Southern California

PSYCHIATRIST

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President's Column

A Two Percenter Begins Her Presidency

Ijeoma Ijeaku, M.D.

Two Percent…

Of the almost one million active physicians in the US, Black female physicians make up about 2%. The first Black female physician; Rebecca Lee Crumpler received her medical degree in 1864 from New England Female Medical College. At the time, there were about 55,000 physicians and only 300 of them were females. Females now make up almost 40% of the active physician population, a great feat indeed. However, in almost 160 years since Dr Crumpler's graduation in 1864, the number of Black female physicians is just at 2%.

The Southern CA Psychiatric Society (SCPS) which is the local district branch of the American Psychiatric Association serving about 1000 psychiatrists in the greater Los Angeles area has been in existence since 1953 and for the first time in its history, one of the two percenters gets to be at the helm of things. While I am excited about the prospects of positive representation and the positive ripple effects, I am apprehensive about the impending mental health crisis coming in the wake of the COVID-19 pandemic. In a year where it has become obvious that health disparities run parallel to racial issues and where we have seen communities of color suffer and die from COVID-19 related issues at disproportionate rates, we know that the mental health crisis will hit these communities more. Yes, the pandemic is considered a once in a lifetime situation and presents unique stressors that continually challenge both the mainstream members of society as well as the marginalized members of society. However, data has shown that members of communities of color have had more than their fair share of this negative impact. I remain hopeful that my colleagues and I in the greater Los Angeles area will use this opportunity to forge strong partnerships that will help improve how we show up as champions of mental health for all but especially for those further marginalized by the extra burden of their race, now formally declared a public health threat by CDC and other agencies.

I received feedback from some of our members alleging that SCPS is becoming too involved and preoccupied with racism and social justice issues. These members have felt that our organization might be getting too political. While I understand that SCPS is not a political organization, could we as psychiatrists truly do our job of evaluating and treating mental illness if we attempt to do it outside of a societal and ultimately social context? As psychiatrists (doctors of the soul) who are literally medical practitioners charged with the special responsibility of understanding the relationship between the signs that we observe in our patients, the symptoms we elicit and their effects on the patient and their families, how could we afford to distance ourselves from the sufferings around us or around our patients? In a digital world, can we really separate ourselves from the experiences of others when we have constant access to these through social media?

As humans, we have obligations to each other because we really are only as strong as the weakest among us. As fear and concerns about our own fragility drive the hate and bigotry in our society, can we afford to stay silent? As Psychiatrists, we receive training in treatment of emotional trauma. Now we have an opportunity to

be open to the trauma that has plagued Black America for centuries as well as the trauma that other marginalized communities must endure for issues ranging from racism to colorism to sexual identification. This is our opportunity to address the inequities that our colleagues, patients and fellow humans live with. How might we create a culture of health equity where every member of society has as much access as the next person to the basic human right of health?

The use of models in psychiatric evaluation, which are broader and more inclusive, are necessary to create this so-called culture of health equity. When we evaluate our patient (another human being), what possible biases might be we be dealing with? Whether we chose to use medical models or broader biopsychosocial models in evaluations, it is important that we implore principles of justice, equity, diversity, and inclusion. When we engage the Asian-American female in our clinics, do we inquire how the recent mass shooting made her feel? Are we hesitant? Is the hesitancy fueled by others? Should we really allow ourselves, deal with the implication and possible trauma of objectification? Might we be calling on our basic humanness if we asked the Hispanic youth in juvenile hall for the fifth time since the pandemic how many of his family members have been lost to the pandemic? Should we be punishing him for vandalism, or should we be exploring his trauma to uncover the emotional pain that he must be dealing with? Can we find ways to help him heal and recover?

While we do our communities of color good by ensuring that every provider starts using the principles of justice, equity, diversity and inclusion in their evaluation and treatment of patients of color, it would be more potent in the long run if we can dedicate ourselves to the education of individuals who are members of communities of color. Research shows that access to racially and linguistically concordant providers increases the potential for improved health outcomes in our patients. It thus behooves us to engage in practices that would create a pipeline to education for members of communities of color to ensure that we grow the percentage of physicians who identify as persons of color.

As psychiatrists navigating today's unique mental healthcare challenges through the lens of pandemic and social justice related issues, we also must deal with other issues threatening our profession at local, regional, and national levels. SCPS has poised itself to collaborate with other organizations serving psychiatrists in the state to ensure that our profession is preserved and that we strongly advocate for the vulnerable population we serve even with the recent dissolution of CPA. Despite the unique challenges of the last year and half, the dedication, passion, and commitment of SCPS members have been impressive. Members have worked hard as they are actively involved in various SCPS committees to ensure that our profession stays vibrant, that our members stay informed and connected and that our patients have access to equitable care.

Please consider joining any of the SCPS committees (check out current committees through our website https://www.socalpsych.org/) by reaching out to our most devoted executive director Mindi Thelen @ scps2999@earthlink.net to contribute your ideas so that SCPS continues to grow and serve all of us.

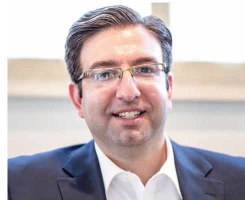
Ijeoma Ijeaku MD MPH FAPA
(a Two Percenter)

In This Issue...

Letter from the Editor 3
Get to Know Your SCPS Board: Haig Goenjian, M.D. 4
Letter from the Guest Co-Editor 8
Asking the Unaskable
Disaster Psychiatry: Covid-19 Era 9
Assessment and Response During
Public Health and Ecological Disasters 11
The Coronavirus: (Podast) 12
Putting Together My First Emergency Kit 16
A Year of Covid-19: Reflections and Lessons Learned 18
Book Review: Dealing With Conflict 19
Council Highlights 20
Classified Ads 22

The Disaster Edition

By Newsletter Editor
Matthew Goldenberg D.O.



Happy Spring!

This month we have a host of timely articles about Covid-19 and other issues related to Disaster Psychiatry. I want to thank this month's Co-Guest Editors, Danielle Chang M.D., who is chair of the SCPS Disaster Relief Committee, and Weei LoAllen, M.D. for helping to craft this month's newsletter.

Dr. Chang, as Disaster Relief Committee Chair, has been pivotal in SCPS's efforts to respond to and to organize resources during this unprecedented pandemic. Dr. LoAllen is an active member of the Disaster Relief Committee. This newsletter edition is an opportunity for SCPS to share some of the work of the disaster and also several articles from our members on this topic.

I want to again thank Dr. Chang and Dr. LoAllen and all of our contributors for their efforts this month!

Later on in the newsletter, please enjoy my question and answer with our incoming SCPS Secretary, Haig Goenjian M.D. This is the first of this year's ongoing series of "Get to Know Your SCPS Board".

Continue to stay safe,

Matthew Goldenberg D.O.
SCPS Newsletter Editor
Treasurer (2020 – 2022)

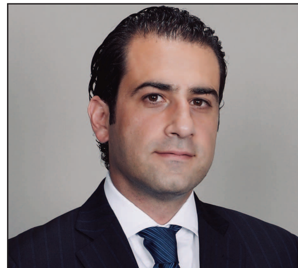
Get to Know Your SCPS Board

By Newsletter Editor
Matthew Goldenberg D.O.

This month I want to share part of an ongoing series of interviews with members of the SCPS Executive Council Leadership. My hope is that this will facilitate SCPS members to better get to know their SCPS leadership.

May a better understanding of the history of SCPS and how our leadership got involved, serve to inspire a new generation of future leaders to join and become active on the council.

For the May 2021 edition of our newsletter, I have the pleasure of presenting my brief interview with Secretary, Haig Goenjian M.D. I hope you enjoy getting to know a little more about your SCPS Council. Thank you to Dr. Goenjian for taking the time to chat with me!



Secretary, Haig Goenjian M.D.

1) What initially sparked your interest in medicine and specifically the field of Psychiatry?
My interest in medicine really first came to mind as an undergraduate at UCLA. I originally had thought of becoming a lawyer, and I think that came from my sensitivity to injustice in the world. But I realized a year into my studies that medicine is one field where there is no debate or controversy, that an individual is purely helping another. To have the fabric of my life's experience be focused on healing seemed infinitely more rewarding.

Psychiatry itself did not practically enter my mind until I was doing my internship in surgery. There were many experiences that guided me to the direction. A few that come to mind are when I was giving informed consent for surgery. Many doctors struggled with this in the trauma setting. It made me realize the power of words. I also realized how long-lasting and impacting psychiatric treatment can be on a person's soul, compared to say, fixing an abscess.

Those examples were more practical, and in some ways superficial. On a more abstract and deeper level, I think it was a path that had been budding since childhood. I could talk about this for days, so I will suffice it to say, the spark of interest still fires to this day.

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

When I initially started, I remember the different residency programs that I interviewed with and how they would compare themselves to other programs. Their selling points would be things like, "we have a great expertise in psychopharmacology". Or, "we have the best psychodynamics training to offer". At that time, it seemed like there was one group of psychiatrists holding on to the need to define psychiatry in terms of psychodynamics. And there was another group that seemed to want to define and differentiate themselves as biologically oriented, or psychopharmacological. I think our field has matured, and many psychiatrists find this division arbitrary and unnecessary.

Another important aspect that I did not imagine was the influence of business on psychiatry. I think our field is being pulled towards quick fixes. Emotional wounds heal at a different rate than what corporate America wants to hear.

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

My primary setting is in phase 1-3 clinical trials. I'm a principal investigator for a private company in the LB and OC areas. It is a small niche, but one I am greatly appreciative to have found. Our company often uses the tagline, we provide academic research at the speed of business. What this translates to is being able to contribute to research, the future of psychiatry, but to do so with a lot less red tape than many other research settings. I often have the chance to work directly with big pharma and influence their decision making on what medications and patient populations to pursue.

I also am an attending at an inpatient hospital. We see a wide range of voluntary patients. This helps me keep my clinical skills intact, but also to have the emotional gratification of helping see patient's progress and heal in the acute setting.

4) What motivated you to become more active with SCPS originally? How did you get introduced to the council and involved? Are you involved in other professional organizations?

Originally, I was made aware of SCPS by Dr. Michelle Furuta. She had asked me to be a part of the Art of Storytelling Documentary, and it was a great experience. I subsequently won the PER award during my Chief year at Harbor UCLA. I was then asked to be on council and was honored to join.

In the beginning, I was a novice and did not realize how important the organization was. As the years have gone by and my understanding of their role in organized psychiatry has grown, I have been increasingly motivated to contribute my time and energy.

5) Where do you see the field of Psychiatry go in the next 10 years? What changes would you like to see for our field and our patients?

I do not know where this field will be in 10 years. I have faith in the science of psychiatry, and that it can continue to grow and evolve. But I think that currently psychiatry is vulnerable as a profession and has a questionable future at this rate.

There are many forces at play that want to see the field divided. Though many of these influences claim to be advocating for the patient, I believe they have ulterior motives. What they really mean, is that they want psychiatry to be outsourced to non-psychiatrists. When we take psychiatry away from psychiatrists, just as if one was to take parenthood away from parents, then it is ultimately the patients, or the children, that suffer.

6) If you could go back in time, with what you know now, what advice would you give yourself related to

your medical education, training and becoming a Psychiatrist?

Don't stop what you're doing.

When I was in training, my supervisors greatly emphasized the need to learn both medications and therapy, and I headed this advice. It was arduous, but in the end, I am very grateful for it. Ultimately, it has helped me become a better physician, and I'd like to think that it has helped my patients.

7) If someone is reading this and thinking about getting involved with SCPS, what advice or encouragement would you give them? What do you enjoy most about serving on the SCPS Council?

My initial draw to SCPS was basically academic or intellectual, I liked what they were doing to help enrich psychiatry on a local level. The driving force now, which has led to dedication, is my conscience.

I would encourage psychiatrists to ask themselves whether they want their profession to be in their own hands. Would you like to be led by your own peers, by your own self, or are you ok with letting your future value and scope of practice be decided by people who may not have your best interest in mind?

8) Surprise me. What is something we didn't know about Dr. Haig Goenjian?

I come from a lineage of American Armenian psychiatrists, which date back to the early 20th century. My great uncle, Garo Aivazian, was the chairman of psychiatry at UT Memphis. He trained my father, and also trained many other Armenian psychiatrists including Hagop Akiskal and Armen "DJ" Djenderedjian. DJ in turn trained my sister and I at Harbor UCLA. This serves as a great honor and motivates me to pass on the knowledge to future generations.

SCPS Presents an Online Meeting:

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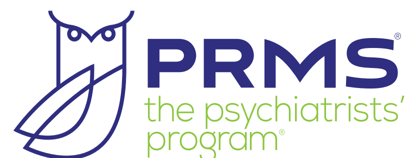

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Letter from the Guest Co-Editor

On behalf of the SCPS Disaster Relief Committee, we would like to thank you for reading this month's special edition of the SCPS newsletter on Disaster Relief Psychiatry.

The SCPS Disaster Relief Committee was reactivated in 2019. Since then, the committee has been meeting regularly to focus on local efforts and has also been representing SCPS as part of the California Disaster Mental Health Coalition (CDMHC), a group endeavoring to improve disaster mental health services across professional disciplines through collaboration and consultation. 2019-2020 was a time of growth for the committee as many of our members did not have much prior experience in disaster relief but were eager to learn. We heard about the experiences of other seasoned disaster relief mental health providers through the CDMHC and learned about the complex public and private systems that interact at the federal, state, and local levels during times of disaster. It became apparent that psychiatrists had the potential to play an important part in disaster relief but our roles have often not been clearly defined in times of disaster in the past.

I joined the SCPS Disaster Relief Committee and became Chair because of my own personal experience with 9/11. As a New York native, I was deeply impacted by the emotional and physical wounds that many of my family, friends, fellow first responders, and community members had experienced from the tragedy. I also saw the power, strength and resilience of communities who stood together. I saw mental health professionals deploy to ground zero to give support to first responders and victims at the scene, and what a difference they made. I had hope that as a committee we could similarly help facilitate the development of a greater role for psychiatrists in future disaster relief efforts. I could never have imagined at that time that we would soon be faced with a global pandemic that would create an even greater need for mental health services.

Throughout the pandemic, we strove to provide support to SCPS members through the dissemination of trusted information, reaching out to individuals, connecting members with opportunities to serve those affected by COVID-19 through warm-lines and other avenues, through a training event with the Red Cross and, most recently, through our town hall entitled A Year of COVID-19: Reflections and Lessons Learned. We continue to build relationships with disaster relief stakeholders and colleagues at the APA Disaster Relief Committee. We learned from our more experienced colleagues that building a community presence, fostering partnerships, taking the time to reflect on things we have learned from our own experiences from COVID-19, and creating opportunities for connectedness were some of the most important things we could do to prepare for future disasters.

I would like to thank our current SCPS Disaster Relief Committee members for their hard work and dedication, including Anum Baig, Rahn Bailey, Ijeaku Ijeoma, Kavita Khajuria, Adnan Majid, Galya Rees, Mindi Thelen, and special thanks to Weei Lo, SCPS Newsletter Co-Editor of the Disaster Relief Edition. We hope you enjoy this month's articles and we look forward to hopefully seeing you at our upcoming panel on the personal experiences of disaster relief psychiatrists (date TBD).

We are always looking for new members and welcome any SCPS member who is interested in joining the committee. To join, contact Mindi Thelen for more information at socalpsychiatric@gmail.com.

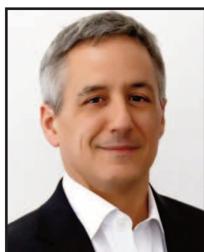
Sincerely,

Danielle Chang, M.D.
SCPS San Fernando Valley Councillor
SCPS Disaster Relief Committee Chair

DISASTER PSYCHIATRY: COVID-19 ERA

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

Lance Wobus, MD
Charles R. Drew University Research Associate



The COVID-19 pandemic has had a traumatic effect on society and has resulted in substantial losses for many. Unemployment has been at a record high, while food insecurity, job losses, and the stress of social isolation are prevalent. The pandemic has also led to enormous mental health problems. The most common symptoms after a disaster are insomnia, anxiety, depression, and bereavement. [1] A recent CDC survey estimates that 26.3% of respondents suffer from trauma and stress-related disorders, 30.9% from anxiety or depression, 13.3% from substance use, and 10.7% from suicidal ideation. [3] People may also self-medicate with drugs and alcohol; reported substance use has increased since March 2020.[2] Healthcare workers have been particularly affected. Challenges for this population include a shortage of PPE, fears of virus exposure, burnout, and inadequate patient care due to insufficient resources. Without addressing burnout, prolonged problems may lead to acute stress disorder and PTSD. [3] One-third of COVID-19 survivors received a neurologic or psychiatric diagnosis within six months of infection. About one in eight had never received a neuropsychiatric diagnosis prior to infection. This suggests there will be an ongoing increased demand for neurology, psychiatry, and primary care services. [4]

Psychiatrists can play a key role in diminishing the traumatic burden. What can psychiatrist do to treat individuals whose mental health has been harmed by COVID-19? Among other activities [1][2][5]:

- Assume leadership roles and provide post-disaster psychiatric care including direct assessment and needed interventions
- Provide psychological first aid
- Help communities to stay informed and disseminate credible information to help individuals reduce risk
- Supply high-quality, evidence-based treatment to those with co-occurring psychiatric disorders
- Practice telemedicine to identify and treat mental health conditions
- Assess safety risks and risk factors
- Differentiate psychopathology from nonpathological distress
- Judge the extent to which exposure to traumatic events will lead to future post-traumatic stress disorder
- Evaluate when short-term pharmacotherapies may be appropriate for symptoms that do not constitute a psychiatric syndrome
- Consider possible adverse effects from psychotropic drugs that may increase risk for COVID-19 complications

The obstacles that challenge mental health professionals throughout a pandemic surpass the usual limits of disaster psychiatry. Additional expertise is needed in areas such as crisis counseling, public health, organizational behavior, psychopharmacology, and providing mental health support services to nonpsychiatric health care workers. [5] Disaster psychiatry must also protect vulnerable individuals in need, as disasters tend to exacerbate inequalities in society. [6] Stresses can contribute significantly to responses after disasters, including backlash

toward specific cultural groups. [1] Psychiatrists must also keep in mind that licensure and credentialing represent an important challenge in disaster work. Mental health workers should be aware of the requirements of the state in which they are doing volunteer work. [1] Lastly, psychiatrists must remind themselves that self-care is a prerequisite in caring for others. [5] This holds true for the patient as well as the physician.

The authors gratefully acknowledge the assistance of Dr. Amit Grover in the preparation of this article.

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Assessment and Response During Public Health and Ecological Disasters

By: Weei LoAllen, M.D.

The global pandemic of coronavirus disease 2019 (COVID-19) exposed the structural challenges in our healthcare system and highlighted the legacy of racial injustice and health disparities faced by minoritized communities. It reminded us, and the public, of the importance of mental health as we reclaim our resilience and build a socially just society. To learn more about how to address ecological and public health disasters such as the COVID-19 pandemic, Dr. Joshua Morganstein, the chair of the APA's Committee on the Psychiatric Dimensions of Disaster, has recommended the following selected articles for our members.

In **Ecological Disasters and Mental Health: Causes, Consequences, and Interventions**, the authors discussed the public health concerns of ecological disasters, including psychological and behavioral health consequences. They summarized the factors associated with increased vulnerability to mental health effects of disasters for individuals. Special considerations for assessment, early interventions, and evidence-based treatment modalities were also discussed. Overall, the authors stressed the importance of consistent community leadership, clear communication, equitable distribution of resources, and active community engagement to optimize response and recovery efforts following disasters. You can learn more about the topic with the full article here.

In **Pandemics: Health Care Emergencies**, the authors provided a succinct review of past infectious disease outbreaks including HIV-1/AIDS, SARS, H1N1 Influenza, and Ebola. They compared the similarities and differences in chemical, biological, radiologic, nuclear (CBRN) events, natural disasters, and pandemic outbreaks. They summarized the important features from prior pandemic outbreaks and topics that need to be addressed in mental health intervention planning for pandemic. They also provided a detailed discussion on the principles of psychological first aid, the principles of psychological support for the victims of pandemics during early response, and the principles of supporting communities during late pandemic response and recovery. The authors illuminated the crucial role public officials and healthcare leaders have, and the importance of mitigating fear-based decisions and promoting prosocial behaviors. Psychiatrists, as they astutely pointed out, can assist disaster planners in facilitating effective communication efforts and treat the adverse mental health effects of pandemic outbreaks. To learn more, you can read the full article here.

In **Enhancing Psychological Sustainment & Promoting Resilience in Healthcare Workers During COVID-19 & Beyond**, the authors distilled the psychological and behavioral effects of pandemic on health care workers. They also reviewed existing best practices from other high-risk occupations and identified efficient responses to optimize workforce well-being and preserve healthcare organizational functioning. At the end of the article, authors provided a list of actionable recommendations that will sustain healthcare workers during times of prolonged crisis events. You can read the full article here.

The Center for the Study of Traumatic Stress at the Uniformed Services University has made their COVID-19 pandemic response resources available on their webpage. You can also access their fact sheet search engine with links to different disaster focused fact sheets on numerous topical areas.

If you would like to learn more about COVID-19 vaccines and other COVID-19-related topics for your county, you can visit these dedicated websites:

Los Angeles **Riverside** **San Bernardino** **Santa Barbara** **Ventura**

The Coronavirus: Psychological Considerations with Special Emphasis on Psychological Support for Doctors, Nurses, EMTs, Other First Responders, Including Members of the Media and the Psychological Support Teams Themselves

This presentation originally appeared as a Podcast at PsychiatryTalk.Podbean.com. It is reprinted with permission.

Posted on March 15th, 2020 by Dr. Blumenfield

Hello, I'm Dr. Michael Blumenfield.

Today's podcast is going to address the psychological issues of the victims and the potential victims of the coronavirus, the people caring for them such as the doctors, nurses, EMTs and other first responders, the mental health professionals who are involved in supporting these groups and also the members of the various media, print TV, etc., who are also fully exposed to the psychological impact of this epidemic by the nature of their work

Of course every one of us is a potential victim of this life threatening disease. We know that if you are older or have a chronic disease, you are more susceptible and of course we know that transmission occurs by exposure to people who are infected. This knowledge creates conflicts about personal, travel and business decisions, which can be quite agonizing and guilt producing when there is a subsequent loss of business or personal opportunity, or if the decision leads to illness and potential fatalities. The nature of this disease often requires isolation and quarantine of people identified as being exposed to this illness. This situation, of course, can be quite psychologically painful to the person involved as well as to their loved ones. However, modern technology now allows the maintenance of face to face, relatively intimate contact via FaceTime, Skype etc. so people can mitigate some of fear, anxiety and depression of this situation. As will be described below group video meetings can be held via Zoom.

Any situation that changes a person's usual interactions and travel patterns, increases the possibility that there could be a temporary hiatus in the renewal of their regular medication. This can be important when a person is taking essential medications for diabetes, heart disease and other illnesses. It can also be very important when people with mental symptoms run out of medications in such conditions as schizophrenia, other psychosis, bipolar disorder, anxiety panic and, of course, depression. This situation can be further exacerbated if pharmaceutical companies cannot get essential ingredients from international sources during a worldwide epidemic.

Mental health professionals in the United States and in many other countries have established very sophisticated techniques for working with patients who have serious medical and even life-threatening conditions as well as supporting the medical and nursing staff caring for them. There is a subspecialty of psychiatry originally known as Consultation-Liaison Psychiatry which has now been subsumed under the particular specialty known as Psychosomatic Medicine.

Of particular note was the work by these specialists in dealing with the AIDS epidemic as well as with burn and trauma patients, cancer, heart disease and other illnesses. It should be noted that during the acute phase of illness, the ideal approach is for the patient or family members to meet individually or sometimes as a couple or family with a mental health professional when there were psychological issues. Sometimes, of course, clergy would be involved. At a later phase there might be referral to some specialized grieving group meetings with others who have lost loved ones. Mental health professionals trained and experienced in this area of Consultation-Liaison may be particularly appropriate to take a leadership role in the delivery of services, especially in running any groups.

During the AIDS epidemic there were often particular fears among medical and nursing staff of contracting the disease, especially before the exact mode of transmission was understood. There were numerous other psychological issues for healthcare workers, victims and families. In situations where there were mass causalities such as after airline crashes and particularly during the World Trade Center 9/11 incident, where there were 1000s of deaths, there were many psychological issues for the families, the surviving victims and also for first responders including the psychological support teams themselves. More recently mass causality events ie. shoot-

ings or bombings have raised similar issues, many of which maybe similar to those that we will be seeing during this coronavirus epidemic.

In the past, particularly prior to 9/11, the usual approach where there were believed to be large numbers of psychological causalities, particularly among the first responders, members of the media or even among the psychological caregivers themselves, was to use the CISD (Critical Incident Stress Debriefing) approach. This is a technique where a specific group of people ie. doctors, nurses, EMTs, members of the media or even mental health personnel, would meet in a group with a psychological consultant who would lead them in a discussion of the difficult experiences that they had been through. For example, after a plane crash or a terrible tornado, the police, firemen, EMTs or even reporters would recount the horrible, sights and sounds that they have seen. They might be describing seeing dead children or maimed victims etc. This technique was based a catharsis model which might encourage the participant to “let it out”, tell about their experiences, nightmares, fantasies and encourage them to discuss how they thought about their own families and personal thoughts. While such a technique might be helpful in an individual therapy or group therapy treatment dealing with less acute situations such as sharing a struggle with substance abuse, many experts soon realized that having each person recount their own painful horrific experience in this group setting, was usually not helpful. In fact, to the contrary, such situations were more likely to intensify the anxiety, panic and worry of the other participants of the group. It is a different situation when someone in psychotherapy is reflecting back about a difficult time in his or her life and brings up some painful memory and then gradually lets down their psychological defenses. Or even in a group therapy situation, a person may recall a difficult memory or a current struggle and is getting the support of the other group members, most of whom are not struggling with very similar acute issues. The CISD model, although very well meaning, in my opinion was not effective. In fact, I believe it had the potential to magnify the problems of the other group members and sometimes would breakdown psychological defenses which were helpful at that moment.

This doesn’t mean that there is no value for specific groups to meet under the guidance of a mental health professionals but the approach, in my opinion, should be one that is supportive and affirmative. The group meeting with a leader might address several areas depending on the makeup of the group. There would usually not be any reason to mix the members of the group and. have first responders in the same group as the mental health professionals or clergy or reporters. If group work is being done, they should ideally each be in their own group.

Depending on the particular make-up of the group there are some potential issues specific groups might address. As I will emphasize in the case of all group meetings and in many cases in individual meetings, because of the potential spread of the Coronavirus, remote face to face techniques should be considered and often will be the preferred form of meetings. Zoom is an excellent system for conferencing with individuals and small groups. Participants do not need have an account. They can see each other. One can also draw on a whiteboard for everyone to see.

Group Meetings Conducted By Mental Health Professionals with Police, Fire and EMTs, Doctors, Nurses and Other Identified Groups Such as Lab Technicians, Coroner’s Office, etc.

When possible, the groups should be homogeneous. Although they often work side by side, there are individual situations that each group deals with and there is often an esprit de corps that would suggest any such group meeting should be homogenous. As previously stressed, using remote communication methods, such as Zoom, should be considered because of the nature of the contagious process that is confronting us. However, since these groups often do assemble regularly for assignment and briefings, a portion of that meeting might be assigned for discussion of mental health issues. That could include

1. A general review of symptoms that the people whom they are helping may be experiencing and review of resources available where they can refer any of the primary victims who need such assistance. The medical providers should be reminded to check to see if their patients have adequate medicine supplies for any mental health or other medical conditions.

2. Stressing the importance of how the caregivers themselves should be getting adequate sleep and when possible spending time with their families

3- When possible it is valuable to arrange for periodic acknowledgement by superiors or other government offi-

cials of the appreciation and value of the work they are doing. This can be an important morale builder during difficult times acknowledgment that it is not unusual for people in their position to have symptoms of anxiety, depression, bad dreams, etc. At the same time do not encourage group discussions of individual difficulties or psychological symptoms or problems that members of the group may be having (the CISD method). Most important, would be providing contact information where they any individual can have a confidential meeting with a mental health professional.

Group meetings with Mental Health Professionals Conducted by Mental Health Professionals Knowledgeable About Mass Trauma

Mental Health professionals are usually comfortable working together and it would be quite appropriate to have psychiatrists, psychologists, social workers and mental health nurses all meeting together. As previously stated because of the contagious nature of the disease process, remote group meeting may be necessary or advisable. If there are people who have experience in the consultation/liaison model of providing support to patients with serious illness and trauma as well as in support of medical and nursing staff, it would be appropriate for them to take a leadership role in this meeting.

1- In the initial meetings of this group, there would be the opportunity to access the mental health professional resources available and identify those with particular applicable experiences. There would need to be a designation who would run sessions for particular groups noted above and who would be available for individual counseling or therapy sessions. Depending on contacts and relationships there could be designated mental health professionals who could reach out and offer support to various leadership people involved in the crisis situation including various agencies and the political leadership.

2- It would be appropriate for a designated experienced mental health professional to review with the group, the nature of the psychological problems that they are dealing with such as fear, anxiety, separation issues, depression, PTSD, grief, etc. which may be occurring in primary patients and their families. This would likely be something that the mental health professionals are familiar with, but some may not usually work in this area on a day-to-day basis. This review should include the approach to children and how to answer their concerns and questions in an age-related manner. There also should be a discussion of importance of avoiding the CISD approach in a group setting, as previously discussed and encouraging those with significant symptoms to be referred for individual sessions.

3- Remind mental health workers of the importance of recognizing that needed medications for mental health and other conditions may be interrupted and consider if substitute prescribers can be provided and if emergency medication can be provided.

4-As there often is loss of life, it is valuable for the mental health professionals to have an alliance with clergy who can be helpful with acute grieving and general support for many people.

5- During these group meeting with mental health professionals, the importance of their valuable role should be reinforced. At the same time the potential impact on themselves should be acknowledged and there should be a method for any of them to have individual, confidential mental health support.

Group Meetings with Members of the Media Conducted by Mental Health Professionals

During the course of a disaster situation or a public health crisis, members of the media are usually totally involved on a full-time basis. They become knowledgeable of the seriousness of the situation and the threat to life, sometimes even more so than the general public. They frequently interview the victims and their families as well as the various first responders and others knowledgeable about the seriousness of the crisis at hand. This group can include reporters, commentators, producers, camera people etc. A group meeting with them where there is an acknowledgement that it is not uncommon for them to have symptoms can be helpful at the same time reminding them that they play an important supportive role in the mental health of their audiences. As previously discussed, the CISD method should be avoided in group meetings but certainly individual confidential counseling sessions should be available as needed.

I would like to conclude with a brief vignette concerning the important psychological role of the media in sup-

porting the worried public at the time of a major incident

Shortly after the 911 World Trade Center Incident, I was scheduled to do a psychological debriefing with various members of the media and the night before I received a call from a family member. She told me she had a dream that a well-known TV news personality was comforting her about this horrific event. In my meeting with the media I used that story to show them how they provided emotional support as well as the news. At the end of my meeting one of the participants came up to me and told me she was one of the senior producers for the network personality my relative dreamt was comforting her and she was sure he will be very pleased to learn he appeared in a comforting role in her dream in addition to providing the news. My relative was also very surprised and also comforted to hear here he would know about her dream.

Dr. Blumenfield is the Sidney E. Frank Distinguished Professor Emeritus of Psychiatry and Behavioral Sciences at New York Medical College and is currently in private practice in Los Angeles, Califonrnia

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Putting Together My First Emergency Kit

By: Weei LoAllen, M.D.

Growing up with experiences of frequent earthquakes, the idea of having an emergency kit for natural disasters was not new. But in my adult life, I delayed and put off the commitment to organize my own emergency kit. It seemed morbid to dwell on these worst case scenarios and too much of an effort to hold onto something I may hopefully never need. Part of me resisted the idea that a disaster could happen at any moment and without warning. It was easier to suppress my anxiety into a corner of my mind and ignore the real possibility of a catastrophic disaster that could place me and my family in existential danger and disrupt the services and infrastructure on which our community relies. I eventually decided to put together my very own emergency kit after moving to Los Angeles. It was not without prompting. I experienced my first Southern California earthquake four days after starting residency training at my program, with aftershocks spanning the rest of the week. This was then followed by the California wildfire season. Within a few months, the COVID-19 pandemic took hold of the world.

According to the Federal Emergency Management Agency (FEMA), Los Angeles county is ranked the most at risk of natural disasters resulting with major economic damage among 3,000 counties that was analyzed in the United States. Riverside county and San Bernardino county also ranked 9th and 10th, respectively, on this national list. Similar to the climate-related disasters, large-scale catastrophes such as a global pandemic and militarized white supremacy can bring unpredictable disruption and destruction to our community. An emergency kit may not completely resolve that anxiety, but it gives us a chance to prepare for such an unfortunate event if it does occur. I followed the list below when I put together my emergency kit, which I hope you will find it helpful too.

The FEMA recommended including the following items in a basic emergency supply kit:

Water (one gallon per person per day for several days, for drinking and sanitation)	Food (at least a three-day supply of non-perishable food)	Battery-powered or hand crank radio and a NOAA Weather Radio with tone alert
Flashlight	Manual can opener (for food)	First aid kit
Extra batteries	Whistle (to signal for help)	Local maps
Cell phone with chargers and a backup battery	Wrench or pliers (to turn off utilities)	Dust mask (to filter contaminated air)
Moist towelettes, garbage bags, and plastic ties (for personal sanitation)	Plastic sheeting and duct tape (to shelter in place)	

Since Spring of 2020, the Centers for Disease Control and Prevention (CDC) has also recommended including **additional items to help prevent the spread of coronavirus or other viruses and the flu:**

Masks (for everyone ages 2 and above)	Soap, hand sanitizer disinfecting wipes	Prescription medications
Important family documents (ID, insurance policies, bank account records) saved electronically or in waterproof and portable container	Infant formula, bottles, diapers, wipes and diaper rash cream	Non-prescription medications (pain relievers, anti-diarrhea antacids or laxatives)
Sleeping bag or warm blanket for each person	Pet food and extra water for your pet	Prescription eyeglasses and contact lens solution

Books, games, puzzles or other activities for children	Matches in a waterproof container	

Additionally, if you have **pet(s)**, CDC recommends including the following items:

Photocopied veterinary records: vaccinations, medication prescription, test results of heartworm (dogs) or FeLV/FIV (cats)	Photocopied registration information (proof of ownership or adoption records) in waterproof container	Pet descriptions (breed, sex, color, weight) and microchip information (phone numbers and addresses)
2-week supply of food for each animal in waterproof containers	2-week supply of water for each animal	Non-spill food and water dishes
Manual can opener	Feeding instructions for each animal	1-month supply of flea, tick, and heartworm preventative
2-week supply of any medications with medication instructions (if applicable)	Toys and appropriate-sized pet carrier with bedding, blanket, or towel	Cleaning supplies for accidents (paper towels, plastic bags, disinfectant)
Litter and litter box (cats), Waste bags (dogs)	Leash, Collar with ID, harness	Pet first aid book and first aid kit

Once the kit has been assembled, it is important to consider where it should be stored. It is recommended to prepare supplies for home, work, and cars. The kit should be stored in an accessible location and all family members should know where the kit is stored. FEMA also recommended keeping a separate “grab and go ”kit at work (includes food, water, medications, and walking shoes) that allows you to shelter at work for at least 24 hours. They also recommended keeping a kit of emergency supplies in your car in case you are stranded.

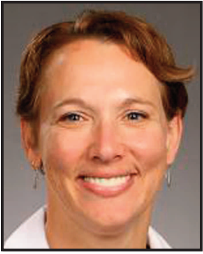
If you have assembled your kit already, remember to maintain it as needed. You may need to replace expired items. Make sure canned food is stored in a cool and dry place, and boxed food is stored in a tightly closed plastic or metal container. It is recommended to review your family’s needs and update the kit at least once every year.

To read more on disasters and emergencies preparedness, please visit:
https://www.cdc.gov/healthypets/emergencies/pet-disaster-prep-kit.html

A Year of Covid-19: Reflections and Lessons Learned

SCPS Town-hall Report

Galya Rees, on behalf of the Disaster Committee



Distancing, hoarding, masking, virtual learning, working, and being. Worries about family's health, colleagues in the hospital, lack of PPE, patients, children, pods, and other morally conflicting concepts. Missing family so much. Some beautiful acts in the community, and some really ugly ones. Civil unrest, reimagining a better one. Surges, resource allocation, moral injury, death, grief, recovery, vaccinations, and hope.

The goal of the town-hall was to bring us together, as psychiatrists, to acknowledge and process the unimaginable loss of lives, learn how we are each weathering this storm and its practical, emotional and moral aspects, and evolve together, a year into this pandemic.

The first part of the townhall was dedicated to checking in and processing. It was moderated by Dr. Samuel Miles and began with a moment of silence in honor of the lives lost to Covid. SCPS members shared their personal experience during this year, including training under Covid, working in correctional facilities, the abrupt transition to telepsychiatry, grief, and social injustice. Clearly, we are all in the same storm this year, but in different boats, and so are our patients, and this was only the beginning of a much-needed discussion.

The second part of the townhall was dedicated to lessons learned (or – "lessons in progress"). Representatives from different SCPS regions and treatment settings shared their experience with the abrupt transition to telepsychiatry, inpatient care under Covid, training, support of frontline healthcare workers, moral injury, and vaccinations.

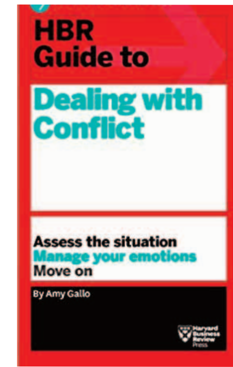
I would like to thank Dr. Samuel Miles, and the following speakers who participated in the townhall and shared their practical experience with the rest of us: Dr. Bipin Patel, Dr. Karen Miotto, Dr. Curley Bond, Dr. Gillian Friedman. Dr. Richard Ha, Dr. Hannah Rogenkamp, and Dr. Rahn Bailey.

Please feel free to contact the members of the disaster committee (or Mindi) with any questions, feedback or suggestions.

We are in this together,

Galya Rees, M.D.

<u>Dealing with Conflict</u>
By Amy Gallo
Harvard Business Review Press
2017
192 pages
$ 19.95 Paperback
ISBN-13: 978-1633692152



Book reviewed by Kavita Khajuria, MD
Culture & Diversity Committee

Gallo outlines the most common sources, styles and tendencies of conflict. In order to address the potentially far reaching consequences, she recommends an appreciation of diversity, cultural norms, and self-awareness. Advice is offered on self inquiry, situation assessment, conversational engagement and conflict resolution. She outlines the pros and cons of conflict, potential struggles, and encourages venting - as well as labelling and management of emotions. She stresses an awareness of the impact of what is said - not the intent – and notes the potential for unresolved conflict to simmer or manifest in unsavory ways, either emotionally or physically – but the benefits to include room for creativity, growth, and improved relationships. Disputes are referred to as opportunities - to learn about people, values, working styles and personalities. This is a clear, organized, and well-illustrated book - it includes scenarios and stories that navigate fairly common situations - potentially helpful for both personal and professional growth.

Election Results:

J. Zeb Little, M.D. - President-elect

Reba Bindra, M.D. - Treasure-elect

Haig Goenjian, M.D - Secretary

Gillian Friedman, M.D. and Aaron Gilmore, D.O. - Inland Region

Michael Feldmeier, M.D. - San Fernando Valley Region

Hanumantha Damerla, M.D. and Eric Wagreich, M.D.
San Gabriel Valley Region

Jonah Schull, M.D. - Santa Barbara Region

Tatjana Josic, D.O. and Roderick Shaner, M.D. - West LA Region

Emily Wood, M.D. - ECP Deputy Rep

Troy Kurz, M.D. and Weei LoAllen, M.D. - RFM Reps

Uchenna Okoye, M.D. - MUR Deputy Rep

Curley Bonds and C. Freeman, M.D. - APA Assembly Reps

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

President's Report
CMA - MOU with CSAP:
Dr. Shaner introduced the CSAP MOU agreed upon by the GA Subcommittee. A discussion included concerns about the divided interests across the 5 DBs and whether this has implications moving forward.
A vote was held as to whether or not to accept the committee's recommendation to ratify the MOU. The motion passed with 1 opposed and one abstained.
CMA Council on Legislation Update:
Dr. Fouras introduced the legislative update and CMA's position regarding current legislation, specifically with regard to SB221. Council discussed what transpired at the CMA council meeting and implications for the MOU.
President-Elect's Report
Calls to members at risk
Dr. Ijeaku first discussed the GA committee's recent meeting and the opportunity to meet with other DBs in order to raise issues and concerns and to work together between CSAP and PPAC in a unified approach for psychiatric advocacy in California. She also acknowledged the concerns raised about the current transition phase with regard to the MOU in CMA and the plan to work together more collaboratively moving forward.
Dr Ijeaku also shared the current situation regarding members who have not renewed membership in SCPS and petitioned Council to reach out to these members at risk of not continuing their membership. Dr. Bindra shared a concern regarding a barrier regarding confusion from some of these members and a lack of understanding of tangible benefits from membership, including that from APA at large. Additional discussion was held regarding maintenance of certification as a potential cause for frustrations of members nationwide.
Diversity and Culture Committee Report:
Dr. Rees introduced the committee's recent meeting and its focus on the subject of focus on underserved populations and racial injustices, especially. The committee recommended that the GA Committee be required to consult with Diversity and Culture Committee in regarding potential social justice implications and any legislation which would have impact on such issues. A motion was made to accept the recommendation which passed unanimously.
Newsletter Committee Report:
Monthly themes
Dr. Goldenberg introduced the current newsletter status and the ongoing themes of each issue forthcoming, including the current issue for Women in Psychiatry. The following theme for April's newsletter will be psychiatric training and trainees. Ms. Thelen requested assistance in identifying any new sources of advertising income moving forward.
Treasurer's Report
February Financials and Cash on Hand Report
Dr. Goldenberg shared the highlights of the Treasurer's Report.
Regarding income, for the month, we are under budget by about $$23,701. For the year, we under budget by $33,198.
Regarding expenses, for the month, we are under budget by about $366. For the year, we are over budget by about $3,084.

We are about $21K under cash on hand as compared to this time last year taking into consideration monies earmarked for PPAC advocacy funds.
A vote was held to accept the report, which passed unanimously. Ms. Thelen shared the concern regarding whether centralized billing should play a role moving forward and that she would not be opposed to moving forward with that if agreed upon.
A vote was held to accept the report, which passed unanimously.

Membership Report:
Dr. Ijeaku presented the 4 new members to be approved. The new members were unanimously approved.

GA Committee Report
Dr. Shaner introduced the GA Committee report, including the SCPS and CSAP MOU which was signed and ratified; working with the Diversity, newsletter, and website committees to overhaul the legislative section of the website; support of the D&CC motion to work together in future legislative advocacy; COVID guidelines for patients with schizophrenia and in identifying schizophrenia for a distinct criteria in providing more urgent access to vaccination
Four motions were made by Dr. Shaner based on recommendations by the GA Committee
The first motion was to take several advocacy actions to better ensure that schizophrenia spectrum disorder was concerned in the same manner as other medical disorders when prioritizing access to limited medical resources like COVD-19 vaccines.
The second motion was to take a WATCH position on SB 221, a bill that added new standards for access to non-medical mental health therapists.
The third motion was to communicate with PPAC regarding upcoming recommendations from GAC regarding continuation of our contract with this organization for state-level advocacy.
The fourth motion was adopt the former CPA Policy Platform for purposes of documenting SCPS policy principles for legislation.

Disaster Committee Report
Dr. Rees shared the report including news from the shared meeting with APA's Disaster Committee and the importance of having been able to build relationships. She also brought attention to the upcoming town hall meeting for SCPS members.

Awards Committee Report
Ms. Thelen shared the Awards Committee report, including the upcoming first awardees for the Diversity and Culture Committee's awardees, a new RFM awardee, and what was previously the PER Foundation awardees. The nominations were approved.

Program Report:
The Program Report was deferred for the month.

Assembly Report
Dr. Soldinger shared that the Rules Committee will be meeting on March 24 and shared some of the themes of the upcoming action papers on the agenda. Dr. Bailey shared upcoming issues regarding governance, diversity, new leadership roles for current residents. Dr. Red shared the process for upcoming action papers and reference committee processes.

New Business:
Dr. Fouras shared the upcoming CMA Legislative Advocacy Day and the opportunities available for CMA members and urged councilors to attend and to attend CMA.

Old Business: There was no old business.

CLASSIFIED ADVERTISEMENTS

I have an office space and unique opportunity for a psychiatrist to open and rapidly grow a successful practice in Southern California, South Bay area. I am a psychiatrist who has maintained a busy practice in Torrance for fifty years. I have an extra private office to rent in my suite which includes a large shared waiting room and access to an office manager, billing service, referral sources, and help in contracting with insurance companies. The office is located in an attractive building with several psychologists, marriage and family therapists, and licensed social workers who can provide psychotherapy and are sources of referrals. It is a few blocks away from Torrance Memorial Hospital and Del Amo Psychiatric Hospital. This is an opportunity to quickly ramp up a practice with the guidance of a seasoned psychiatrist nearing retirement who can also refer new and current patients. Interested psychiatrists can contact office manager Gigi Flores at 310-375-2140/Email: John_Moeller@ymail.com

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San Fernando Valley . . . . . Danielle Chang, M.D. (2022)
. . . . . Michael Feldmeier, M.D. (2024)
San Gabriel Valley/Los Angeles-East . . . . . Hanumantha Damerla, M.D., M.D. (2024)
Eric Wagreich, M.D. (2024)
Santa Barbara . . . . . Jonah Schull, M.D. (2024)
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South L.A. County . . . . . P.K. Fonsworth, M.D. (2023)
Ventura . . . . . Joseph Vlaskovits, M.D. (2023)
West Los Angeles . . . . . Tatjana Josic, D.O. (2024)
. . . . . Patrick Kelly M.D. (2023)
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SCPS Newsletter

Editor . . . . . Matthew Goldenberg, D.O.

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