Southern California

PSYCHIATRIST

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President's Column

Politics Trump Science..... Again

George A. Fouras, M.D.

As psychiatrists, we understand that the importance of youth attending school is far more than obtaining the skills of the "3Rs", reading, writing, and arithmetics. Schools provide the environment to develop social skills and to explore emotions in a safe and nurturing place, and, in general, contribute substantially to the normal developmental trajectory of children. Some of the worst adverse outcomes related to not receiving these benefits can be seen in our jails and prisons.

Soon after the Covid pandemic forced the closure of skills onto online forums, parent, educators and advocates have been clamoring for a return to in person classrooms. In the beginning, science, drove the decision making process as we began to understand how the virus was transmitted, treatments were being investigated, and hospitalizations soared. However, once it became apparent that a vaccine was likely, and quickly, politics reared its head, demanding attention.

Now that frontline healthcare workers have been largely vaccinated, we turn our attention to who should be next. The first week of March AB 86 will come before the legislature. This bill would provide $2B in incentives to open our schools again. It initially targets grades kindergarten through second grade by April 1. If a county is in the red tier, then all elementary schools would be eligible and at least one grade in middle or high school. Of note, is that it does not mandate openings but rather, leaves the decision to local school districts and unions.

Not coincidentally, it comes at a time when Governor Newsom is facing the likely prospect of a recall election.

Los Angeles Unified School District is poised to receive 4000 doses of vaccine in the first week of March. They have put forward that they would need 25,000 doses in order to adequately vaccinate school personnel, and would take 5-6 weeks, making mid April the target to reopen. However, this is also contingent on negotiations with United Teachers of Los Angeles, who oppose reopening schools until Los Angeles moves from the purple to the red tier. A position that most would say is not based on science.

But amid all of these discussions and negotiations, one group: the youth and their families, have been left out of the equation. We have already seen the inequity in that some private schools have already been able to open while public schools have not. For schools to reopen, what about ensuring that children have the opportunity to receive a vaccine? In addition, communities of color: Latin and African American predominantly, have been disproportionately affected by the virus. They have experienced first hand, the tragic effects of the virus on their families as their loved ones become sick and some die. Even now, that the vaccine is available, it does not often reach them. For others, hesitancy to be vaccinated comes from distrust of the government based on their historical experiences. As a result, many families may be hesitant to send their children back to school for fear of bringing COVID, back to the home.

It is true that science has been considered in legislative decisions more this year than last year. But even now, science should be guiding our policies regarding school openings than what is politically expedient.

The psychological toll on students and families have been the subject of numerous columns in the lay press and scientific literature which strongly suggests that anxiety and depression have become more prevalent among students than was evident in the pre-covid era.

And, finally, a myriad of political actions which we have witnessed during the pandemic is a stark reminder that we must all participate in the political process. We can do this by joining with key organizations that promote, not only our profession, but the well-being of children and families.

In This Issue...

The Women's Edition

By: Matthew Goldenberg D.O.
SCPS Newsletter Editor

This month I am pleased to introduce our second newsletter theme, which is timed in honor of Women's History Month. This month, our theme and focus is on "Women and Psychiatry".

Women's History Month facts:

Women's History Month had its origins as a national celebration in 1981 when Congress passed Pub. L. 97-28 which authorized and requested the President to proclaim the week beginning March 7, 1982 as "Women's History Week."

In 1987 after being petitioned by the National Women's History Project, Congress passed Pub. L. 100-9 which designated the month of March 1987 as "Women's History Month."

Since 1995, presidents have issued a series of annual proclamations designating the month of March as "Women's History Month." These proclamations celebrate the contributions women have made to the United States and recognize the specific achievements women have made over the course of American history in a variety of fields.

Before you dive into these high quality and very thoughtful articles, I want to thank Mindi Thelen our executive director for her help in collecting and organizing another quality and substantial newsletter. I want to thank each of the authors who contributed their story. More than most months, these articles share personal stories, sacrifices and vulnerabilities. Each of the women who submitted their journey and experience in medicine and psychiatry is illuminating the path for the next. For those of us, who have not lived the experience of being a woman in psychiatry, it is important and humbling to read these testimonies.

Beyond the contributions of our female colleagues to our field and to our patients, the burden of wearing so many hats, having to balance so many roles and facing challenges and stressors that men do not, contributes to the increased risk of female physician burnout and suicide. It is important to bring attention to these and for our field to do better, for all of our female colleagues.

So, join me this month in honoring and valuing the contributions of Women in Psychiatry.

Stay safe,

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

A funny thing happened on the way to our forum.....

by: Walter T. Haessler, M.D.

I have written about twenty articles for Southern California Psychiatrist over the past ten years. During the first half of that period, there were several issues in which my article was the only contribution from a member. It's good to see how our publication has expanded and improved in recent years under the able leadership of Editor Matt Goldenberg and Executive Director Mindi Thelen.

My second article here, and the one that got me started as a writer, was inspired by annoyance at Psychiatric News. They had rejected, without comment, my letter to their editor expressing criticism of that publication for editorializing in a front-page "news" article. I was very pleased that SCPS supported me by publishing that letter, along with an introductory article explaining the situation and adding some further thoughts. (1)

That was the only Southern California Psychiatrist article of the twenty-or-so that ever generated a reply from a member. (And some of them have been rather political in nature, which ought to please or annoy at least somebody.) I asked Mindi about the lack of feedback, and she assured me that that was par for the course at the time: members weren't writing articles, nor were they providing feedback on the articles of other members.

(This is not meant to be self-congratulatory, but the one member who did reply was laudatory to the point of my embarrassment. Among other things, he asked, "Where did you get the courage to stand up to them like that?". [My answer, in part: As I get older, I care less and less if others don't like what I have to say.] We spoke on the phone for an hour and a half.)

About a year later I submitted another article to Psychiatric News, which also was rejected without comment, and which also ended up being published in Southern California Psychiatrist. (2) This time I asked for, and received, a copy of the Psychiatric News mission statement. The statement includes "...serving as a forum for the exchange of a full range of ideas and opinions among members, thus assisting in creating a sense of community."

Well, maybe some full ranges are fuller than others. Skeptical, I also looked up forum: "...a periodical etc. which provides an opportunity for conducting a debate.". (3) Psychiatric News doesn't act like they want to conduct debates. In fact, they seem pretty darned impenetrable as far as publishing dissenting opinions. And that's not how a forum works.

Further, if you are on the side of truth, you do not fear dissent. And if you are a seeker of truth, you do not just allow dissent — you embrace it. Aristotle put it this way: "It is the mark of an educated mind to be able to entertain an idea without accepting it.".

What brought all this to mind was the article by Dr. Racquel Reid in the February 2021 issue of Southern California Psychiatrist. (4) Dr. Reid, briefly stated, considered APA's apology to be too little too late. She did not mince words, referring to it as "...an insipid statement...devoid of any type of meaningful objectives...", addressing a situation that should have been addressed before she was born.

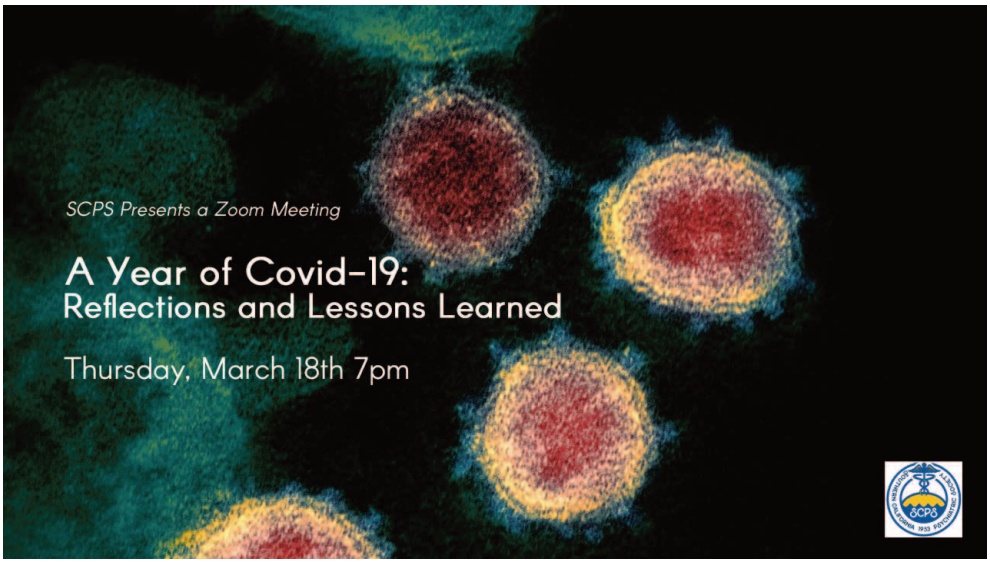
(Dr. Reid also made reference to her 2015 article in The American Journal of Psychiatry, (5) and her unsuccessful effort to have a follow-up article published in that publication. I remember the article, and remember my reactions to it. In fact, when I started writing this article, it was my intent to comment at some length on it. But in light of the length and content of the above — which was to be my introduction — I think it is better to split off those comments into a separate article.)

But I don't want to end without addressing Dr. Reid's statement that each year she is hesitant to renew APA membership, and that, "Whether I renew my membership this year is frankly irrelevant." Well, it's not irrelevant to me. Her reference to APA's response as "insipid" resonates with my feelings several years ago when I was going through a similar situation with them. Yes, they're a tough nut to crack, but they won't become less so if

those toward the ends of "...a full range of ideas and opinions among members..." drop out.

And, as Dr. Reid is finding out, SCPS is more interested in — or perhaps less afraid of — the exchange of widely differing opinions and ideas than is APA. Thomas Jefferson said that if he had to choose between having a government without newspapers or newspapers without a government, he would not hesitate to choose the latter.

(1) WTHaessler: Counterpunching. Southern California Psychiatrist, July 2012
(2) WTHaessler: 0 for Two. Southern California Psychiatrist, October 2013
(3) The New Shorter Oxford English Dictionary, Clarendon Press, Oxford, 1993
(4) RReid: Response to APA apology letter to BIPOC released January 18, 2021. Southern California Psychiatrist, February 2021
(5) RReid: Reflections on Ferguson. American Journal of Psychiatry, 2015; 172: 423-4



Please join the SCPS Disaster Relief Committee's Town Hall,
A Year of Covid-19: Reflections and Lessons Learned.
Thursday, March 18, 2021, 7 – 9 p.m. via Zoom

This Town Hall will provide members an opportunity to join us in a moment of silence, and an opportunity to grieve together and acknowledge the immensity of the past year. This part of the program will be facilitated by Samuel Miles, M.D.

Then, stay for a discussion of the Covid-19 response and lessons learned from various health systems in the SCPS area.

For Zoom Link and to RSVP - socalpsychiatric @gmail.com

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In honor of Women's History Month, we felt it would be useful to reflect on some of the challenges facing women who try to navigate the roles of working as psychiatrists and as mothers.
Here are the reflections of a few parent-psychiatrists over the last few decades.

Joanne Seltzer, M.D., Ph.D. is a Board Certified Psychiatrist who is semi-retired. She is currently working at Loyola Marymount University in the Student Psychological Services and as an Auditor for the Medical Board of California. She continues to teach at the UCLA School of Medicine and would love to return to volunteering at Homeboy Industries, where she has learned to perform laser gang-related tattoo removal. She did a psychiatric residency at Cedar-Sinai Medical Center, also serving as Chief Resident there. Following that she completed psychoanalytic training at the Southern California Psychoanalytic Institute, earning a PhD in psychoanalysis. She became a Training and Supervising Psychoanalyst, teaching there and at ICP. Prior to psychiatry she attended medical school at SUNY Stony Brook and then completed an internal medicine residency and nephrology fellowship. The areas of practice that have been of most interest through her career are working with college age and graduate students as well as psychosomatic issues.

Experience with Career & Kids:
When I applied to medical school, there were no such things as politically correct questions to ask or not ask women. At many of the schools where I applied in 1970, I was asked to justify taking a male's place - by interviewers wondering if they would be wasting at least $25000 a year in my education - if I got the training and then decided to retire or work part-time to raise children. Many didn't believe that it was possible to be a competent mother and work full time either. In 1970 there was just the beginning of an openness to admitting more women.

I chose first to do a residency in internal medicine, and then a fellowship in nephrology - inspired by an extraordinary nephrologist who was a humanitarian and a champion of equal opportunities for women. Nephrology also presented the intellectual challenge of being able to manage patients who were fluid restricted and navigate all sorts of complicated medical conditions and drug problems that were harder due to compromised kidney functions. However, I realized during the course of that fellowship that I wasn't passionate enough about some of those problems to continue to work a 60-80 hour week. I had become more interested in the devastating effects of kidney failure on the various family members whose roles and responsibilities changed the family dynamics. I shifted to psychiatry, signing up for another residency.

I didn't start my family until after I finished my psychiatric residency - the right guy hadn't come along until then. I was an older mom, with my older son born when I was 39. My husband was very supportive and proud of my career - and he had some flexible work hours at that time. As our children grew older, he continued to be supportive - and there were several advancements to management he passed in order to continue our team approach to child raising. If we had a sick kid or an appliance that decided not to work, he could usually cover in the morning by distance working at home and then go into the workplace. I worked mornings and until about 2 pm - then I came home to my second job of after school enrichment activities and carpooling for the kids until they went to college. When I participated in evening professional meetings, he was the babysitter.

The feelings of guilt and being pulled in too many directions never went away - I didn't really have time for friendships with other women unless they overlapped with my kid's friendships. We prioritized spending time with families who had kids like ours. I had hobbies that atrophied until my kids were college age, when I realized that being an empty nester was highly under-rated. I missed the hustle and bustle of having the kids and their friends around, but I really loved having time to travel with husband, meet a girlfriend for a drink, and revisit my hobbies.

Janet Martin, M.D., Ph.D. is a board certified psychiatrist working in outpatient private practice in the San Fernando Valley and West LA, treating mood disorders, anxiety disorders, and other psychiatric conditions according to the biopsychosocial model. She completed residency training in psychiatry at Cedars Sinai Medical Center, where she was Chief Resident during her senior year. She received her Ph.D. from the Department of Neurobiology and Behavior at UC Irvine, studying neuropathology in frontotemporal dementia. She completed her medical training at UC Irvine as well. She primarily treats adults, though has some focus on working with young adults/transitional youth at the Optimum Performance Institute in Woodland Hills. She is currently serving as co-chair for the SCPS Women's Committee.

Experience with Career & Kids:

"That's terrible!" was the response of my male psychiatrist boss at a residential treatment program when I told him I was pregnant. I was 36 years old (in 2006) and had spent over 10 years of my relationship with my boyfriend-turned-spouse trying hard not to get pregnant during medical school, grad school, and most of residency. We almost thought we had waited too long, as it actually took 1.5 years of 'Not trying Not to get pregnant' before I became pregnant. I suspect my boss' reaction is not uncommonly thought, if not spoken out loud. I'm sure this is one of the many challenges faced by women in the workplace, as they bear the responsibility of bearing kids. As I was 3 weeks pregnant when I graduated from residency, I did not try to build up a large private practice. This worked out very well, as I worked part-time with a residential treatment program, a community clinic, and my own private patient practice. I had a smooth first 8 months of pregnancy, other than brief scares of a false-positive triple screen testing and needing an amniocentesis given my "advanced maternal age." I almost made it through the last day of my planned work at the community clinic before maternity leave. Unfortunately, I was unable to see my last patient that day in the clinic because of 20 minutes of agonizing side pain, which turned out to be back-to-back contractions. I went to the hospital and my first child was born 12.5 hrs later. She was 5 weeks early and had to stay in the NICU for 18 days. I went back to work gradually after a couple months off, which allowed some accommodation for "mommy-brain" syndrome (which should be an actual diagnosis). I remember thinking I should take 6 months off next time, as it is a challenging time to work through sleep deprivation and breast feeding. My residential program boss survived my absence, although I heard later he made the same comment to his clinical director of the program when she became pregnant a few years later. I even covered all his patients when he was out for a couple months for open heart surgery, and I did commiserate that his situation was actually "terrible."

My second pregnancy went smoothly until the start of the 7th month, as my OB/Gyn was 'on to me' and put me on bedrest when she caught my cervix funneling too much, as she did not want the second kid to fall out early. I fortunately had been winding down my practice in anticipation of maternity leave. Unfortunately, my disability insurance denied my claim, as they had listed pregnancy as a "pre-existing condition," since I had acquired the insurance just after residency when I was pregnant with my first child. I tried to explain to them that I had not been pregnant for the past 2 years (that I was not an elephant), but they did not seem to understand. I gradually went back to work again, a couple months after my second child was born, feeling slightly envious of Scandinavian countries with more supportive maternity leave policies. Ironically, my disability insurance sent me a check a year later, saying they had made a mistake in denying my claim. I thought that could have been useful a year earlier, so I would not have felt as pressured to return to work as soon as I had.

Overall, I consider myself very fortunate. I have been able to maintain a part-time practice for the past 14 years, so that I am able to enjoy the fruits of my labors (2 great kids) and help numerous patients. I am also extremely grateful to have a very supportive spouse and several part-time nannies over the years, who have been critical in enabling me to have such a fulfilling lifestyle.

P.S. I did stop working with the residential treatment program for ~5 years after having my second child until there was a change in leadership. The therapist who had received the same "terrible" comment now runs the program, and she is wonderful.

Dr. Kristina Eipl is a general adult psychiatrist at Adelpha Psychiatric Group located in Pasadena and currently serves as co-chair of the Women's Committee. She earned her M.D. at Johns Hopkins University and completed psychiatry residency at NYU in 2018. She then moved to Los Angeles and began a small private practice before joining Adelpha in 2019. She focuses on utilizing various modes of psychotherapy and enjoys working with students and young adults with anxiety and mood disorders as well as reproductive psychiatry patients.

I just had my first child in August, so I am still learning how to be a parent, how to balance having a career and a kid, and how to balance having a career and a kid during a pandemic. I chose to go into private practice in large part so that I could have a more flexible schedule which would allow me to be home more with my family. What has been most helpful for me is being part of a very supportive and understanding group practice. I was able to take about three months off for maternity leave and gradually add more hours and patients to my schedule, all while working from home.

Pre-pandemic, I had planned on utilizing daycare and relatives for childcare. But, in the COVID era, my husband and I have opted to split childcare between the two of us in order to minimize the risk of exposure. Fortunately, we both have careers that allow for flexible hours, and I am still limiting the hours that I work.

Working from home during the pandemic has actually given me the opportunity to spend more time bonding with my son than I would have otherwise, and for that I am grateful. I started scheduling longer lunch breaks so that I could feed and play with him during the day. Noise-cancelling AirPods have also proven to be essential for seeing patients while my son is fighting naptime in the other room. Naps and bedtime are when I do all of my other work for the day, including administrative tasks. It has been very difficult balancing childcare and maintaining a career with only one other caregiver, but the extra time spent with my son has been invaluable.

SCPS Women's Committee Update

The mission of the SCPS Women's Committee is to provide a forum for women psychiatrists to support, inform, and promote a culture of growth, diversity, and collegiality within the Southern California psychiatric community. The committee holds semi-annual events that enable networking across sub-disciplines and geography, dissemination of best practices in both the business and science of psychiatry, and group discussion around the challenges faced by women psychiatrists in California, the US, and the world.

The Committee has organized biannual brunches for women psychiatrists to connect and discuss topics relevant to women's issues. We were partially derailed by the pandemic this past year, but with the encouragement of our fearless Executive Director, Mindi Thelen, we put together a virtual brunch meeting on November 8, 2020 for women psychiatrists: "Parenting & Working from Home During the Pandemic" presented by two wonderful Child & Adolescent Psychiatrist speakers Jessica Jeffrey, MD, MBA, MPH and Brooke Spanos, MD. They discussed the impact of the pandemic on children's mental health and various strategies to support parents during these trying times.

Ijeoma Ijeaku MD MPH FAPA is a Nigerian-American lady born in San Francisco and raised in Nigeria. The exposure to the lot of underserved people created a hunger to help alleviate the medical, social, and economic implications for the affected societies. She is one of the founding members of the SCPS Women's Committee and is featured in the 2016 SCPS documentary titled The Human Experience of Being a Psychiatrist. She is currently the President-Elect for SCPS.

She is certified by the American Board of Psychiatry and Neurology in general psychiatry as well as child and adolescent psychiatry and is a fellow of the American Psychiatric Association. She is currently an attending child, adolescent, and adult psychiatrist with the Riverside University Health System (RUHS). She is clinical faculty at RUHS and at the University of California, Riverside School of Medicine.

Ijeoma is a wife and mother who loves to spend quality time with her family.

For as long as I can remember, I have wanted to be a Doctor. My maternal grandmother was a pioneer in her chosen field of midwifery. She established a maternity home albeit medical dispensary in her community, while being wife and mother to nine children, at a time when girl child education was still unheard of in her corner of the world. I remember my mother (with her MSN), a most dedicated nurse educator, suggesting while I was growing up that being a doctor might not allow me time for a family. I wanted to have children, be a wife and do many other things in addition to being a doctor. I became a mom to Ola while still in Med School at the University of PortHarcourt, Nigeria and took my Hippocratic when she was 3.5 years old.

Between my medical education and transitioning to my medical career here in the US, I had EJ and Ure in quick succession and became a mother of 3. Shortly afterwards, my husband and I divorced, and I had to rely heavily on my parents and other family members to help with my children while I studied for and passed my USMLE exams, all the while supporting my young family as a certified nurse assistant. By summer 2008, I began my MPH program at Loma Linda University, 450 miles from my apartment in the SF Bay area. I got accepted into Loma Linda Psychiatry Residency by 2009, bought my first home and relocated my family. I had a firebrand for program director, who was the catalyst for my growth and development in new dimensions. Keshab Chandra Mandal writes that female empowerment could be defined in five separate categories: social, educational, economic, political, and psychological. As my growth and development occurred in other dimensions, I was able to repair my relationship with my husband. To date, I continue to work on creating synergy with my life partner.

As my career took off, I learnt to embrace the values that had helped define my progress towards the goals that I had set for myself early in life; be a doctor, be a mom, be a wife, be other things and change my world. I believe that to achieve any goal, I must have an A team for support and authentic feedback. This team ensures that my goals are being met even when I cannot physically be in all places at the same time. Indeed, collaboration with others ensures that I can have it all even when I cannot be at all places at the same time. I am indebted to those who are unafraid to give me feedback even when it is negative for indeed, I become stagnant if I am unable to grow. Given that I play many roles, balance is critical. I am quite intentional and purposeful about my self-care thus ensuring enough time and energy for my rejuvenation and upliftment. I am big on staying centered and being mindful. My faith is a huge part of my drive towards wholeness.

The biggest gift of my life is motherhood because in becoming an authentic nurturer, I started a journey where I am committed to vulnerability and courage in the same breath. This openness and authenticity between my adult/late teen children and me allow us to have those important and sometimes difficult conversations about personal and non-personal issues (this practice is modified with Nazo my 7-year-old who was born during the last few months of my fellowship at USC). Beyond the relationship with my children, the gifts that have come with motherhood allow me to have a different perspective with my patients and their families in my child and adolescent psychiatry practice. The commitment to another's emotional wellbeing takes courage especially for the teen who has been traumatized and is unable to trust and connect. Sometimes that is all I can bring to the table- the courage that I am committed to helping them even when they are unable to trust anyone. Sometimes that is not enough but a lot of times, it works…

Behind Our Tears and Joy on This Monumental Inauguration Day

Dear Colleagues in the APA Women's Caucus,

When I witnessed the historic inauguration of Vice President Kamala Harris today, I surprised myself. Like the women psychiatry colleagues I spoke with from all over the country, I felt much more emotion than I had expected: So much joy and exhilaration and also tears—sometimes outright weeping—took us by surprise, arriving at the surface from a suppressed place.

Maybe that's the place we keep hidden deep inside ourselves where we file painful things so that we can keep going—like when we realized that the "old boys' network" was working its magic for our male colleagues in their advancement but not for us or noticed the disregard for women's mental health in our medical school curriculum. It's the place that allowed us to keep going when we overheard our male fellow interns rank our looks on a one to ten scale. or when we put up with sexual harassment and innuendo from all directions because we thought we had to if we wanted to become a doctor, or when we looked around for women role models at the highest levels of our medical centers only to find the rare professor who had made it through. It's the place where we have filed away the many times someone asked women physicians of color questions that should have been directed at the housekeeping staff, and the place where we stored our disappointment when no one seemed curious or motivated to find out why women had twice the rate of depression and anxiety than men. And for some of us, it's the place where we filed away the painful feelings of impending separation when staring into the eyes of the infant we had just given birth to or adopted, knowing that as mothers in this country we would get no guaranteed accommodation to return to work part time, no break on our academic tenure clock, and no appropriate paid leave to participate in the growth or care of our child.

Each of us woman physicians has had to fit into a system created for men and not designed with our beautiful biology in mind. To some degree or another, we have all had to take a journey that was harder for us than for the men who made the rules and were invested in keeping the system the way it was. Today one of us got through . . . she won one of the prizes she had dreamed of. This achievement is cause for great celebration. Just seeing a woman in the role of vice president will give our girls and boys a different world to look to for inspiration.

Amidst our joy is also the sad reminder that many women in our past, including our own mothers and grandmothers, and maybe even ourselves, were denied the opportunities we dreamed of to use our gifts to the highest levels of achievement. Many women psychiatrists have had their own dreams vanquished by just too much adversity.

Meanwhile, women have been tending to the heart of the world for a long time. While we have one eye fixed on the impossible challenges that society has presented to us, we can also acknowledge that some women psychiatrists have managed, in the midst of their zigzagging work and family responsibilities, to weave together a strong, resilient family life. They have helped create a home environment, whatever its composition, suffused with their own personal family values, launching their children into the world every day to face its challenges, bolstered by the love they have received at home.

Hallelujah, Vice President Harris! We are ecstatic that a woman has broken one more barrier. But we are also aware of how much more we must do to make real change for women in psychiatry and achieve equity. We need wholesale structural and institutional changes that will let us reach our full potential—including changes that will let us be promoted and paid equally with our male colleagues.

Let us now remember this day and let it motivate us. Join me in doing all that remains to be done, wherever you are working and whatever district branch you can work through. And remember to take care of yourselves and ask for help when you get overwhelmed.

My instinct was to invite my young grandchildren in the next room to watch the historic inauguration with me, but I thought better of it. What I want for them is a new normal: a world where the high achievements of women don't seem so unusual to young hearts and minds.

Sincerely,

Maureen Sayres Van Niel, MD, President, APA Women's Caucus maureen.vanniel@gmail.com

Work-Life Integration During Covid-19: Unique Challenges and Opportunities for Women

By Misty Richards, M.D.

"How are you?"

These three words have been incredibly powerful this year as we watched a global pandemic redefine our core values, our priorities, and our vision for the future. This question also reveals the unique challenges placed on women to seamlessly navigate the concept of work-life integration during an unprecedented time in history.

As a psychiatrist who specializes in perinatal and infant mental health, attachment is the name of my game. During this COVID-19 era, I have watched vulnerable mothers feel robbed of the opportunity to celebrate their matrescence and, instead, attempt to navigate motherhood alone. When I meet them for their zoom appointments and ask them these three words – "*How are you"*- I am not surprised when I see their tired eyes well up with tears. They are often bouncing a baby, hiding in a deep recess of their home, or pointing the camera directly at their exhausted face to try to hide stained pajamas. They are unsteady, unsure, and afraid, seeking permission to reveal their deep fear of being inadequate. Our virtual meeting space instantly transforms into a metaphorical holding environment where the shared goal becomes acceptance and grace.

"How are you?"

I ask this to my female colleagues who continue to work full-time while trying to manage their home life. This question is often met with confusion, as this question has not been asked of them since the pandemic started. Or maybe ever. They respond with an abrupt "fine" as they quickly answer a phone call while ordering groceries via an app for the week. They are almost troubled by this question, as the answer slightly scares them. It is not a nice, tidy answer that can be filed away or crossed off an endless to-do list. The answer may unleash a can of worms that they do not have the bandwidth to address as they attempt to white knuckle even harder to cross the imaginary finish line. They are now full-time home school teachers, breadwinners, and reassurance-givers all at once. They can not take their foot off the gas pedal for one second, or their entire system that is hanging by one mighty thread could crumble. Everything is *fine.*

"How are you?"

This question is almost announced by senior leadership officials – often men – during one of the 8 back-to-back zoom meetings during the day. I search in the ocean of squares for a friendly face, for receptive eyes, for someone who is really curious about the answer to this opening question. After surveying the zoom room, I notice that the proportion of women to men is small, reflecting the striking fact that female faculty continue to be underrepresented at the highest rankings in academic medicine. The women log in on time, listen carefully, and contemplate challenging bold statements by either unmuting their mic to comment, writing in the chat box, or wishing they had done one of the above immediately after the meeting ends. They are painfully aware that it is a privilege to sit at this table while trying to operationalize "leaning in," though not too much. A bigger table - where we can all truly see each other- would help.

"How are you?"

I ask this to my female URM colleagues during this time of civil unrest and uncertainty. Silence.

The power of three words, a question, has never felt so difficult to answer. In this special month of women's history, we celebrate the unique contributions of women who are mothers, partners, professionals, friends, sisters, and daughters. Women are often the ones to ask these three words to those around them, prepared to truly hear and embrace the myriad of responses that come their way.

During the COVID-19 era, women have struggled with work-life integration, as the boundaries that differentiate

work from home are no longer clear. Evidence shows that caregiving demands disproportionately affect women, whether it be watching over children or aging relatives. Specifically, childcare duties have dramatically increased with children quarantining at home, as mothers shepherd their children through the new world of remote learning. Mothers are often tasked with orchestrating the logistics, while watching nervously as their child's social-emotional development slows in response to significantly less peer interaction and more screen time. Additionally, households are often working with less income, as salaries have been cut or jobs lost due to COVID. This further pressurizes the system, placing increased burden on women to "do it all," from housework, to schoolwork, to professional work.

This model is not sustainable and, to no surprise, has led to significantly more women than men reducing their work hours or leaving the workforce altogether. A report from the Century Foundation and the Center for American Progress found that the American economy could incur $64.5 billion per year in lost wages and economic activity from this fallout. Another alarming statistic is that, by September 2020, four times as many women as men left the workforce altogether. We need to do a better job of supporting women and restructuring a broken system. This is not to dismiss the challenges presented to men or the heroic efforts of anyone, regardless of gender, during this trying time. This is to celebrate women, specifically, who tend to be the safety net for not only their families, but for society as a whole.

"*How are you?"*

What is your response to this question? Whether male or female, parent or no parent, employed or unemployed, your response matters. The answer could be revealing of your changed values, refined priorities and ever-evolving vision for the future. While COVID-19 has certainly challenged us all, it has also given us the opportunity to do some soul searching. In this process, re-calibrate expectations that are placed on you by society, by family/friends/colleagues, and most importantly, by yourself. Take time to restore your mind and body with meditation, exercise, boundaries, and more white space in your calendar. Because how you feel is foundational for how you (re)build your life.

Members with unpaid SCPS and/or APA dues will be dropped from membership on March 31st.

We don't want to lose you.

Please contact socalpsychiatric@gmail.com
For information about how to pay your dues.

Members who are dropped may no longer use the F.A.P.A. or D.F.A.P.A. designation, nor may they vote, serve on committees, or in an elected position.

The Mental Health of Women during COVID-19

Rahn Bailey M.D., DFAPA, ACP
Chief Medical Officer of Kedren Health
Assistant Dean at Charles R. Drew University

Ayush Arora
Research Associate

How hasn't COVID-19 changed our lives? With numerous loved ones lost, business operations curtailed, and long-standing plans canceled, we have all gone through a lot. As the pandemic continues, it is important to recognize the toll it has taken on different social groups as well, especially women, who occupy important roles in institutions that are crucial to the United States' response. Women make up 78% of total hospital jobs, 70% of pharmacy jobs, and 51% of grocery store roles- all of which have been critical occupations for patients as well as the general populace.[1,2] Because of stay-at-home orders along with social distancing, there has been increased strain on mothers who have been navigating their kids being at home during school hours, working remotely, and potentially even expecting a child. Pregnant women are distinctly subject to added stress. Furthermore, incidence of intimate partner violence (IPV), which victimizes women to a great extent, has dramatically grown worldwide during the pandemic. Even during the early stages of lockdown there were reports of up to 25% increases in emergency calls to police regarding IPV complaints.[3] IPV would clearly impact a woman's psychological, emotional, and often physical health. Whether women serve as healthcare workers, homemakers, or in any other capacity, it is clear that the pandemic has taken a great toll on their mental health, and is important to recognize.

COVID-19 has severely exacerbated the mental health of female healthcare workers. Among this population, especially in epicenters for the virus such as in China, women had high rates of depression, anxiety, and insomnia at roughly 50%, 45%, and 34% respectively.[4] There are a number of factors that contribute to these statistics. Some include fear for one's personal health, extended isolation so as to not spread any potential infection to her family, and even potential post-traumatic stress after witnessing numerous deaths in care facilities.[2] These factors can manifest as physical symptoms such as exhaustion, fear, and sleep issues.[5] The risk that health care workers face on a daily basis has greatly increased due to the pandemic. Because a high percentage of these workers are female, it makes sense that we see a sharp rise in psychological symptoms among women overall as well.

Another aspect to consider regarding women's mental health during COVID-19 is the special risks that pregnant women face. Despite limited studies, there has been clear observance of premature birth outcomes among pregnant women diagnosed with COVID-19.[6,7] There are also obvious considerations to be made for their children. Neonates that tested positive for COVID-19 suffered from numerous symptoms such as nausea, shortness of breath, irregular heart rate, and even death.[6] Due to the risks associated with contracting COVID-19 while pregnant, many women suffer from a degree of fear regarding the health of their soon-to-be-born child. This can manifest in some of the psychological as well as physical symptoms described earlier.

Overall, there are a host of psychological stressors that arose due to the COVID-19 pandemic. These stressors have ended up targeting occupations/roles that women commonly occupy in society, such as being healthcare workers, pregnant, or even just day-to-day caretakers. Therefore, it is important for all of us to be aware of these

issues to best be able to support the women in our lives.

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Women and Major Depressive Disorder

Rahn Bailey, M.D., DFAPA, ACP

Hascal Humes, M.D.

Women's health within the field of Psychiatry deserves a special focus. There are many psychiatric disorders that affect men and women in at different rates, including depression and anxiety (1). Further, there are other psychiatric disorders that are unique to women such as those related to hormonal change. These include premenstrual dysphoric disorder, perinatal depression, and perimenopause-related depression. In particular, perinatal depression has significant effects on the depressed women themselves as well as the development of their children (1). Today it is clear that these topics in addition to many others are in dire need of further exploration.

Major depressive disorder (MDD) affects hundreds of millions of people around the world and is a leading cause of disability. In the United States, patients with diagnosed mood disorders account for 60% of all suicides (2). As mentioned before, depression is an important consideration especially in women's health because women are now known to be twice as likely to be diagnosed with MDD as men and four times as likely to have recurrent MDD. Studies have shown that there are also distinctions in symptomology, severity, and response to therapy and treatment, with women tending to have more severe symptoms (2). It is also important to note that women are more likely to have a comorbid anxiety disorder. In the background of this new knowledge, there has been an interest in exploring the biological basis of depression to hopefully lead to novel therapy and better outcomes.

Fortunately, recent advancements in neuroscience and refined investigation tools have accompanied this renewed interest. An understanding of the biological bases of the now described clinical differences between men and women may be on the horizon. Recently, large scale transcriptomics studies have suggested unique pathologies for depression based on gender (3). Transcriptomics is the comprehensive analysis of whole sets of transcripts for an organism, corresponding to developmental stages and specific physiological conditions (3). Model approaches such as this are elucidating the complex nature of the underlying mechanisms that make up depression.

So far, new research suggests that there are indeed biological differences that characterize depression. This is

an important component of women's health research, given the disproportionate number of women who are afflicted by MDD. These differences include not only the hormonal factors that affect mood, but also the genetic sex and developmental exposure (3). Various nuances in this topic are still deserving of further attention. Altogether it is important to highlight how sex-specific factors might result in divergent pathology and subsequently novel therapy for women with MDD.

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Dr. Bailey is Assistant Dean of Clinical Education and Professor of Psychiatry, Department of Psychiatry & Behavioral Medicine, Charles R. Drew University School of Medicine and Chief Medical Officer of Kedren Community Hospital System.

Dr. Humes is a Research Associate with Kedren Community Hospital System & Charles R. Drew University.

Intimate Partner Violence and Substance Use

Amit Grover, MBBS
Daniel Cho, M.D. MPH

One in three women in the United States have encountered some form of physical violence by an intimate partner, according to the National Intimate Partner and Sexual Violence Survey of 2010. Moreover, one in seven have been injured and one in ten raped by an intimate partner (1). This is disgusting, vile, and sad. Intimate Partner Violence (IPV) alone is a public health concern. Substance use has been shown to be a major component in this type of violence, with many associations between the two.

IPV may be defined as physically aggressive type behaviors occurring between two people in a close liaison. The term "intimate partner" represents a current or former spouse, monogamous relationship, or dating relationship where there is a physical attraction and emotional connection (2). IPV can be categorized into four types: physical, sexual, stalking, and psychological. These different types of intimate partner violence can occur concurrently. It causes the victim a great deal of emotional, physical, and mental trauma.

The Centers for Disease Control and Prevention indicates victims of intimate partner violence are at a much greater risk for engaging in behaviors like smoking, illicit drug abuse, and alcohol binge drinking (3). This can be attributed to the cognitive and emotional distress that come from these traumatic encounters. Studies indicate that anger, fear, and humiliation experienced by women play a key role in provoking substance use (4).

In general women who are victims of IPV can turn to substances of various kinds as a coping mechanism, but there seems to be an increased association specifically with cannabis and opioids, whereas alcohol and cocaine have an increased association with the perpetrator who conducts the violence (5). Other substances, like methamphetamines, have an increased association with overall violent and aggressive behavior. A study by the National Institute on Drug Abuse shows that violent behavior was 6.2x more likely to occur when subjects were using methamphetamines (6).

Moreover, women may be coerced into using substances as a manipulation tactic by their partners. This activity can reinforce the idea that engaging in substances together can strengthen their bond. Over time this can lead

to a ‘double dependency’ where the victim becomes dependent not only on the substance but the harmful relationship itself (2).

In the absence of substance use there is a decreased prevalence in IPV (7). A study showed, male and female subjects are more likely to have physical altercation on days of substance use, after controlling for male partners’ antisocial personality (ASP) disorder and couples’ global relationship distress (7). Other studies have shown that treatment of substance use disorders can decrease the incidence of IPV (8). When IPV among partners in remission were compared to relapse cases after treatment, a 2-3 fold increased incidence of IPV was found prior to SUD treatment versus after (8).

Much research has been conducted to highlight the associations between IPV and substance use, abuse, or disorder. Therefore, it is vital that we include screening for IPV in our patients struggling with SUD, particularly due to the fact that many women do not feel comfortable discussing these issues voluntarily (9). It impacts and destroys the lives of countless numbers of individuals with several often resulting in death (2).

Thus, it is imperative that as clinicians we approach these suspected patients with a compassionate, understanding, and observant approach, so that we do not miss the opportunity to identify this crucial finding. We can alleviate much pain and suffering in society by aiding in the treatment of such a pernicious type of violence.

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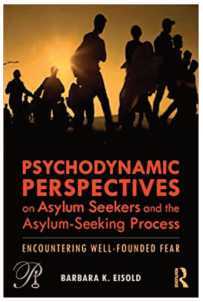
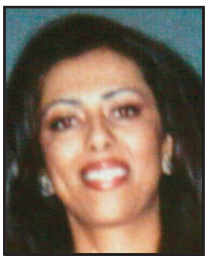
Dr. Grover is a Research Associate at Charles R. Drew University of Medicine and Science and Kedren Community Health Center.

Dr. Cho is an Assistant Professor & Associate Residency Training Director of Psychiatry at Charles R. Drew University of Medicine and Science/Kedren Community Health Center and a Past APA Board of Trustees Leadership Fellow.

Psychodynamic Perspectives on Asylum Seekers and the Asylum-Seeking Process
By Barbara K. Eisold
Routledge Publishing
2019
188 pages
$39.95 Paperback
ISBN 978-1-138-35445-6

Book reviewed by Kavita Khajuria, MD





As a guide to the evaluation of asylum seekers, this book provides psychodynamic, forensic and politico-cultural perspectives. According to Eisold, 65.6 million persons are forcibly displaced, of which 22.5 million are refugees, and 2.8 million seek asylum worldwide. Many can't return home as a result of ongoing conflict or situations that caused their original flight. Over half a million asylum seekers in the United States are waiting to have their pleas heard by an asylum official.

Eisold discusses the nature of these evaluations and outlines potential implications for the clinician and the asylum seeker. She discusses the psychosocial assessment process, interpreters, concepts of vicarious and witnessing resilience, and notes the difficulty in recollection of details of the actual event as the more common symptom of trauma.

'Heroic' asylum seekers from around the world – in this chapter, Eisold cites four important life affecting experiences of the client from her observation, regardless of their cultural differences. Other topics include the 'protestor/ resister role', the drive to get closer to the unspoken pain of tortured elders, reenactment, reliving trauma-related aspects of the lives of older relatives; secondary traumatization, denial, the difficulty of the immigrant experience and divergent outcomes.

'Female Genital Mutilation and the Aftermath' – A descriptive case study really brings this to life compelling the reader to understand the life story, abuse and horrors endured. It evokes a respect and appreciation of the survivor, and allows for observation of pragmatic difficulties and hurdles in the asylum seeking process. The concept of personal agency from a psychodynamic perspective is explained as well as in reference to the asylum seeking experience.

'Central American Women on the Run' - this chapter offers an excellent historical and anthropological review of the Maya civilization, and discusses feminicide, the nature and extent of negative attitudes towards women in Central America, and history as the background to the creation of normative unconscious processes. Other concepts include machismo and Marianismo, female compliance, current male-female relations and the complexities that currently exist to overcome patriarchy and the grip of honor codes. These are well illustrated with select case studies.

The appendices conclude with an outline of asylum law, the imprisonment of asylum seekers, facts and figures on female genital mutilation and a prospective affidavit.

The material is extensively referenced. I found the case studies to be informative and helpful as a window into the struggles with respect to various cultural contexts. The stories were frequently dire and horrendous, and disturbing if not mortifying at times - but also offered a glimpse into tremendous courage and resilience. I suggest this book as a general guide for psychiatrists or therapists who work with or evaluate asylum seekers. B. Eisold is a psychologist, psychotherapist, evaluator of asylum seekers, and is in private practice in New York City.

Council Highlights
January 14,2021
Eric Wagreich, M.D., *Secretary*

Outline of Notable Meeting Events and Discussion

The meeting was called to order by Dr. Fouras at 7:03PM.

Meeting Minutes
A motion was made to accept the minutes from November Council meeting and Executive Committee Report, which passed unanimously
President's Report
PPAC Contract Report
Dr. Shaner introduced the proposed contract between PPAC and SCPS, which included the compromises between the two groups and associated rationale for the compromises, which were made alongside the GA Subcommittee and PPAC, resulting in the shared compromise agreement. He noted the important overriding priority that SCPS has an effective ongoing ability in the immediate term to powerfully advocate at a legislative level for our patients and our profession, for which Dr. Shaner acknowledged key compromises within our agreed upon budget. This would place SCPS in an advisory role. He shared the recommendation from the GA Subcommittee. Dr. Soldinger affirmed the importance of having read the shared compromises and his feeling that this agreement was a positive start in our relationship with PPAC, and the assumed positive trajectory of our relationship and role within PPAC in future years.
A conversation was welcomed and Ms. Thelen clarified that while there are SCPS members on the PPAC board that their membership does not equate to a responsibility toward SCPS in this context, to which Dr. Fouras agreed and noted those members' fiduciary responsibility to PPAC alone in that context. Dr. Goldenberg shared his concerns that SCPS would not hold any votes on the PPAC board and the importance of seeing the final contract prior to a formal agreement. Dr. Fouras emphasized that the current contract was the expected final contract save for an approval by legal counsel review. Dr. Soldinger affirmed that if any significant changes were to be made after such a review then the council would be notified prior to a formal agreement. Dr. Goenjian noted his concern that SCPS should hold a more prominent role in PPAC's actions. Ms. Thelen added that there is financial transparency in the following year's tax returns, but that it would be beneficial to have more transparency. Additional discussion was held including reservations about and support for the agreement and a review of the bylaws to guide further discussion.
A motion was made to accept the contract and have it sent to legal counsel for review. The motion passed with two opposed, which included the compromises between the two groups and associated rationale for the compromises, which were made alongside the GA Subcommittee and PPAC, resulting in the shared compromise agreement.

APA Membership Procedures
Ms. Thelen reminded Council about the APA's recent action to leave SCPS out of the DB window due to our choice not to sign the DB Window contract as required by APA. She asked for guidance from Council as to how to proceed given additional developments within APA's proposed reinterpretation of bylaws. Various opinions were shared as to what various pathways can be taken to preserve SCPS's best interest and to maintain best access to our members and our finances. Various members recommended leading off on continuing where the EC left off last year with communicating with the APA board on this matter.
Area 6 ECP Rep
Ms. Thelen shared that the nominee for Area 6 ECP Rep was a past member of SCPS and APA, and the current plan is for that member to re-join APA and SCPS and to continue running for the position.
CMA Specialty Delegates
Dr. Fouras introduced the need for Area 6 of APA to hold representation to the CMA under specialty delegation, with the caveat that Area 6 does not meet the CMA criteria for a specialty delegation for psychiatry due to its lack of sufficient CMA membership. Dr. Fouras recommended that OCPS, NCPS, and SDPS along with PPAC together could together constitute a statewide advocacy organization now that CPA has dissolved. Ms. Thelen noted the importance of clarification from CMA and APA prior to further development. Further discussion was held. Dr. Ijeaku recommended having Dr. Murphy present at the next council meeting to clarify what action he would like SCPS to take. Dr. Fouras offered to reach out to Dr. Murphy to further clarify this question, which was

agreed upon by Council.

Vaccinations for Private Practitioners

Ms. Thelen shared developments about having received many calls over the break from private practitioners requesting access to the vaccination, as well as members' difficulty accessing appointments to receive a vaccination. A lengthy discussion was held about how to best assist our members in connecting them to vaccination resources. It was agreed upon to update our COVID website with the specific links to their respective areas' public health departments.

Office Lease

Ms. Thelen shared an update about the office lease and whether we could find a sublease versus having to buy out our lease. She noted that the option to buy out the lease was declined. It was agreed upon that we consult with legal counsel Dan Willick as to our possible options.

Virtual Installation

Dr. Ijeaku introduced the idea of holding a virtual installation due to the pandemic reaching into its second year and the bylaws requirement of holding a formal installation. A discussion was held regarding the possibilities for a virtual installation and awards ceremony. April 24 was offered as a tentative date for the event.

President-Elect's Report

Nominating Committee/Assembly Rep

Dr. Ijeaku presented news of newly approved positions and developments with the nominees. A vote was held to ratify the new nominee, Dr. Uchenna Okoye to DMURR position, which passed unanimously. She also shared the news of Dr. Fogelson's resignation from APA Rep position and the support for Dr. C. Freeman to run for the position, which would be for a three year term alongside Dr. Bonds for a four year tenure. It was also recommended to send Dr. Fogelson a letter of gratitude to Dr. Fogelson thanking him for his years of service.

Diversity and Culture Committee

Dr. Rees shared the committee's proposal for a new award named after George L Mallory Award, and that the committee will share forthcoming nominations. A vote was held to accept the award, which passed unanimously.

Newsletter Committee Report

Dr. Goldenberg shared the committee report including the need for articles for coming newsletters and the possibility of acquiring new committee members to help in seeking additional contributions moving forward. Ms. Thelen emphasized the importance of featuring strong contributions from members in order to continue strong online readership and to solidify advertising funds moving forward.

Treasurer's Report

November Financials and Cash on Hand Report

Dr. Goldenberg shared the Treasurer's Report, A motion was made to accept the Treasurer's Report, which was passed unanimously.

Membership Report

Dr. Ijeaku shared the membership report, which included 1 RFM and 5 general members. The members were approved unanimously.

Legislative Report

Dr. Shaner shared the legislative report for statewide legislation, including one bill for preservation of pandemic-era billing post-pandemic, and the other regarding LPS reform and speculation as to how a change in administration may affect legislation.

Dr. Soldinger shared national and assembly news, including the need to push for widespread vaccination against the coronavirus, and an assembly member being the victim of a scam, which gravely affected his professional positions. He proposed the idea of an action paper to address the fallout.

Program Report

Dr. Gales shared the program report including the upcoming training on January 30th with Drs. Nemeroff and Yellowlees. Dr. Red contributed that this will be a new experience, and we will move forward with adaptations moving forward to find more attendees. Dr. Wagreich raised the possibility of advertising outside of our DB and area to raise attendance.

Assembly Report

Dr. Silverman shared an update that the MOC has delayed a development. Dr. Shaner asked about whether any Area 6 discussions have involved bringing back the collegiality between the 5 DBs. Drs. Soldinger and Red noted that no recent meetings have involved such efforts. Ms. Thelen raised the question of whether our representatives should raise the subject. She also raised the question regarding the status of talks with the ABPN and developments with MOC thereof. A discussion was held regarding what efforts SCPS can do to reach out to other DBs to improve relationships and move forward for restoration of advocacy and statewide relations.

The meeting was adjourned by Dr. Ijeaku at 9:38pm.

CLASSIFIED ADVERTISEMENTS

Director of USC Care Psychiatry and Behavioral Health Services

Clinical Assistant, Associate, or Professor of Psychiatry and the Behavioral Sciences (Clinician Educator)

The University of Southern California (USC), founded in 1880, is the largest private employer in the City of Los Angeles. As an employee of USC, you will be a part of a world-class research university and a member of the "Trojan Family," which is comprised of the faculty, students and staff that make the university what it is.

Director of USC Care Psychiatry and Behavioral Health Services
The Department of Psychiatry and the Behavioral Sciences at the Keck School of Medicine of USC is seeking a board-certified and California licensed / license-eligible psychiatrist to serve as the **Director of USC Care Psychiatry and Behavioral Health Services.** The position will comprise approximately of 50% time for administration, management, and leadership activities and 50% clinical care services across different sites (Consultation-Liaison, Integrated, and Outpatient Psychiatry and Behavioral Health Services on the USC Health Sciences and University Park Campuses).

The director will report to and work closely with the Chair of Psychiatry and the Behavioral Sciences at USC regarding all clinical, administrative, and educational functions within USC Care Psychiatric Services overseeing all Clinical Service Directors and faculty members.

In addition, the director will assist the Chair of the Department of Psychiatry and the Behavioral Sciences to achieve strategic goals, including expanding patient access, improving quality of clinical care, tracking measurement-based outcomes and productivity metrics, promoting collaboration across divisions and departments, and elevating department profile across the university and the nation; promote fiscally responsible clinical operations; lead recruitment and retention efforts for excellent and diverse faculty; and design, implement, and evaluate new programs and initiatives within USC Care Psychiatry and Behavioral Health Services.

Administration

Lead all administrative, clinical, educational, and personnel activities

Oversee clinical operations across all USC Care Psychiatry and Behavioral Health Services:

Outpatient Services on the USC Health Sciences and University Park Campuses

Consultation-Liaison Services at Keck and Norris Hospitals

Integrated and Collaborative Care Services at the USC Health Sciences Campus

Participate in University, health system, departmental, and division meetings and committees as assigned

Clinical

Provide mental health support for the USC Value Based Services Organization (VBSO) to help reduce medical spending on high utilizers of care

Direct and oversee initiatives in quality assurance/compliance, quality improvement, and patient safety through the collection and analysis of data from the Electronic Medical Record and other sources

Provide direct patient care services and clinical consultation and guidance on all services

Teaching/Mentoring

Collaborate with faculty educators to provide training to medical students, psychiatry residents and fellows, and

trainees from other allied disciplines

Minimum Qualifications

MD or DO Board certified by ABPN in Psychiatry
Licensed or license-eligible in the state of California
Demonstrated experience successfully leading healthcare organizations or units
Commitment to diversity, equity, inclusion, and experience in working with diverse patients, faculty, and staff
Commitment to the highest standards of professional ethics and integrity
Desire for continuing professional growth and commitment to excellence

Preferred Qualifications

Master's degree in health administration (MHA) or Business Administration (MBA)
Bilingual or multilingual is considered a plus but not required

Application Deadline: Until position is filled.

Starting Date: Negotiable

This is a faculty position in the Department of Psychiatry and the Behavioral Sciences at the Keck School of Medicine of USC. Salary is competitive, and contingent on experience. A generous benefits package includes health insurance, sick time, paid vacation, tuition assistance for eligible employees and their eligible dependents, professional days, and a stipend for professional development.

For inquiries contact: Mary Nguyen (mary.nguyen@med.usc.edu) with the subject line "Application for Director of USC Care Position".

Please apply at the link above or below and upload:

Your CV
A cover letter expressing your interest/fit for this position and specific experience leading behavioral healthcare organizations, including goals and outcomes achieved. Please include any experience working with diverse patients/faculty/staff if applicable.
Three (3) references from current/former direct supervisors, with ideally at least one (1) that can speak to the candidate's experience leading a behavioral healthcare group or organization

USC values diversity and is committed to equal opportunity in employment. The Department of Psychiatry strongly values diversity, equity, inclusion and is committed to hiring excellent and diverse faculty. All genders and members of all racial and ethnic groups are encouraged to apply.

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