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Explicating and Enhancing Children's Psychological and Physical Health: Developments Over Time

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Thank you for the introduction, Omar, I appreciate that you overlooked my numerous screw-ups and when I acted like jerk over the years. A collection of those stories would have taken up all of our time.

I need to note that I have no relevant financial relationships or affiliations with commercial interests to disclose—except for the modest royalties I receive from the books and book series.

I was raised in a small midwestern town – where parents and teachers would often say, don't get too full of yourself, or you'll get a swelled head. And don't brag about yourself, nobody wants to hear you brag.

One can get a swelled head over a Distinguished Award and I am appreciative.

I do need to share how my actions have not always been Distinguished.

When I was 8 years old, I used to go to the park at the top of my street, and used a forked stick to prop open a bubbler water fountain. The water flowed into a series of channels and lakes with dams that I constructed with dirt, stones, and bricks. I rounded up a ragtag group of neighborhood kids to build their own offshoot canals. We did this every day for many months, every chance I could get.

One day, the water department guys drove up in a white city truck, put the propping stick in a pocket of their gray coveralls, removed the fountain, capped the pipe, and left without a word to us. There's the capped pipe.

The water has never been turned back on in the 63 years since. To this day, no jogger, no walker, or no neighborhood kid can get a drink at that park. Every other park in that town has a drinking fountain. To this day, I am sure nobody in that Missouri town knows why there is no water there or who was responsible for having it turned off.

I recently grabbed a screen shot of the capped pipe from street level view of Google Maps—it's like a monument to me. Now you know what kind of person you are honoring today. I just hope that other of my legacies have more beneficial impact.

So, what should be the roles of a Distinguished Career presentation?

Should it be:

(a) *the blustering braggart*

(b) *the septuagenarian historian*

Or (c) *the sage commentator* ?

Instead of focusing on one, I'm going to do all three. But, briefly.

Seeing as how this award is for a "Distinguished Career" it does throw one into that bragging mode – sort of pulling for talking about yourself. So, let's start with the bragging part which my teachers warned me about:

When I took my first job at the University of Alabama I was appointed Coordinator of the Clinical Child Concentration within the Clinical Psychology program. I was bewildered by the lack of standards and guidelines,

So, I started writing on training in the specialty and conducting research in clinical child and pediatric psychology. I interacted with early leaders in Section I, such as Marilyn Erickson, June Tuma, and Constance Fischer.

After 13 years, I moved to the University of Kansas and we created a new training program where I was for 28 years. KU offered an amazing chance to build on what I was writing about--dedicated specialty training. It wasn't easy-peasy; we faced both support and opposition and resistance to our very existence. [I'll skip the internal struggles at the university, but over a glass of wine, I'll tell all—or over a glass of whine.]

The chair of the then APA Committee on Accreditation initially refused to even consider our petition for approval. Accrediting a clinical child psychology program such as ours would not occur on "his watch" and that "they would pick us apart so nothing was left." And he did. It was DENIED.

His successor, a wonderful professional, was more helpful. Our accreditation was APPROVED a few years later, but not in clinical child psychology as a newly emerging substantive area as we petitioned but as a clinical psychology program with an "emphasis."

We were also told that many CUDCP and NCSPP programs opposed specialty training standards and even the presence of our program was threatening because they feared they would have to improve their own child training (and they didn't want any more dictates on their programs)

Looking back, because of those obstructionists and many other detractors, perhaps we worked harder to prove our worth and the importance of the specialty.

The KU program was able to hire excellent faculty including Kathy Lemanek, Eric Vernberg, Yo Jackson, Bridget Biggs, Ric Steele, Paula Fite, Christopher Cushing, Omar Gudino, Matt Mosconi, Julie Boydston, and now Kristy Allen.

And there are now close to 90 graduates of the program doing good things in the world and solving problems. I'm proud to have been a part of their lives. In my career I chaired 50 dissertations plus one ongoing this year.

In terms of my research career,

I made the decision early to follow multiple topics. Reflecting my diverse interests, and what my students brought, my KU Research Team chose the name, Stone Soup Group, from the children's story of collaboration and teamwork for different contributions to a common goal.

In addition to my interests, unexpected opportunities presented themselves--This included therapeutic classrooms for children with serious emotional disturbances; the Alvin Ailey dance camp for at risk inner city youth; and a pizza company funding community wide programs for child passenger safety.

My vita smells like a potpourri mixture of research topics, activities, and positions.

And you can sort my projects and publications loosely into these categories with many outliers:

Imitation and Modeling (social development)

Childhood Injuries (community wide injury prevention programs involving 10,000 school children)

Intensive Mental Health Program--therapeutic classrooms for children with serious emotional disturbance for 10 years and 7 classrooms

Alvin Ailey dance camp for at-risk inner city youth 20+ years High risk, exposure to violence and health risk behaviors, program evaluation

Program evaluations– of mental health programming, camps for children with chronic illnesses and community-based food supplement programs

Children with Chronic Illnesses (adjustment, quality of life, adherence)

Policy and Advocacy

Prevention/public health

Professional Issues Education & Training, Mentoring, Ethics, Clinical Practice, Service Delivery

World Health Organization International Classification of Diseases; clinical utility

These projects and others were fully engaging, and, I hope, useful to the world. But, you're lucky, I'm not going into detail on each of these!

My research started as an undergraduate with Mark Thelen at Mizzou in social learning theory with both basic research into imitation processes and applied modeling. (In graduate school, Albert Bandura once wrote me a note praising a publication, which went a long way to reinforcing me at a hard time with my advisor).

I'm proud of having accepted Dr. Bandura's last publication before he died at age 95 when I was serving as Associate Editor of *American Psychologist*. It is an outstanding paper, but I hope it wasn't a conflict of interest given my appreciation for him.

My first publications in the *Journal of Clinical Child Psychology* were case reports: An encopretic adolescent and a failure-to-thrive infant. These were followed by several research publications and the last couple were of a treatment outcome and a future directions piece invited by Mitch Prinstein.

Now, I do want to highlight a large scale research project that has consumed over 15 years of involvement.

My work with the World Health Organization on the revision of the International Classification of Diseases stretched me the most intellectually as it moved me out of my regular range of topics and activities, and offered me opportunities to work with some amazing experts around the globe.

With psychologist Geoff Reed as the lead scientist, we created an empirical research paradigm applicable to a range of mental and behavioral disorders. We met around the world to coordinate dozens of field trials.

We built a Global Clinical Practice network of close to 18,000 mental health professionals worldwide, and conducted studies in multiple languages with hundreds of participants from 164 countries.

We innovated a methodology in case-controlled field studies and the findings of multiple working groups met the primary goal of clinical utility. The teamwork continues today.

This was on a shoestring budget because the W.H.O. gives away the ICD and does not sell it for profit as a proprietary product.

You can visit ResearchGate for the Project listing and get open access articles by the multitude of collaborators and ICD disorders.

Development of Mental and Behavioural Disorders chapter, Eleventh Revision of the International Classification of Diseases and Related Health Problems (ICD-11), World Health Organization

Still bragging here,

Over my career, I had many opportunities to curate information through journal editing and book publications.

Although a journal editor might make many enemies with rejections, nobody has mugged me (yet), although I've been cornered at social hours by complaining authors. I certainly learned a lot about people's personalities and foibles. Journal

editing is self-serving in so many ways for keeping on top of advances in the field. I got to learn from some of leading researchers and clinicians.

Similarly, I also found book editing and writing sometimes tedious, but personally beneficial and instructive while trying to provide accurate and useful resources for trainees and professionals. You might not make minimum wage for the amount of work, but the books look impressive on your parent's coffee table.

And now, on Zoom calls, be forewarned, I look behind the speakers to see if my books are there.

Still bragging more,

Over time, I got to serve on a number of boards and committees, I was seated at many tables (sometimes in the hot seat). I hope that I justified my existence there by positive contributions. I'll discuss now only the most relevant position.

I was elected to the Section I board, and then to President. During my terms, given my interests, the Section formed a TF on Model Programs in Service Delivery in Child and Family Mental Health with a stellar group of clinical researchers. We evaluated submissions and ended up identifying 20 model programs that demonstrated successful implementation in meeting the needs of children and families. We eventually published a book under auspices of Section I and Division 37.

One innovative activity of Section I (1991-1992) was the Task Force Consultation Project chaired by Sandra Russ to site visit and consult on enhancing clinical child psychology training to follow up from the 1985 Hilton Head training conference (1991-1992). I believe 3 universities were site-visited; I did one. That activity just faded away.

But enough bragging, let's turn to the second role as *the septuagenarian historian*; to reflect on the field and its historical challenges and changes

Around the time I was building lakes and dams in Ridgeview Park, in 1959, Alan Ross published a book entitled *The Practice of Clinical Child Psychology*.

Dr. Ross was a visionary and served as the first president of the Section on Clinical Child Psychology when founded in 1962.

In the 1959 book and later at the 1985 Hilton Head training conference, Dr. Ross argued that the field needed to accomplish several tasks. We can now check off that we have fulfilled much of Alan Ross's visions:

Dr. Ross wrote that the field needed to:

(1) build formal organizations (and we have these!)

Society of Clinical Child and Adolescent Psychology

Society of Pediatric Psychology

Clinical Child and Pediatric Psychology Training Council (CCaPPTC)

Clinical Child and Adolescent Psychology Specialty Council (for COS)

→these are strong, vital organizations

And in developments Dr. Ross could not have predicted in 1959, the rise of technology has allowed these organizations to provide accurate updated information to parents, trainees, and professionals.

Websites of Division organizations

Effective Child Therapy

Helping Give Away Psychological Science

Info About Kids.org

→these are amazing resources

Second, Dr. Ross said the field needs to:

(2) establish scientific journals,

Journal of Clinical Child and Adolescent Psychology

Evidence-based Practice in Child and Adolescent Mental Health

Journal of Pediatric Psychology

Clinical Practice in Pediatric Psychology

→these are exceptional and important/and there are others.

New journals were required at the time because the predominant *Journal of Consulting and Clinical Psychology* did not accept child articles.

Third, Dr. Ross said the field needs to:

(3) hold professional meetings and conferences,

APA convention programming

SSCAP Clinical Practice Institute

JCCAP Future Directions Forum

Miami International Child Adolescent Mental Health Conference

Society of Pediatric Psychology Annual Conference

National Conference in Clinical Child and Adolescent Psychology in Kansas
Kansas held this for 13 meetings with D53 support and KU initially put up a large financial subsidy. I don't know what's up with the conference now, but I would love to see it revived in some form.

Fourth, Dr. Ross urged that the specialty needed to:

(4) develop training and education standards for clinical child psychology specialists.

Hilton Head Conference on Training Clinical Child Psychologists: Tuma, 1985 [[which was supposed to once and for all solve our need, but didn't]]

I contributed to this literature:

Journal of Clinical Child Psychology: Task Force of: Roberts, Erickson, & Tuma, 1985;

Training Recommendations by a Work Group of NIMH and the Section on Clinical Child Psychology: Roberts et al., 1998

As did Yo Jackson: 2 Jackson et al. papers:

The field <u>has</u> established:

<u>Postdoctoral</u> Residency Competencies for Clinical Child Psychology Specialty, inclusive of Pediatric Psychology (Task Force, 2018)

Also, we have:

Clinical Child and Adolescent Psychology Education and Training Taxonomy (Specialty Council TF, 2021)

not guidelines per se, but an organizational framework, serving as sort of an architecture

We now have ongoing: the

CCaPPTC Training Guidelines Development Task Force

chaired by Cathy Stough with multiple organizations represented including D53→we can hope to see training standards eventually.

Finally, Dr. Ross said we need to:

(5) achieve recognition by credentialing, accrediting, and licensing bodies.

CRSPPP recognition came in 1998 and continued renewals

American Board of Clinical Child and Adolescent Psychology

→it took some work to become formed mainly by Al Finch and Mike Nelson; it does an excellent job of credentialing specialists

What we don't have yet: Specialty accreditation at the Doctoral or Internship level

We do have: COA Postdoctoral Accreditation in Clinical Child and Adolescent Psychology

We do not have yet: Specialty licensing in the states (although if honest and ethical, the licensed psychologist must practice within trained competence)

Reflecting on these developments to where we are today, let's turn to my third role as (c) *the sage commentator*

The ***sage commentator*** concludes that, while not all of Alan Ross's recommendations can be checked off, we do have a robust and thriving field of clinical child and adolescent psychology.

*The SSCAP organization is exceptionally strong

*Our researchers are excellent

*Our clinical practitioners are now trained on a stronger evidence-base.

*Our training programs, frankly, draw the highest quality of applicants (I'm serious, and it's not just because we pay so well).

*There are many more jobs

All of that summary is nice, but the sage commentator also reminds that it wasn't easy-peasy. The way things are today is not the way it's always been. We almost didn't get to our present state of strength and vitality.

There were two early barriers with long-lasting impediments to developing the field.

In WWII, many psychologists had been drafted to work with soldiers as patients with later increased funding of VA hospitals which also paid for clinical psychology training, and put the focus on clinical (adult) psychology. I'm not saying that soldiers and adults didn't deserve treatment, but so do children, and the experiences put blinders onto the eyes of prominent psychologists who could not see anything but their own narrowed view of the world.

The second barrier was The Boulder Conference on Graduate Education in Clinical Psychology in 1949, which was soon after the war. The chair and participants were mostly VA and adult psychologists; they considered clinical child psychology, but said →no way.

The report stated that:

> "There are at present no generally recognized specialties within clinical psychology, except for the rather dubious distinction between work with children and work with adults" (Raimy, 1950, p. 189)

This position dismissed clinical child psychology and detrimentally influenced the development of proper training through accreditation policies rather restrictive on clinical child, but seemingly not on general clinical or clinical adult psychology.

Clinical (adult) psychology took over the brand name of Clinical Psychology:

> Coursework and experiences became adult oriented.
>
> psychopathology courses became adult oriented,
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> psychotherapy courses became adult oriented,
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> assessment courses became adult-focused,
>
> Research methodologies were adult-based, mostly college sophomores, and so on.

Clinical Child training became an "add-on" and the field had to fight against the hegemony of clinical adult psychology to create an identity of psychological research and service for children and youth.

In a position statement that may be seen as either plaintive or defiant, the Executive Committee of Section I asserted in 1969:

"Clinical child psychology is not a specialty. In fact, it is the general field, and adult clinical psychology is the specialty." (*Section on Clinical Child Psychology Newsletter*, Minutes of the Executive Committee, p. 9)

Yet, clinical adult psychology has predominated and remains today a form of tunnel visioned, implicit bias.

This mentality continued as a barrier into 1981 when June Tuma and a Section committee [Anthony Mannarino, Gerald Koocher, Marilyn Erickson, and Donald Routh] prepared a CRSPPP-type petition for APA recognition of clinical child psychology as a specialty. The petition was denied with the language that the committee "was confident concerning its decision that the materials did not support the recognition of clinical child psychology as a specialty" Maybe you are a "special proficiency."

It wasn't until 1997, when Section I, led by Susan Campbell and James Johnson submitted a petition for recognition of clinical child psychology as a specialty. This petition was approved in 1998.

And renewed in 2005, 2012, and 2019.

The consequences of this recognition are important, but the demands of the recognition process are enormous. We're talking 100s of pages of documentation.

In another historical event, in 1993, NIMH and Section I supported a writing conference with additional funding from the University of Kansas to prepare training guidelines which were then submitted to APA governance for approval after review and approval by the Section I board and the APA Committee on Children, Youth, and Families.

A prominent psychologist-politician who claimed to be a family therapist blocked it from consideration. When asked why he blocked it, he said he personally had not been involved in its development (although family psychology had reviewed it and had no problems); he objected to clinical child psychologists working with families. This was similar to the arguments by school psychology that we cannot work with schools--and we should stay in clinics because that was in our name.

Most importantly, this guy had the governance position to scuttle it—we learned a valuable lesson in power politics. The training recommendations were eventually published in an APA journal, *Professional Psychology*, but without the official approval by APA Council or accreditation.

These types of blockages and resistance have plagued our field repeatedly over the years.

Even from the start-up of our organization in 1962, our founders recognized the need to have a bigger presence within APA in order to get things done—to get a seat at the adults' table. We were a mere Section in the Division of Clinical Psychology—like sitting at the kids table for dinner. Feeling neglected and ignored even in 1973, the Section Board supported forming as a Division.

It was denied by APA because Division 12 opposed it.

The tipping point came many years later with egregious discounting of our concerns. In 1997-8, we re-proposed to move Section I to become an independent Division. This was again opposed by those who thought the move was divisive and harmful to Clinical Psychology and Division 12. We overcame the obstacles and achieved independence in 2000. This move opened opportunities and freedom to act to make SSCAP what it is today.

Because of continued opposition to accrediting in clinical child psychology, the board of the new Division in January 2000, unanimously adopted a resolution to

COA acknowledging the substantial growth in the field and asking for accreditation status. It was a brilliant piece of advocacy and it was ignored by COA.

The SSCAP resolution was also introduced as an APA resolution to Council of Representatives, and after approval by several caucuses and other Divisions, 37 & 54 and notably by some school psychologists, it still looked doomed to fail, so it was withdrawn rather than risk a public rejection. So, we have no accreditation in the specialty.

What did we learn from these multiple obstacles and many successes? As the saying goes, “if you don’t get seats at the table, you’re likely on the menu”, and, as Shirley Chisholm said: "If they don't give you a seat at the table, bring a folding chair." and better yet get into the biggest chair to fulfill our mission.

The Sage Commentator comments: There are still multiple challenges in society, both in America and internationally, that require our expertise;

We know all of this

*children, adolescents, and families are in dire need of mental health services

*the services are fragmented and inequitably unavailable

*funding for services is grossly insufficient

*there are inadequate numbers of trained professionals

*research funding is inadequate AND

*the pandemic has magnified these adverse situations

And we know this:

*the actions of our politicians and our governmental institutions, in general, [in a word] →suck.

We must enlighten them.

Just like the activists from the ‘50s and ‘60s onward, we must be persistent in pursuit of our goals, and vigilant in monitoring and reacting to challenges.

We must take on the good fight not just for guild issues, but because the profession benefits our public, the children, adolescents, and their families, who deserve competent assessment and treatment and service delivery as a fundamental human right.

We have the opportunity to make a difference, but we can only achieve this by becoming more proficient and involved in Advocacy.

We need to Advocate:

*On behalf of the discipline of psychology as a science

*On behalf of the profession of psychology for clinical services

*On behalf of clients/patients, especially underserved and vulnerable populations, and social justice issues, including equity and access to quality health care services, advocacy for patients' rights,

*For quality health care at individual, institutional, community, and systems levels in public and private sectors.

There was once a strong emphasis on child advocacy in the organization and this was reflected in the *Journal of Clinical Child Psychology*. The founding editor, Gertrude Williams, seen here as a formidable advocate against corporal punishment in the schools. In this picture, taken from the Journal, she looks quite intimidating, but she was compassionate professional with positive energy and passion for child advocacy. Her successor editor, Diane Willis, was an exceptional advocate for advocacy.

Some later advocacy articles were published, notably a 1991 special issue edited by Jan Culbertson and a 2005 special section by Karen Budd and Sheila Eyberg (under the editorship of Wendy Silverman).

However, I couldn't find an article in JCCAP since 2005 that had advocacy in the abstract and none were ever in EPCAMH. As an editor, I know how dependent journals are to what is submitted in order to publish, but journal images can be burnished to became attractive outlets for advocacy, child advocacy in particular, once again.

I was pleased to see this Summer 2022 issue of *InBalance* newsletter, in which Dr. Mooney wrote about "The Advocacy Imperative" on the concerns of transgender youth and health care providers in Texas and elsewhere.

Unfortunately, not many psychologists, including clinical child and pediatric psychologists, have the ability, knowledge, or motivation to engage in advocacy and public policy. There is often a sense that they don't want to get their hands dirty with politics, or that it's beneath their dignity, or that it's somebody else's job. As a result, our rising specialists have limited role models and limited education to develop advocacy competencies.

Now, I was fortunate to start my career at Alabama where they engaged in many social justice issues, including right to treatment suits against the state mental illness system (Wyatt v. Stickney) and for residents at the state mental retardation centers.

With these role models as colleagues, I was supported to do a sabbatical at the Vanderbilt Institute for Public Policy Studies (VIPPS) and worked with Penny Brooks, a developmental psychologist, and we later edited a special issue of the *Journal of Social Issues* and a *Social Policy Report*. (Amazingly, we had to justify why children's injuries is a social issue).

As a clinical child/pediatric psychologist, I testified in a Senate hearing and wrote a number of policy analyses.

I went to Capitol Hill at least twice a year for 25 years on behalf of child abuse legislation, funding for NIH, for common sense research standards, and for graduate student funding. I ate a lot of "rubber chicken" at fund raising dinners; and we even hosted our Congresswomen at KU—In this photograph, you see Yo Jackson who worked on this; and Joy Gabrielli when she was in the program. This may be the only time that my colleagues looked attentive to what I was saying.

Nonetheless, being an advocate means being a <u>persistent and insistent</u> voice on issues that matter.

Being an advocate is not performative activism, with only perfunctory statements of solidarity, and clicking likes on Twitter or Facebook, but we need to be willing to do the hard and persistent work of advocacy <u>and</u> <u>action</u>.

I make it sound like I was a major player, a king and queen maker, an influencer, but I wasn't; I was just around a long time and took advantage of opportunities. I did not enjoy these, I just felt advocacy was important and so necessary. I put up with the discomfort, always happy when we were done.

I advocate the following three priorities for our Advocacy

> "**Priority #1: Quality clinical services for children, youth, and their families.** It has not been sufficiently recognized that service to children, youth, and families requires special skills that go beyond adult work. . . .
>
> **Priority #2: Better training to serve children.** Professional competence to render quality clinical services to children, youth, and families is intrinsically related to training to attain that competence, to standard-setting or credentialing to confirm that competence has been attained, and to continuing education and reevaluation to assure the maintenance of that competence.
>
> **Priority #3: Better research to serve children.** Both basic research and applied clinical research on children, youth, and families should be improved and should be increased support. While maintaining research in fundamental determinants of psychological development, there should be increased support of research and research training on psychological disorders, diagnosis, assessment, treatment, rehabilitative, and preventive."
>
> Priorities & Future Directions in Clinical Child Psychology: Section I Executive Committee (1978, *The Clinical Psychologist, 32*, p. 18)

This should be our "elevator speech." AND, it is nothing new, though, it is official Section I policy from 1978.

Our future must take this direction to do more if we are to fulfill **The current Vision of SCCAP:**

> **"to improve the mental health and resilient development of children, adolescents, and families with a full commitment to promoting diversity, equity, and inclusion."**

As I reflect on my career, I am grateful I found superb mentors. Diane Willis, Gene Walker, Carolyn Schroeder, Phyllis Magrab, and others.

More than anything, I *never* wanted to disappoint them,

They were willing to challenge me with opportunities, call me out with decency and diplomacy when I screwed up, support me when I was right, value what good I could do. True mentors and major leaders in the field.

As I worked in this field, I learned from good people doing important work in those olden days: Paul Wohlford, Gerry Koocher, Don Routh, Dick Abidin, Al Finch,-Susan Campbell, Jim Johnson, Sandra Russ, Sheila Eyberg, June Tuma, Marilyn Erickson, Russell Barkley, Bill Pelham, and so many other many brilliant contributors, even if some were irascible at times. Maybe, I was the irascible one. Personal relationships and learning the latest and greatest ideas were the best rewards for working hard.

I was fortunate to go to Graduate School with Annette La Greca, who became our co-author, a lifelong friend, and fellow traveler, including service together on the Section I board. And I got to know another Purdue graduate Tom Ollendick, who also served on the board and as Journal editor. This picture is from 1993 when I had brown hair, a mustache, and was still full of piss and vinegar.

I owe much to my 8th grade girlfriend, Karen. Here we are in our windblown look. I stayed very busy in my career because Karen made me. She kept me on the straight and narrow and out of pool halls and honky-tonks.

My career was not planned or always planful. An educational commentator, Matt Reed, wrote just this week of "happy accidents" which helped people get to where they are (and I think many leaders in the field look back and see where this happy accident points occurred). I resonate to this concept: paraphrasing Reed, be accident-prone, put yourself in situations for people and activities are, go to where happy accidents happen, where the action is. This is a bit like Pasteur's comment that chance favors the prepared mind. Be ready.

Now, back to Missouri children as they played in park; I did have a team of neighborhood friends--making dams, lakes, and canals. This was a group of neighborhood kids creating, building, and excited to play in the mud and see their ingenuity. But still, the water was capped off and never restored. A KU graduate recently reframed my guilt legacy as: Maybe some of those kids desperately needed this social interaction. Maybe the water project took someone's mind off a difficult home life (and yes, there was domestic violence in that middle class neighborhood even in those "good old days").

I do have regrets, but, capping those 1950s pipes may have reduced exposure to lead—an important prevention of neurodevelopmental disorders, so some good may have come out of it. That'll be my story and I'm sticking to it.

I need to accept this Distinguished Career Award without too much of a swelled head, yeah I know, I did brag. I very much appreciate your forbearance of my story-telling, disguised as sage commentary.