Southern California

PSYCHIATRIST

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President's Column

Thank You for an "E" Ticket Ride

George A. Fouras, M.D.

After returning to Southern California in 2017 to my current post at LA County DMH, I was also warmly welcomed back to attend the SCPS Council meetings. I was honored to have been nominated for President- elect in 2018. This will be my final column for the SCPS newsletter and I would like to thank my fellow officers, council members, Executive Director, and you, our members, for the support that I have received over the last 2 years.

When I reflect on the last two years, it seems amazing to me what has occurred and what we have accomplished. Perhaps one of the most significant events was functioning not only as President- elect, along with Dr. E. Cheung (President) representing SCPS at the CPA council, but also as the CPA Treasurer. During our tenure, we witnessed the effects of long standing differences of opinion between DBs as to how the CPA should function, slowly lead to its demise. Once I realized that CPA was insolvent, it was my duty to not only ensure that SCPS was protected from liability, but also that CPA would be able to settle its debts without going into bankruptcy. Despite our best efforts, CPA was dissolved in September 2020. It was heartbreaking to see an organization which had effectively advocated for our specialty and our patients for over 30 years disappear.

However, out of the ashes rose other organizations which would continue legislative advocacy. After a committee was formed with co-chairs, Drs. Ijeaku and Red, a thorough vetting process was undertaken which chose the Psychiatric Physician Alliance of California (PPAC) to contract with in order to continue to advocate for psychiatry. We signed the contract earlier this year which allowed us to retain the expertise of Mr. Randall Hagar and Mr. Jim Gross, who had worked with CPA, assuring that we would have effective representation in Sacramento.

During my year as President I have been happy to see that we have weathered the storm that is COVID. Many of you have experienced challenges, to your personal health, that of your families and for the patients that you care for. It is my hope that we are beginning to see the light at the end of the tunnel, and look forward to better days ahead. Despite significant financials hurdles we have managed to function well with SCPS staying fiscally intact.

We should also take some satisfaction in a few of the other things we have accomplished:
1) The formation of a Finance Committee, chaired by the current Treasurer, who this year and next is Matthew Goldenberg, D.O., and is tasked with managing the SCPS budget and investments creating intermittent reports for council along with recommendations.

2) The re-organization of the SCPS Government Affairs Committee. Co-chaired by Drs. Shaner and Soldinger, this active committee has already been highly effective, providing input to the PPAC GA committee and indirectly to the CMA Council on Legislation in March.

3) The formation of the Diversity and Culture Committee. Co-chaired by Drs. Ijeaku and Rees, they have been incredibly actively from the start, crafting statements for distribution and responding rapidly to current events.

4) The Disaster Services committee chaired by Dr. Chang, was only recently re-organized in 2019. However, they immediately were tasked to address one of the most consequential disasters of our time: COVID-19.

In closing I would like to again thank our Executive Director, Ms. Mindi Thelen, and my colleagues on council for your support during this action packed year. It has been a privilege to serve you all, and I wish Dr. Ijeaku all the best as she takes the reins for next year.

And finally, for those members who may be curious about the title, Google “Disneyland ticket book”.

In This Issue...

Click here for full details.

The Residency Edition

By: Eric Wagreich, M.D.

SCPS April Guest Newsletter Editor

The idea to focus the theme of this month's newsletter on psychiatric training and trainees came to me as my own four years as a psychiatry resident come to a close. My year as Secretary of SCPS and Area 6 Resident and Fellow Member Representative to the APA for Area 6 is also ending, and I am preparing for fellowship. The past four years, which originally seemed to me like an eternity, have somehow rocketed by, and I find myself in a place of reflection amid the myriad transitions and adjustments to professional life, family developments, and personal growth. Amid all of the countless hours of learning and patient care, I am overcome with more thoughts than are reasonable to process in one introductory statement, so I will try to be concise in my own focus.

Speaking from personal experience, a great deal of my growth and development as a psychiatrist and advocate thus far has been the result of my experiences in organized psychiatry. Mentors have helped guide me through nuances in parliamentary procedure, methods for being an effective advocate, and pushing myself out of my comfort level into leadership roles. My world view as a psychiatrist has expanded beyond the clinic and the hospital into the systems and government levels. I have formed meaningful, positive bonds and with colleagues and mentors I otherwise would not have had the opportunity of meeting or getting to know on a deeper level. Though I am forever grateful for matching in my residency program, without my experiences in organized psychiatry, my training would not have been as diverse as it has been.

Psychiatry is at a pivotal time as a profession. Between the exponential growth in interest in our field and attention to and acceptance of mental health as an important contributor to overall wellbeing, psychiatrists will continue to play an outsize role in society. We are in a unique position to guide the intersection between health and ethics, and to help the greater local, national, and world populations grow into a climate of realized potential and responsibility. This takes strong leaders with a solid foundation in advocacy and morality, and while those concepts are to a degree innate, they can be emphasized in training programs, mentor-mentee relationships, and within the field of organized psychiatry. At a time where the work-life balance of psychiatry has become a strong source of interest in our profession, to not focus on the importance of our ethical, civil, and moral responsibilities would be extremely short-sighted in fostering a strong sense of responsibility among future trainees.

This month we have the distinct honor of hearing from various SCPS members about issues affecting our future trainees and the future of our profession. Dr. Bailey who has hit the ground running since his move to Southern California, Ayush Arora, and Dr. Wobus have contributed a very important piece on the current state of representation by psychiatry trainees from minority backgrounds. Dr. Katie Camfield, one of our Resident and Fellow Member Representatives, reflects on her experience and growth through engagement in organized psychiatry within SCPS. We also have two inspiring and related articles by Phuong Vo, who has shared with strength and honesty her journey into psychiatric residency (congrats on your match!), and an enlightening follow-up by our President-Elect, Dr. Ijeoma Ijeaku on how best to support students and trainees. Finally, Dr. Larry Gross, a lifelong veteran of organized psychiatry and resident training, shares his experience as a mentee and mentor within psychiatry and organized psychiatry, and why serving in these roles is so important for personal and institutional growth. I hope that this month's newsletter can help to inspire involvement in organized psychiatry at the district branch level and beyond, and serves as a call to reflect on how we all want to contribute to the future generations of our profession collectively, for an inspired and collaborative path forward.

My SCPS Mentoring Experience

By: Matthew Goldenberg D.O.
SCPS Newsletter Editor

This month I am pleased share with you our third newsletter theme, “Psychiatry Residency and Training”.

I want to thank our guest editor Dr. Eric Wagreich. This month’s newsletter was his vision and his energy helped to solicit and edit the articles that follow. I want to also thank each of the authors who contributed such high-quality articles.

I completed my residency training at Banner Good Samaritan Medical Center in Phoenix, Arizona and my addiction psychiatry fellowship training through the UCLA/Cedars program. While I am glad to be done with my training, I remain appreciative to my attendings and program directors who gave so much of their time and mentoring to help me and my co-residents/fellows gain the knowledge and experience we would need to care for our patients.

Personally, I am long way from academic psychiatry, as I spend the majority of my professional time in private practice. However, much like in residency, when I was active with the Arizona Psychiatric Society, I value my service to SCPS because of the mentoring opportunities it has provided.

The mentoring has been a two-way street. I continue to have the opportunity to receive mentoring from SCPS’s seasoned leaders and have had the pleasure of helping to mentor and orient our newer and younger members.

We know that psychiatry is an always evolving field and each of us are continually learning and perfecting our craft. For many of us, SCPS has been one such opportunity to get and receive mentoring from esteemed colleagues and to those up and coming in our field.

Please write in and share your training stories, thoughts on mentorship or any other responses you have the articles that follow.

Stay safe,

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

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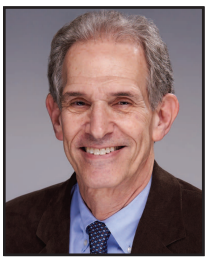
Reflections on Mentorship…

By: Lawrence Gross, M.D.



When Eric Wagreich asked me to write something for the newsletter on mentorship in organized psychiatry, it came up during clinical staffing of one of his outpatients. That's right – Eric, our SCPS Secretary (and guest editor of this section on mentorship), is a fourth-year resident at USC and already has a track record of service to the APA at the local, regional, state, and national levels. As a faculty supervisor, I regularly talk with him (phone or Zoom, not yet back to in-person) about his clinical cases, but we try to make time to catch up on other things, including SCPS/APA issues. I am honored that he considers me a mentor, but his participation in organized psychiatry pre-dates the two years I have known him, and our "catching up" is bidirectional, with Eric often informing me of important issues and changes. This is part of the natural cycle of mentorship and career development as the mentee/resident moves from trainee to colleague, with expanding clinical and organizational roles. Eric is well ahead of the curve, but his request (which I could never refuse!) led me to think about my history in organized psychiatry.

To begin with, I was not active in district branch activities as a resident in my native West Virginia, but I joined the APA and I observed my faculty mentors involved at the DB/state level. West Virginia is certainly different from LA, but I got the message that there is a larger psychiatric community outside my training program and that BELONGING IS IMPORTANT. When I came to LA as a clinical fellow and then as junior faculty (Early Career Psychiatrist in APA terms), I continued my membership in APA/SCPS, but I was not actively involved until my then-boss, Rodney Burgoyne (also a supervisor and longtime mentor) became SCPS President and asked me to join and then chair the Academic Liaison Committee. I have remained on this committee since that time, but I have been part of other SCPS committees over the years, reducing my involvement when my children were young, and later serving as treasurer, president, assembly representative, and currently a member of the APA Council on Advocacy and Government Relations.

Each activity seemed to build on the previous ones, with mentors every step along the way. Mentors included more senior faculty/supervisors, peers who got involved before I did, and other colleagues, both local and distant, who paved the way for me in the SCPS, APA, and other psychiatric organizations. There are too many to mention by name, and some may not consider themselves mentors, but they were important to me – which brings me to this point: You may not think of yourself as a potential mentor (or mentee), but you are. I learned by observing people I respected belonging to organizations and being actively involved. I learned from them and enjoyed working alongside like-minded colleagues with a common purpose – whether it was on a local committee or a national council. They expanded my feeling of belonging to different professional communities, often with the opportunity to mentor residents, fellows, and other colleagues. As your participation continues, the personal relationships grow and often become longlasting, facilitating the next generation. Hence, your former residents/fellows become colleagues, friends – and mentors!

Sometimes mentorship is formal (e.g., fellowships, leadership positions), but often it is not. Organizational involvement broadens our professional life, expands our connections, and works to improve the lives of our colleagues and patients. Based on my experience, becoming a good mentor requires being a good member:

- Belonging matters – join organizations that reflect your interests and priorities
- Get involved – don't wait for someone to ask you; people will notice your interest
- Get others involved – encourage colleagues with similar interests
- Share your passion, your experience and, whenever possible, your expertise
- Enjoy your organizational work, relationships, and being part of the growth of your mentees – as they enrich your growth as well.

An Analysis of Psychiatric Residency

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

Ayush Arora and Lance Wobus, M.D.
Research Associates

On March 19 the AAMC released the names of roughly 35,000 recently graduated doctors who will begin US medical residency training this year. Applicants and residency programs are then mutually assigned through the National Resident Matching Program (the "Match") or through the Supplemental Offer and Acceptance Program (SOAP).

Data from the 2021 Match clearly indicates the competitiveness of psychiatry as a medical specialty. This year over 1900 students matched into psychiatry with only three spots unfilled.1 Furthermore, though training slots in psychiatry have increased more than 5% every year since 2017, no more than twenty open positions have remained after the Match. This indicates a growing interest year-over-year. There are several possible explanations: a favorable work-life balance in the specialty, competitive salary, and efficacy of newer treatment methods such as medications/psychotherapeutic techniques.2 This demand has led many to declare that "psychiatry is the new dermatology."

Within this competitive landscape, minorities in medicine continue to face additional challenges. A significant racial disparity remains between psychiatry and the general population. 6.6% of all US psychiatry residents are African American while 8.3% are Hispanic. However, in the general population, these figures are 13.1% and 17.1%, respectively.3 During medical education, one study noted disparities in the receipt of academic awards among medical students along ethnic lines.4 In another recent study, minority residents describe three major themes in their training: "a daily barrage of microaggressions and bias, minority residents tasked as race/ethnicity ambassadors, and challenges negotiating professional and personal identity while seen as 'other'" 5 Notably, in January 2021, the American Psychiatric Association "apologized to Black, Indigenous and People of Color for its support of structural racism in psychiatry." 6 The writing process of this document was covered in the February SCPS newsletter as well. Two authors listed above led this project.

Institutions have been established with the goal of addressing disparities in psychiatric practice. A prominent example in Southern California is the Charles R. Drew University of Medicine and Science (CDU) where Dr. Gul Ebrahim heads the effort as Psychiatry Program Director and Assistant Professor. Dr. Ebrahim notes that minorities have historically dealt with discrimination and a lack of social justice. The mission of the CDU program is to develop equality, remove disparities and injustice, and produce clinically skillful physicians who serve underserved populations. This has been no easy task especially as CDU's residency program, encompassing 12 specialties, was shut down with the closure of Martin Luther King Jr. Hospital in 2007. Thankfully, recent efforts have yielded success. In 2017, the MLK Hospital reopened. CDU was then able to restart resident recruiting for Family Medicine (FM) and Psychiatry. FM has had 8 residents each year since our first new class in 2018. Psychiatry filled 6 spots (2 advanced) in the first two years 6 followed by 6 PGY-1 residents in 2020. There are 8 psychiatry residents starting in July 2021. That first psychiatry cohort will graduate in 2022. Additionally, this year CDU hired 8 Internal Medicine residents for the first time since MLK Hospital's closing.

Minorities have been eager to fill the demand for physicians to address the needs of high-risk populations. They come to our program with a record of high achievement, excellent scholarly activities and qualifications, and a passion for psychiatry. Therefore, it is important to further encourage minority residents in our field.

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Rahn Bailey, M.D., giving a vaccine shot at Kedren’s robust communty vaccination center.

The Fire Every Time

By: Michael Mensah, M.D.

This past year sucked. As I write this, tact might compel revision: COVID exposed the structural fault lines that, ironically, comprise our racial caste system.[1] But that same tact contributed to many psychiatrists caught unaware of these faults before our world was shaken. There is a growing appreciation for those who saw this turbulence coming thanks to our double consciousness of racism and the rest of the world.[2] Such appreciation may follow from our country's habit of coping with existential crises by centering its disenfranchised—usually Black and Brown people, and often women—to restore its moral credibility.

Other folks—those insistent on the fairness of the status quo—are shocked and appalled by revelations of the brutal past. Its glaring ugliness begs them to ask a rhetorical question: "Is this who we are?" Another way of putting it: "How could I unintentionally be part of such a harmful project?" My answer: "It is what it is…"

Excuse my empathic failure. I am tired, and the question feels like fire, every time. It's a familiar burn, what some have deemed an unnatural disaster or an unfortunate aberration. To salve my burns born of the heat of ignorance, I seek relief in other minds during these unprecedented times. Unlike in Ray Bradbury's dystopic Fahrenheit 451, books help extinguish the burn. So I read, probably more than I should, likely to escape into a mind space less like mine: less angsty, less angry, and less dark.

Cooler minds prevail. James Baldwin, author of The Fire Next Time, helps explains my burnout. Questions like "Is this who we are?" or, as one UCLA professor and JAMA editor put it in February, "Given that racism is illegal, how can it be so embedded in society that it's considered structural?"[3] betray a "liberal innocence" necessary to maintain a racial caste system.[4] In sum, as Professor Clarence C. Gravlee recently wrote, liberal innocence—or liberal non-knowing—must be maintained for social racial order to continue unchallenged.[5]

Another professor, Charles Mills, goes further in explaining what he calls the "epistemology of ignorance", a concept with which feminists are likely familiar.[6] Eligible children are rewarded for obedience in and out of the classroom and, once adults, maintaining a social order that purportedly protects the dignity of all involved. We agree to abide by these rules—a social contract—which in turn depends on our obedience to reinforce the social order.

Racism is a tacit part of this contract; when made explicit, it directly challenges dignity.[7] It threatens to reveal the social order as socially and arbitrarily constructed—and similarly destroyed, thereby posing a mortal threat to the current social order. If rule following, morally upstanding, social contract abiding citizens knew their existence depended upon the exploitation of marginalized people—and not their own bootstrapping innovation or divine providence—the relentless, rugged, perhaps even hypomanic optimism exemplified by Teddy Roosevelt and mimicked thereafter might be lost.[7,8] Knowledge of and subsequent agreement that present day racism exists will fundamentally alter the social order. To protect against such tumult, rules and structures controlling which information reaches us—namely school, media, and culture—imbue most of us with the assumption that we are not racist, and accordingly punish those who dare assert otherwise.

Until now. COVID-19 stress tested the social order, and it failed. As such, I must assert otherwise. Racism is clearly an adaptive challenge in medicine and psychiatry, meaning that addressing the issue will require upheaval, change, and sacrifice for a better tomorrow.[9] As such, like climate change, it is a test of our commitment to the social contract's ultimate objective—a better society for our children. A change is coming—we can get a hold of it, or we can sit in denial until it gets a hold of us.

Yet I know many still reading right now—many more have surely stopped—are uncomfortable with the tone and content of what I've written. My structural formulation above purposely avoids blaming any one reader for reinforcing the racist status quo. I'm aware that doing so would emotionally derail this message—and possibly do further harm to my career. This is just one of the many lessons my peers of color and I must learn to successfully navigate professional spaces. However exhausting this maneuvering, it is twice as necessary. All of us know

cautionary tales of Black and Brown medical students, residents, and even attendings subject to exile for breaking the racial social contract. That fact that we know this evidences the double consciousness I mentioned earlier. The fact that some reading might not evidences the epistemic ignorance I mentioned later. While closed mouths don't get fed, mouths open too often get broken—and then wired shut.
It might hurt to read what I wrote above. Trust me: the burn hurts more, every time.

Michael Mensah is co-Chief Resident in the Department of Psychiatry at UCLA and Resident Fellow Member Trustee on the APA Board of Trustees. Next year, he will go to Yale as a National Clinical Scholar for a two year fellowship

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Interview with Katherine Camfield, M.D., M.P.H., SCPS Resident-Fellow Member Representative

I had the pleasure of interviewing Katherine Camfield, M.D., M.P.H, one of our Resident-Fellow Member Representatives who is serving her second term in that role, and an outstanding friend and colleague with whom I have trained at USC. Following is our interview with brief edits for context.

What is your name, current level of training and plan for after residency?
Katherine Camfield, PGY4 in psychiatry at University of Southern California/LAC+USC Medical Center. After residency I'll be doing a one-year fellowship in Emergency Psychiatry in Denver, Colorado.

What is your relation to SCPS and how did you first become involved?
I have been fortunate enough to be one of the Resident-Fellow Representatives for the past two years. I first heard about SCPS several years ago from [you]. I had been looking for a way to get more involved with advocacy and experiences outside of residency, and SCPS sounded like a great way to do that.

What has your experience been like serving on Council?
These past two years have been extremely educational and rewarding. I have met so many psychiatrists from various fields that are dedicated to making positive changes. On the council itself, there are usually lively discussions

regarding the direction of psychiatry and how to best help our patients and profession, especially here in Southern California. It is a safe space for council members to share ideas and have passionate discussions in which member can respectfully agree or disagree without judgement.

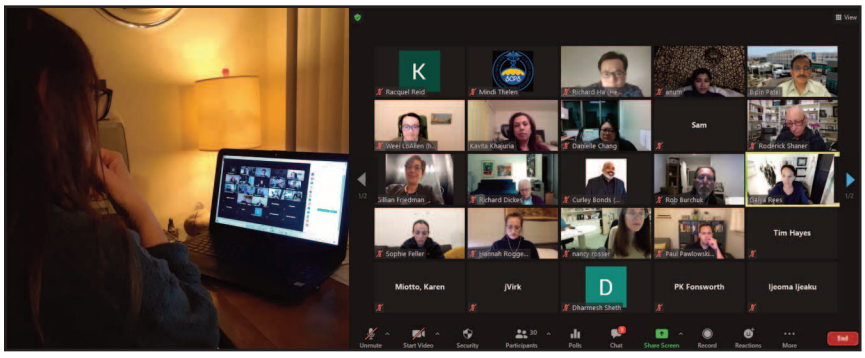
What does SCPS council actually do and how does SCPS help our members, patients, and profession?
I had no idea how vital organized psychiatry was until I became involved with SCPS. It's a way to give a voice to our patients, many of whom are marginalized. It provides a support network for psychiatrists and makes us aware of issues within the profession that we otherwise may never have known about. Having a united front when lobbying for local, statewide, or national legislation is extremely powerful. For me personally, SCPS has provided mentorship and guidance that will be so valuable as I transition out of residency.

Why do you feel it is important for trainees to get involved with organized psychiatry?
Organized psychiatry is a way to make meaningful change. You can bring issues faced by your patients or colleagues to a broader audience. You can meet people that may be facing similar challenges and work together to solve them. You can get involved with lobbying at various levels of government. Just understanding the mechanisms of organized psychiatry will help you navigate the professional world after residency.

What words of advice do you have for a trainee considering running for a council position or liaison role?
Don't be afraid to ask questions! The system of organized psychiatry is different than what people may have been exposed to in residency. The members of council that have been involved longer are amazing resources and can help explain the various processes. They can also help guide you if you have specific interests within organized psychiatry.

Do you have any other words of advice or thoughts for your fellow trainees or for our attendings providing mentorship?
Start small! There are plenty of committees and sub-groups you can join and events you can attend that will help you make connections. For example, you can attend one of the educational events held throughout the year, or a luncheon like the one held annually by the Women in Psychiatry group. These are simple ways to meet new people and possible mentors outside of your institution.

Eric M. Wagreich, M.D., PGY4
Chief Resident of Inpatient Psychiatry
USC/LAC + USC Adult Psychiatry Residency Training Program



Thank you to all who attended the Town Hall: **A Year of Covid-19, Reflections and Lessons Learned**.
Thanks to those who shared their experiences and to our presenters.
Stay well and healthy!

Almost Psyched Out

By: Phuong Vo, M.D. (Candidate 2021)

I went to medical school with the intention of becoming a psychiatrist. I was fascinated by the memory components of the brain, the developmental theories that encompassed human behavior, and the psychopharmacology that can give someone back their livelihood and functionality. I yearned to be a part of the unique field that uses your own mind to connect with another person and relies on a humanistic approach as well as utilizes the doctor-patient relationship as a mainstay treatment modality through therapy. There was something incredibly intimate about the field, and I found myself learning more about myself and my patient with each enlightening and vulnerable conversation that disguised itself as history taking. Prior to medical school, I earned a Bachelor of Science in Psychobiology, worked in a lab looking at fostering resilience in first generation college students, and received a master's degree in Biology with an emphasis on evolutionary Psychiatry with a final capstone discussing depression in animal models.

My first day on inpatient psychiatry was almost as cliche as something from a movie and I was face-to-face with my own incredible discomfort towards the discipline. The unit was locked, and I got my keys stuck multiple times, while being unsure if there was a patient behind me ready to run through. I almost tried to leave a locked door and triggered an alarm that had the nurses laughing for a short bit. One of my first patients was actively delusional and ran away from me into the wrong unit. I was summoned for a "show of force" code with an agitated patient. As a small, barely over 5-foot tall Asian-American female, I was acutely aware of my non-threatening position and lack of strength to help with any restraints or IM medication administration.

Yet it was not necessarily the borderline comical nature (pun intended) of my first psychiatric patient experiences that made me consider looking elsewhere for professional satisfaction, it was my perception of my own helplessness as a medical student and as a single cog in the wheel of an entire system that I had no control over that can make or break my patients' trajectories. It was the acute realization that I was lost when it came to my prognosis of patient well-being when they were (subjectively) stabilized and sent out to the world to fend for themselves once again. Much like emergency medicine physicians who treat the acute issues and rely heavily on patient follow up to primary care physicians, I felt that same way in my experience but felt even more daunted by the seeming lack of resources for the most vulnerable patients that I saw - those that had clearly fallen through the cracks. Had their brain neurobiology changed from drug usage? How could they find secure housing, maintain jobs, or get appointments for proper follow-up care with all the stigma and lack of resources? I saw a giant wall in front of me and did not think I could get through. On top of that, due to the longitudinal but separated nature of my medical education clerkship, I was unable to see the progress of my patients on a day-to-day basis and did not see how they progressed. I did not see the satisfaction of psychiatric care until I was able to rotate on an outpatient basis more consistently.

What brought me back into Psychiatry was seeing hope in my patients, particularly within the adolescent population. I may not have come back into Psychiatry if I did not see the recovery process or how patients could improve when I did my outpatient child and adolescent psychiatry rotation. The course of many psychiatric illness takes months, and this poses a problem for medical students sometimes when they are unable to deeply appreciate the recovery process. Clerkships as currently designed may not necessarily give medical students the window of opportunity needed to observe or notice these changes in their patients, but the change is profound and brings control back into the lives of patients. As I worked with an attending who engaged me in new and meaningful ways regarding psychiatric practice, and as I gladly observed my patients gaining control of their lives, I redefined my own aspirations and goals.

Apart from unique personal experiences, psychiatrists deal with stigma within the medical community and larger society. I am constantly aware of the stigma regarding psychiatric disorders and the discipline. It can be difficult to stave off comments saying that I "must be crazy to want to work with the crazies." It may not seem quite as straightforward as cardiology is or oddly enough neurology, even though we share the same organ, but that is also what makes it such

a fascinating field that allows you to grow as a human, along with your patient. “So, you went to medical school to do talk therapy?” My mother asked me, blinking, and confused, when I told her what discipline I was interviewing for during residency application season. It was difficult to describe to her in more detail. There were not obviously understandable terms related to Psychiatry in Vietnamese. The Vietnamese term for psychiatrist literally translates into “the doctor who treats insanity” and the terms for depression, bipolar disorder, schizophrenia are vague terms that do not carry much understanding within my culture. It was tough for me to tell her, too, due to being shaped by my own unconscious biases against the discipline itself. I was worried about not making my parents proud or concerned about what my parents would say when trying to describe to others “what I do as a job”. It is an odd field to be in when you are a doctor, but when you clarify what kind of doctor, people tell you that “so…”

Last week, I matched into a Psychiatry residency and could not be more thrilled to join this field that had both broken my heart and given me deep satisfaction with my life and education.

Let Us Not Let Them Psych Out (Our Role as Educators)

by: Ijeoma Ijeaku M.D. MPH FAPA

Early last year, one of the third-year students assigned to me declared that she had gone to Medical School to become a Psychiatrist but was seriously doubtful about pursuing this specialty. She noted that she was no longer feeling that Psychiatry was her passion due to series of issues ranging from lack of fulfillment to lack of support to not having a mentor who shared her passion…

According to the Merriam-Webster dictionary, to teach is to cause to know, to guide the studies of and to impart knowledge. Some have argued that teaching is the noblest of professions for these reasons. As Psychiatrists and champions of care and advocacy for the most vulnerable of populations – the mentally ill, it behooves us to act with diligence, dedication, and devotion when we impart knowledge to the next generation of both psychiatric and non-psychiatric trainees as they rotate through our practices/services. According to the AMA, two in five physicians screen positive for depression and mental health issues, and burnout and other stressors are prominent across the continuum of physician education and practice. Medical students, meanwhile, are three times likelier to die of suicide than their counterparts in the general population.

Research suggests that medical students begin medical school with better mental health than their peers. Burnout in medical students has been associated with self-reported unprofessional conduct and decreased altruism. The most significant stressor in the first year appears to be related to the transition from college to medical school (i.e., increased workload) in second year, the stress associated with a more competitive/less supportive school environment seems to peak, by third year students appear to struggle most with balancing school/clinical work with their other life responsibilities and this year that has been associated with a decline in empathy and by fourth year, students experience the most direct confrontation with mortality and suffering. Students reported that they rarely talk about these events with their attendings due to a variety of reasons, including limitations in perceived attending understanding, their role in the hierarchy, and concerns about grading.

Strengths-based education has been utilized by educators and focuses on the student as an integral part of the model. Strengths-based approaches value the capacity, skills, knowledge, connections and potential in individuals and communities; in essence the things that work. Focusing on strengths does not mean pretending that challenges or deficits or struggles are not real. Educators using this approach must recognize the importance of collaboration with the instructed. Collaborations have the primary goal of enhancing feeling of empowerment in the instructed thus encouraging true development and mastery. A strengths-based approach can enhance well-being. Research suggests that people who have a chance to use their strengths are on average 74% more engaged at work and that awareness of one’s strengths enables individuals to be 31% more productive. Like Albert Einstein opined Everybody is a genius but if you judge a fish by its ability to climb a tree, it will live its whole life believing that it is stupid

So how might we utilize strengths-based education during clerkships, psychiatry residency and fellowship trainings? Given that strengths-based education is a collaborative effort, I would suggest looking at three fundamental aspects: the learning environment, the student/trainee and the educator/attending. The Learning Environment should be set up with clear expectations and boundaries, roles should be well defined and there should be regular feedback from both the trainee and the educator. This environment should foster real engagement and encourage continuous growth of all participants with goal of ongoing advancement. Understanding the Student/Trainee's personality type and talents would be an important part of the collaboration as this would showcase the natural strategies of the trainee that seem to work. The story behind the student/trainee is the most important aspect of this collaboration as it allows them to take stock of where they have been and where they are going with emphasis on showcasing their resilience so far and reviewing coping strategies that have worked in the past. It is also an opportunity to reassess and/or redefine goals and aspirations for life within and outside the walls of Medicine as they face their fears, concerns and ongoing drives and pressures. The educator/attending, in teaching younger and upcoming colleagues, is charged with painting the landscape of medical practice. They accomplish this by humanizing medicine using narratives to define the patient while staying sensitive to their own stressors and coping strategies. The attending needs to create a professional relationship and the safe space that allows the student/trainee to maximize their experience by providing feedback to the educator about their experiences in psychiatric practice and even outside the practice, as well as asking for what they need/want as part of their training. The attending will learn to emphasize what works and manage what does not in this collaborative effort.

Further Readings:

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What is strength-based education? Edward Anderso

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Resilience Among Medical Students: The Role of Coping Style and Social Support. Gwen Thompson, Rosanne B. McBride, Charles C. Hosford & Gwen Halaas, Pages 174-182 | Received 22 Feb 2015, Accepted 15 Nov 2015, Published online: 11 Apr 2016

Orchestrating Change: Music & Mental Illness

By Kavita Khajuria, M.D.
Art of Psychiatric Medicine Committee
Culture and Diversity Committee

Mental health is a major theme nowadays, especially in the arts and music. UCLA's Friends of the Semel Institute recently held a screening discussion of a new documentary film 'Me2/Orchestra' - a film about an orchestra created by and for those with mental illness, and those who support them. The program featured seven clips from the documentary, combined with conversations from Ronald Braunstein (Music Director and Maestro); a flutist, two filmmakers, an executive Director, and an academic staff from UCLA. The objective of the documentary was to promote acceptance, understanding, and break preconceptions about those with mental illness. The orchestra was cited as a vehicle for change.

The journey of Ronald Braunstain was touching and inspiring - a brilliant and renowned musician dropped by the music industry at the age of thirty after a diagnosis of Bipolar Disorder, who later created Me2/Orchestra, a 'stigma-free zone' wherein musicians would not be judged - eventually expanded to other metropolitan areas and to those who do not have mental illness, but likely have family members who do. When asked why this type of orchestra was more fulfilling than a conventional one, Braunstein referred to the ability to relate more as a human being. He cited 'good days and bad days', friendships, support and emotional generosity - as well as gratification derived from the observation of other's growth.

Sandy Bartlett the flutist, spoke about her diagnosis of Bipolar Disorder, Anxiety disorders and A.D.D, including times when she felt out of control, abandoned, or perceived by others as slow or less capable. She spoke of the importance of having a place wherein she wouldn't be judged, and described the venture as an enjoyable challenge, despite a continued and residual fear of stigma.

Dr. Mark Tramo from UCLA briefly explained the relation of music with different parts of the brain - including motor, somatosensory, cognitive and cerebellar, as well as social and emotive aspects. Acknowledging a need for randomized control trials, he cited an initiative with NIH called "Sound Health" - a recognition of alternative treatments with incorporation of the arts and centuries old wisdom.

The event also included clips from the story of Dylan - an orchestra member with a diagnosis of schizophrenia, and his supportive mother. Realities included incarceration to complicate the mix, yet the heartwarming persistence of support and acceptance by the orchestra and his mother. Dylan referred to his approach in the face of challenges as to 'roll with it', and described the orchestra as a 'lifeline', an 'organism', and a 'tribe' that welcomes one back, regardless.

Documentary clips were interspersed with discussions. Orchestra performers additionally commented on the gratification derived from performance in correctional facilities and the overall pride and impact on family, who referenced 'orchestrating through each others lives'. Acceptance and empowerment persisted as common themes. All of this conveyed an important message: Those with mental illness have plenty of capabilities - don't shut them out.

The link between music and mental states are intriguing, but nothing new - the association between music and the mind date back to the ancient Vedic ages, wherein attempts were made to correlate the seven core musical notes with eight elemental moods (1). The first formal report on music therapy was published in 1964 - studies have increased over the past few decades, including in those with psychiatric disorders, with a focus primarily on adolescents and older adults. Musical hallucinations have been found in a variety of mental illnesses - with prevalence rates ranging up to 2.5%, with a tendency to be higher in the elderly, with the highest prevalence in those with OCD - musical obsessions are the more common feature, usually described as irrational music or nonsensical musical tunes (1).

Music therapy in addition to standard care has been found to have significant effects in patients with schizophrenia, with respect to negative symptoms, depression, anxiety, global functioning (1), and hallucinations (2). An RCT in India with 272 patients with chronic schizophrenia revealed significant improvement in PANSS scores with respect to anergia, activation and depression subscales – although other outcome measures included aggression, agitation, wandering, or other behavioral problems. The use of Indian classical music and non-lyrical flute music revealed lowered scores of depression, with significantly greater improvement in the music group compared to control groups who received treatment with psychotropics. Most of the studies demonstrated positive results. Other disorders wherein music therapy has been studied include Substance Use Disorders, ADD, Rett's Syndrome, learning disorder and epilepsy. Another cited advantage of music is as an alternate mode of communication for patients with limited speech and language abilities - including those with dementia.

Studies and numbers aside, cultural contexts are critical to consider. Music has its own internal sense of meaning founded on structure and cultural norms (3). In contrast to Western forms, Indian music therapy involves expression of devotional feelings as the key element.

Music has far reaching scope and depth – it encompasses the life span and human physiology: Nizamie and Tikka note early human development to be linked to melody, harmony and rhythm. Music activates specific brain areas and impacts dopamine and oxytocin - pleasant and unpleasant tunes also predominate activity in different regions of the brain (1). Music is well known to alter pain perception and affect blood pressure, respiratory and heart rates. As a language of emotional life, music may allow for projections, and expression of early childhood experiences or unconscious traumas.

Music has numerous applications within mental health settings, including, but not limited to background music, group singing and dance accompaniment. Benefits in a therapeutic environment include positive alterations of mood, improved concentration and attention, enhancement of coping and relaxation, facilitation of self esteem and personal insight, and enhanced social interactions and awareness (1). Music is a well known tool for emotional regulation in correctional facilities.

The long reach of the pandemic has compelled isolation, stress or sadness for many, triggered illnesses for some, and enforced self entertainment for almost all. Listening to familiar music has been recommended during this time, as it may comfort the mind, evoke positive memories and associations (4), and has the ability to reduce ruminations, suicidal ideations and a number of other negative mood-related behaviors. It can also stimulate the brain to facilitate a sense of control and empowerment, if the music is new (5). That being said, it's something to be done mindfully, as studies reveal that men especially, react negatively to aggressive and sad music, as these seem to promote neuroticism and anxiety (5). Access to music has increased overall - in 2020, Spotify reported an increase in listening capacities by fifty percent (6) - one site offers a playlist of songs whose lyrics specifically include themes of therapy, anxiety, depression or grief, that some may relate to (7).

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Film Review: The Father

By: Tim Thelen

Without ever verbalizing the name of the main character's disease, Oscar Best Picture contender, The Father presents a heartbreaking and frightening portrait of an elderly man stricken with Alzheimer's. The amazing Anthony Hopkins plays 'Anthony' – a retired engineer grappling with his failing memory, yet he is in denial - or simply can't comprehend his medical condition. Hopkins' sympathetic, and occasionally humorous portrayal of the sweet old man who enjoys listening to opera makes Anthony's emotional undoing all the more devastating.

In the opening scene, Anthony's daughter Anne (the excellent, Olivia Coleman) anxiously arrives at her father's London residence, and his dementia soon becomes apparent. She tactfully tries to break the news that she has met someone new and will be soon moving to Paris to join him. A new caretaker (played by Imogen Poots) will need to be hired, despite Anthony's insistence that he is completely capable of taking care of himself. However, he is clearly too impaired for life on his own. He doesn't even remember that his other daughter, Lucy has died, and keeps wondering why she hasn't gotten in touch.

We learn that Anthony is a retired engineer, and at one point he states that he is a man of high intelligence. This seemingly egotistical boasting is an innocent attempt on his part to explain away his recurrent confusion. Also, his brutal honesty, which often hurts the feelings of both his daughter and his caretaker are innocent faux pas on his part - as he is sadly just a victim of the disease.

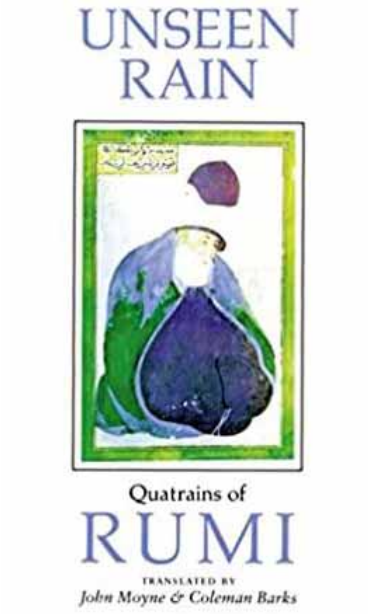
The less that's said in this review about further plot developments the better, because as the film's approach gives us a direct impression of Anthony's deteriorating mental state, the viewer often becomes completely disoriented as newly introduced characters are seen from Anthony's altered state of mind, and may not represent reality. Essentially, we become immersed into the position of someone with Alzheimer's disease. As characters and set-pieces change, we don't know if we are correctly interpreting events which have just happened, and we are continually forced to sort out the puzzle of the simplest conversations. Soon Anthony's questions of "When?" often turn to the deeper questions of "Why?" And when things become too overwhelming for Anthony he is recurrently seen retreating down the hallway to the safety of his bedroom.

Still Alice, the 2014 film starring Julianne Moore as a woman in the early stages of Alzheimer's was an admirable dramatization of this crucial topic, but The Father goes well beyond in terms of emotional impact. This is primarily thanks to Hopkins' tour de force, but also because much of this film is brilliantly designed as a psychological mystery. First-time director, Florian Zeller has adapted his play of the same name, and brought the story to the screen with a first-class production. (Although the film is nominated for 6 Academy Awards including Best Picture, Actor, Supporting Actress and Adapted Screenplay, director Zeller surprisingly did not pick up a nomination in the Best Director category.) A devastating depiction of the ramifications of this disease, The Father is certainly the "feel-bad" film of the year, however, it is a masterfully-assembled, unique and important motion picture.

★★★★★

Unseen Rain
Quatrains of Rumi
Translated by J. Moyne and C. Barks
Shambala Publications
2001
96 pages
$14.95 paperback
ISBN: 978-1570625343

Book reviewed by Kavita Khajuria, MD.
Art of Psychiatric Medicine Committee
Culture and Diversity Committee



"I have lived on the lip
of insanity, wanting to know reasons.."

Unseen Rain is a collection of short poems by Rumi. Mevlana Jelaluddin Rumi (1207-1273) was a legendary transcendental poet and philosopher of the Sufi tradition. The general theme of Rumi's thought was that of union with the beloved - akin to many other mystics and Sufi poets. This collection of mystical poetry focuses on the wonders of life and love - tones and themes include yearning and bewitchment, delights and dilemmas, and contentment and confusion - but also of pain and madness. Other themes include the wonders of the eternal, the honor of honesty, and the link of humanity. Translated into free verse, these can feel simple or inexplicable, and can open the door to a variety of resonating reflections. Poems range from the short and playful to the intricate and exhilarating.

The precise link of spiritual practices to solace is unclear - but research reveals it may help one cope with illness or dismal life circumstances. Spiritual practices carry additional importance in terms of instilling hope, comfort, self-respect and compassion - and can further the appreciation of meaning in life. Such works offer a reflection of mental states that may enhance cultural sensitivity - as people may seek a variety of routes to existential understanding.

Council Highlights
February 11, 2021
Eric Wagreich, M.D., *Secretary*

Outline of Notable Meeting Events and Discussion

The meeting was called to order by Dr. Fouras at 7:14 PM.

Introductions

Acceptance of Agenda
A motion was made to accept the agenda which was approved unanimously
Meeting Minutes
A motion was made to accept the minutes from January Council meeting and Executive Committee Report, which passed unanimously
President's Report
CMA Specialty Delegates
Dr. Murphy, guest from SDPS introduced the CMA Specialty Delegation and the proposal to accomplish continued inclusion of all 5 DBs in the delegation. He provided a brief power point regarding the background of the delegation and history resulting in the current issue. Dr. Goldenberg asked that it be noted that he requested guests be excluded in the discussion due to concerns over conflicts of interest, which was overruled by Dr. Fouras given the lack of appropriateness in excluding paid members. The floor was opened for discussion for which Dr. Arroyo joined in.
A motion was made by Dr. Ijeaku for SCPS to join with CSAP in an MOU that is to be vetted by the GA Committee which would ultimately be approved by the executive committee. A discussion was held regarding the motion. It was agreed upon that the MOU would need to be brought to the EC by Feb 20. A vote was held and the motion passed with 14 in favor, 1 opposed, and 1 abstained.
Virtual Awardees
Ms. Thelen introduced the awards ceremony and the virtual installation and awards ceremony to be held April 24 at 4pm. The committee recommended delivering awards from 2020 which had not been given due to COVID. The committee's recommendation was to accept the proposed awards from 2020 and 2021. A motion was made to approve the committee's recommendation which passed unanimously.
PPAC Report
Randall Hagar presented the PPAC report and thanked the council for joining with PPAC for psychiatric advocacy in California. He shared an optimistic outlook on the year ahead for Psychiatry and the challenges ahead. He shared that psychology's lobbying efforts to advance practice opportunities have been stifled due to losing their primary lobbyist, but that challenges remain, resulting from the passage of AB890. He also emphasized the current efforts by PPAC to try and guide the forthcoming process in the implementation of AB890.
Diversity and Culture Committee
Dr. Rees shared updates from the Diversity and Culture Committee including recent articles shared and APA's apology letter and the George Mallory Award and a request for nominations for the award.
Newsletter Committee Report
Monthly Themes
Dr. Goldenberg introduced the report and the significant contribution from Mindi and the Diversity and Culture Committee especially for Black History Month. He also made a request for members to make a theme for upcoming months such as the current work on a women's contribution theme for March.
Treasurer's Report
January Financials and Cash on Hand
Dr. Goldenberg shared the Treasurer's Report, which reflected that for overall income we are under budget by about $8,498; for expenses we are over budget by about $3,450, and about $75,000 cash-on-hand compared to last year, though consistent with last month, this figure is misleading due to yet-to-be transferred PPAC dues, and a more accurate assessment is that we are about $62,000 under cash on hand compared to last year. A motion was made to accept the Treasurer's Report, which was passed unanimously.
Office Lease - Committee Recommendation
Dr. Goldenberg shared an update to the office lease concern and the various options available. The Finance Committee's recommendation is to continue paying our lease as is and to continue searching for a sublease in

the interim. No vote was needed as this is the current action and would not result in any significant change.
PRMS Proposal - Committee Recommendation
Dr. Goldenberg presented the finance committee's review and recommendation of the PRMS Partnership proposal. Dr. Goldenberg thanked the members who contributed to the committee's work including: Matt Goldenberg, D.O., Chair, Ijeoma Ijeaku, M.D., Zeb Little, M.D., Galya Rees, M.D., Rod Shaner, M.D., Eric Wagreich, M.D. (past member) and also Mindi Thelen, Executive Director.
The committee made the following recommendations via motions and they passed:
Reject the Partnership proposal
Authorize the finance committee to develop and negotiate a sponsorship agreement with PRMS
Use the outline in the finance committee report as a general framework for a sponsorship agreement with PRMS and bring the final product back to council for approval.

Membership Report

Membership Report
Dr. Ijeaku asked for approval to accept the new members which passed unanimously.
APA Membership Issue
Dr. Ijeaku shared an update with communication with Lisa from APA and receiving more access to the DB window and her positive experience with the conversation.
Calls to Delinquent Dues Payers
Dr. Ijeaku presented the delinquent dues list and requested members of Council assist in reaching out to members on the list. Three members were asked to be taken off the list given payments since the list was distributed.

GA Committee Report

Website Recommendations
Dr. Shaner provided the report. This included that the committee will begin meeting monthly with PPAC prior to forthcoming council meetings. He also shared that there are efforts to revitalize and the website to include various committee recommendations for GA, public affairs, diversity, PPAC, and APA affairs to be included for members and general traffic to be able to view our defined interests and efforts in advocacy. He provided additional details about the website recommendations. A vote was held to accept the committee's motion which passed unanimously.

Program Report

Dr. Gales shared an update from the Program Committee including attendance for a the recent meeting as well as upcoming opportunities for programming.

Assembly Report

Dr's. Soldinger and Red provided a brief update for the assembly including that an alternate method for proposal of Dr. Friedman will also be taking over the remaining tenure for Dr. Fogelson.

New Business:

Ms. Thelen shared that SCPS has been mailing masks to various members with some being returned.

Old Business:

Dr. Ijeaku raised the question of when we can begin looking into who will be providing advocacy representation through the GA Committee. Dr. Shaner shared that by April the committee would be reviewing the contract and whether additional options should be pursued between June and September when billing information would be due for the following year's budget.

The meeting was adjourned by Dr. Fouras at 9:30pm.

Dear Readers,

We are anxious to hear your ideas regarding themes we might cover in this newsletter. If you have any ideas please let us know.

We are always accepting article submissions. If you would like more information on how to submit an article, please email Mindi.

socalpsychiatric@gmail.com

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