Southern California

PSYCHIATRIST

Volume 68, Number 3 November 2019 Newsletter of the Southern California Psychiatric Society

President's Column

Our Calling

Erick H. Cheung, M.D.

Dear SCPS Colleagues:

It's been a rough several months, as many of you and your patients have been affected by the multiple fires in our region. The impacts are wide reaching, from direct threats to person and property to the disruption of professional practices and the psychological impact of traumatic events. I hope that you and your families are safe, and know that all of your efforts to maintain support for your patients during these challenging times are appreciated.

Fires, evacuations, and disasters of this magnitude can be frightening and traumatic for everyone. It is especially hard for children. It is also immensely difficult for our patients who are working hard to overcome mental illnesses or who may be predisposed to difficulty with anxiety, mood, and behavioral reactions in the face of significant stressors.

The calling for our profession is louder than ever at times like this. We provide strength for individuals and communities, like a beacon in the night. When we rise to the challenge, standing on our foundation of principles in medicine and our pledge to serve those in need, and we remain resilient by virtue of our training, we are living up to our calling as physicians and our practice as psychiatrists.

I am reminded of the humanity (not just the treatments) that we offer to our patients in distress and crisis, by William Carlos Williams in his essay "The Practice":

> "I have never had a money practice; it would have been impossible for me. But the actual calling on people, at all times and under all conditions, the coming to grips with the intimate conditions of their lives, when they were being born, when they were dying, watching them die, watching them get well when they were ill, has always absorbed me.
>
> "I lost myself in the very properties of their minds: for the moment at least I actually became them, whoever they should be, so that when I detached myself from them at the end of a half-hour of intense concentration over some illness which was affecting them, it was as though I were reawakening from a sleep. For the moment I myself did not exist, nothing of myself affected me. As a consequence I came back to myself, as from any other sleep, rested."

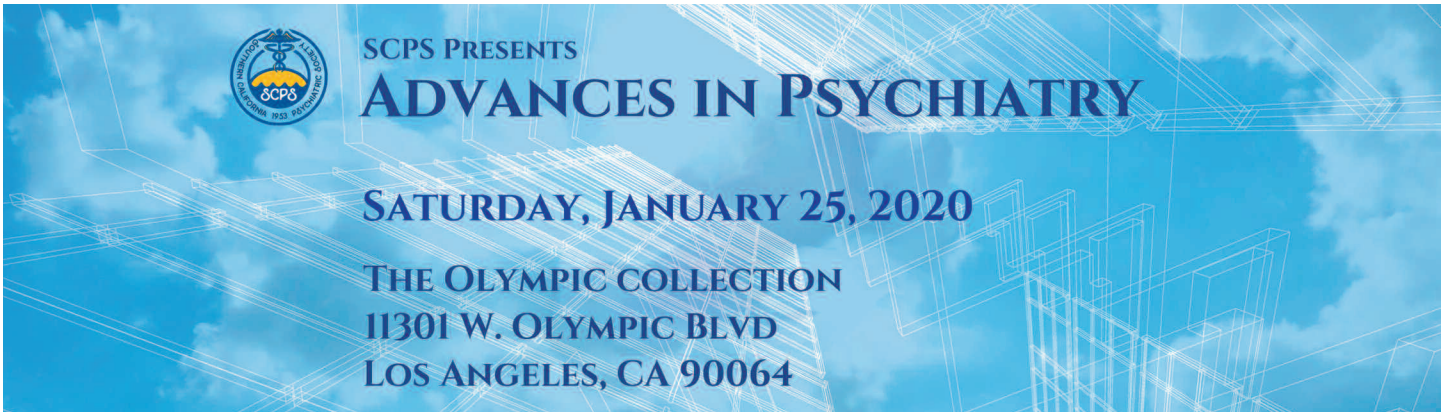
In This Issue...

Colleagues, take good care of yourselves. Remember that rest, respite, sleep, food and water are the primary tools of early intervention. We can share these basic tips for "normalcy" with our patients and also help them "name" the expectable reactions of sadness, numbness, anger, fear, and confusion. Encourage natural recovery processes such as talking to colleagues, spouses and family, neighbors and friends. Check in with other people who were affected. Social connectivity decreases the sense of helplessness and hopelessness, decreases isolation, and facilitates the recognition of persistent problems.

For resources to help children with coping, below are links to multiple resources available from the National Child Traumatic Stress Network:

Simple Activities for Children During Evacuations or When Playing Outside is Restricted
Strategies to Manage Challenges for EMS and Other First Responder Families
Trinka and Sam: The Big Fire - e-book for young children. (En Español)
Helping Youth After Community Trauma: Tips for Educators
After a Crisis: Helping Young Children Heal
Age-Related Reactions to a Traumatic Event
Parent Guidelines for Helping Children Impacted by Wildfires (En Español)
Wildfires: Tips for Parents on Media Coverage (En Español)
SAMHSA Disaster Distress Helpline: Call 1-800-985-5990 or text TalkWithUs

You may also find the Disaster Recovery Information Toolkit on our SCPS homepage: https://www.socalpsych.org/



Underappreciated and Stigmatized: Benzodiazepines in Clinical Practice
Richard Balon, M.D

Lithium and Mood Stabilizing Anti-Convulsants in Bipolar Disorders and Related Conditions
Mark Frye, M.D.

Psilocybin Therapy: Safety Concerns and Clinical Approach
Brian Anderson, M.D.

Mindfulness Interventions to Promote Sleep Health and Reverse Inflammation
Michael Irwin, M.D.

For Full Details and to Register:
https://www.socalpsych.org/event/advances-in-psychiatry/

Is the DSM the "Bible of Psychiatry"?

By: Matthew Goldenberg D.O.
SCPS Newsletter Editor

Halloween has come and gone, and Thanksgiving is nearly upon us. I want to begin this season of appreciation by thanking past SCPS President, Dr. Joseph Simpson, who took up my challenge to write about guns and the impact and implications on mental health. Last month, we published two articles that he wrote which discussed the current implications that mental health and the field of psychiatry have with the epidemic of gun violence and mass shootings that are occurring.

This month, we are featuring an article about the Diagnostic and Statistical Manuel (DSM-5) by Samuel Miles M.D. Dr. Miles gives his reflections through the lens of a long career in psychiatry that has spanned the last three versions of the DSM. The DSM is often praised and often ridiculed and criticized but it is what we have to depend on to practice evidenced based psychiatry. I want to thank Dr. Miles for his efforts and for providing some historical context and for sharing his perspective on this important topic!

In the pages that follow, you can also learn more about a pending action paper that was generated by SCPS leadership regarding the mental health of those who are detained in immigration detention centers and also find my Q + A with of president-elect George Fouras M.D.

With the fires displacing many of our colleagues and patients, I hope you and your family stay safe out there and have a very happy Thanksgiving.

Best,

Matthew Goldenberg D.O.
SCPS Newsletter Editor
Secretary (2019 – 2020)
Email: docgoldenberg@gmail.com

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Featured Article

Reflections on DSM

By: Samuel Miles, M.D.
Associate Clinical Professor of Psychiatry, UCLA

I was recently asked to review an article which criticized psychiatric diagnoses, specifically the DSM-5, as not being scientific. My reaction was similar to the one I experience when I hear someone describe the current version of DSM as the “Bible” of psychiatry. I was amused (Is a beaker ‘scientific’?).

As we know, the Diagnostic and Statistical Manuel (DSM) is a product of a committee process, with a goal of creating a reference for clinical practice and also for researchers to make accurate reproducible diagnoses of mental disorders. Therefore, in this way the DSM is a tool for scientific research, but it does not represent scientific truth. To the best of my knowledge none of the versions of DSM were delivered from the mouth of God.

Let’s take a step back and reflect how we got here. Through my training, the diagnostic manual of the time was DSM II. It was relatively simple, with distinctions between organic and functional disorders. The functional disorders were divided into neuroses, psychoses, and personality disorders. Endogenous depression was distinguished from reactive depression through vegetative signs. Schizophrenia was diagnosed with Bleuler’s four A’s, and/or Schneider’s first rank symptoms. Neurotics suffered. People with personality disorders made others suffer. I do not recall if DSM II included diagnostic criteria. Even if it did, we did not use them. (I do recall looking at a list of diagnoses at times when the diagnosis did not seem straightforward.)

The clinical interview was central to the functioning of a psychiatrist, as we lacked a uniformly agreed upon diagnostic criteria. Through our training, we honed our skills to assess and develop a therapeutic alliance, and to obtain data from the patient and from our reactions to the patient to lay down the groundwork for a treatment which might be most helpful to the patient. Evaluation was focused on understanding a patient’s functioning in work, social, and intimate spheres. The most important aspect of a diagnosis was a formulation, which distilled an understanding of who the patient was and why he/she was coming for treatment at that time. The formulation could include various perspectives, including conflicts, deficits, and defensive measures. In many ways, the lens by which the psychiatrist viewed the patient, was nearly as important as the patients clinical attributes when making a clinical formulation in the days of DSM-II.

Things changed with the publication of DSM-III in 1980. Diagnostic criteria were now atheoretical and based on data that was both observable and replicable. Thus, hallucinations, and delusions, were the basis for a diagnosis of schizophrenia. Less well defined “ambivalence,” and “autistic thinking” of the Bleuler criteria which are more difficult operationally were discarded. The goal was to create diagnostic criteria that could be used, and replicated by psychiatrist and non-psychiatrists, throughout the world. The biggest leap forward was that his diagnostic criteria was even replicable by psychiatrists with different theoretical perspectives. Giving every psychiatrist the same lens by which to view patients was essential in order to promote progress in therapeutic approaches and advances in the field of psychiatry and for psychiatry to become truly a global profession. Those goals and philosophies persisted with subsequent publications, most recently DSM 5.

Throughout these recent revisions, diagnoses were standardized, however, some remain quite heterogeneous. For many a certain number of category A criteria would have to be present with some from category B, etc. This meant that there were many non-overlapping ways to come to the same diagnosis. (For example, in DSM 5 there are almost 24,000 possible symptom combinations for panic disorder)
Heterogeneity does not bother me. There are many causes of pneumonia and there are many ways in which coronary artery disease presents itself.

What did initially bother me was the inner conflict I sometimes experienced during an evaluation between my desire to continue to hear what the patient was telling me, and my need to check off specific elements of history or

symptoms in order to make a diagnosis within a short period of time. It seemed like, at times, the diagnostic schema distanced me from my patients. Over time, I learned to reconcile the conflict with efficiency. I essentially conducted two parallel evaluations. One allowed me to understand my patient and his or her development with special focus on family, social, intimate, educational, and work function. The other allowed me to make a specific DSM diagnosis.

The categorical approach to diagnosis (which has persisted as DSM-III evolved to the current DSM 5) has its strengths and weaknesses. On the one hand, diagnoses were made to be much more reliable as various practitioners could more easily agree on the presence or absence of specific symptoms. On the other hand, important factors were excluded out of the diagnostic schema.

A positive result of the categorical approach is that we can now predict poor response to antidepressant medication for patients in the bipolar spectrum. Still there is more fine tuning to be done. As we know there is another subgroup of poor responders which is not predicted through DSM diagnosis – those who suffered early childhood abuse and neglect, who often require psychotherapy along with, or instead of antidepressant medication.
One aspect that DSM-5 seems to be lacking, is determining the functional level of a patient. While we want to know about our patient's symptoms and make an accurate diagnosis, we also need to measure and track their functioning. DSM-III and DSM-IV acknowledged this by including the GAF on Axis V. Unfortunately, that was too unidimensional to be very useful. It was dropped in DSM 5 and has not been replaced in a meaningful way.

Overtime, the DSM system has led to more consistent diagnoses. For example, we no longer use five different names for the same syndrome. However, there may be a problem with reliability. Interrater reliability for major depression in DSM-III was an impressive 0.80. In the field trials for DSM 5, it was 0.32. Something is wrong!
It's not perfect, but it is ours

Get to Know Your SCPS Board

By Newsletter Editor
Matthew Goldenberg D.O.

This is part of an ongoing series of interviews with members of the SCPS Executive Council Leadership. My hope is that this will allow our members to get to know their leaders. May a better understanding the history of SCPS and how our leadership got involved, inspire a new generation of future leaders to join and become active on the council.

For the November 2019 edition of our newsletter, I have the pleasure of presenting my brief interview with President-Elect, George Fouras M.D. We hope you enjoy getting to know a little more about your SCPS Council.

President-Elect, George Fouras M.D.

1) What initially sparked your interest in the field of Psychiatry?

Actually, psychiatry (adult) was the last thing on my mind. I thought I would go into primary care or pediatrics at the beginning of my training. It was only after having my child psychiatry rotation that I developed a desire to enter this specialty. The ability to work with kids and families was very appealing. You may also have an incredible impact on the life trajectory of a person, something that I found rewarding.

2) How has the field changed or been different than you initially imagined?

Yes, and not for the better. My training was very much in the bio-psycho-social model. Our approach to patient care was quite broad. Now, it seems like everything revolves around medications. The enormous pressure to prescribe has very much changed our practice. In addition, the ever increasing beauruacratic burdens, such as with EHRs and billing are not what I ever envisioned.

On the positive side, I find it impressive that what we have known empirically, has now been shown to be true by more rigorous methods such as advanced imaging and assays.

3) Tell us about the area of psychiatry in which you practice or your practice setting?

My entire career has been based on public or community psychiatry. Out of residency, I was offered a position to work with Child Welfare with the City and County of San Francisco. What started out as a small project, providing consultation to the Presiding Judge of the Unified Family Court regarding prescriptions for psy-

chotropics to youth in the child welfare system, led to my role both in the state and nationally on the subject of oversight of prescribing practices for youth in the child welfare and juvenile justice populations.

Another aspect of my work, now with Los Angeles County DMH, is that I am in a position to participate on developing statewide policies regarding children's mental and physical health.

4) What motivated you to become more active with SCPS originally? What brought you back and what were you doing in between?

This is another one of those things where I "fell into it". Dr. W. Arroyo was my supervisor in residency and approached me one day saying, "I think you should run for the MIT (now called RFM) Rep for Area 6". Not knowing what Area 6, or SCPS or an MIT Rep was, he went over it with me and the rest, as they say, is history.

During my time as the MIT rep, I would participate in most of the SCPS meetings. Then when I moved up to the Bay Area, I went on to become the ECP Rep, and from there, a variety of other positions with NCPS and CPA. For awhile, I was not active in organized psychiatry in California at all, moving over to the SF Medical Society, eventually becoming President, and active with CMA.

In 2017 I was offered a position back at LA County DMH and moved back to LA. It was like I had never left. Since I knew so many people here already, I very quickly moved back onto the SCPS Council, first as a councilor and now as President-elect.

5) Where do you hope to see the field of Psychiatry go in the next 20 years? Any plans or initiatives for your year as President of SCPS?

Hmm, how Jules Verne. I think that we will see an incredible expansion into imaging becoming available as a diagnostic tool and a greater emphasis on pharmaco-genetics, so that we can predict who will have a response to medication, rather than the trial and error method we have now. However, I also think that we will have a vastly different practice landscape in which there is some form of universal coverage or single payer, but I doubt we will have "Medicare for all", nor the elimination of private insurance.

There are a few things I hope to accomplish while President. It is likely that CPA will begin to bill members directly. Implementing that for SCPS will be a challenge, although a good one. I also anticipate that SCPS will be at the forefront of keeping CPA strong as our state affairs advocate. Lastly, I am hoping to encourage our members to become more politically active locally and enhance our relationship with the Los Angles County Medical Assoc. (LACMA) and CMA.

6) If you could go back in time, with what you know now, what advice would you give yourself related to your career as a Psychiatrist?

I'm not sure that it would be regarding specifically about psychiatry. For several years, I am watching medical students as they journey through medical school and find myself a bit envious. It was such a great time to learn and experience new things. Now, the tools they are using are fantastic. If I had it to do all over again, I would stop and savor the opportunity more than I did. I also wonder what would residency be like, now that I have some life experience. Also: If someone offers you a Medical Director position straight after residency. One word. Don't.

7) Surprise me. What is something we didn't know about Dr. George Fouras?

I love new experiences and adventure. My motto is to not let an opportunity slip by you. So, after my undergrad training and before medical school, I bought my first Harley-Davidson motorcycle and rode West from Ohio to Sturgis, SD to attend the rally there in August 1985. From there I rode to Seattle, then San Francisco before returning to Columbus to begin medical school. I showed up on my first day with a long beard and a ponytail, much to the chagrin of the Dean of the school.

More recently, I bought 12 laps at the Las Vegas Motor Speedway driving a Ferrari 430 GT racecar. Awesome! Ask me to show you the DVD.

Call to Action:
What I Learned from Writing an Action Paper Requesting a Formal Position Statement Regarding the Screening for Mental Illness of Detained Immigrants

By: Eric M Wagreich, M.D., PGY-3
LAC + USC Adult Psychiatry Residency Training Program
APA Area 6 RFM Deputy Representative

I currently serve as both SCPS Resident Liaison to the LAC + USC Adult Psychiatry Resident Training Program and as the Area 6 RFM Deputy Representative for the APA. As a result, I am often asked by my peers why they should become a member of a professional organization like the American Psychiatric Association (APA), the California Psychiatric Association (CPA), or our district branch, the Southern California Psychiatric Society (SCPS). Beyond the career support, networking, and opportunities for leadership, I stress the ability to advance and stand up our field, and advocate for our patients as major benefits and responsibilities. For this edition of the newsletter I am excited to share a recent example of how SCPS has enabled me to effect change within our field.

I was elected to serve as CPA RFM Deputy Representative at the beginning of this academic year. Since then, news headlines have been awash with countless headlines describing atrocious acts being inflicted on immigrants detained within camps, and the inevitable mental health crisis that would inevitably affect this vulnerable population. Journalistic exposés like a recent article in Politico have revealed a new spike in the frequency of suicide attempts within detention centers. Feeling frozen in outrage as I treated numerous patients who were becoming increasingly afraid that Immigration and Customs Enforcement (ICE) officers would kick open their doors and deport them or their loved ones, I ruminated over how I could be of use. A most fortuitous answer came in the way of a formal process within the standard organizational operations of the APA – an action paper.

As a reminder, an action paper serves to identify a particular deficit or problem within mental healthcare, the APA, or society at large, and propose a solution by way of action within the APA itself, be it in revising an organizational process or asking the APA to make a public statement about an issue.

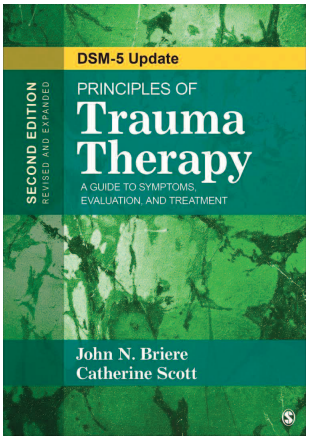
After scouring the APA's action paper database, I was surprised to discover that no action papers had previously proposed a formal position statement asking for the timely screening of mental illness within this specific population. I therefore wrote an action paper which proposes that the APA create a formal position statement regarding the screening for mental illness of detained immigrants, in addition to various other specifications related to their treatment and rights. I received an incredible amount of mentorship throughout my writing process in the form of guidance with the writing and submission process and acquiring sponsorships and endorsements. Doctor William Arroyo provided invaluable experience and time throughout the writing process, helping to identify crucial resources, editing the paper and providing encouragement and insight. Doctors George Fouras and Heather Silverman have taken the initiative to restructure the paper with the eventual goal of parallel passage through the California and American Medical Associations in order to further strengthen our call to action. The work is far from done, however, and the next step will be defending its passage at the APA Assembly Meeting in November.

While the ultimate result of this proposed action paper is unclear, and it does not inherently ensure a change in the behavior of the federal government and law enforcement, it is action. I learned that the action paper process gives a voice to experts and trainees alike within our field and to vulnerable populations. It provides a framework by which we can initiate change within our own organization and society as a whole.

This experience taught me that we are not powerless as individuals, and especially not as professionals, and by speaking out together, our collective voice has a greater chance of being heard. This is just another example which I can cite to my peers about how getting involved with organizations like SCPS, CPA and APA can empower each of us to make a positive impact on our society. I appreciate this opportunity to share my experience with the action paper process with readers of the SCPS newsletter and look forward to providing an update as it moves down the pipeline.

Principles of Trauma Therapy:
A Guide to Symptoms, Evaluation and Treatment, 2nd Edition
By J. Briere Ph.D and C. Scott, MD.
SAGE Publications, Inc
2015
440 pages
$78.00 Paperback
ISBN 978-1-4833-5124-7

Book reviewed by Kavita Khajuria, MD

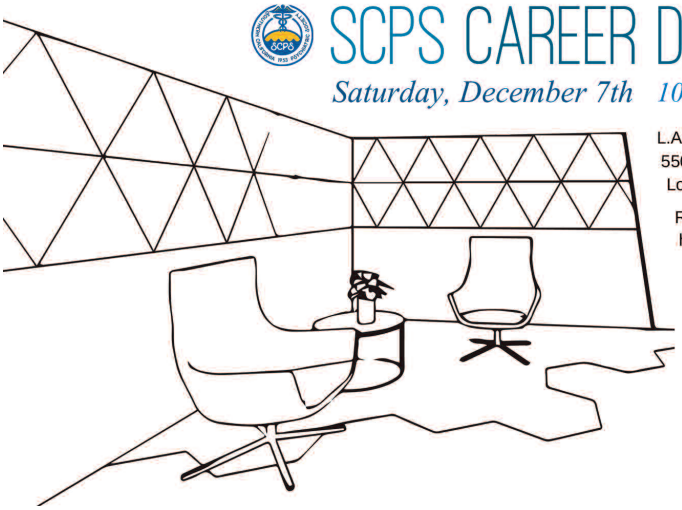


This book is a comprehensive review of trauma and trauma focused therapy, highly practical in application, described as a hands-on guide for clinicians and trainees. A theoretical basis for assessment and intervention include an ongoing discussion of the scientific and clinical realities impacting the treatment of trauma - which continue throughout the book. The first section reviews the basic concepts of trauma, its effects, and the assessment of trauma and posttraumatic outcomes. Major types of traumatic events are outlined and stress disorders are discussed, with reference to frequent comorbidities.

The second section discusses central issues in trauma treatment, including distress reduction, affect regulation, cognitive interventions, emotional processing, identity and relational functioning, mindfulness related to trauma, and treatment of the effects of acute trauma. It concludes with a chapter on trauma related psychobiology and psychopharmacology - intended for medical practitioners and psychiatric trainees, but could be a helpful review for the practicing psychiatrist. Authors cite empirically- supported trauma treatment techniques, and focus on 'titrated' exposure with an emphasis on sensitivity and mindfulness of the therapeutic window. Material is presented in a manner that is educational, humane and practical.

John Briere, PhD, is Professor of Psychiatry and Behavioral Sciences at the Keck School of Medicine, USC; Director of the USC Adolescent Trauma Training Center of the National Child Traumatic Stress Network; and Remote Program Faculty at the Institute for Meditation and Psychotherapy; past president of the International Society for Traumatic Stress Studies. He is author of a number of books, articles, and psychological tests in the areas of trauma and interpersonal violence.

Catherine Scott, MD, is Assistant Clinical Professor of Psychiatry and the Behavioral Sciences at the University of Southern California Keck School of Medicine, formerly the Medical Director of the Psychological Trauma Program at Los Angeles County + USC Medical Center, and the Associate Medical Director of the Psychiatric Emergency Service at Los Angeles County + USC Medical Center. Her clinical and research interests include human rights, women's issues, and the remediation of sexual violence and its effects.



SCPS CAREER DAY 2019

Saturday, December 7th 10:00am - 3:00pm

L.A County Department of Mental Health
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Lunch Included

Council Highlights
September 12, 2019

Matthew Goldenberg, D.O., *Secretary*

The meeting was called to order by Dr. Cheung at 7:12PM.

Introductions: All council members in attendance introduced themselves, their current position, affiliations, work-setting and any conflicts of interest.

Minutes from the previous meeting were unanimously approved.

CPA Resolution: Dr. Cheung discussed the highlights of the resolution and agreement. A discussion took place.
The resolution was unanimously approved.

Vacant Positions: Dr. Cheung discussed open Council positions from South Bay, Santa Barbara and Ventura. Nominations were made by Council members to fill the open positions.

APA Recruitment Grant: Dr. Cheung discussed a grant proposal to recruit and maintain membership of SCPS.

Newsletter: Dr. Goldenberg thank Dr. Bonds for his contribution to last month's newsletter of Race and Psychiatry. Dr. Goldenberg encouraged members to contribute articles and share the newsletter with colleagues.

Action Paper: Dr. Wagreich discussed his action paper about psychiatrist's role and the impact of the immigrant detention policies and detention centers. A discussion took place and suggestions were made for the submission process.

President-Elect Report: Dr. Fouras discussed the most recent CPA meeting highlights including centralized billing, CPA dues billing and CPA PAC funding. He recommended all SCPS members attend the upcoming CPA meeting.

Treasurer's Report: Dr. Ijeaku provided a financial update. Dr. Furuta has taken a medical leave of absence and Dr. Ijeaku (treasurer elect) has assumed the treasurer position. The Council discussed sending a letter to Dr. Furuta.
The financial report was unanimously approved.

Legislative Report: Dr. Shaner discussed the importance of CPA PAC and the legislative and bill submission/voting process and provided an overview of several bills related to the practice of psychiatry.

Assembly Report: Dr. Soldinger discussed that action papers will be presented later this month. He mentioned that the APA Assembly will next meet in November.

Membership Report: Dr. Ijeaku listed the members who joined during the summer. She then presented recommendations from the membership committee about new members to be put to vote.
The new members were unanimously approved.

Program Report: Dr. Gales discussed the recent spring meeting on Suicide and the upcoming educational meeting which will feature talks including benzodiazepines, bipolar disorder and other topics. The meeting will be held on Saturday, January 25th, 2019 at the Olympic Collection. A general discussion was then had about the content and purpose of future meetings.

New Business: There was no new business.

Old Business: Dr. Soldinger discussed that the future of PER still needs to be addressed and discussed the history of the organization and its purpose. Dr. Silverman provided additional information and context of the current status of the organization.

The meeting was adjourned by Dr. Cheung at 8:39pm.

The SCPS Annual General Membership Meeting Was held prior to the September Council Meeting. Here are some photos from that event.

President, Erick Cheung, M.D., leads the meeting.

Roderick Shaner, M.D., gave the legislative update.

On October 23rd, Steve Soldinger, M.D., attended
A CAPP (Californians Allied for Patient Protection) Reception
Honoring Assembly Member, Christy Smith

Film Review: Joker

By: Tim Thelen

As the controversy surrounding Todd Phillips' **Joker** is finally starting to fade, the film has already become the highest grossing R-rated movie of all time. Despite the widespread popularity, this is a film that presents many dichotomies - funny/sad; reality/illusion; violent/sensitive; good/bad, success/failure.

Joaquin Phoenix is amazing as the introverted rent-a-clown in the city of Gotham. Often without delivering any dialogue, Joaquin brings a physical and emotional quality to the character that is truly painful, and rarely seen in the cinema. His character, Arthur Fleck suffers from uncontrollable laughter and crying - Pseudobular Affect – PBA (after Google search) which usually manifests in people with ALS, MS and other neurological conditions. What works in **Joker** is the sympathy we feel for its central character, and that's why it's so upsetting when Arthur turns violent. We can feel the pain instilled from repeated bullying, insecurity, identity issues, and lack of career encouragement from his mother (whom he still lives with). Arthur is more likeable (and pathetic) than either of Robert De Niro's characters in **Taxi Driver** or **King of Comedy**, two movies from which **Joker** draws heavily upon.

Ultimately, however, this is a **Batman** franchise movie and not everything in the film rings true. The cartoon elements infiltrate the narrative as the film progresses. **Joker**'s presentation of the medical field is strictly comic-book stereotyping: the social worker/psychiatrist liaison is mechanical and entirely without warmth or sympathy. When it becomes apparent that funding for health services is expiring, the "therapist" turns cold and Arthur rightly accuses her of not listening to him.

When it opened a month ago, this film was heavily protested due to fears that the Aurora, Colorado shooting tragedy at a **Dark Knight Rises** screening could be repeated. But in all fairness, **Joker** is no more or less morally irresponsible than countless other violent films produced for profit over the last 50+ years. Even before the establishment of the film ratings board in late 1968, society has debated whether or not violent films inspire violent actions. We shouldn't forget the influence of stylized and often humorous presentations of violence and anger in films and TV over the years. As a kid who was "lucky" enough to be brought to R rated films as a 10-year old, I was easily impressed when Jack Nicholson insulted the waitress and shoved everything off the table in **Five Easy Pieces**. Or, for that matter: on television when Batman and Robin battled the Joker!

Should we take this kind of movie seriously? **Joker** is from the DC comic brand, but as filmmaker, Martin Scorcese recently commented, "Marvel movies don't really qualify as 'cinema,' these films are more like theme parks." **Joker** is sad, dark and violent, and does nothing to reduce the stigma surrounding mental health, but one could still find a valuable and timely message: access to guns can be deadly. Joaquan Phoenix and director, Todd Phillips have crafted a very effective movie, although thanks to the on-screen violence, a difficult one to recommend.

Rating: 3.5/5

The SCPS Fall Women's Brunch was held on Sunday, October 6th
at the home of Jacquelyn Green, M.D.
Our Speaker was Misty Richards, M.D., who spoke about Work/Life Balance.

The LA County NAMIWalk was held on Saturday, October 5th, at Grand Park.

Committee Corner
Program/CME Committee

The SCPS Program/CME Committee is the committee that develops the premiere annual Psychopharmacology Update, annual Spring Meeting, and other various CME events. The committee is always looking for members who have an interest in continuing medical education or accreditation regulations. SCPS members who also belong to journal clubs, or who read research papers on their own are a big asset to this committee.

The committee has been exploring ideas that would appeal to our younger members –so early career members and residents would be graciously welcomed to the committee roster. Early career psychiatrists and residents would be welcome to submit ideas even if they cannot commit to full committee membership. The committee has been looking at more digital options for meetings, like: live streaming our meetings, making our meetings available as enduring materials (for CME), or webinars, and more. Anyone interested in working on any of these projects would be more than welcome! In the meantime, please let us know if any of these meeting formats appeal to you by contacting Mindi at scps2999@earthlink.net.

The committee usually meets (randomly on Tuesday evenings) between July and September to plan the Psychopharmacology Update, and then again, between January and February to plan the Spring Meeting. During the rest of the year, the committee meets on an as-needed basis. Please let us know if you are interested in joining our committee! Scps2999@earthlink.net

See you at the Advances in Psychiatry Meeting!

ALL EDITORIAL MATERIALS TO BE CONSIDERED FOR PUBLICATION IN THE NEWSLETTER MUST BE RECEIVED BY SCPS NO LATER THAN THE 1ST OF THE MONTH. NO AUGUST PUBLICATION. ALL PAID ADVERTISEMENTS AND PRESS RELEASES MUST BE RECEIVED NO LATER THAN THE 1ST OF THE MONTH.

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