:** "Don't tell me what you can't do. Tell me what you can!"

- **Note:** Often need to switch from external locus of control bunker/ mentality to more proactive internal locus of control mentality.

- **Quote:** "Most failing organizations developed a functional blindness to their own deficits. They are not suffering because they cannot solve their problems. They are suffering because they cannot see their problems." *John Gardine*

- **Quote:** "The real difficulty in changing the course of an enterprise lies not in developing new ideas but in escaping old ones." *John Maynard Keynes*

- Each person needs to become a change agent and choose to:

    - Control your attitude.
    - Take leadership of change.
    - Chose their battles carefully.
    - Be tolerant of management mistakes. They are human too and dealing with their own anxieties and problems with change. We are all middle managers. We all have bosses.

- Keep a sense of humor.
- Don't let their strengths become weaknesses.
- Manage their stress with stress management.
- Support higher management.
- Invent the future instead of redesigning the past.

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Attachment 8: How To Run A Meeting

1. Discussion about meetings:

    A. The function of meetings:

        1. Passing information.

        2. Reviewing works in progress.

        3. Problem solving.

        4. Social

        5. Gathering support.

        6. Motivating

    B. Common problems encountered with meetings:

        1. What are these meetings for?

        2. What a waste of time and money! I could use the time to do other things.

        3. There's not enough time to get everything done we need to.

        4. Who's in charge? Politics, power, and privilege.

        5. They never start or end on time.

        6. We can't do this because so and so needs to be here and isn't.

2. Guidelines for improving meetings:

    A. The importance of planning and preparation ("Piss poor planning leads to piss poor performance").

    B. Before the meeting:

        1. Decide whether the meeting is necessary? Are there other ways to get what needs to be done done?

        2. Set goals.

        3. Decide who is needed at the meeting.

        4. Consider a formal agenda.

        5. Select the appropriate time and place.

6. Make sure the room and physical necessities are available (Is the room available? Will A/V enhance the meeting? Issues of food, etc.)

7. Do the participants need to do anything or receive anything before the meeting?

8. Who should run the meeting?

9. Decide if minutes are needed? If yes, then what will be the format (see attached), who will take the minutes, and who will be responsible for typing and distributing them?

   Note: I prefer that minutes include action items for each item discussed. If done skillfully, the action items become the core agenda for the next meeting.

C. The meeting proper:

1. Start on time.

2. If there is an agenda, send it out to the participants ahead of time with data and suggested solution plans.

3. If there is an agenda, stick to it (keep the focus!).

4. Start the meeting with a brief summary of the goals for the meeting.

5. Keep the meeting moving. Maintain order. Expect results/ decisions.

   Note: It may help to reframe problems as issues or challenges.

   a. The problem stated with pertinent data presented (warts and all!).

   b. The problem is analyzed to discover pertinent dimensions and implications.

   c. Possible solutions are raised without regard to the merits of the merits of the particular solution. Avoid premature closure at this point.

   d. Solutions are analyzed for their feasibilities (the pros and cons of each are raised).

e. Focus on what can be done versus what can't be done (internal locus of control).

f. The best solution is chosen.

g. Discussion on how to put the solution into action including barriers to implementation to be dealt with.

6. Involve as many persons as possible, making sure they get to the point.

7. Ask people to speak clearly and audibly.

8. Continually review goals and summarize what has gone on as the events unfold point.

9. Deal with problems in an orderly manner.

10. In position as a meeting leader, differentiate and choose wisely between your varied roles as leader (initiator, opinion giver, elaborator, clarifier, tester who raises questions to test where group is, and summarizer).

11. Know when and how to end the meeting. Remember that most administrative meetings are not psychotherapy sessions and, therefore, do not need your psychotherapy skills.

    a. There's no rule you have to go on until the times up.

    b. Don't rush decisions in the interest of time (act in haste, repent at leisure), ask whether there should be another meeting to continue on this point.

       Note: Think through; however, why a decision has not been made. Is it because a decision doesn't need to be made? Was the decision bumped because there were more important decisions to be made? Can it wait until the next meeting? Is there a price to be paid by delaying the decision?

       Note: You should differentiate progress from process at meetings. Action is often slowed by an overemphasis on process, empowerment, consensus, and perfection. If a decision needs to be made and you don't have time to build consensus or you feel you won't get to consensus, then what can be done? You can make decisions based on less than consensus (say 70%). This allows the group to deal with the "naysayers," the OCD, the ODD, those lovers of the status quo, or the powerful minority that, for whatever reasons, can stop/slow any project/plan regardless of its importance or need to get done. The

perfect is sometimes "the enemy of the good" and can lead to inaction.

c. Summarize your perception of what occurred at the meeting, as well as unfinished issues. Check these perceptions with the other participants.

d. If necessary, set future meetings and goals.

3. End the meeting on time.

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Attachment 9: Delegation

1. *What is delegation?*

   The shortest definition I could find was *delegation is the assignment of tasks and/or goals to others.* Most authors added to the definition the fact that the "authority" to get the task done goes with the delegation.

2. *What is logic of delegating?*

   a. Most references speak to issues of how the act of delegation can help the delegator, the delegates, and the overall organization.

   b. The virtues of delegation:

      - Delegation multiples your productivity.
      - Delegation promotes managerial flexibility.
      - Delegation is a primary aid in time management.
      - Delegation allows your subordinates to grow. You are teaching/coaching potential managers for the future.
      - Delegation, if done correctly, can improve interpersonal communications.
      - Delegation can improve the moral and self-esteem of subordinates.
      - People who are stimulated at work tend to have enhanced job satisfaction.
      - Delegation can improve trust and confidence.
      - Delegation can promote organizational efficiency (two heads are better than one).
      - Delegation facilitates decentralization and diversification.
      - Delegation allows one to have a better idea for the skills of those that one works with.

3. *Why don't people delegate more if it is such a wonderful thing? (resistance, barriers, and fears)*.

   a. Preference for doing things yourself. The joy of doing things you know how to do versus more anxiety provoking things.

   b. Uncertainty about what needs to be done, how, and when.

   c. Lack of prioritizing what is important and what is not.

   d. Comfort with confusion or skillful use of confusion.

   e. Fear that the job will not be done to your "high standards." The reality is that there is usually more than one way to get the job done. It is probably better to adopt a "batting average" theory versus a model based on perfection.

f. Fear that if you give up your work, you will have nothing to do. If this is indeed true, then someone would be looking at the overall work to be done.

g. Fear you will be seen as lazy.

h. Fear you will be seen as a bestowal of "dump jobs."

i. Poor interpersonal skills, poor communication skills, fear of confrontations, involved in delegating, and fear of rejection from subordinates.

j. Fear that your subordinates will learn your job and replace/surpass you (insecurity).

k. No one to delegate to who has the skills, time, or willingness. Consider hiring someone or evaluate how you are going about things. Is your shop efficient? Are you training and orientating appropriately? How are your relationships with your subordinates?

l. No time to teach someone how to do the job (that is probably exactly the time to do it).

m. A bad experience with delegation in the past? I won't let this happen to me again!!

4. *What to delegate?*

A. A "continuum concept" in which you divide what you do into the following categories:

1. Things you **must** do:

- Rituals and ceremonial duties that depend on your position.
- Policy making
- Specific personnel matters like performance reviews, evaluation, disciplinary incidents, praise, conflict resolution.
- Crisis
- Confidential issues.
- Things your boss wants only you to do.

2. Things you **should** do, but someone could help you with.

3. Things you **could** do, but someone could do if given the task.

4. Things others **should** do, but you can cover in an emergency (to help them develop and learn new skills).

5. Things others **must** do, (things that the subordinates are expert at or could do better than you).

Please note: For categories 2-5, you need to consider whether your subordinates are trained or not in the specific duties you are considering for delegation.

B. Things that you might consider delegating:

- Routine tasks.
- Tasks that are mandated to be done by the institution.
- Trivial tasks (things of this nature may not be necessary to do in the first place).
- Specialties in which others have expertise.
- Pet projects (that don't represent the best use of your time. Often these are jobs from the past that you are reluctant to party with).

5. *Who to delegate to?*

A. Need to know your people so that you delegate to the right person for the job.

B. Consider potential goals:

- To get the job done (usually the case).
- To develop a subordinate.
- To evaluate a subordinate.

C. Questions to ask:

- Does the person have the skills?
- Does the person have the time?
- Does the person have experience?
- Does the person have the personal qualities needed for the job?
- Consider any potential political or systemic ramifications of delegating to one person versus another?
- What is this persons past performance in similar tasks?

6. *The process of delegation*

A. Make the decision that you wish to delegate.

B. Define the job/task to be done (and what isn't to be done).

C. Decide what authority is necessary do to the job.

D. Select the person that is appropriate for the job.

E. Appropriate negotiations with the selected person.

This should include:

1. Descriptions of the job (with chance for mutually negotiated changes in the description to meet the needs or to accommodate to the ideas of the subordinate).

2. Description of why the job is important (how does it fit in the larger scheme of the organization).

3. Why you chose this person.

4. What might be the benefits and problems should the job be taken.

5. Ideally, the subordinate should be able to refuse the job with no reprisals.

6. Description of results expected, including specific requirements or timelines, feedback, controls, reports, review, and supervision. There should be **no** surprises!

F. Carry out what is agreed upon in the negotiations, sticking to the guidelines set up. Renegotiate changes as necessary (mid-course corrections).

G. Don't forget positive reinforcement and praise if the job is well done. Do not take credit for their achievements. If they fail, take the blame yourself as the "accountable party." Analyze why the delegation failed and the task wasn't completed as desired. Learn from your mistakes and re-adjust as possible.

H. Remember that the process is impacted on by the following issues that can be addressed:

- Who you hire.
- The policies and procedures of your organization.
- The practice routines of your organization (the standard of care).
- How you orient people.
- How you train and supervise people.
- The interpersonal environment/politics of your organization.

7. *Who said this?* "Surround yourself with the best people you can find, delegate authority, and do not interfere as long as the policy have decided upon is being carried out."

Answer: Ronald Reagan: "What Managers Can Learn from Manager Reagan," Dowd, A.R.: *Fortune*, September 15, 1986, pp. 33-41. This was less than a year before the Iran-Contra scandal.

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Note: All of these books or similar books are available in the "Business" section of major bookstores. Business books are a growth industry with new books coming out each month. Most of these books have something on delegation and are fairly interchangeable. Other than the book by Jenks and Kelly, you probably don't need to pursue this topic in the other references. My handout is a compilation of the above articles and is fairly complete.

Attachment 1

April 2017 AACAP Owls News

Trying to be a mentor can be tormenting

A mentor is a person who guides a less experienced person by building trust and modeling positive behaviors. An effective mentor understands that his or her role is to be dependable, authentic, and tuned into the needs of the mentee. The term comes from a character in *The Odyssey* named Mentor, who is the friend of Odysseus and entrusted with the care of Odysseus' son, Telemachus when Odyssey goes off to the Trojan Wars. To complicate matters, Athena, the Goddess of the arts, reason, wisdom, heroic endeavors, and the womanly arts, often appears in the guise of Mentor to aid both Telemachus and his father.

Martin Drell, MD

Have you ever begun a project that you thought would be simple and then suddenly it wasn't? Well, that's what happened with this column. It started out as a simple column on mentoring. The idea was triggered by an Eriksonian 8th Stage life review that led me to a resolution that I'd like to spend more time mentoring. This sounded like a great thing to do! It also seemed a great idea for a column, as mentoring is one of the main identified duties of the Owls.

As I prepared to actually write the column, I tried to remember the psychosocial crises of the 8th Stage. I was pretty sure it was "generativity vs. despair" with generativity, a synonym for mentoring. When I went to check, it turned out that I got the "despair" part of the dichotomy right, but noted that "generativity" was from the 7th Stage of Adulthood and not the 8th Stage, which is "integrity vs. despair."

I then looked up the definition of generativity, which is defined as the process of assisting the younger generation in developing and leading useful lives. That is what I resolved to do in my 8th Stage! I took consolation in the fact that I had spent my 7th Stage engaged in training and education and was probably being generative all along. I hoped that I had accrued some "wisdom" along the way, which is, after all, one of the basic attributes of Erikson's 8th Stage. My resolution was amended to continuing to be a mentor.

My next question was to answer whether mentoring was the same as generativity. I suspected that there are other ways to be generative without mentoring. Therefore, I read more on mentoring. Having done so, I became confused as to what mentoring was and was not. For instance, how is mentoring different than supervision? I see these as different activities, with supervision being far more comfortable for me. While doing supervision, I am in a defined, paid role with a defined set of goals, including assessment and feedback. I tell my trainees during orientation that when they sign on as trainees, there is an implicit assumption that the faculty and I know things that the trainees don't. What seems such a simple assumption turns out to be not so simple, as supervision is often fraught with problems and pitfalls (anxiety, transferences, and sensitivities) on both sides. An article on the mentor-protégé relationship provides a table of such pitfalls.

Table 1: Potential Pitfalls *(from Haines, 2003)*

Lack of time	Unrealistic expectations about advancement or promotion
Protégé lacks requisite skills to meaningfully contribute	Jealousy and gossip
Protégé does not take coaching or feedback seriously	Mentor takes credit for protégé's work
Protégé "plays" mentor against supervisor, boss, or associates	Mentor does not keep commitments
Protégé becomes resentful	Mentor becomes possessive of the protégé's time
	Mentor won't "let go" when protégé is ready for independence

Trying to be a mentor can be tormenting

Indeed, I recall numerous instances in which trainees and supervisors felt this process was actually hurtful. I also remember numerous requests by my residents for mentoring, and requests by my faculty that residents be assigned mentors, that went poorly. Assigning mentors can cause more problems than it's worth. These experiences have led me to often joke with the trainees that there has been no instances over the years in which any resident or faculty member has died in the actual training process. Having said that, I can't but note that the remark reflects more than a bit of ambivalence and hostility.

After not specifically answering my question as to what mentoring is and isn't, I then proceeded to identify key mentors in my life. This turned out to be another simple project that went awry. Unbelievably, I had trouble coming up with candidates. What was this about? My best guess was that it had to do with my overly ideal definition of what constitutes a mentor/protégé relationship, that being a mutually agreed upon, long lasting relationship that enhances the lives of both parties. By this high standard, one would probably not have that many mentors in one's life. My next best leading theory as to why my list of mentors was so short was attributed to my conflicted relationship with my father who was always mentoring me whether I wanted it or not. That relationship was often neither ideal nor mutually agreed upon, but was most definitely long term. It continues long after his death in 1999. Could it be that the problem boiled down to a "daddy transference?"

Negative cognitions then began to flow. My mind wandered to the fact that I always studied for tests alone. The logic went something like this: either I'd find out my study partner was smarter than I, which would upset me, or I'd find out I was smarter than them, which would also upset me and made me feel the endeavor was not of value. My theories, however, certainly explained my greater comfort with supervision, which is more structured and with a clear, one up/one down relationship. Undoubtedly, it is my fault that I have had so few mentors or couldn't think of any. It's obviously because I have too little altruism, empathy, compassion, mutuality, along with too much unrealized competition, pride, and narcissism. How could I possibly be a protégé or a mentee with all these flaws? I was upset.

Using my best cognitive coping skills, I challenged my negative beliefs and wondered if I had actually had many mentors but was too dense, anxious, and conflicted to realize it. Using this reframe, I came up with a slightly longer potential list of potential candidates. There was part of me that was really curious to ask these candidates if they considered themselves mentors, but that seemed a dangerous thing to do. What would happen if they said they weren't or dissembled? I remembered numerous conversations with my father in which he seldom answered my questions. Back again to my transference theory and more negative thoughts.

All this research and soul searching did not sway me from my fast growing belief that mentoring is more complicated than I first thought. I wondered if this was only my issue. I felt better after asking several people about mentoring in their careers. All of them started

out sure that they knew what mentoring was, but ended up more confused about mentoring after my discussion with them. Was this a contagion of negativity? Many of the people I talked to further complicated matters by asking me questions that I had not thought of: Is your therapist a mentor? Can you pay for a mentor? What of consultations? Do mentors need to be older? What about issues of gender in the mentor/protégé relationship? Do mentors and mentees have to like one another? Are mentors friends? If not, can mentors become friends? And if they were to become friends, how would that change the mentorial relationship? I found this all intellectually interesting and mildly unsettling.

I felt somewhat better still when an additional, more in depth, literature review made it clear that there are many definitions of what a mentor is. It listed various types of mentorship, including supervisory and situational mentoring, that occur over varying periods of time. Mentoring can be short term or long term. I realized that my original definition probably was indeed too specific and idealized. Using this knowledge, I differentiated between having a long-term "idealized father" mentor, which would probably be difficult for me, and having shorter term and situational mentors. With this redefinition, I suddenly had a long and distinguished list of people, often supervisors, bosses, teachers, friends, and even my father, who had significantly enhanced my career and life. I feel much better about my wish to do more mentoring now that I have a more comprehensive definition of how to be an effective mentor and more latitude as to what I think a mentor can do (see Table 2). I suspect I might be able to fulfill some of the listed actions. Time will tell!

Table 2: How to be an Effective Mentor *(from Haines, 2003)*

- Provide Support
  - Listen
  - Create a structure
  - Express positive expectations
  - Serve as an advocate
  - Share yourself
  - Make special gestures to foster the relationship
- Provide Challenge
  - Assign challenging tasks
  - Engage in discussion
  - Explore dichotomies
  - Construct hypotheses
  - Set high standards
- Provide Vision
  - Model exemplary behavior
  - Develop new language and new ways of thinking
  - Nurture the protégé's self-awareness

While I work on my mentoring resolution, I would invite the Owls, who I hope are less conflicted and confused than I, to share their experiences with mentors and as mentors over the years. To start the ball rolling, Tom Anders and Pirooz Sholivar have shared some of their positive experiences involving mentors, and Joe Jankowski will update us about the formal mentoring program of the Owls.

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MARTIN J. DRELL, M.D.
OWL'S NEWSLETTER
JUNE, 2023

Book Review: *Say the Right Thing*

By Kenji Yoshino and David Glasgow

When I heard about the book: *Say the Right Thing*, I immediately ordered a copy. My hope was that it would help me in my efforts to say the right things when involved in the many "difficult conversations" that are continuously taking place around identity issues. My hope was that I could switch out of my "doom loop" that "whatever one says is wrong." In our fractious and polarized world in which it seems that 50% of people will disagree with you on whatever your position is. I hoped for a simple, how-to book with guidance on what to do rather than focusing on what I have been doing wrong. My hopes were boosted by the fact that the authors are both from the NYU Law School's Meltzer Center for Diversity, Inclusion, and Belonging. Early in the book they divulge that they are both gay men who were closeted as youth and have had their own extensive experiences with identity conversations and their resultant anxiety of being stifled, labelled, and perhaps cancelled. They believe such conversations are inevitable and are now intensifying as more and more formerly muted groups find their voices. They point to the proliferation of new terms that are being constantly invented such as non-binary,

neurodivergent, white privilege, white women's tears, toxic masculinity, mansplaining, tone policing, gender queer, etc. These can be used against one or perhaps, they say optimistically, used to initiate discussions. The authors promise to be evidence based, practical, non-judgmental, and non-shaming in their quest for justice.

The book is laid out in 7 interrelated principles. These chapters are:

Principle #1: Beware the Four Conversation Traps which are to deny, to avoid, to attack, and to deflect. Such behaviors complicate engagement and make "non dominants" feel you don't have their backs which, in turn, leads to potential misinterpretations as to what your actions are! Your silence leaves a void that allows others to speak for you. As I often say: Defenses often work in the short run but often they don't work in the long run and cause problems in one's relationships.

Principle #2: Build Resilience. The authors note that identity conversations are often like "slow motion car crashes." To deal with them, they say that one needs to adopt a growth mindset vs a "closed mindset." These concepts, popularized by Carol Dweck, Phd (Mindset: The New Psychology of Success; NY: Ballontine Books, 2007), urge one to be open to challenges with the wish and hope for success. The authors point out that success is more likely if one realizes the discomfort implicit in these transactions and how they are complicated by "reflexive" responses to the feelings of fear, anger, guilt, and hopelessness that include the already mentioned avoidance, denial, deflection, and attacking. They go over strategies that may improve such conversations. They advise being humble, especially with regards to one's biases as well as what it means to be privileged.

Principle #3: Cultivate Curiosity. This section builds on the previous principle and suggests adopting a learning posture that allows for a growth mindset. They suggest ways of increasing your knowledge. They suggest that differing people and groups have different experiences and learning styles. Some may have to start slowly with reading and googling. Ultimately, the

authors suggest that one should attempt to cultivate diverse friendships. They warn, however, the reader that one should choose one's friends wisely as not everyone will be capable of helping one in his or her voyage of discovery. The persons you try and associate with may have experiences, feelings, and defenses that make it difficult for them to reciprocate your efforts. If one finds such a friend, they suggest using "I" language, listening more than talking, being on the lookout for the possibility of misunderstandings, and asking for clarification on what they call "unknown unknowns." When reading this section, I kept thinking that they suggest "walking a mile in the other's shoes."

Principle #4: Disagree Respectfully. Following the adage that to make an omelet, one needs to break a few eggs, they speak to the reality that such discussions often lead to emotions and disagreements. What then? They point out that such disagreements are inevitable and that one is left often with the dilemma of how to respond. To assist the reader, they introduce the concept of a controversy scale.

Tastes Facts Policies Values Equal Humanity

<--->

Least Controversial Most Controversial

The goal of this scale is to decide where you are on this scale with regards to tastes, facts, policies, values, and equal humanity and then to plot where you think the other person is on the same scale. They comment that with identity disagreements, usually the "more privileged people and the less privileged people almost always fall at differing positions on the controversy scale." They urge the reader to look for "uncommon commonalities" (i.e., points of agreement) that are usually present, but, all too often, are lost during the "fog of war." They also suggest thanking the other party for their feedback.

They identify 3 levels of disagreement:

- Green – Issues where most think it's OK to disagree.
- Red – Where most think that a disagreement is unacceptable.
- Yellow – Where not everyone is in agreement as to the form of the disagreement.

They urge one to be mindful of the disagreement and whether one has the knowledge or energy to continue. After all, they say, "not all arguments are created equal." They urge doing more homework and going to other trusted people for consultation if one is not sure which level a disagreement is.

They stress that what is going on is usually an ongoing process that can be re-engaged with in the future.

Principle 5: Apologize Authentically. Another example of a situation in which it seems "whatever you do, you are wrong," is the issue of apologies. Some advise me to never apologize. Those that advocate this stance feel that an apology legitimizes the sense that one has done something

wrong. All too familiar are situations when someone apologizes and the apology is not accepted and is declared as being inadequate and things are made worse. In this section, the authors attempt to describe what goes into an appropriate apology. They speak of the 4 R's of: Recognition, Responsibility, Remorse, and Redress that need to be considered. One needs to acknowledge that one has erred and to take responsibility for causing harm. The authors add that one needs to frame an apology that expresses contrition and takes actions to correct the harm and to assure that the harm does not re-occur. The authors present a host of defenses that get in the way of apologizing including not apologizing, "if-pologies" that don't actually take responsibility, "but-pologies" that provide qualifying reasons for why you did what you did, "faux-pologies," and "talk-pologies." This section is replete with examples of how not to apologize and highlights the difficulties in apologizing authentically.

Principle #6: Apply the Platinum Rule. The Platinum Rule involves helping people as they wish to be helped. To apply this rule assumes that you have a firm idea of your motives and biases (implicit or explicit) and that you are doing the right things. Even if your motives are

appropriate, one needs to consider whether the other person wants your help as you propose it in the first place. They may want to do things themselves or feel that your assistance is "patronizing, trivializing, empty, or counterproductive" (p149). To improve the chances of being successful, the authors suggest consulting others, conducting research, or discussing your ideas with an appropriate ally.

Principle #7: Be Generous to the Source. In this section, the authors discuss the actions that can be taken if one witnesses non-inclusive behavior. They help the reader think through when and how to act. They point out that there is an obligation to the perpetrator of the non-inclusive behavior who perhaps deserves to be understood as well as a sense of humility that "save for the grace of God," you might be the perpetrator of non-inclusive behavior. They suggest being gracious and differentiating ignorance from maliciousness. They differentiate the behavior from person and try to minimize the inculcation of guilt. They, once again, encourage Dweck's open mindset that involves the exploration of potential mistakes of one's own. They point out that not all situations or people deserve the same generosity, especially those that are strangers,

unreceptive to help, or engaged in political activism. The authors understand that what to say and how to say it are important, especially if one is emotional, and they provide a guide to strategies complete with easy to understand scripts to use. They urge one to "know thyself" and choose a few "go-to-phrases" that fit your personality.

I found this book practical, evidence based, non-judgmental, and non-shaming. It was a "good review" of concepts and strategies when dealing with "uncomfortable conversations" concerning identity issues. Therapists constantly deal with individuals and their problems with themselves and their interactions with others. The minute I made this link, I realized that the book and its 7 principles seemed to be very similar to CBT manuals. I especially thought of the numerous manuals on anger management that walk the individual through how to slow down, analyze the situation, consider who you are dealing with, identifying your triggers and those of others. The manuals include suggestions on how to enhance empathizing, how to deal with one's cognitive distortions and coping strategies (good and bad), as well as trying to non-judgmentally understand the cognitive distortions and coping strategies of others. If successful, these strategies

will hopefully help one to be less impulsive and to realize that anger can overwhelm one's frontal lobe and can get one in trouble.

This realization helped me to conceptualize the book in a very understandable way. I realized that the majority of readers may not be therapists and that they will be greatly assisted. It made sense that these skills would be valuable for lawyers and business school attendees who are usually not psychology majors but need to know these skills in order to lead, communicate, and understand individual behaviors and group dynamics in the twenty first century. I suspect, sadly, that the book will also be helpful to the psychiatrists that are not immersed in therapy as much as they were in the past. As a CAP who also identifies as a therapist, I will continue to wrestle with the dilemma of how to deal with matters such as identity issues that are complicated by the unconscious resistances, defenses, transferences, and "ghosts in the nursery" which are often referred to as "implicit biases." This seems, as always, to be a rate-limiting step that bedevils the process of getting along with people in general, regardless of what era we are in. I await a future practical and non-judgmental book that will help me with my personal unconscious and those of others. Until then, I will continue to read books on psychotherapy.

Trying to be a mentor can be tormenting

out sure that they knew what mentoring was, but ended up more confused about mentoring after my discussion with them. Was this a contagion of negativity? Many of the people I talked to further complicated matters by asking me questions that I had not thought of: Is your therapist a mentor? Can you pay for a mentor? What of consultations? Do mentors need to be older? What about issues of gender in the mentor/protégé relationship? Do mentors and mentees have to like one another? Are mentors friends? If not, can mentors become friends? And if they were to become friends, how would that change the mentorial relationship? I found this all intellectually interesting and mildly unsettling.

I felt somewhat better still when an additional, more in depth, literature review made it clear that there are many definitions of what a mentor is. It listed various types of mentorship, including supervisory and situational mentoring, that occur over varying periods of time. Mentoring can be short term or long term. I realized that my original definition probably was indeed too specific and idealized. Using this knowledge, I differentiated between having a long-term "idealized father" mentor, which would probably be difficult for me, and having shorter term and situational mentors. With this redefinition, I suddenly had a long and distinguished list of people, often supervisors, bosses, teachers, friends, and even my father, who had significantly enhanced my career and life. I feel much better about my wish to do more mentoring now that I have a more comprehensive definition of how to be an effective mentor and more latitude as to what I think a mentor can do (see Table 2). I suspect I might be able to fulfill some of the listed actions. Time will tell!

Table 2: How to be an Effective Mentor *(from Haines, 2003)*

- Provide Support
  - Listen
  - Create a structure
  - Express positive expectations
  - Serve as an advocate
  - Share yourself
  - Make special gestures to foster the relationship
- Provide Challenge
  - Assign challenging tasks
  - Engage in discussion
  - Explore dichotomies
  - Construct hypotheses
  - Set high standards
- Provide Vision
  - Model exemplary behavior
  - Develop new language and new ways of thinking
  - Nurture the protégé's self-awareness

While I work on my mentoring resolution, I would invite the Owls, who I hope are less conflicted and confused than I, to share their experiences with mentors and as mentors over the years. To start the ball rolling, Tom Anders and Pirooz Sholivar have shared some of their positive experiences involving mentors, and Joe Jankowski will update us about the formal mentoring program of the Owls.

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Attachment 11:

A Primer on Implicit Bias: Part I
(What is it and Theories as to Why it Exists and Persists)

Martin Drell, MD

Martin Drell, MD

Implicit Bias (also referred to as unconscious bias) is a very popular topic of late as our society deals with the realities of social injustices ranging from issues of racism, gender biases, feminism, anti-Semitism, islamophobia, xenophobia, ageism, bullying, medical and healthcare inequities, Jim Crow laws, colorism, differences in rates of police stops, detentions, rates of incarceration/sentencing across races, financial, salary and promotion inequities, and housing discrimination to just name a few. As I write this, I find myself anxious that the above list has failed to document a form of injustice and that my oversight will cause umbrage and be considered an unconscious sign of discrimination on my part.

What then is implicit bias?

Implicit bias refers to attitudes or stereotypes that affect ones understanding, actions, and decisions in an unconscious manner. These decisions are involuntary and without the individual's awareness or control. Because of this, these decisions are not accessible through normally used powers of introspection (Schnierle, 2019).

Implicit biases are related to, yet distinct from, explicit biases, which are biases that are conscious and accessible through introspection. Implicit and explicit biases are related in that they influence and reinforce each other. They are both, in turn, influenced by one's environment and culture.

The concept of unconscious processes is certainly not new. They are clearly described in the works of Sigmund Freud, although historians of the unconscious have made it clear that the history of the unconscious predates Freud by many centuries (Ellenburger, 1970).

As I read about implicit bias, I recalled past experiences that, upon reflection, seemed to be examples of implicit bias. The first experience I remembered occurred when the daughter of an African American doctor friend of my father's came to our house when I was very young. She had an African American doll. I remember my curiosity about her doll and a vague sense of unease. I had never seen such a doll. Something was not right.

My next memory, as a teen, also involved dolls, those being used in the experiments (often referred to as the "Doll Tests") of Kenneth and Mamie Clark. In their experiments, these two African American psychologists showed African American children (ages 3-7 years) identical black and white dolls and asked them which they preferred. The African American children, even though able to clearly identify which of the dolls looked most like them, preferred the white dolls. The children attributed more positive characteristics to the white dolls. The Clarks concluded from their experiments that experiences of prejudice, discrimination, and segregation created a sense of inferiority among African American children and damaged their self-esteem. Their conclusions were used by Thurgood Marshall and the NAACP in their Supreme Court arguments in the Brown vs. the Board of Education of Kansas case that ruled that segregated schools were unconstitutional (Clark, 1939-1940).

A similar experiment (Bland, 2017) that fascinated and unsettled me began the day after Martin Luther King, Jr.'s assassination in 1968 when a white teacher named Jane Elliott (Elliot, 2005), in an all-white school in Raceville, Iowa, asked her students how they thought it would feel to be a black boy or girl. To help her students answer this question, she invented the "Blue Eyes, Brown Eyes" experiment in which she segregated children by their eye color and prioritized first the blue eyed group and then the brown eyed group, creating two alternating "have" and "have not" situations.

Elliot reported the first "have not" group suffered frightfully quickly from lowered self-esteem, stigma, and bullying. The teacher explained that this experiment gave the designated "have not" children an experience of being discriminated against. Jane Elliot added that when the first "have not" group was switched over to being the "have" group, they were also mean and condescending to the new "have not" group, but not quite as mean and condescending as the previous "have" group had been to them. The children related that the experiment had taught them how it felt like to be "on the bottom" and that they "did not want to make anyone feel like that ever again."

Another example came when I read an essay in Malcolm Gladwell's book Blink (Gladwell, 2005) as an adult. The essay dealt with the introduction of "blinded" auditions in the hiring of musicians for major orchestras. Gladwell described how traditional non-blinded auditions had led to the hiring of mostly men. After the introduction of several policy changes that included curtains so that the gender of those auditioning could not be determined, the percentage of female hires precipitously increased. In this essay, Gladwell detailed the extent of the changes that needed to be made, including the need to muffle the sound of the woman's high heels as it prejudiced the decision-making process. I find it a shame that the changes actually implemented did not involve equalizing the playing field by having the men wear high heels. Gladwell concluded that these charges made many male classical musicians aware of their own sexism and stereotypes concerning female musicians.

Why Does Implicit Bias Exist?

The question of the hour seems to be why does implicit bias exist if it is responsible for such injustice and suffering? Interestingly, its existence is often explained as having "survival value" as it allows humans to quickly distinguish quickly between friends (those like us) and enemies (those not like us that might hurt us) and other sources of danger. The theory goes that in order to protect us, the brain looks for patterns and shortcuts that allow it to make sense of the flood of sensory stimuli it constantly has to deal with (Pressner, 2016). Thus, anything that looks like a snake is avoided, even though it may turn out to be only a stick. The thought is that it is better to avoid many sticks that look like snakes than to make a fatal mistake regarding a snake that looks like a stick. The survival process leads to heightened suspicions, hypervigilance, negative thoughts, and avoidances that are also thought to be part of the genetic underpinnings of anxiety disorders. Remember that dead persons cannot carry on their genes to the next generation.

These Darwinian survival responses are thought, overtime, to have influenced our brains as they evolved over thousands and thousands of years. The records show that earlier species, many which exist to this day, developed fast, automatic, and reactive brains that survived by depending on quick reflexes, like the "fight or flight" reflexes that do not allow much time to think about things. Remember that thinking and the time it takes can be lethal! This part of the brain in these species has been pejoratively referred to and memorialized as the "Lizard brain" (Armour, 2016) which, over the years, elaborated into the modern "limbic system" whose key organ is the amygdala, an almond shaped set of neurons in the temporal lobe that is the emotional center of the brain that responds to fear and threats.

Closer evaluation of this evolutionary theory would suggest that there are considerable downsides to doing everything reflexly, especially in the more complex civilizations that evolved over the same

thousands and thousands of years. Using Freudian parlance, this would be like only having an Id — a definite disadvantage in the "Me Too" Era! The evolutionary theory would have it that over time, the cortex, with its abilities to make the executive decisions needed in more complex situations, evolved and that the combination of the cortex and the reflexive lizard brain together created enhanced survival value. In modern parlance, we refer to the "reflexive brain" as influencing us from the "bottom up" and the cortex as influencing us from the "top down." Although not perfect, the constant interplay between these bottom-up and to-down responses give humans a distinct advantage. To add a dash of credibility, the neurosciences and brain scans seem to verify these evolutionary theories (Luskin, 2016).

On a historical note, it appears Sigmund Freud, without the benefit of brain scans, came up with a similar model with the Id as the bottom-up component and the ego/superego as the top-down component in constant interplay and tension within the person and between the person and the civilization he finds himself embedded in.

Unfortunately, It appears that coming up with definitions and accompanying evolutionary theories and brain scans that seem to support these theories is an easier task then trying to figure out how to deal with the detrimental consequences of unconscious Implicit biases. The main conundrum boils down to: how is our society to deal with processes that are out of one's awareness? I will try to address this conundrum in part two of this Primer on Implicit Bias, which will appear in the next issue.

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Primer on Implicit Bias: Part II (How to Deal with Implicit Bias)

To begin to answer the questions of how to deal with implicit bias, it might be good to consult psychoanalytically trained therapists who not only believe in the unconscious (n.b., not everyone does), but have spent a century evolving therapeutic techniques to help people deal with unconscious processes. Such therapists would, I believe, be the first to explain how hard it is to change unconscious beliefs and therefore, the actions based on them.

Competent therapists would advise strategies aimed at consciously bringing the problem to the patient's awareness, along with its consequences. Subsequent strategies would then continuously confront the patient with the origins and consequences of their actions in in their everyday life and in the therapy. This painstaking "working through" of these unconscious events would include suggestions as to new thoughts, narratives, and actions that could be successfully tried.

Most psychoanalytically trained psychotherapists will humbly admit that many of their therapies fall far short of success even after long periods of treatment, even in patients who explicitly know they have a problem and "consciously" want to change. Even more humbling still is Freud's comment that even the most successful therapy does not exempt one from the ongoing "miseries of everyday life."

Business interests in America and the West have attempted to address the impact of bias through I.B. (Implicit Bias) training. This training is based on the idea that I.B. needs to be addressed and that it can be successfully moderated, hopefully in short amounts of time. These attitudes have assured that I.B. training has evolved into a big business of its own.
I.B. training contains the following strategies that are similar to psychoanalytic ones. They can be summarized as:

1. Calling attention to the problem of I.B. and its crucial impact on society.
2. Making people aware that I.B. is something they need to deal with, and finally:
3. Dealing with it!

Most I.B. trainings start by providing a test or experience to make its participants aware of their own implicit biases. The most often used test used is the I.A.D. (Implicit Association Test) (Greenwald & Banagi, 1995). This test, which you can take for free at https://implicit.harvard.edu/implicit/education.html, identifies implicit bias. It does so by detecting the strength of people's "automatic" associations between concepts regarding groups such as black, gay, or Jewish, and equally automatic evaluations and stereotypes concerning these groups, such as good/bad, athletic/clumsy, and/or rich/poor. The test is based on the hypothesis that measured responses are quicker when they are linked to already existing unconscious ideas regarding these groups. An example would be that one is assumed biased if your response to "gay people" and the evaluation word "bad" is made quicker than "gay people" and the evaluative word "good." The test includes numerous opportunities for similarly timed responses such as the pairing of the concept "straight people" and the evaluative word "good" vs. "straight people" and the evaluative word "bad."

Most people agree that the I.A.T. is a valuable test in that it appears to be an "objective" measure to introduce the idea that those who take it that they have implicit biases. It is noted that the I.A.T. has its naysayers who question its validity,

scoring, and reliability, especially during retests. Regardless of these scientific arguments, it does seem that the I.A.T. is a legitimate way to point out that the test taker potentially has biases.

For the less scientific among us, similar results can be achieved by other means. My favorite comes from a TED talk by Valerie Alexander (2018) entitled "How to Outsmart Your Unconscious Bias." In her presentation, she starts with a mind exercise involving three visualizations: "Imagine you get on a plane and the pilot says hello. Then imagine going to dinner and sitting next to a couple celebrating their wedding anniversary. Finally, imagine a keynote presentation at a national tech conference." Ms. Alexander then follows up by asking her audience whether the audience pictured the pilot in the first visualization as an African American, whether the wedding couple in the second involved two men, and whether the presenter in the third was a woman. Her mind experiment makes the same point that people have their unconscious biases but engages the audience's cortexes in a much more enjoyable manner. On a personal note, I much preferred Valerie Alexander's strategy to the I.A.T., which I found quite annoying. If the truth shall set me free, then I prefer a process that is less irritating.

The I.B. training then usually moves on to educate participants as to various theories concerning unconscious bias (n.b., examples of which were described in Part 1 of this Primer), as well as its impact. The next, more difficult phase of the training is to reduce the level of and impact of unconscious bias. This involves bias reduction strategies such as exposing participants to "counter-stereotype" exemplars, like President Obama who challenge myths regarding African Americans, and bias mitigation strategies which include changes in policies aimed at leveling the playing field such as the earlier mentioned "blinded" auditions of musicians described in Malcolm Gladwell's book *Blink* that led to many more female musicians being hired into major orchestras. Other strategies include "perspective taking" ("Walking a mile in someone else's moccasin's") which includes efforts to increase empathy for a "stereotyped" group, and increased opportunities for contact with stereotypes groups. These opportunities can be facilitated by encounter groups, discussion groups stimulated by videos/movies showing the stereotypic group, or through job relationships made available through successful diversity hiring practices, although the practices can generate politically uncomfortable discussions, such as those concerning affirmative action.[1] A final example would be through the practice of unconditional loving kindness meditation. I did mention that some of these strategies might vary as to their levels of complexity, costs, difficulty, and success.

The next big question regards whether these trainings actually work? The answer to this depends on one's definition of what success means and is complicated by the hundreds of different and varying trainings available.

There have been many recent articles that question the helpfulness of I.B. training. (Gassam, 2018; Kim, 2017 & 2018, and Dobbin & Kalev, 2017) Lee Jussim, PhD in his 2017 article sums this up succinctly by saying that, "My own view is that the research

[1] Just to show the complexity of these issues, Robin DiAngelo, in her book White Fragility, says that a white person insisting that white people are being discriminated against because of affirmative action is an example of white fragility which she defines as the intense feelings and argumentativeness that white's experience when confronted with the topic of racism.

framed on implicit bias has been wildly oversold, and its proponents have often leaped to conclusions not justified by the data."

A more fine-grained summary of these concerns would include questions as to the validity of the I.A.T. test that is used in many programs, questions as to the quality of the training programs, and questions concerning the research evaluations of these programs. The latter questions focuses on the measures used, the quality of the research performed using on these measures, and the scarcity of long term follow-ups. There are separate concerns about the impact of making the trainings mandatory, the problems of "one shot" or short trainings, and, most importantly, the failure of these trainings to actually lead to "real life" changes over time.

Best practices established despite the lack of definitive research in most all of the areas involved (Kirwan Institute) include:

- Involvement of the entire company with "buy in" from top to bottom of the organization.
- Creation of a mission statement or its equivalent which spells out clear definitions and goals.
- The necessity of quality, well organized trainings that utilize adult learning theories.
- The need for clear, explicit clarification of the negative impact of I.B.
- The need for clear feedback to and from participants about the training.
- That the training should be considered only a small part of larger, more systemic efforts that aim at implementing policies and procedures that will reduce the past impact of I.B. by consciously implementing changes in the present and the future, especially with regards to hiring practices.
- That the trainings should optimally be delivered in teams or groups that work closely together.
- That the trainings should not be mandatory and "one shot" (unless perhaps your goal is to get your organization out of various public relations (PR) disasters that routinely beset corporations by showing you are doing something quickly).
- That there should be a well-developed process to determine the success of the training.
- That one should never underestimate the resistances to change in our society.
- That one should likewise not underestimate the power of societal justice movements to facilitate for change over time.

The literature emphasizes that when thinking about social change, one should optimistically think of the changes in our society that have occurred in the last 50 plus years, the fundamental principles of our country which may not always be followed but are there to inspire us and perhaps bring about change by making us feel guilty and ashamed, the rapidly changing demographics in the U.S., the equalizing aspects of "Capitalism" (n.b., if it leads to more purchasing, it will be done!), the potential positive impact of social media and the internet, generational aspects of change, and the power of the vote.

On a sobering note, I have shared my article with several African Americans. When asked if they felt things were better than 50 years ago, not a single person agreed with my comment. They all, in varying ways, said emphatically that things were still

bad. As I stated earlier, it depends on one's definition of success and one's perspective.

It is clear that dealing with implicit biases is and will continue to be a monumental task. Several articles and books make it clear that totally eliminating implicit bias is impossible. These authors contend that we are all biased and that the goal should be to realize this with attempts at becoming an "anti-racist racist." A variation on this statement is put forth by Ibram X. Kendi, (Kendi, 2016, 2019) who says that people are racists, and therefore, cannot be non-racists. The opposite of racist, he says, is anti-racist.

I will end this primer with three quotes from Jennifer Eberhardt's 2019 book entitled *Biased: Uncovering The Hidden Prejudice That Shapes What We See, Think, and Do*, which nicely summarize the existing situation relating to implement bias and attempts to deal with it. The quotes speak to the complexity of this topic and span from the optimistic to the painfully real.

- "Bias is operating on a cosmic level… it deserves a cosmic response."
- Dealing with bias, "won't be simple, cheap, or without stumbles and scorn."
- "Diverse groups are more creative and reach better decisions, but they aren't always the happiest groups of people. There are more differences, so there is apt to be more discord. Privilege shifts, roles change, new voices emerge."

I suspect that the last quote meant to prepare readers for Freud's "inevitable miseries of everyday life?" What is your definition of what success in these endeavors would be? And being true to the topic, what potential biases, conscious or unconscious, may have influenced your answer?

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At a recent meeting, I clarified that the Heads of Child and Adolescent Psychiatry oversee all aspects of their organization (training, research, service, and administration). It is noted that many heads are also training directors or "used to be training directors." With regards to training, this means setting the overall goals for training, as well as prioritizing what is taught and who teaches it. These latter matters can be delegated, training directors come and go, and often need to be mentored. This means that Heads need to know about curriculum planning, especially the Total Curriculum.

Attachment 12: Curriculum Planning: The Larger Picture

A "total" curriculum to me, as a three-time Training Director, is a systemic and dynamic process that considers all aspects of training and education as its focus. The aspects would include:

- Didactics – What is taught? I divide these into topics mandated by the RRC vs. those topics suggested by RRC vs. those topics that you feel are important for your fellows to know or that your child division has expertise. (Note that these latter expertise are very important in recruitment.) How often? How much? What strategies of training are used (reading based, problem-based learning, experiential, interactive, case conferences, journal clubs, film groups, etc.
- Supervision – How often? For how long? By whom? By which disciplines? When? At which sites?
- Grand Rounds – How often? What topics?
- Clinical sites where training occurs – Inpatient units, outpatient clinics, consultation/liaison, in pediatric homes, etc. This is often dictated by the goals of these sites, which often change, and the faculty assigned to these sights.
- Staging in training over the two years of the fellowship – Which things are taught throughout the two years vs. in blocks? Which topics are taught earlier in training. This would include crash courses, basic courses, and latter advanced courses.

A "Total" curriculum needs to be systemically looked at and considered whatever your initiative is. Thus, one needs to consider:

- How to coordinate your topic area with other areas in the overall child training.

- Decisions as to the allocation of resources across various topics, all of which may be RRC mandated or felt to be important by the faculty. I note that this is often seen as a "zero sum" exercise in which more on one topic leads to less for another topic. There is no such thing as a "perfect" curriculum.

- How to link and coordinate what you're doing across the general and child programs. In reality, child programs are the "end users" of what the general programs teach. What can you do to enhance training across the trainees' entire education and training. Can there be a coordinated psychotherapy track for the general and child programs?

- Decisions as to how to allocate child division's resources for the training of general psychiatrists, medical students, and other disciplines (child psychologists, social workers, nurse practitioners, etc.). These decisions are complex and need buy-in from the departmental administrative hierarchy.

- Evaluation as to whether your efforts are being successful from the trainees and trainers standpoint. This would include evaluations, surveys, tests scores, etc.

To enhance your learning on curriculum, I advise you to check out the ACGME Program Requirements for Graduate Medical Education in Child and Adolescent Psychiatry (ACGME-approved: February 9, 2015; effective: July 1, 2015. Revised Common Program Requirements effective: July 1, 2016. Revised Common Program

Requirements effective: July 1, 2017). I have also included a chapter on Psychiatric Residency Curriculum: Development and Evaluation (Chapter 7).

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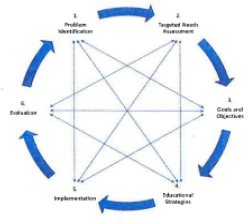
Appendix: At the 2020 AADPRT Meeting in Dallas, there was a planning session on curriculum planning. The presenters offered 3 aids from the literature. These included:

1. The Kern Cycle for medical curriculum development. This is a six-step approach.



KERN cycle for medical curriculum development. The KERN Cycle presents a six-step approach to curriculum development for medical education (thick arrows). The thin arrows illustrate dependencies and consequences regarding all other steps. Consequently, it is advisable to reiterate the cycle stepwise, not only to get a better curriculum, but also to become flexible at reaching to immutable alterations. This corresponds ultimately with the basic principles CQI- Continuous Quality Improvement (Plan, Do, Check, Act) and the endeavor of continuous improvement.

2. The SMART acronym, attributed to management guru, Peter Druker, is to guide goal achievement.
   - Specific (simple, sensible, significant).
   - Measurable (meaningful, motivating).
   - Achievable (agreed, attainable).
   - Relevant (reasonable, realistic, and resourced, results-based).
   - Time bound (time-based, time-limited, time/cost limited, timely, time-sensitive).

The SMART acronym has been updated to SMARTER. The added E stands for Evaluated; The added R stands for Renewed.

3. Miller's Pyramid (1990) for Assembly Clinical Competence (a good for curricular).

4. Several organizations have model curriculum. These include American Association of Directors of Psychiatric Residency Training (AADPRT), Association of Directors of Medical Student Education in Psychiatry (ADMSEP).

Attachment 13: Being Systemic

The quality of being systemic is one that is often seen in successful leaders. This quality is difficult to define, as describes the ability to understand those factors that impact the entire system that you are dealing with. Those that are systemic seem to be able to visualize the chess board and anticipate moves into the future. They are proactive and move beyond thinking about here and now reactions to thinking about reactions over time, which is called naturally transactional.

I refer to being systemic as the tendency to always think to yourself "and then what?" This tendency, which can be correlated with OCD, is best if used in moderation and not in all situations.

Some people seem to be systemic perhaps learning from key people in their families or mentors. I suspect it can be taught and practiced. If trying to hone this skill, one could do well to study the Bio-Psycho-Social systems influenced theories of George Engel, family systems therapy, or the good enough Mother-Infant transactions as envisioned by Winnicott. All of these accentuate the reality that individuals are always part of groups and larger systems. As Winnicott said, "There is no such thing as an infant." Wilfred Bion expanded on this notion. He was an English Psychoanalyst who was influenced by Melanie Klein, other colleagues at the Tavistrock Clinic, and his work at a military hospital during WWII with psychiatric casualties (PTSD, shell shock). Due to the large numbers of casualties, Bion met in groups. His work in these groups led to theories of group dynamics that can generalize to all sorts of other groups, including faculty groups. His insights gave leaders ways of improving group functioning. He posited that there were different basic unconscious group defenses (called basic assumptions: I) dependency, 2) fight/flight, and 3) pairing these defenses were used to cope with the primitive anxieties generated by groups. These include:

1. Relating to the leader transferentially as an omnipotent leader who will deal with problems actively, thus allowing the group and its members to be passive. This is correlated inevitably by jealousy of the leader and the wish to dispose of the leader. (Heavy lies the head that wears to crown!)

2. Overfocusing on one fear to the point where you don't deal with other issues that also need to be dealt with.

3. Overfocusing on the future while not dealing with the present.

4. Valuing "groupness" over the individuals in the group as in religious cults where the group turns to the omnipotent leader (see #1). The followers are again passive and wait to be told what to do. History is repeated with leaders who exploit and take advantage of others using these defenses.

5. FOMO (fear of missing out) with an overfocusing on the lives of others vs. oneself and one's own mission.

6. Fight or flight behaviors that do not allow for realistic communication and problem solving.

Bion is horrible to read. I would suggest using secondary and tertiary sources to try and understand him.

Lessons I have gleaned from his work are that leaders…

1. Should identify goals with input from the group.

2. Should remind the members of the group of the overall tasks of the team.

3. Should be clear and stick to the "here and now" even when trying to achieve future goals.

4. Should emphasize that the group is all in this together.

5. Should expect imperfection. "The perfect is the enemy of the good" and good enough is generally good enough.

6. Should encourage the passive members of the group to speak up and those that overtalk to allow others their turn.

7. Should not scapegoat individuals but should attempt to "drive out fear." The leader should look to the group dynamics to see what is making people anxious. Illogical behaviors are usually logical if one knows the system and the context of the situation.

Bion's work contributed to the field of group dynamics and organizational consultation, Tavistock groups and the AK Rice Institute grew out of Bion's work at the Tavistock.

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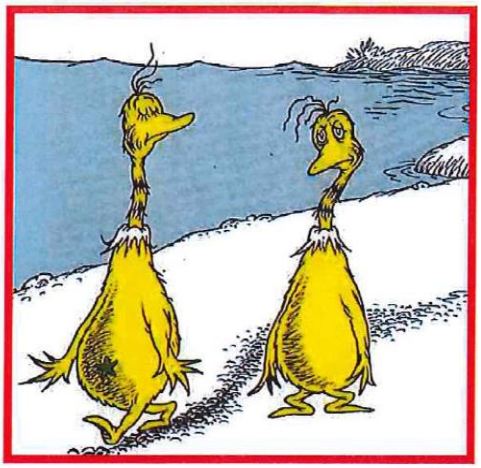
Attachment 14: The Sneetches

I believe all child psychiatrists should carefully look at the Sneetches and think through whether we are the Star-Belly Sneetches and how this has influenced how we act and negotiate.

THE SNEETCHES
by Theodor Geisel (1961)

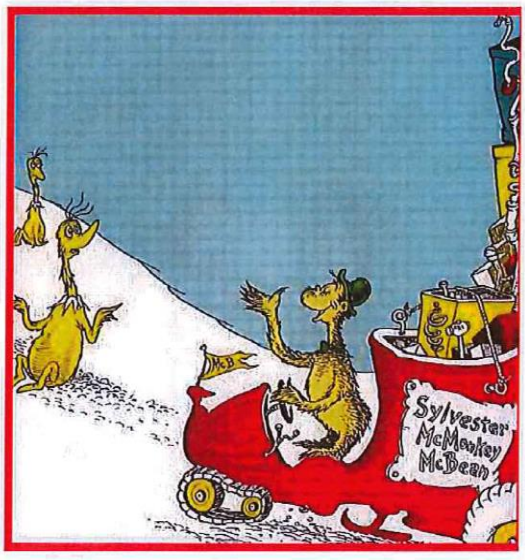


Now, the Star-Belly Sneetches
Had bellies with stars.
The Plain-Belly Sneetches
Had none upon thars.

Those stars weren't so big. They were really so small
You might think such a thing wouldn't matter at all.
But, because they had stars, all the Star-Belly Sneetches
Would brag, "We're the best kind of Sneetch on the beaches."
With their snoots in the air, they would sniff and they'd snort
"We'll have nothing to do with the Plain-Belly sort!"
And whenever they met some, when they were out walking,
They'd hike right on past them without even talking.

When the Star-Belly children went out to play ball,
Could a Plain-Belly get in the game...? Not at all.
You could only play if your bellies had stars
And the Plain-Belly children had none upon thars.

When the Star-Belly Sneetches had frankfurter roasts
Or picnics or parties or marshmallow toasts,
They never invited the Plain-Belly Sneetches.
They left them out cold, in the dark of the beaches.
They kept them away. Never let them come near.
And that's how they treated them year after year.



Then ONE day, it seems...while the Plain-Belly Sneetches
Were moping and doping alone on the beaches,
Just sitting there wishing their bellies had stars...
A stranger zipped up in the strangest of cars!

"My friends," he announced in a voice clear and keen,
"My name is Sylvester McMonkey McBean.
And I've heard of your troubles. I've heard you're unhappy.
But I can fix that. I'm the Fix-it-Up Chappie.
I've come here to help you. I have what you need.
And my prices are low. And I work at great speed.
And my work is one hundred per cent guaranteed!"

Then, quickly, Sylvester McMonkey McBean
Put together a very peculiar machine.
And he said, "You want stars like a Star-Belly Sneetch...?
My friends, you can have them for three dollars each!"

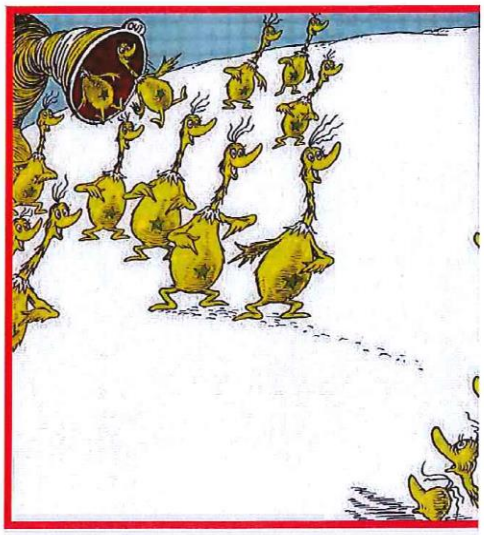
"Just pay me your money and hop right aboard!"
So they clambered inside. Then the big machine roared
And it clonked. And it bonked. And it jerked. And it berked
And it bopped them about. But the thing really worked!
When the Plain-Belly Sneetches popped out, they had stars!
They actually did. They had stars upon thars!

Then they yelled at the ones who had stars from the start,
"We're exactly like you! You can't tell us apart.
We're all just the same, now, you snooty old smarties!
And now we can go to your frankfurter parties."

"Good grief!" groaned the ones who had stars at the first.
"We're *still* the best Sneetches and they are the worst.
But, now, how in the world will we know," they all frowned,
"If which kind is what, or the other way round?"

Then up came McBean with a very sly wink
And he said, "Things are not quite as bad as you think.
So you don't know who's who. That's perfectly true.
But come with me, friends. Do you know what I'll do?
I'll make you, again, the best Sneetches on beaches
And all it will cost you is ten dollars eaches."

Belly stars are no longer in style," said McBean.
"What you need is a trip through my Star-*Off* machine.
This wondrous contraption will take *off* your stars
So you won't look like Sneetches who have them on thars."
And that handy machine
Working very precisely
Removed all the stars from their tummies quite nicely.



Then, with snoots in the air, they paraded about
And they opened their beaks and they let out a shout,
"We know who is who! Now there isn't a doubt.
The best kind of Sneetches are Sneetches without!"

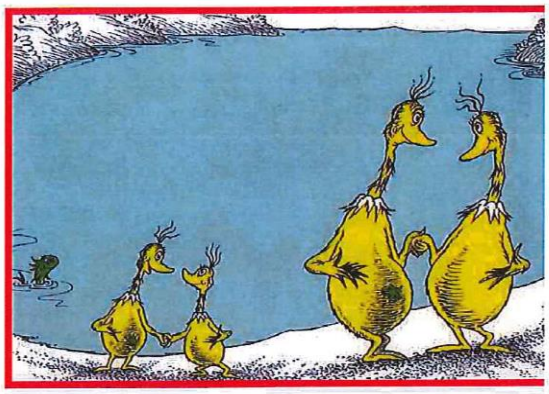
Then, of course, those with stars all got frightfully mad.
To be wearing a star now was frightfully bad.
Then, of course, old Sylvester McMonkey McBean
Invited *them* into his Star-Off Machine.

Then, of course from then on, as you probably guess,
Things really got into a horrible mess.

All the rest of that day, on those wild screaming beaches,
The Fix-it-Up Chappie kept fixing up Sneetches.
Off again! On again!

In again! Out again!
Through the machines they raced round and about again,
Changing their stars every minute or two.
They kept paying money. They kept running through
Until neither the Plain nor the Star-Bellies knew
Whether this one was that one...or that one was this one
Or which one was what one...or what one was who.

Then, when every last cent
Of their money was spent,
The Fix-it-Up Chappie packed up
And he went.



And he laughed as he drove
In his car up the beach,
"They never will learn.
No. You can't teach a Sneetch!"

But McBean was quite wrong. I'm quite happy to say
The Sneetches got really quite smart on that day,
The day they decided that Sneetches are Sneetches
And no kind of Sneetch is the best on the beaches.
That day, all the Sneetches forgot about stars
And whether they had one, or not, upon thars.

The end.

Attachment 15: Part I - Trending Issues: Burnout and Wellness

If you read my handout, it is clear that things are changing and that many people (n.b., up to 50% of physicians in recent studies) feel stressed and burned out or on the way there. A Mayo Clinic handout on burnout says that it is the result of many stressful factors including:

- **Lack of control.** An inability to influence decisions that affect your job — such as your schedule, assignments, or workload — could lead to job burnout. So could a lack of the resources you need to do your work.

- **Unclear job expectations.** If you're unclear about the degree of authority you have or what your supervisor or others expect from you, you're not likely to feel comfortable at work.

- **Dysfunctional workplace dynamics.** Perhaps you work with an office bully, or you feel undermined by colleagues, or your boss micromanages your work. This can contribute to job stress.

- **Mismatch in values.** If your values differ from the way your employer does business or handles grievances, the mismatch can eventually take a toll.

- **Poor job fit.** If your job doesn't fit your interests and skills, it might become increasingly stressful over time.

- **Extremes of activity.** When a job is monotonous or chaotic, you need constant energy to remain focused — which can lead to fatigue and job burnout.

- **Lack of social support.** If you feel isolated at work and in your personal life, you might feel more stressed.

- **Work-life imbalance.** If your work takes up so much of your time and effort that you don't have the energy to spend time with your family and friends, you might burn out quickly.

Reference: Job burnout: How to spot it and take action (9/15/17). Retrieved from: https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/burnout/art-20046642

People who are "burnt out" are not "happy campers" and are cynical and critical about what they do. They are often involved in downward escalating cycles of grief and woe. When at work, they are irritable, impatient, and/or withdrawn. Their productivity is usually decreased. They can have somatic complaints and may compensate with poor lifestyle choices (drugs, alcohol, eating disorders) that have subsequent physical consequences (diabetes mellitus, obesity, heart disease, high blood pressure), and emotional consequences (adjustment disorders, depression, anxiety, suicide, etc.). Their feelings can impact their interpersonal relations both inside and outside of work.
Burnout can be addressed by an objective assessment of one's stressors and trying to deal with them in constructive ways. There are a host of CBT manuals and self-help

books on stress reduction, mindfulness, relaxation techniques, exercise, and life balance that can be quite helpful.
It is noted that that ACGME has evolved over the years from protecting patients to protecting trainees (an emphasis on work hours, more prescriptive requirements, more monitoring, etc.). In my estimation, these actions have increased the stresses on faculty. I believe the ACGME agrees with this and now thinks that something needs to be done. They probably will not admit that their past actions have played a part in creating the problem. In response, the ACGME has now announced initiatives that put the medical schools in charge of the wellness of their faculty and staff, in addition to the wellness of trainees and patients. As leaders, you will be asked to figure out how to enhance the wellness of your faculty. Hopefully, our bosses will do likewise to reduce our stresses. I cynically await my orders on how to make this all occur starting with mandated training modules on wellness and burnout that come with warnings that failure to complete them in a timely manner will potentially lead to dire consequences for myself, my school, and the human race in general.

On a more upbeat note, I would urge you as the head of a Child Division to look at the factors listed above that can lead to burnout and realize that you can reduce stress and burnout by running your Divisions in ways that people feel more in control, have the information they need, have clear, appropriate, and individualized job descriptions that match with their strengths and values, and are supported and mentored to be successful. Leadership is important!

Attachment 15: Part 2 - Fluffiness and Why This Follow-up Column to My Previous Column on Burnout Is Not on Wellness as was Promised

Writing about burnout [1] was a "piece of cake." It is a trendy topic complete with many data-based articles, statistics, many variables, and opinion pieces to learn from. It is a real problem, in that it is linked to job dissatisfaction, anger, frustration, depression, early retirement, and perhaps physician suicide (400/year).

When confronting the issue of what to do about burnout, things proved less easy. I had planned and promised a companion piece to my burnout article on the equally as trendy topic of wellness and its promotion. When I went to write the piece, however, I instantaneously encountered a problem, which I dubbed the "fluffiness" problem. I was not quite sure what this problem was, but I viscerally knew I didn't want my article to be "fluffy." In thinking over my concerns, I realized that fluffiness was associated not only with wellness, but with resilience, as well as the Happiness Movement, with their near magical promises that if you do such and such activities, you will be well or resilient or "happy;" whatever that means. I see all these concepts as linked inexorably to Maslow's Hierarchy of Needs. From the perspective of Maslow's hierarchy I note that physician burnout seems very high up on the hierarchy? After all, don't those doctors with burnout all have well-paying jobs, financial security, and their basic physiological and safety needs met? Would not the billions of people in the world who still live on less than two dollars per day love to have such problems? My mother would call this "complaining with two loaves of bread under your arms." I would add personally that my mother frequently responded to my frequent litany of angsts with her well-meaning "two loaves" retort. When she did, I felt horribly invalidated by her lack of empathy. She hurt my self-esteem. As a commentary, I often think that modern psychology, child psychiatry, and our culture have all conspired to raise the Maslowian bar so high with a commensurate raise in our psychological aspirations and expectations of parents and all caregivers leading to many unintended and unfortunate consequences such as "helicopter parents," "entitlement," and lower self-esteem. My theory is seconded by Simon Sinek's very popular TED talk on millennials in which he states that many of the problems with millennials are the product of "failed parenting strategies that told their kids they were special, that they could achieve whatever they wished, and were rewarded for participation regardless of their ranking (n.b., the trophies for all approach).

As further evidence of this tendency, I would point out that the Happiness Movement seems to have trouble with defining exactly what its goals are. Martin Seligman, in his 2012 book: Flourish: A Visionary New Understanding of Happiness and Well-being [2], devotes a chapter in which he discusses being content vs. being happy. He seems to conclude that being content and happy may not be enough, that one's goal should actually be "to flourish." There is an oppositional part of me that resents that it is not ok for me to be merely content and that to settle for that is somehow not enough. Surely, such messages are a slippery slope to a sense of unease and failure and might perhaps even contribute to my becoming "burned out." Remember the old adage that if you want a happy life, lower your standards. As a psychiatrist who spends many a session with patient's chock full of various resistances who have troubles carrying out the simplest of suggestions, like taking a pill every day as prescribed, I distrust easy solutions, especially as I humbly see how hard it is for me to carry out my physician's seemingly simple orders, especially those to lose weight. The voice

beckoning me to my refrigerator every night is far more powerful than my physician's sage and well-meaning suggestions every six months. The ever-present voice from my fridge also allows me to easily overlook the sticky note on my refrigerator with the acronyms H.A.L.T. that details four potential etiologies of "night eating."

H: Hunger
A: Anger
L: Lonely
T: Tiredness

Having thought through my concerns involving fluffiness, I have therefore come to the conclusion that Wellness, Resilience, or the Happiness Movement are not so simple and that they probably not the magical cure for burnout. Having come to this conclusion, my problem with fluffiness has evaporated and I will now move onto some hopefully non-fluffy thoughts on how to deal with burnout.

I believe that burnout is the culmination of many complex variables that so varies from person to person that it can best be handled by a comprehensive model, such as George Engel's systems informed developmental biopsychosocial model [3]. This model, I might add, is comprehensive enough that it would include wellness, resilience, and happiness however they are defined or however I may fluffily think about them. They are part of the solution, but certainly not all of it. Having taken such a strong stance vs. wellness, resilience, and happiness. Thus, I have no problem with ACGME's recent initiative to promote wellness, especially now that it explicitly includes wellness as a goal for the faculty and not just the residents in what I took earlier to be too much of a "zero sum game." After all, if the first-year residents aren't on call, someone needs to take their place. I believe that burnout solutions should address faculty, trainees, and patients. This goal certainly makes things more difficult.

I will now return to where I left off at the end of my previous Burnout column! "In truth, different people respond to stresses differently based on their individual developmental, bio, psycho, social determinants" (thank you George Engel). Due to this reality, responses need to include a multitude of plans addressed at the level of the individual, his/her work environment, and the larger culture.

At the level of the individual, we as psychiatrists, are wonderfully trained to assess, conceptualize, diagnose, and design treatment programs for those with "burnout," which is a syndrome and not a diagnosis. Are we not the experts at dealing with the symptoms/manifestations of burnout, such as stress, loneliness, rejection, fear of failure, sleep problems, depression, anxiety, attentional problems, perfectionism, poor self-esteem, problematic thought processes, self-defeating behavioral, interpersonal relationships, responses to trauma, masochism, attachment issues, exhaustion, sleep problems, lack of motivation, depersonalization, and lack of empathy that are listed as part of the syndrome of burnout in article after article. If in fact it is a variant of depression [4], as some articles suggest, are we not the experts at its assessment and treatment?

From the standpoint of the workplace, the task would seem to be designing and redesigning work environments so that they address the list of problems listed in the Mayo Clinic handout [5] that includes the following contributing factors: lack of

control, unclear job expectations, dysfunction, workplace dynamics, mismatched values, poor job fit, extremes of activity, lack of social support and work-life balance. Multifaceted and well-designed programs addressed at these workplace problems will go far in reducing burnout if they are actually implemented.

Melissa Ashton's Perspective piece in the November 8, 2018 New England Journal of Medicine entitled "Getting Rid of Stupid Stuff," [6] is a great short article that deals with several of the above listed factors. In this article, she details a program she implemented in which she involved and empowered staff to identify "stupid stuff" and to actions to eliminate and moderate some of the "stupid stuff," especially regarding the Electronic Medical Records. I might add that her project is a brilliant example of CQI (Continuing Quality Improvement) which often involves small focused achievable projects based on mutually identified real life problems. Such small projects, if successful, provide morale building opportunities. I caution the reader, however, to avoid the overwhelming tendency in CQI to do too many things at once, which I would add to the list of factors leading to burnout. The longest journey, as they say, begins with a single step. Start with one or two performable projects and go from there. I would also note from past experience, that such programs are seldom successful without true buy-in and cooperation of the leadership in your Institutions.

At the Medical School level, programs to educate physicians as to the signs and symptoms and seriousness of burnout including lectures, handouts, Grand Rounds, Town Halls, articles, and computer modules, should be mandatory, but are only a beginning. More complicated efforts will need to be implemented, including resources regarding treatment and support (EAPs, student health services, and referral programs, including impaired physician programs). Stigma Abatement efforts will be crucial as physician's are still hesitant to seek treatment for varying reasons, two of which are the failure and narcissistic injury in divulging one's weaknesses (n.b., The Superman/Superwoman doesn't say ouch syndrome) and fear of the consequences if one self-reports and seek referral programs that are available. Medical Schools should also provide education and access to wellness programs, yoga, fitness facilities, Balint groups[7], mindfulness programs, deep breathing exercises, relaxation techniques, as well as lectures/discussions/exercises on life-work balance (n.b., another "fluffy" subject in my estimation).

The goals of the totality of these efforts will be to create a trauma informed and secure "attachment-based" medical school cultures that promote compassion, care, caring, self-care connections, resiliency, and remove barriers to the delivery of quality care to our patients which is what provides physicians with meaning and is why they became physicians in the first place. Remember from my burnout article that physicians who find they are doing meaningful work, if only 20% of the time, are less prone to burnout[1].

At still higher levels, we need to realize that parts of our society are broken or were never created and press for social justice policies for not only physicians but for all citizens concerning adequate jobs and pay, appropriate medical and mental health insurance coverage and services, safety net programs; maternity, paternity, and family leave, quality daycare, and quality education for all throughout the life span.

As I list these aspirational programs, and wonder if they will ever occur, I am beginning to feel fluffy again, so I will finish my suggestions and not proceed to still higher,

perhaps ever more unrealistic levels of suggestions. I hope to have made it clear that dealing with physician burnout is not a simple matter in which one solution will fit all. I hope also that I will have suggested enough ideas that one can feel that they can easily play their part, whether big and small, in assisting in the amelioration of burnout.

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Attachment 16: An Impostor's Take on Impostor Syndrome

A young entrepreneur I see for therapy had been the COO of a very 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 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 woman 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:

1. 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.
2. 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.

3. 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 one nature end of the continuum are those with a "fixed mindset" who feel their success is due to innate ability while at the other end of the continuum are those with a flexible "growth mindset." Dweck's research shows that those with "fixed mindsets" want to look smart and avoid challenges that might challenge their genius status. Dweck favors a parenting style that validates flexible efforts towards goals. Upon reading her work, I couldn't help but to associate to a few 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, stature who promptly crashed and burned.

4. 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.

5. 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 success and failure and their consequences. 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 ones 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 explaining 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 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 academic processes of promotions 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 perhaps 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, even though impostor syndrome as an entity long predates that much talked about and often maligned generation of millennials.

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Attachment 17: Gaslighting: Casting Light on a Familiar Phenomenon

The Oxford Dictionary named gaslighting as one of its most popular words of 2018. Apparently, my patients read the Oxford dictionary, as they keep on bringing gaslighting up in therapy. Most tell me they feel like they have been or are being gaslighted. This is not a good feeling. The patients, mostly women, feel like they are victims and that they all want to know how to deal with it and not fall prey to it in the first place. One male patient guiltily admitted to gaslighting his past two girlfriends. He wanted to know why he did it and how not to go it again.

Gaslighting is one of those terms that I know what it is but wouldn't like to be forced to intelligently explain it to someone else. I kept on wanting to look it up and put off doing so, as no one asked me to explain it. I suspect that's probably because people seem to know what it is. Then still another patient brought it up on the same day that I read that the lead song on the Dixie Chicks' (now just the Chicks) long awaited album (after 17 years) was entitled "Gaslighter" in honor of the lead singer's ex-husband. I had clearly been sent on a mission by the culture and social media gods.

Gaslighting is defined as a form on psychological manipulation involving victimizers and victims in which a person or a group sews seeds of doubt in a targeted individual or group causing them to question their own memory, perception, or judgment. If successful, it undermines thinking and subjective reality and thus, can lead to cognitive dissonance, confusion, anxiety, depression, low self-esteem, somatization, and disempowerment in the victims. The victimizers, for their part, manipulate via the use of misdirection, contradiction, misinformation, and invalidation.

The term ostensibly comes from a 1938 play by Patrick Hamilton, a British playwright. The play was subsequently made into a British movie in 1940 followed by a more famous and better made American movie in 1944 that was directed by George Cukor and starred Charles Boyer and Ingrid Bergman. In this classic film, Charles Boyer marries Ingrid Bergman after a two-week whirlwind affair. They move into the London townhouse of her deceased aunt and guardian, a world-famous Opera Singer, who Ingrid used to live with until the aunt's violent murder during an aborted robbery ten years before. Strange events begin immediately to occur. These events include hearing footsteps, missing objects, and the dimming of the gaslights. The Charles Boyer character suggests that these events are his wife's imagination. She wonders if she is going insane. He does not dissuade her from her doubts about herself. He continues to question her sanity, and isolates her, and ultimately plans to have her institutionalized. The gaslighting continues until the intervention of a Scotland yard inspector (played by Joseph Cotton) who admired the aunt and fancies her niece that unmasks Charles Boyer as the villainous murderer of the aunt who had returned to the scene of the crime to find the jewels that he could not find at the time of the murder.

The legal sounding and narrow concept of gaslighting seems to focus on a victimizer who consciously manipulates a victim for some sort of conscious gain. The name comes from the movie in which Charles Boyer is clearly a criminal. This term "gaslighting" is associated more with women as the victims, although some articles attribute this to societal influences on women, their roles, and their personalities. Those that believe in societal influence feel that the process of gaslighting often involves males as the victims, even though when this occurs, the men are reluctant and

ashamed to talk about it, as this would go against their societally assigned masculine roles.

Psychodynamic explanations involve the projection of content by the victimizer onto the victim who interjects what is projected via projective identification. The ubiquity of the use of projections, introjection, and projective identification has led me to think of gaslighting less narrowly and more along a continuum. To do so expands the concept to variations that seem less straightforward and less criminal. The minute I made this switch, I came up with many related and familiar processes that fall along a spectrum of well-known and related interpersonal interactions. This led, in short order, to the linkage of gaslighting to personality disorders (sociopathy/ narcissism), racism, fictitious disorder by proxy, folie a deux, brain washing, child abuse, bullying, and co-dependency. The process of "grooming" used by traffickers and child predators came to mind, as did the tactics of cult leaders and dictators. Then came RD Laing's concept of demystification, Winnicott's Concept of the False Self, and psychological aspects of feminism and the male gaze. Certainly, Orwell's theories on the use of propaganda and "the Big Lie" daring people began to believe lies when they are stated often enough.

Special mention should, of course, be made to the Stockholm Syndrome, a condition that can occur when abused people identify with their abductors in a positive manner. This syndrome was coined after a 1973 bank robbery in Stockholm in which four hostages were taken and held captive for six days after which they failed to cooperate with police and raised monies for their abductors' defense lawyers. These events have been depicted in a 2011 movie called "Stockholm" with Ethan Hawke and Naomi Rapace.

The ease in coming up with related concepts made me turn to how underlying processes can be seen in politics. I immediately related to many friends and patients that railed against being gaslighted by President Trump. This quickly led to advertising, falling in love, and normal parenting being added to the list. It did not pass my notice that most of these phenomena involved power differentials' that are implicit in the relationships of children to their guardians. The underlying defenses and coping mechanisms can surely be used for good when the power is used for positive results for the "victim," as well as evil when it isn't with all points in between.

The literature lists the control strategies used by gaslighters. They include withholding and controlling information, countering/invalidating information, verbal abuse (often couched as joking), denial, diversion, diagnosis, trivializing, minimizing, and undermining. All these make the receiver of the gaslighting doubt and to not feel good about themselves. The victim responds usually in logical ways that ensure that the cycle continues and worsens. They respond with initial disbelief followed by subsequent defensiveness at what the gaslighter says and attempts to maintain the attachment. The latter response leads to the often-heard question as to why battered wives don't leave their marriages. Of course, having children involved makes the leaving is even more difficult. The victim may agree with the strategies used and apologize. They may make excuses and vow to do better the next time. They may become increasingly hyper-vigilant and hypersensitive and try to follow the commands/wishes of their abuser. The pervasiveness of these patterns of behaviors is reinforced by statistics that show that gaslighting is prevalent in 30-40% of relationships. I suspect that the only thing that has changed in the past few years is that the word is

now more well know. I note that despite being well known, my patients are quite inarticulate at explaining in detail what they mean when they say they feel this way. Martin J. Drell, MD Editors Column - Gaslighting: Casting Light on a Familiar Phenomenon Martin J. Drell, MD 6 7 Mentoring Matters Richard L. Gross The literature is quite straight forward, and to me, oversimplified as to how to treat this phenomenon. The treatment involves:

1. Being aware of the phenomenon, especially the narrowly defined description that involves one party consciously manipulating another for a specific goal. Psychoeducation and Google searches can assist in this regard.

2. Having the victim be aware that it is occurring.

3. Monitoring the process over time to identify patterns of behavior and one's responses to them.

4. Check for the usual signs and symptoms.

5. Involving yourself in a "healing" relationship that can provide validation for how one is feeling. This might include therapy, support groups, and friends.

6. Think about the part in your process, even though you may find it difficult to do, as both parties may be locked in mutually self-reinforcing interactions.

7. Try to change one's relationship if possible.

8. Be prepared to give up the relationship if your attempts to change it led to a worsening of the situation and it seems nothing will change it. This is difficult to do, especially in important, albeit flawed relationships. Professional help may especially be helpful at this point, especially as the relationship is often linked to other past important, yet flawed relationships with past significant others, as well as one's family of origin through numerous generations. Suggested References: From my experience in therapy with people who say they have been gaslighted, such tactics are often easier said than done.

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Attachment 18: LSU Faculty Evaluation Form

LSUHSC SCHOOL OF MEDICINE - NEW ORLEANS
FACULTY ANNUAL REVIEW FORM

Appointment (Hire) Date _____
Date of Review Meeting _____
(An updated CV is to be on file in the departmental office)
(One or more ACTIVITIES WORKSHEETS may be appended)

NAME _____

DEPARTMENT _____

TITLE/RANK / _____

% EFFORT DISTRIBUTION:
Teaching: _____
Research: _____
Service:
a) Clinical: _____
b) Administrative: _____
c) Other: _____

(NA = not applicable)

Major Accomplishments for Academic Year

Self-Assessment on Prior Goals
(If applicable, outline specific organizational features that facilitated or hindered progress toward goals and overall performance)

Objectives Prior Year	Progress Made

Specific Goals for Next Academic Year

Long Range Professional and Career Goals

SUMMARY ASSESSMENT OF ACADEMIC PERFORMANCE IN CONTEXT OF RANK AND STATUS
(1-7, lowest to highest;
1=definitely not meeting performance expectations,
4=satisfactory achievement of performance expectations,
7=definitely exceeding all performance expectations)

Numerical Self-Assessment:	1	2	3	4	5	6	7
Supervisor's Numerical Assessment:	1	2	3	4	5	6	7

Supervisor Comments and Action Plan for Professional Development

Supervisor: _____ Date: _____

Faculty Member: _____ _____

AADCAP
American Association of Directors of Child and Adolescent Psychiatry

American Association of Directors of Child and Adolescent Psychiatry

EVALUATION FORM

2024 Annual Meeting: New Division Directors Virtual Roundtable

With Martin Drell, MD, Victor Fornari, MD, & Margaret "Meg" Benningfield, MD

Directions: Please **circle** the number for each statement according to the following scale and return the completed form at the end of the presentation:

1	2	3	4	5	6	7
Poor	Fair	Good	Very Good	Very Nice	Excellent	N/A

1. The content of Dr. Drell's presentation was:	1	2	3	4	5	6	7	N/A
2. The delivery of Dr. Drell's presentation was:	1	2	3	4	5	6	7	N/A
3. The quality of Dr. Drell's AV/handouts was:	1	2	3	4	5	6	7	N/A
4. The content of Dr. Fornari's presentation was:	1	2	3	4	5	6	7	N/A
5. The delivery of Dr. Fornari's presentation was:	1	2	3	4	5	6	7	N/A
6. The quality of Dr. Fornari's AV/handouts was:	1	2	3	4	5	6	7	N/A
7. The content of Dr. Benningfield's presentation was:	1	2	3	4	5	6	7	N/A
8. The delivery of Dr. Benningfield's presentation was:	1	2	3	4	5	6	7	N/A
9. The quality of Dr. Benningfield's AV/handouts was:	1	2	3	4	5	6	7	N/A
10. The contribution of the presentation to the development of new insights and skills was:	1	2	3	4	5	6	7	N/A
11. The quality of group/peer discussion was:	1	2	3	4	5	6	7	

12. Was the presentation: ☐ too long? ☐ too short? ☐ about right?

What suggestions would you have to improve the presentation?

If the opportunity were available, would you choose to participate in this type of seminar again?

☐ Yes ☐ No ☐ Maybe

If you answered yes, which administrative topics would you like discussed in the future?