Southern California

PSYCHIATRIST

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President's Column

Celebrating the Holidays in the Time of Covid-19

George A. Fouras, M.D.

Thanksgiving is now behind us and we have the holidays of December to look forward to. This is a time for reflection. When we are able to get together with family and friends, reflect on the past, enjoy the now, and plan for the future. Many of us had made plans months in advance, booked our tickets, and looked forward to spending some time together after months apart. It looked like we would be able to balance the need for safety with our desire to forego another Zoom meeting for an actual face to face gathering, even if socially distant.

However, after Labor day the number of COVID cases kept rising. For the week prior to Thanksgiving, desperate measures were re-introduced trying to "flatten the curve" with little effect.

For those who have been watching the news, it is difficult to see the crowds at the airports. Many of us can relate to having "Covid fatigue" and long for the days when we can return to some form of normalcy, whatever that may turn out to be.

The announcement of 3 strong vaccine candidates that are seeking emergency FDA approval provide some hope. Yet, there is also reservations, not only among the public, but with our colleagues as well, as to the safety and efficacy of any vaccine.

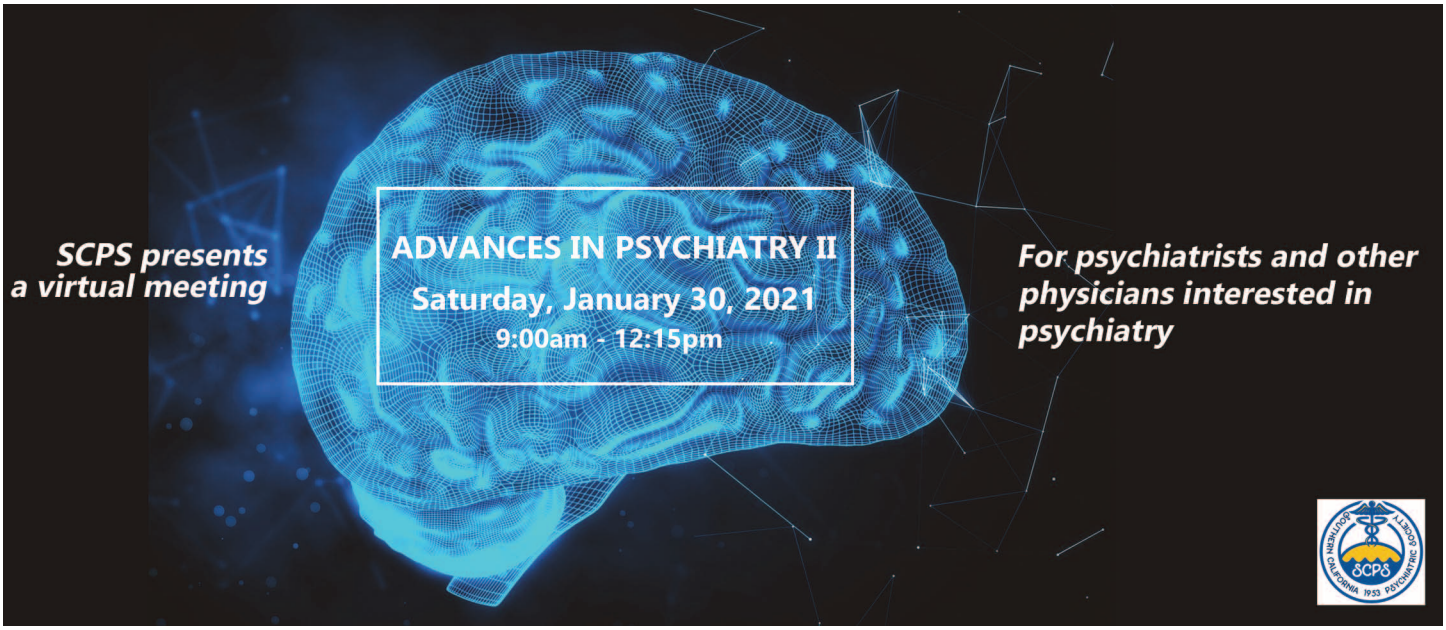
At the time of this writing, Los Angeles, and perhaps the State, is poised on the brink of having another high level lock down period to save our beleaguered healthcare system from collapse.

But there is light at the end of the tunnel. Perhaps not this month, and maybe not in time for holiday celebrations, but soon. Our profession is not only here to support our patients, but also our colleagues who are asked to provide service to our society often at great expense to themselves emotionally and physically.

Be safe. Take care of your patients, your family, and yourselves. As was once said in the beginning of the HIV epidemic: "Be here for the cure."

Thank you all for being who you are and for the work that you do. I wish you all Happy Holidays, and best wishes for the new year.

In This Issue...



Paradise Lost

Charles B. Nemeroff, M.D., Ph.D

Matthew P. Nemeroff Endowed Chair, Department of Psychiatry & Behavioral Sciences; Director, Institute for Early Life Adversity Research; Professor, Department of Psychiatry & Behavioral Sciences.

Dr. Nemeroff will discuss how genetic polymorphisms and epigenetics effect psychiatric disease vulnerability. This talk will also explain how a gene variation effects brain development and function so that the risk of a depressive episode or PTSD is increased. Dr. Nemeroff will explore and describe how early life experience produces persistent CNS alterations and its implications.

Coping with Covid-19: Technology Matters

Peter Yellowlees, M.D.

Professor of Psychiatry and Chief Wellness Officer at UC Davis Health

Dr. Yellowlees will review the impacts of the Covid-19 pandemic on mental health, and describe current telepsychiatry practices, including legal and regulatory changes, and how Covid-19 has led to a dramatically increased use of telepsychiatry, which he will describe as being good for the well-being of Psychiatrists and other mental health providers. He will conclude with thoughts on the silver-linings associated with the pandemic, and will discuss the long term trends for the use of telemedicine and other health IT technologies.

3 Hours Category 1 CME will be provided

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the American Psychiatric Association (APA) and the Southern California Psychiatric Society. The APA is accredited by the ACCME to provide continuing medical education for physicians. The APA designates this activity for a maximum of 3 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of theirparticipation in the activity.

Use This Link For Full Details and Registration

https://www.socalpsych.org/event/advances-in-psychiatry-ii/

Thank You

By: Matthew Goldenberg D.O.
SCPS Newsletter Editor

I want to thank all of the authors who submitted articles this year. Our SCPS Newsletter would not be what it is without your contributions.

During the pandemic we have averaged 500 to 600 unique readers per month, with some months as high as 900 readers. Since the newsletter has gone digital, this is the highest number of viewers we have had. This is a direct result of the high-quality articles submitted by our colleagues, for our colleagues.

The newsletter needs your continued participation. Please consider submitting an article in 2021. Feel free to reach out to me or Mindi (scps2999@earthlink.net), if you would like suggestions or help with a submission.

Please also have a very happy and safe holiday season. Look forward to seeing you all in 2021.

Stay safe,

Matthew Goldenberg D.O.
SCPS Newsletter Editor
Treasurer (2020 – 2022)
Email: docgoldenberg@gmail.com

The following message was sent in response to last months' Letter from the Editor: **Physician Safety**. The author has asked to remain anonymous.

"I was assaulted by a patient during a routine outpatient follow up appointment. It was from a patient that has Schizoaffective Disorder - Bipolar Type who was in an irritable manic episode. He got really agitated because I mentioned his diagnosis, which I have done before in the past without incident. He then punched me in the head. I attempted to escape, but he blocked the doorway. Even though I pressed a "panic button", nothing happened immediately, so I then pinned him against the wall, while he was punching my back repeatedly, which bought enough time for help to intervene. I ended up pressing charges against this patient and never heard from him again. Afterwards, arrangements were made in my office so that my desk was closest to the door. I consider myself lucky because I wasn't injured, had some capacity to defend myself, and was able to return to work the next day. My Supervisor offered me to take the next day off, but I refused to allow this incident to prevent care to my 14 patients scheduled for the next day. However, if this happened to some other colleagues, or if the patient was

more dangerous, the outcome could have been catastrophically worse.

I agree that some type of database (like CURES) may be helpful. Sadly, security was not increased after the incident."

This letter/op ed from SCPS member, Sanford Weimer, M.D., is in response to the dissolution of CPA and the letter that is enclosed with your dues statement for 2021.

"For many decades, the California Psychiatric Association (CPA) served as an extremely effective advocacy organization for psychiatrists due to the formidable team of the legislative affairs director, executive director and government affairs committee that worked well with legislators and their staff to protect the interest of psychiatrists and safety of our very vulnerable patients. During the last CPA meeting, the decision to pursue dissolution became unavoidable as the organization is unable to sustain itself and perform its duties. This occurred after notices of withdrawal from CPA were received from the San Diego, Orange County and Northern California district branches. Therefore, CPA will be no more as of the end of this month. …"

Dear SCPS Membership,

I was appalled and saddened to read of the demise of CPA. I was painfully reminded how much out of the loop I have been in recent years, yet my heart has always been committed to organized medicine.

We are sending the wrong symbolic message to our patients. We, who advocate for good communication, rational thinking and decision making and social cooperation are setting a bad example. This is a self destructive message to the state legislature where so much important decision making happens that affects our patients and our practices. It is a gift to those who would devalue the training of medical doctors and purport to slip into an attenuated role after a few hours of coursework. The successor fragments will no doubt have diminished political clout and confuse our members and the public.

I do regret not being there to argue for a solution not a dissolution. I have chaired GA committees in three district branches, garnered the first major attention to the CPPAC, raising quintuple the income during my tenure, one of the last MD county medical directors, and an early recipient of the Ed Rudin Award.

I say shame on those who put whatever concerns ahead of the strength and prestige of statewide membership, and I ask where is APA in all this which diminishes our national standing at a critical historic moment. I would be happy to participate, even chair, a committee to re-org the statewide solution.

Sincerely,

Sandy Weimer, M.D.

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Disaster Recovery in the Context of Social Capital and Covid-19

By: Kavita Khajuria, MD
SCPS Disaster Relief Committee

How important is social capital for recovery? Can trauma have positive effects?

I was asked these questions by a sociology researcher from Greece, shortly before the outbreak of Covid-19.

Social capital is the effective functioning of social groups through interpersonal relationships, with a shared sense of understanding, values, trust and reciprocal cooperation – considered vital for wellbeing. My initial assumption regarding the benefit of social capital in the aftermath of traumatic events was to affirm the positive. But to assess the implications of social capital, one has to delve deeply into the social fabric of the community. Preliminary reading affirmed a positive relationship in general - but some studies indicated mixed findings with nuances (1).

One study explored the relationship between social capital and disaster mental health outcomes (PTSD, anxiety and depression) in combination with individual factors (appraisal, coping behavior and social support). Results indicated cognitive social capital (with appreciation of community linkages) - to be negatively related to mental health problems, and structural social capital (community linkages) to be associated with anxiety, but not PTSD or depression. Results demonstrated affected populations to likely benefit - especially from a combination of individual stress reducing interventions and psychosocial interventions that foster cognitive social capital. These findings were in sync with previous studies which found the cognitive component of social capital to be negatively related to mental illness - and tight-knit social structures to not necessarily lead to better mental health outcomes (2).

In another model, social support was considered a key resource for understanding positive outcomes of life crises, and a predictor of positive change in the aftermath of traumatic life events. It was considered a possible precursor to personal growth by influence on coping behavior and by fostering a successful adaptation to life crises. It was thought that to seek social support improved social resources by provision of sympathy or reduction of isolation (1). Loneliness and isolation were also found to be a particular determinant of mental health in older refugees (3).

A different multilevel study assessed structural social capital and cognitive social capital - and found both components to facilitate collective efficacy - structural social capital provided the resources necessary for collective action, while cognitive social capital created the right mindset to engage in collective action. These findings suggested that in communities of higher social capital, disaster affected individuals tend to rely on the social context to address disaster related demand, and may not need to employ individual resources. It also found that high social capital decreased the association between the individual emotional response to disaster and post traumatic stress (4).

Then there are other experts who emphasize that “no two persons experiences of an event are identical, or even similar... the mechanisms by which social transformations occur seem to often lie in the transformations in individuals” (5), underlying the potential for growth from adversity or trauma. And on another perspective, others have demonstrated that informal ties, particularly neighbors, have been the ones to regularly serve as actual first responders - communities with higher social capital and community leadership tend to demonstrate the highest satisfaction with community rebuilding and the quickest recovery (6).

How does this relate to Covid-19 trauma recovery? The above results generally related to the more common worldwide traumas which didn’t necessarily exclude in-person contact. Traditionally, the emergency extension or neighborly nod typically involved some sort of brief contact, usually visual, and in-person. But the coronavirus does not allow nor reward in-person contact – on the contrary, physical exposure is returned with increased risk and illness. Physical distancing may also aggravate social decline, but doesn’t exclude social connection - digital and online connections have been the human link for many, minimizing the effects of social isolation.

Social capital has various forms, including bonding and bridging. Bonds are formed through common interests and mutual attractions, while bridging is embedded in the connections that link those from different communities and backgrounds (7). Contained within both lie vertical connections that span all power gradients - often referred to as links. Bonding, bridging and linking are related, yet distinct. According to data on crisis recovery, all 3 forms are necessary for an effective recovery - exemplified by studies on earthquakes and pandemics (8). While one or two forms may provide a partial safety net, the greatest benefits are derived when all three are present - as noted by Pitas and Ehmer, access to N95 respirators and face shields illustrated the point, when state, federal and foreign entities were in competition.

Although digital media has taken a crucial role in communications, it makes meaningful bridging and linking more difficult (8). Furthermore, online social capital is a relatively new phenomenon, and despite the link between social media and social capital, existing research doesn't address the current reduced face-to-face communication in this context, so the results remain to be seen.

In the end, it's projected that social connections of all forms will be critical in the collective response to Covid-19 (8). Although the effects of social media are less well understood, digital and other media-related forms of communication remain crucial for social connection, and will likely be valuable tools in future crises.

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Dedicating Ourselves to Equity, Diversity, Inclusion, and Justice: UCLA/David Geffen School of Medicine Psychiatry Residency Training Program

By: Katrina DeBonis, M.D.

As someone who graduated from this residency program and served on the faculty for eight years before becoming the Director of Residency Training in 2018, I can attest to the ways our residency program and department have demonstrated dedication, innovation, and growth with regards to health equity, diversity, and inclusion. This is not the work of any single faculty or resident but is the result of an immense team effort. I wanted to highlight some of our work from the past three years, efforts that continue to evolve and signal our dedication to provide an inclusive, innovative training environment that fosters the next generation of leaders in psychiatry.

Holistic Recruitment: Approximately four years ago, our program started redesigning applicant screening, interview, and ranking procedures with the goals of minimizing bias and enhancing equity. These efforts have included implementation of a holistic review process for all applicants and a restructuring of the way we discuss the strengths of applicants at rank meetings to minimize sources of bias and improve equity in the selection process for applicants. Our program has also added interview days with a focus on justice, equity, diversity, and inclusion. We created a Visiting Elective Scholars Program to provide applicants from backgrounds underrepresented in medicine funds to support their travel and lodging while doing a sub-internship in psychiatry at UCLA. With implementation of these measures, we have seen the representation of our residency training program better approximate the representation of the applicant pool at large, and that of our diverse Los Angeles community. Compared to five years ago, residents who identify from backgrounds historically underrepresented in medicine have grown from 10% to 27%.

Health equity, structural competency, and anti-racism in education: Over the past few years we have focused our energy to ensure our curriculum prepares our residents with the knowledge, skills, and attitudes to effectively work with patients from diverse backgrounds and to advocate for equitable care for under-resourced communities. We have developed two concentrations, or leadership pathways, in Community and Global Psychiatry (www.uclacgp.com). In addition, we have added 49 hours of new didactics that span the four years of training that teach structural competency, social responsibility, and physician advocacy via modules focused on local public health crises: homelessness, criminal justice system, and immigration asylum. Classes include transgender mental health, the history of racism and legacy of slavery in psychiatry, and the closure of Los Angeles' Men's Central Jail and alternatives to incarceration.

Clinical Experiences: We have expanded our community psychiatry offerings with new clinical electives in a range of public mental health systems, from the VA to non-profit organizations and from field-based homeless services to jail diversion programs. New clinical electives include rotations with the Department of Health Services Office of Diversion and Re-entry, Department of Mental Health Urgent Care Center, homeless services with The People Concern, and the Los Angeles Human Rights Initiative (asylum clinic).

Leadership: Our residency program has created a resident-faculty subcommittee within the Residency Oversight Committee on Justice, Equity, Diversity, and Inclusion. For the past three years, EDI chief residents have helped to lead innovative programming for our program, such as Social Justice Teach-ins and physician advocacy events. Our Department has established a LGBTQ+ Pride Alliance to foster and strengthen our department's LGBTQ+ community. Dr. Eraka Bath as the department's Vice Chair for Equity, Diversity, and Inclusion, has been transformative in identifying areas of improvement, organizing faculty development, and addressing long-standing gaps in recruitment and retention of faculty from backgrounds under-represented in medicine.

All of the work above has been accomplished through resident and faculty innovation and collaboration. Some of our residency program reforms are described in more detail in peer-reviewed publications. While our residency

program and department continue to have much work to do to promote diversity and inclusion in our learning environment, we have dedicated ourselves to prioritizing this work in all aspects of our residency program. In just the past three years, we have seen improvements in creating more equitable recruitment processes, the development and implementations of a structural competency and anti-racist curriculum, expansion of clinical opportunities to work with under-resourced and structurally disadvantaged communities, and the development of departmental leadership roles to hold us accountable and drive us forward towards our mission of integrating principles of Justice, Equity, Diversity, and Inclusion into all institutional policies and practices.

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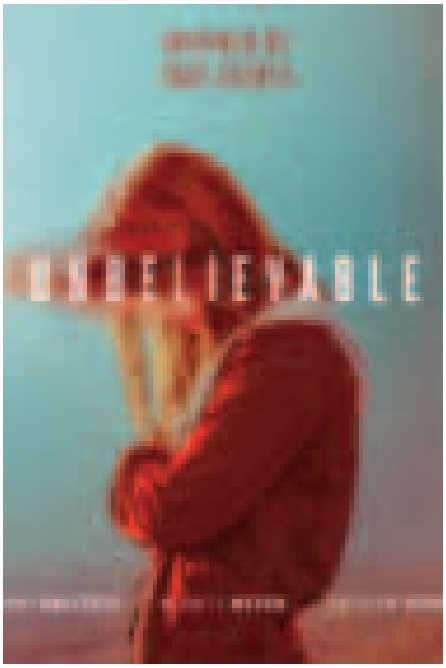
Congratulations to SCPS member, Martha Koo, M.D., who has been elected to the Beach Cities Health District's Board of Directors.

We urge SCPS members in the South Bay to reach out to Dr. Koo with any concerns or needs specific to your area.

“Unbelievable”

Media Review

By Kavita Khajuria, MD.



‘Unbelievable’ is a superb and heartbreaking Netflix miniseries based on a true story, starring Merritt Wever, Kaitlyn Dever, and Toni Collette. It originally aired in September, 2019 and was based on the 2015 news article “An Unbelievable Story of Rape”, authored by T. Christian Miller and Ken Armstrong. It’s based on a story about a teen charged with a false report of rape, and runs parallel stories of women in 2008 and 2011 who were sexually violated by the same serial rapist. It takes the viewer through the journey of the first victim in its entirety. One can sense the victims shock, belief and disbelief, but perhaps more disturbingly – the disbelief by her foster mothers and the police. It also portrays two female detectives assigned to the cases - their relentless dedication and the inherent risks involved in this type of work.

Having worked in a forensic setting and having conducted forensic psychiatry evaluations in other venues, I can say with certainty that this story resonates with reality on many levels. The depth of the victim or survivor story is personal – yet universal. It can be spoken or unspoken, heard or unheard, and can get lost in the shuffle of the justice system. Acceptance or denial can be other challenges. The false reporting charge and the gross misjustice that initially ensued in the series was hard to stomach. Despite an unwillingness to seek or receive therapy, the benefit of an empathic or experienced therapist can be invaluable, as it becomes evident here. This series may enhance professional awareness and growth, given the intricacies it portrays based on true events. Along with superb acting, it conveys critical messages, including the innumerable costs of sexual assault and the inherent complexities within the criminal justice system.

Intimate Partner Violence:
What You Should Know/What You Can Do

Ijeoma Ijeaku MD MPH FAPA
President-Elect Southern CA Psychiatric Society
Rahn Bailey MD, DFAPA, ACP
APA Minority/Underrepresented (MUR) Trustee

On March 11, 2020, the World Health Organization (WHO) declared the COVID 19 a pandemic, just a month after it had previously declared that the condition is a public health emergency of international concern. Within several days of this declaration, various states in the US put into place the shelter-in-place/stay at home orders. The order to stay home gave rise to various levels of anxieties about the nature of the novel virus including its transmission pattern, associated symptoms, and fatality rates. The schools were shut down, companies cut back on their productivity and even shut down in some cases leading to the worst unemployment situation in US history since the Great Depression with over forty million job losses. Of those who still had jobs, some took pay cuts and most had to start working from home. As our homes became the new hub for all aspects and domains of our lives, the impact of the physical distancing from others began to really hit us. Even as the public health concern for viral transmission was the top priority, there was also concern among social services providers that there would be a rise in intimate partner violence as vulnerable individuals had to shelter in place with their abusers.

According to the Centers for Disease Control and Prevention (CDC), Intimate Partner Violence (IPV) is a serious, preventable public health problem that affects millions of Americans. The term “intimate partner violence” describes physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.

Data from CDC’s National Intimate Partner and Sexual Violence Survey (NISVS) indicate:
About 1 in 4 women and nearly 1 in 10 men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime and reported some form of IPV-related impact.
Over 43 million women and 38 million men have experienced psychological aggression by an intimate partner in their lifetime

IPV starts early and continues throughout the lifespan. Teen dating violence (TDV) is IPV in adolescence. An intimate partner kills twenty percent of homicide victims in the US and a current or former male intimate partner kills over fifty percent of female homicide victims in the US according to data from US crime reports. Survivors can experience mental health problems such as depression and posttraumatic stress disorder (PTSD) symptoms. They are at higher risk for engaging in behaviors such as smoking, binge drinking, and sexual risk behaviors.

According to the editorial from New England Journal of Medicine titled ‘A Pandemic within a Pandemic — Intimate Partner Violence during Covid-19’, people of all races, cultures, genders, sexual orientations, socioeconomic classes, and religions experience IPV. However, such violence has a disproportionate effect on communities of color and other marginalized groups. Economic instability, unsafe housing, neighborhood violence, and lack of safe and stable childcare and social support can worsen already tenuous situations. In addition to personal approaches, IPV needs to be addressed within the context of addressing social factors, especially against the backdrop of a pandemic that is causing substantial isolation.

According to a recent publication in emergency radiology, there was a higher incidence and severity of physical intimate partner violence (IPV) during the COVID 19 pandemic compared with the prior three years. These results suggest that IPV victims delayed reaching out to health care services until the late stages of the abuse cycle during the COVID-19 pandemic.

As Psychiatrists navigating tele-psychiatric services and utilizing other non-traditional means of psychiatric care in the pandemic era, we owe it to our patients and their families to specifically screen for possibility of intimate partner violence in addition to our usual psychiatric evaluation given the facts that there is currently under reporting of intimate partner violence with very grave outcome. Psychiatrists should ask pertinent questions with empathy. We should utilize welcoming, nurturing and non-judgmental approach when we screen for IPV to increase the likelihood of identifying victims. Screening should be of utmost importance when there are indicators that our patients have risks factors such as loss of employment, financial hardship, substance use, issues with childcare services and other support systems as well as history of prior abuse/violence.

When we identify victims, we should evaluate further for safety and homicide risk and we should quickly connect these victims to the appropriate social support services. We should consider referrals to other medical providers and therapists as necessary. We should also consider treating psychiatric disorders that accompany these situations such as Depression, Anxiety and PTSD.

Find help in the community by calling the National Domestic Violence Hotline at 1−800−799−7233 (SAFE) or TTY 1−800−787−3224.

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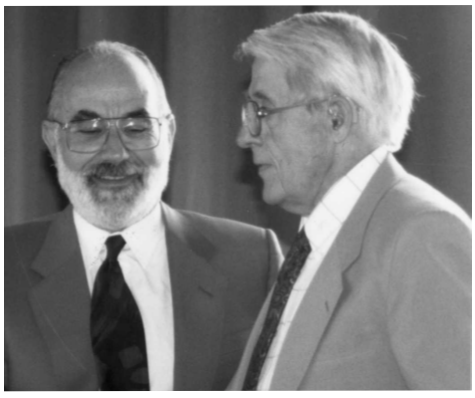
FLASHBACK PHOTOS

Drs. Edelstein, Silverman, and Iris Onkin.

Carlo DeAntonio, M.D.



Drs. Lipson and Satterfield.

Dr. Sue Turkel.

Council Highlights
October 8, 2020
Eric Wagreich, M.D., *Secretary*

Outline of Notable Meeting Events and Discussion

President's Report
AB890 Update
Dr. Shaner shared an update regarding the recent passage of AB890, along with the note that there is current confusion regarding the actual implications of its passage, and helped to clarify what the outcome may be, and the space for SCPS to help to guide future implementation to best protect the care of individuals with mental health problems.

Inland Empire NAMI Walk A motion was made to continue to support the NAMI Inland Empire, and passed with only 1 vote in opposition.

President-Elect's Report
Update from General Membership Meeting
Dr. Ijeaku presented an overview of the General Membership Meeting, and noted an overall positive reception from the meeting. Mindi shared that there was positive feedback from members. Dr. Goldenberg also noted his agreement with the idea of having additional such meetings via Zoom to keep members involved and informed.
Nominating Committee
Dr. Ijeaku provided a brief overview of the status of the Nominating Committee and invited those interested to become involved in the committee.

Diversity and Culture Committee
Dr. Wagreich presented the Diversity and Culture Committee's recommendation and subsequent motion to hold a special election which would result in a change in bylaws in order to create two new voting member positions on Council – a Minority and Underrepresented Representative and Deputy Minority and Underrepresented Representative. A vote was held with 23 in favor, none against, and none abstained. The draft recommendation was approved and plans were made to send a ballot to general membership for the special election.

Vetting Committee Report
Dr. Cheung shared an update from the Vetting Committee, including that PPAC has continued to establish itself, along with various contribution tiers for benefits for contributing member organizations. A discussion occurred regarding the implications of the contributions going toward PPAC and how SCPS, along with PPAC can continue to shape mental health advocacy in California.

Disaster Relief Committee Report
Dr. Chang provided an update from the Disaster Relief Committee, and shared the current charge, the current pressing issues the committee is addressing, and announced the upcoming Red Cross Training.

Newsletter Report
Dr. Goldenberg requested guidance from Council regarding whether to publish an editorial in the newsletter. A motion was made by Dr. Soldinger that "We accept the article with the current revisions and that moving forward, all articles go first to our Newsletter Editor " a discussion was held. The vote was called to question and the motion passed.

Treasurer's Report
September Financials and Cash On Hand Report
Dr. Goldenberg shared the Treasurer's Report, which reflected that for overall income we are under budget by about $30,002; for annual expenses we are about $14,265 under budget; and about $3,263 under cash-on-hand compared to last year. A motion was made to accept the Treasurer's Report, which was passed unanimously.
Office Lease Update
Dan Willick provided an update regarding the possibility and options surrounding lease abatement versus termination.

Exploring new revenue sources
Dr. Goldenberg shared some options for additional sources of revenue including private sponsorship. After some discussion, it was decided that Finance Committee would look further into various revenue streams

Membership Report:
Dr. Ijeaku provided the membership report and recommended we accept the new members, whom were accepted unanimously.

Legislative Report
Dr. Soldinger provided a brief report, and Dr. Shaner shared a list of some recent successes stemming from state legislative advocacy. Dr. Cheung shared an update regarding changes to laws surrounding EMS workers and delivery of care.

Program Report
Dr. Gales provided a brief update regarding some upcoming programming for CME opportunities in January for psychopharmacology and telepsychiatry, and some upcoming podcast plans. Dr. Kelly also shared news of another upcoming training on November 22. It was reported that SCPS' ongoing CME program would receive CME credit through the APA joint sponsorship program unless SCPS produces multiple options for CME through enduring materials.

Assembly Report
Dr. Red shared that Area 6 will be meeting in the coming week, and had no further updates.

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