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President's Column

I Am Woman...Authentic Dr Mom

Ijeoma Ijeaku, M.D.

In a recent review of the suffrage movement, I came across a flier from the Women Suffrage Party which is housed at the Museum of the City of New York titled *Twelve Reasons Why Women Should Vote*. It is a fascinating document as it listed why the movement wanted women to have the right to vote. The 12th reason is supposedly a summary of why women should vote, and it notes that 'it is for the common good of all'. Whether we are reviewing abortion laws which pertain to decisions being made about a woman's body or whether we are looking at equal pay for similar work, or looking at creation of opportunities for those who identify as female, it is indeed for the common good that every single member of society must stay engaged in conversations about what it means to treat anyone less than another because of their gender…

Keshab Chandra Mandal writes that female empowerment could be defined in five separate categories: social, educational, economic, political, and psychological. While the social empowerment is such a huge force especially in the informational age and social media's ability to deliver messages in a timely and profound way, representation becomes very important. The election of a female vice president in the US is such a remarkable historic moment because it gives the girl child an opportunity to imagine what she could become. The power of an education or involvement in the political process or having an earning power are all important aspects of the female empowerment. The real empowerment of the female in my opinion is her psychological empowerment. This is her ability to transgress the "traditional and patriarchal taboos and social obligations" thus allowing her to go beyond what is expected of her in society. This can improve her self-confidence, self-worth, self-efficacy. It gives her control of her income/other resources and body. Empowerment allows the female access resources and avail herself of opportunities that help her express the highest, truest, and best version of herself. To become this truest version of herself, especially when important decisions are to be made, she should continually ask of herself 'am I working towards the best expression of my potential or am I moving away?'

For as long as I can remember, I have wanted to be a doctor. My maternal grandmother was a pioneer in her chosen field of midwifery. She established the first maternity home albeit medical dispensary in an area encompassing several communities and was responsible for delivery of hundreds of babies annually for the four decades that she ran that maternity, all this while being wife and mother to nine children, at a time when girl child education was still unheard of in her corner of the world. I remember my mother (with her MSN), a most dedicated nurse educator, suggesting while I was growing up that being a doctor might not allow me time for a family. While she meant good based on her understanding of opportunities and societal expectations, I wanted more, I wanted it all…children, husband, career, and many other things in addition to being a doctor. I became a mom to Ola (now med student) while still in Med School at the University of Port Harcourt, Nigeria and took my Hippocratic when she was 3.5 years old. I had EJ (college undergrad student) and Ure (senior in high school) between med school and my medical career here in the US. During my training at Loma Linda University General Psychiatry residency program, I had a firebrand for program director who was the catalyst for my growth and development in new dimensions. She challenged me in very important ways to embrace true power which lies

in vulnerability and authenticity…

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

The biggest gift of my life is motherhood because in becoming an authentic nurturer, I began a journey where I am committed to vulnerability and courage in the same breath. This openness and authenticity between my adult/late teen children and I allow us to have those important and sometimes difficult conversations about personal and non-personal issues (this practice is modified with Nazo, my 8-year-old who was born during the last few months of my fellowship at USC). Beyond the relationship with my children, the gifts that have come with motherhood allow me to have a different perspective with my patients and their families in my child and adolescent psychiatry practice. The commitment to another's emotional wellbeing takes courage especially for the teen who has been traumatized and is unable to trust and connect. Sometimes that is all I can bring to the table- the courage that I am committed to helping them even when they are unable to trust anyone. Sometimes that is not enough but a lot of times, it works…

P.S A huge shout out to SCPS' mama bear, Mindi who has served SCPS in excellence and who has nurtured so many psychiatrists in the greater Los Angeles area in the last 30 years. A shout out also to SCPS Women's Committee for keeping the psychiatric sisterhood going and to the female members of SCPS who inspire me and many others, as well as those who are coming up in their journey and trying to strike that balance necessary for success.

Happy Women's History Month!!!

In This Issue...

https://youtu.be/WYngSYBT7Vo

Gary Tsai, M.D. is the Director of the Substance Abuse Prevention and Control, a division of the Los Angeles County Department of Public Health. In this role, he is responsible for leading over 400 staff with a budget of approximately $400M, overseeing a full spectrum of substance use prevention, treatment, and recovery support services for the 10 million residents of Los Angeles County. Dr. Tsai is board certified in both general adult psychiatry and addiction medicine.

Having experienced the stigma and criminalization that often accompanies serious mental illness as the son of a mother with schizophrenia, Dr. Tsai is a passionate advocate for improving our behavioral health systems. He is a member of the Advisory Board of the Treatment Advocacy Center and Strong365 (a One Mind project) and a former APA / SAMHSA Minority Fellow.

In his pursuit of meaningful change, Dr. Tsai is also the founder of Forgotten Films, a film production company that focuses on social issue projects, with particular expertise in the area of behavioral health. He is the producer and co-director of ***Voices*** (http://voicesdocumentary.com/), the award-winning documentary film about psychosis that premiered on public television in May 2015 for Mental Health Awareness Month and was awarded a 2016 SAMHSA Voice Award. He also produced and co-directed a short film about the criminalization of mental illness titled ***Mental Illness on Trial***, which premiered at the Socially Relevant Film Festival in New York and featured notable mental health advocates such as Patrick Kennedy.

Dr. Tsai completed his medical training at the University of California, Davis School of Medicine and his residency training at the San Mateo County Psychiatry Residency Training Program. His professional interests include public psychiatry, severe mental illness and early intervention, behavioral health policy, addiction, cultural psychiatry, and media/technology in behavioral health.

Women's History Month Edition: (With Late Breaking News About SCPS Advocacy)

By Newsletter Editor
Matthew Goldenberg D.O.

Happy Women's History Month!

This month, we have two major topics we are excited to share with you.

First, I am pleased that this month is the second annual Women's Month theme for our SCPS newsletter. I want to thank our guest editors; Janet Martin MD and Kristina Eipl MD. They are the co-chairs of the SCPS Women's Committee.

You can view past Women's committee events and get engaged via the SCPS website. As we come out of the social isolation caused by Covid-19 pandemic, the Women's Committee will surely be having events. If you are interested in participating, please reach out to Mindi!

I want to thank all of the authors for contributing high quality articles and for helping to celebrate Women's History Month and our Women themed newsletter!

The second topic we are covering in this month's newsletter is the change in SCPS advocacy for 2022. Not to diminish our wonderful women's edition, we do have additional and important information to share regarding the advocacy news of the last couple of weeks.

After an extensive evaluation process, as you know from email updates, SCPS has chosen to join the California State Association of Psychiatrists (CSAP). There are articles to follow that should help you to better understand the decision-making process and also the new offerings of CSAP.

We all owe a great deal of thanks and appreciation to Dr. Rod Shaner and Dr. Steve Soldinger, the SCPS Government Affairs Committee (GAC) co-chairs, for co-chairing an immense effort to establish the best possible advocacy for SCPS and its membership in 2022.

I also want to thank Dr. Shaner and Dr. Soldinger, both longtime leaders of advocacy in California, for the very thoughtful and informative article that follows later in the newsletter which provides additional details about SCPS's advocacy efforts and goals. They are both former SCPS presidents and currently serve as SCPS State Legislative Representative and Federal Legislative Representatives respectively.

Thank you is also due to Dr. Ijeoma Ijeaku, our current SCPS President. Her strong leadership facilitated a comprehensive and thorough discussion, successfully leading SCPS through a difficult and pivotal stage in the history of our organization and effective advocacy for California.

Finally, I want to thank Mindi Thelen, for her dedicated service to SCPS during this recent 2-year period of

unprecedented contention and uncertainty, which started with the dissolution of the California Psychiatric Association (CPA).

I am assuming our members are interested in better understanding both the process and the reasons for the outcome of this major decision and step that SCPS has just undertaken. I hope to provide the highlights in the paragraphs that follow, and additional information is in the articles later in the newsletter.

Over the past 5 months, a large and diverse group of SCPS members spent more than 50 hours on reviewing opportunities for advocacy partnerships in 2022.

The process was objective, exhaustive, and equitable. Potential partner organizations were asked for the same materials and were analyzed in exactly the same manner. The process itself was illuminating and helped to make clear distinctions between each organization.

After an exhaustive vetting, the California State Association of Psychiatrists (CSAP) appeared to be the best advocacy organization with whom to partner in 2022.

In contrast to the other opportunities available to SCPS, the officers and staff provided all of the information requested for SCPS's review in a timely manner. They were fully transparent in all aspects of their organization and organizational decision-making processes; they have no COI (i.e. they do not accept pharmaceutical company money); and they offer full voting representation for SCPS and its membership. These will all be areas of significant improvement and will resolve the concerns that SCPS Council had identified with our advocacy in 2021.

Paul Yoder (CSAP lead lobbyist and Executive Director) met with the SCPS Government Affairs Committee (GAC). The SCPS GAC reported to the SCPS Council that Mr. Yoder has extensive experience as a healthcare and psychiatry advocate, strong connections in Sacramento and across the state and has leadership skills that will benefit SCPS and SCPS advocacy efforts through our collaboration with CSAP.

The SCPS GAC report noted that every aspect of CSAP was extensively put through a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis. In the end, CSAP was reported to be the clear and best choice for SCPS advocacy in 2022 and a motion was made to join CSAP.

I, along with 17 other council members, voted in favor of this motion because CSAP appeared to be the strongest advocacy organization that can represent SCPS and our membership.
I also voted in favor of joining CSAP because it reunites the California District Branches (which SCPS members-at-large have expressed as being important to them after CPA dissolved), it gives psychiatry a unified voice which is essential to effective advocacy and creates a real California state(wide) organization, which puts SCPS in compliance with the APA assembly code.

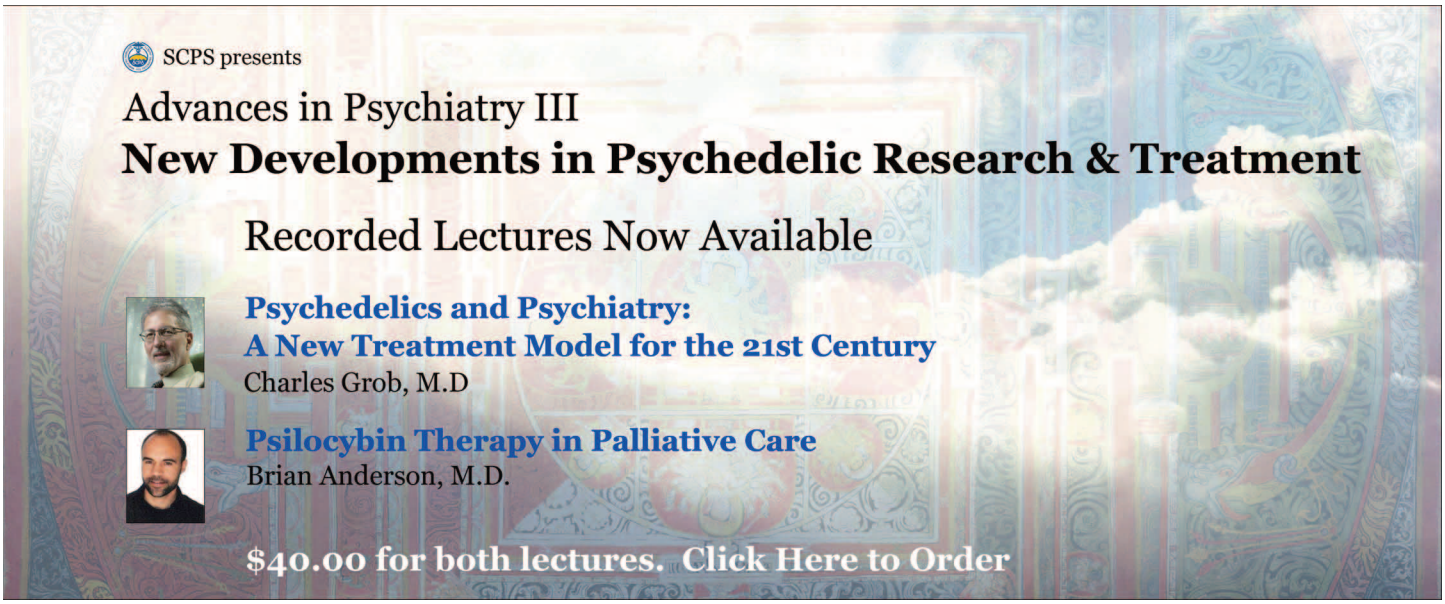
I want to personally thank the SCPS Board for taking their individual fiduciary responsibilities to SCPS so seriously and voting for the best and strongest option available to SCPS and its members. We should be grateful to the members who served on the committees that vetted the options, for the amount of time and energy that was put into this important decision for SCPS.

Over the course of this year, and the years to come, it is my hope that every SCPS member will have an opportunity to participate in and benefit from SCPS advocacy efforts. SCPS is stronger and has more advocacy tools and support today because of our new partnership with CSAP.

I imagine there will be townhalls, committee meetings and other venues to discuss the future of SCPS and SCPS advocacy efforts both at SCPS and CSAP. I look forward to seeing you all there!

Continue to stay safe,

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



Psychedelics and Psychiatry: A New Treatment Model for the 21st Century
Charles Grob, M.D.
This presentation demonstrates how the psychedelic treatment model represents a paradigm shift in the conceptualization and treatment of psychiatric disorders. An overview of modern clinical research findings with MDMA and psilocybin will help to clarify emerging perspectives with broad potential implications for the future of psychiatry. The role of recent developments in public opinion conjoined with an evolving legal landscape in regard to hallucinogens will be addressed as they impact current research endeavors. The presentation will conclude with all important attention to optimizing safety and ethical parameters for clinical research with hallucinogenic drugs.

Psilocybin Therapy in Palliative Care
Brian Anderson, MD, MSc
The field of psilocybin research has expanded rapidly over the last 5 years with new clinical trials for a variety of indications being initiated on a regular basis. There is also a growing interest in regulatory alternatives that are making Psilocybin mushrooms and other psychedelics more readily available in the US. Given this growing interest in these substances, there is an ever more urgent need for robust and reliable information on the safety and potential efficacy of psilocybin. Over the last several decades, treating existential distress in patients with serious medical illness has consistently been a leading indication for psychedelic therapies. This talk will explore 20th and 21st Century data on the use of psilocybin for mood, anxiety, and existential distress in clinical populations, with a focus on palliative care patients. We will focus on the limitations of current data, health risks and contraindications, and an evaluation of how the potential benefits of psilocybin therapy compare to currently available interventions.
https://www.socalpsych.org/member-services/recordings/

Pregnancy and Childbirth in COVID-19

By: Kristina Eipl, M.D.

Matrescence is a term coined in 1973 by medical anthropologist Dana Raphael to describe the dramatic physical, emotional, psychological, and hormonal changes associated with becoming a mother (Sacks 2017). Over the past two years, this transition to motherhood, already a monumental, life-altering event, has been further complicated by the COVID-19 pandemic. As a psychiatrist treating reproductive mental health issues as well as a new mother myself, I continue to be impressed by the far-reaching impacts of COVID-19 on pregnant and postpartum women. The effects range from life-threatening medical complications to subtle yet powerful psychological consequences.

At a time in life when there are so many things one could worry about, pregnant women now have the added burden of worrying about contracting COVID-19 during pregnancy. When infected with COVID-19, pregnant or recently pregnant women are at increased risk for severe illness than those who are not pregnant. They are also at increased risk for preterm birth and stillbirth among other pregnancy complications (CDC 2022). At the same time, pregnant women have demonstrated less acceptance of the COVID-19 vaccine than non-pregnant women (Skirrow 2022).

According to a recent meta-analysis of global studies on maternal, fetal, and neonatal outcomes between Jan 2020-Jan 2021, there have been increases in maternal deaths, stillbirths, ruptured ectopic pregnancies, and maternal depression, with considerable disparity between high-resource and low-resource settings (which of course speaks to the larger issue of healthcare inequality but which is beyond the scope of this article) (Chmielewska 2021). Another study in Quebec in a high-resource, well-educated population indicated higher levels of depressive and anxiety symptoms in pregnant women during the pandemic than prior to March 2020. Interestingly, perinatal depressive symptoms have been associated with lower levels of maternal antenatal attachment, whereas anxiety symptoms alone may not have the same effect on attachment (Berthelot 2021).

It has been observed that increased social support from family, friends, and the healthcare system contribute to lower levels of perinatal anxiety (Filippetti 2022). Unfortunately, many women saw a decrease in their social support during the pandemic, particularly in the early stages of COVID-19. Over the past two years, pregnant women have been allowed either no support person or only one support person during antenatal visits and labor. Many previous opportunities for maternal bonding and educational activities such as baby showers, birthing classes, prenatal yoga classes, lactation classes, parenting classes, and mommy and me classes have been either forgone or limited to Zoom. Then there are the limited visits with family due to social distancing and travel restrictions. Women who would normally have had relatives in the home to help with caring for their newborns have had to do without. Additionally, some women have reported negative behaviors attributed to the pandemic, including decreased physical activity or increased unhealthy behaviors like alcohol use postpartum (Ahlers-Schmidt 2020).

From Zoom baby showers to the medical risks of COVID-19 infection during pregnancy, the pandemic has significantly altered the experience of matrescence over the past two years. While I am hopeful that society will continue adapting to the presence of COVID-19 and allow for safer and more supported experiences of pregnancy and childbirth, it is important for mental health providers to be aware of the increased vulnerabilities of new mothers during this time.

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For Full Details:
https://www.socalpsych.org/event/psychological-first-aid/

Postpartum Depression: Are the DSM – 5 Criteria Hindering Us?

By: Gillian Friedman, M.D.

From the earliest days of medical literature, physicians have recognized an association between childbirth and risk for maternal mental illness, though causal hypotheses have varied widely and have often reflected the stereotypes and fancies of the time more than any sound biologic underpinning. Hippocrates, our medical forebear, believed that disruptions in the discharge of uterine fluids after childbirth led to agitation and madness as these fluids collected instead in the breasts and the head.

In the past few decades of modern medicine, a wide research base has now confirmed that the perinatal period is a time of increased risk for the onset of depressive disorders, with multi-site research by the Centers for Disease Control and Prevention (CDC) finding that about 1 in 8 women experience postpartum depression, and prevalence rises as high as 1 in 5 women for certain subgroups. (1) This significant prevalence makes postpartum depression the most frequent complication of pregnancy (2), more common than either preeclampsia or gestational diabetes. Unfortunately, it can also be one of the more deadly complications, as suicide is a major cause of death in the post-partum period. A recent large 15-year population-based Canadian study found that suicide accounted for 5.4% of all perinatal deaths (3), while another 2005 review found suicide to account for up to 20% of postpartum deaths. (2)

The costs of unrecognized and unaddressed postpartum depression are high for infants as well. Women with postpartum depression are less likely to breastfeed and show more difficulty bonding with their infants; additionally, maternal depression increases the risk for longer term developmental problems such as cognitive and language delays. (4)

One complicating factor in adequately diagnosing and treating postpartum depression is the ongoing debate about what it actually is phenomenologically. The hypothesized mechanisms for increased risk of depression in the perinatal period are multifactorial, leading some to conceptualize perinatal depression as a cluster of disorders rather than a single disorder. Prior history of depression and family history of depression are risk factors, as are a variety of psychosocial factors, in particular low availability of instrumental support from others in caring for the baby. But there are biological changes unique to the perinatal period that also play a role. While absolute hormone levels show poor correlation to depressive symptoms, there appears to be a subset of women who are particularly susceptible to mood effects from the rapid hormonal, neuroendocrine, and HPA axis shifts that occur around the time of delivery (such as a precipitous fall in hormones like estrogen and progesterone, and fall of the neuroactive steroid allopregnanolone). Elucidation of the role that these steep hormonal changes can play in the onset of postpartum depression has spawned the development of the novel postpartum depression medication brexanolone (marketed under the trade name Zulresso), which acts essentially as exogenous allopregnanolone to restore plummeting levels. The rapid response rate to this allopregnanolone boost (significant after just 2.5 days of treatment in Zulresso's randomized controlled trials) can provide a life-changing advantage for moms who are responders when compared to the weeks generally required for response to traditional antidepressants. As other neuroendocrine modulators are developed in pharmaceutical research, brexanolone is expected to become only one of several novel treatments specific for depression of peripartum onset.

Unfortunately, the elasticity in the concept of postpartum depression is muddied further by radical differences among researchers and health leadership organizations in their view of the duration defining the postpartum period. While common vernacular refers frequently to "postpartum depression" as though it is a unique diagnostic entity, it has never been categorized as such in the DSM. The specifier "with postpartum onset" was introduced with DSM – IV, but included only episodes of depression with onset in the first 4 weeks after delivery. This narrow time specifier contrasts with the World Health Organization's definition that includes onset up to a full year following delivery. ICD -10 uses yet a different time frame, with a cutoff of 6 weeks post-delivery. Research studies mostly use time frames ranging 6 months to 1 year post-delivery; some also include depression starting during pregnancy. Even prior to DSM – 5, several prominent international organizations for reproductive psychiatry professionals and consumers, such as Postpartum Support International and the Marcé Society, strongly advocated that the DSM specifier (which now in DSM-5 does at least include depression beginning during pregnancy)

be extended on the postpartum end to a full 6 months post-delivery.

Why does the time frame of the DSM specifier matter? It's not just semantics. Currently the narrow post-partum time frame for the DSM-5 specifier (now renamed "with peripartum onset") has real world consequences for women seeking treatment. For example, the DSM – 5's narrow 4-week postpartum window leads insurance companies to frequently deny brexanolone authorization if women haven't had an evaluation specifically with the Edinburgh Postnatal Depression Scale within those first four weeks postpartum. However, multiple barriers prevent the majority of women who need treatment from getting assessment in that narrow time frame. Stigma, guilt, concerns about being labeled an unfit mother, lack of access to mental health providers, and a host of other barriers may prevent women from recognizing and seeking help for postpartum depression, even when symptoms are long-standing and severe. One survey of British mothers found that 1/3 of women who fell in the depressive range on postnatal depression screening at 8 months postpartum were still depressed 12-19 months later, but only 15% had pursued help or been referred to a mental health practitioner. (5) Additionally, there is increasing evidence that the 4-week cutoff after delivery is just too limiting to accurately capture the true variability in postpartum depression presentations, and fails to recognize patients who may be most at risk. To this point, a recent multi-site international study by the Postpartum Depression: Action Towards Causes and Treatment (PACT) Consortium identified that women with initial onset of postpartum depression symptoms up to 8 weeks post-delivery had among the most severe symptoms, and another clear subgroup had initial onset of postnatal depression even more than 8 weeks post-delivery.(6) Grigoriadis et al., in the aforementioned population-based Canadian study, found that the highest risk for completed suicide was actually at 9 to 12 months postpartum. (3)

Organized psychiatry ought to prioritize bringing our DSM nomenclature better in line with expanding evidence that the scope of peripartum depression is not well captured with our current classification system. To help change things for moms with peripartum depression we first have to change ourselves. Unfortunately, the recently published DSM-5-TR has not taken action to extend the post-delivery time frame for the peripartum onset specifier. Let's make sure that re-evaluation of this specifier is a priority for the next revision.

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Women's Rights and Mental Health

By: Janet Martin, M.D., Ph.D.

The past couple of years have been challenging for everyone, but it has been especially challenging for women. We have all had to deal with a world-wide medical disaster, which somehow morphed into a political mess. Women have also experienced the brunt of job loss and child-care conundrums during the pandemic. According to a McKinsey report, women make up 39% of the global workforce but accounted for 54% of the job losses during the pandemic. Furthermore, women's rights are being restricted in many parts of the world, which has a significant negative impact on their mental and physical health.

Women have historically faced discrimination in most of the world, but many countries are improving their gender equality factors. Analysis of gender inequality in the last quarter century in 7 regions of the world indicates that parts of Europe and East Asia (particularly Japan) and the Pacific (Australia), as well as North America (particularly Canada), have lower levels of gender inequality, whereas parts of Latin America, South Asia, and Sub-Saharan Africa have the highest levels of gender inequality (Yu 2018). This study found that greater gender inequality is associated with greater incidence of depression in women. GDP is also associated with greater rates of depression in women compared with men, with wealthier countries having slightly lower rates of depression. (Interestingly, countries with greater wealth gaps showed increased rates of depression in men.)

The World Health Organization (WHO) has noted that gender-based violence, discrimination, poverty, and pressures of being in multiple roles increase the rates of depression in women to about twice the rates in men. The World Psychiatric Association (WPA) has made recommendations to improve mental health for women by supporting equality in basic human rights, the education of girls, women's marital and reproductive rights, and the elimination of violence and discrimination. Violence against women is still a major issue in many parts of the world. Experiencing or witnessing violence or abuse early in life predisposes individuals to psychiatric illnesses later, adversely affects self esteem, and increases likelihood of involvement in abusive relationships (Stewart 2006). Violence against women is most often committed by someone known to the victim. One study in India in 2012 found that 98% of rapes were perpetrated by someone known to the victim. Legal action in 2013 in India has recognized other forms of violence as well, such as acid attacks, sexual harassment, voyeurism, and stalking. The country also passed an act to protect women in the workplace from harassment and promise gender equality. India had also made inroads into improving rights for the LGBTQ community in 2009 when the Delhi High Court decriminalized consensual homosexual activity, but then, the Supreme Court of India overturned the ruling in 2013 (Rao 2015). In comparison, the U.S. Supreme Court finally made same-sex marriages legal in the U.S. in 2015, and the Netherlands and Canada were the first countries to legalize such marriages in 2001.

Access to care is difficult for women in many parts of the world, but the actual treatment of women with mental illnesses can be even more problematic. Human Rights Watch has found that people, particularly women and girls, have been chained up for months or years in numerous countries due to psychosocial disabilities that have been attributed to witchcraft/curses, possession by evil spirits or the devil, or past sins. For example, in Ghana, a prayer camp had girls aged 5-12 chained up for being witches. Also, many institutions with shackling practices are overcrowded and unsanitary (Sharma 2021).

What can we do to improve the mental health of women throughout the world? Many of the problems can be improved with increased education, efforts to reduce poverty, legal actions to protect women's rights and safety, and improving access to health care. Supporting organizations such as WHO and WPA, as well as other organizations promoting women's rights, can help. The website mentalfloss.com lists 15 organizations helping women around the world as of March 2018. For instance, the Women's Global Empowerment Fund helps underprivileged women in Uganda with business training and micro-loans. The Center for Reproductive Rights has helped improve reproductive health policies in many parts of the world and helped free El Salvadoran women sent to prison for having stillbirths. Women for Women International has helped women displaced by conflict in Iraq, Rwanda, and Syria with education. It will take major shifts in culture in many parts of the world to improve women's rights, which will take many years, but this just means we all must be perseverant in our efforts to make the world a mentally healthier place.

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For Full Details:
https://www.socalpsych.org/event/thinking-of-gender-without-pathology/

Women: Forging Our Own Paths in Medicine

Theresa Sevilis, DO, Director of Academic Advancement at TeleSpecialists, LLC

We all have a unique journey in medicine. Despite the differences in what brings us to the field or leads us to the specialties we choose, women tend to share a common challenge: How do we balance lifestyle and career? As I began my journey in medicine, it became clear early on that I was destined for acute stroke care. But I fought my future right up until fellowship applications. I tried to enjoy outpatient subspecialties so I could have the lifestyle I wanted for my family, but it all just came back to acute stroke care for me. Luckily, I was at a program that was developing a telestroke system, which allowed me to see the potential for an acute stroke career that allowed for more work life-balance. So, I gave in to my future and applied for vascular fellowship with telestroke aspirations.

Like many early career physicians, I was afraid to jump fully into this non-traditional pathway of medicine, so I started my career with telemedicine in the academic setting. It did not take long for me to realize that the standard hierarchy of medicine was not designed for women (or any parent) that views their family and career as equal. I saw my future in my female colleagues, and I knew it was not the future I wanted for myself or my family. I had to make some extremely hard and scary decisions. Would I sacrifice my baby years for my career, or my career for years with my babies? Not a decision anyone should have to make, but an all too common one. I decided to try to find my balance from the beginning rather than struggle in those early years to prove myself. I needed to find a path that allowed me to have those very precious years with my babies but also allowed me to continue to grow in my career. I decided to jump ship from a traditional career in academic medicine and believe this is one of the best decisions I have ever made.

While I was searching for the right option, I was fortunate to come across a telemedicine company that allowed me to find not only the work-life balance I was after but also continue to reach my professional goals. I was able to provide high quality care for acute stroke patients across the country who otherwise would have limited access to specialty medical services. In addition to direct patient care, I was also able to work with individual systems on program development and quality improvement. But the icing on the cake was that I did not have to leave teaching and research behind either. I have helped to develop a national program for resident and physician education. The relationships built with hospitals across the country have not only provided educational opportunities but a large network for research as well. This network allows for large scale research studies that can be done by few others. I have found my place, my balance, and I am excited for my future.

I encourage all female physicians to stop and think about what they want, not what options have been laid out for them. Look beyond the academic vs private practice mindset that is typically presented to you. These models were designed around an outdated patriarchy. As female physicians, we need to start creating our own models that allow for more work-life balance, not only for us, but for all of our colleagues, regardless of gender or specialty. So do not be afraid to take that scary leap out of a system that was not built for us and forge your own path.

The is a modified version of the originally published article in NeurologyLive
https://www.neurologylive.com/view/taking-the-leap-forging-your-own-path-in-medicine

Dr Theresa Sevilis is the Director of Academic Advancement at TeleSpecialists, LLC where she oversees research, and educational opportunities for the psychiatrists and neurologists within the practice. In addition, she is a Regional Medical Director for TeleSpecialists, LLC and the Stroke Director for Winter Haven Hospital. She is board certified in both Neurology and Vascular Neurology. Dr Sevilis has a passion for acute stroke care and quality improvement in medicine.

The Not So Mysterious Case of the Counter Synonyms

By: Reba Bindra, M.D.

Be honest with yourself about what image pops into your head when you see the terms “physician” and “leader”. The artificially established norms that our collective subconscious are repeatedly inundated with assigns these words to males. While these types of associations are not exclusive to gender, the focus of this article is female physician leaders. *(Note: For purposes of clarity, I am using traditional representations of gender. The challenges of those identifying outside of these constructs are unique and truly deserve their own spotlight).*

I have sought leadership positions throughout my life going back to high school. The same traits that were once praised as “assertive and organized” eventually translated to “aggressive and controlling”. Over the last 30 years, my experience across settings, location and size of institution have followed general patterns. History seemed to repeat itself. Often. Comparing notes with my female colleagues over the years has been both comforting and alarming. It’s not confirmation bias, it’s reality.

There are exceptions to any narrative. For example, there are those that believe that since we elected a female vice president, gender equality has been achieved (insert eye-roll emoji here). In 2020, the Bureau of Labor Statistics estimated women’s earnings were 82.3% of men’s. For women of color, the gap was even wider. How much ground has really been gained? But I digress.

Consider the following 2 categories of leadership traits:
Category A: Aspiring, Assertive, Determined, Decisive, Takes charge, Bold, Patient, Strong
Category B: Too ambitious, Opinionated, Not a team player, Aggressive, Unapproachable, Passive

Category B is what I call “counter synonyms” to Category A. This is the practice of applying different terms to the same actions. Let’s take a closer look at some counter synonyms:

Female: *Too ambitious*. One of my favorites. This conjures up an image of Godzilla wearing lipstick stomping through the streets of Downtown L.A. blindly crushing everything underfoot. (Did Godzilla breathe fire too?). It’s ok for me to be a little bit ambitious, just not too much because then I am “power hungry” or asking for more than I “deserve”.
Male counter synonyms: *Determined, Aspiring*, *Go-getter*. LEADER.

Female: *Opinionated.* This one is just LOL. Please tell me who doesn’t have an opinion. I’ll wait. During meetings, I have found that if I make a facial expression indicating anything other than deference, I am a…what do they call a female dog again?
Male counter synonyms: *Educated, Wise* and well, they simply get to have opinions. LEADER.

Female: *Not a team player*. When a decision needs to be made, there cannot be any dissent among the ranks before I make a final decision. Anything short of this and I am on the path to authoritarianism. On the other hand, if I go the extra mile to try to achieve unity (which is virtually impossible in most cases), I am cast as “indecisive” and a “people pleaser” (see “Passive” below).
Male counter synonyms: *Decisive, Resolute, Not required to be a team player*. LEADER.

Female: *Aggressive*. Defending an opinion (or just having one), speaking my mind or having a direct communication style theoretically should have served me well as a leader. Instead, I was “abrasive” and “forceful”. Speaking directly is frowned upon in women who are expected to have a more empathic communication style. Or maybe I’m that way because I need my voice heard? Or the simplest explanation: must be that time of month. We have all heard this. I was once advised to be more “passive” in my leadership role. This was not the year 1974, it was much more recent than that.
Male counter synonyms: *Assertive, Bold*, *Strong*. LEADER.

Female: *Passive*. (Didn’t you just call me aggressive?) For women, passive is seen as unemotional and de-

tached (Oh, like the opposite of emotional and opinionated? Geez, this is a no-win situation). Passivity is equated with being a “people pleaser”. (But I thought you wanted to me to be inclusive). Someone help. Please.
Male counter synonyms: *Patient, Composed, Methodical*, LEADER.

It’s easy to discount my experiences as being just one person’s narrative or representing only a small set of women. Expelling these ideas by citing exceptions is dismissive and distracts from the very real issues female leaders face every day, in every context.

To my fellow female leaders, the glass ceiling often feels like double-paned safety glass, seemingly impossible to break. But it’s not. Even when I was effectively prevented from pursuing my AMBITION (yes!), I found other avenues. There is not but one path to your leadership goals. Time to erase the counter synonyms and resist the temptation to retreat as so many of us have. Be bold, be assertive, be aspiring, be determined, be wise. These traits are yours, not just 82.3% of the time but all the time.

Book Review and Article Summary

by: Kristina Eipl, M.D.

Textbook Review:
Women’s Reproductive Mental Health, edited by Lucy Hutner, MD, Lisa Catapano, MD, PhD, Sarah Nagle-Yang, MD, Katherine Williams, MD, and Lauren Osborne, MD

This year APA published the first comprehensive textbook of women’s reproductive mental health. It is based on the National Curriculum in Reproductive Psychiatry https://ncrptraining.org which was conceived in 2013 and consists of six core competencies: relationship between reproductive cycle stages and psychopathology, epidemiology, pathophysiology, and phenomenology of psychiatric disorders during pregnancy and the postpartum, including pharmacokinetic changes, treatment of perinatal disorders, including but not limited to psychopharmacology, psychiatric symptoms related to infertility, pregnancy loss, birth trauma, and delivery of offspring with major health problems, premenstrual mood disorders, symptoms related to perimenopause.

The book is broken up into two parts: reproductive health across the lifespan and pregnancy and the postpartum period. The first part covers topics such as female sexual dysfunctions, contraception, infertility and perinatal loss, premenstrual mood syndromes, and perimenopause. The second part includes chapters on the diagnosis and management of specific psychiatric disorders during the perinatal and postpartum periods. I found the book to be well-organized. The writing is clear and concise. The authors are clearly knowledgeable in their subjects. The only drawback is that the charts and illustrations are not in color, which makes them slightly more difficult to read. Overall, I find it to be an invaluable resource in treating women’s mental health issues and would recommend it to anyone treating women of any age.

Article Summary:
Declared Insane for Speaking Up: The Dark American History of Silencing Women Through Psychiatry, by Kate Moore

https://time.com/6074783/psychiatry-history-women-mental-health/
In this opinion piece, Kate Moore, author of The Women They Could Not Silence, describes the case of Elizabeth Packard, a woman who was committed to the Jacksonville Insane Asylum in Illinois in 1860 by her husband after asserting her independence. She goes on to offer other examples of the medicalization of female behavior based on the theory that women’s reproductive organs caused madness. She also offers examples of present day attempts to silence women by presenting them as ‘crazy’, including Harvey Weinstein’s lawyers’ plot to make his accuser Rose McGowan seem “increasingly unglued.” She ends the piece by recalling Packard’s “triumph over the patriarchy” and work in the Anti-Insane Asylum Society.

What country do we live in?

By: Janet Martin, M.D., Ph.D.

I ran across an intriguing article by Stotland et al, which mentioned that, in 2016, the governor of Indiana, a man named Michael Pence, signed a law forbidding abortions for genetic defects, made it a felony to donate fetal tissue, and required all fetal remains be buried or cremated. The U.S. Supreme Court upheld the handling of fetal remains requirement in 2019, but did not comment on a lower court's ruling, which struck down the provision barring abortions for genetic/disability reasons.

In the last half century, abortion laws have been becoming more liberal around the world due to the diligent work of human rights advocates, women's rights activists, and general improvements in public health. However, reproductive rights are increasingly being restricted in many parts of the U.S. without any basis in medical science. Access to reproductive health care and safe abortions is critical to the mental health of women and their families. The ability for women to decide when and if they want to have children is a basic human right with life-long impact. More unfortunately, these abortion restrictions have a disproportionate impact on minority and underprivileged populations.

Women have abortions for many reasons, including domestic violence and rape, and factors affecting the ability to care for a child, such as poverty, lack of education, poor social supports, and preexisting mental illnesses. It is estimated that over 73 million women worldwide have abortions each year and 30,000 die from illegal, unsafe abortions. In the US, about 30% of women have an abortion by age 45. Some states in the U.S. require abortion providers to provide misleading or inaccurate information to patients, such as having an abortion will increase their risks for depression, substance abuse, suicide, inability to bond with future children, or even breast cancer. Unfortunately, many women seeking abortions are already at increased risk for mental illnesses, so abortion can be correlated with some of these risks without having a causal relationship. Stotland et al points out that studies show that the best predictor of mental health after an abortion is a woman's mental health status before the abortion. Furthermore, difficulty in obtaining an abortion increases stress for women, as they will not let restrictions stop them from obtaining an abortion if they feel it is necessary. It's intriguing that even women who protest outside abortion clinics will seek abortions at that clinic after the clinic's usual operating hours, as they may oppose abortions on religious grounds, but recognize the necessity of such a procedure in a particular circumstance.

One significant danger to women's rights is the concept of fetal personhood. This concept puts the woman into a legal conflict with the fetus, as this does not acknowledge the impact of pregnancy on the woman. As Stotland et al so eloquently puts it, the woman is reduced to "an incubator for a potential person". The 2016 law in Indiana demonstrates this dilemma, as fetuses are to be treated with the dignity a person deserves. OB/Gyn clinics treat the products of conception just as they do other biological tissues. If the fetal tissue is to be cremated or buried, who is to pay for the services? What happens to spontaneous abortions that may occur at home? In a much more thoughtful approach, Canada has decided not to endow the unborn with the rights of personhood.

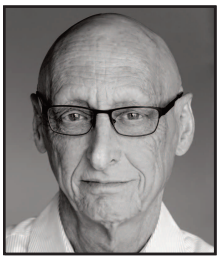
Last year, when I learned that the U.S. was pulling out of Afghanistan, I remember feeling a sense of dread thinking about how the women and girls there would retain the modest gains they'd made in human rights with the Taliban back in power. I felt ambivalent about U.S. troops returning to America. Now, I think we need some serious help in our own country to maintain the hard-won human rights for women here.

Stotland NL, Shrestha AD, Stotland NE. Reproductive Rights and Women's Mental Health: Essential Information for the Obstetrician-Gynecologist. Obstet Gynecol Clin North Am. 2021 Mar;48(1):11-29.

This site provides useful information about reproductive health policy and the potential outcome of overturning Roe v. Wade:
https://www.guttmacher.org/article/2021/10/26-states-are-certain-or-likely-ban-abortion-without-roe-heres-which-ones-and-why

SCPS Re-Joins Fellow District Branches in Statewide Advocacy

Roderick Shaner, M.D.
Steve Soldinger, M.D.
Co-chairs, SCPS Government Affairs Committee



SCPS takes a big step this month to further re-knit our California District Branches into a powerful statewide organization that will unite our voices into a powerful force for advocacy for our profession and patients. We'll have new effectiveness in Sacramento with state government and in the meeting rooms of the CMA's Council on Legislation.

Four of the five APA district branches in California—SCPS, NCPS, OCPS, and SDPS, together representing some 90% of APA members in California, are now once again working together as the California State Association of Psychiatrists (CSAP). This fulfills the priorities of our SCPS membership, strongly expressed in our townhall meetings and Council for the last two years:

> Unite California APA District Branches to rebuild the formidable membership-driven agenda of psychiatrists across California.
> Ensure that state and federal governments address the needs of our patients and practices in a rapidly changing landscape.

Like the California Psychiatric Association (CPA) before it, CSAP is first and foremost a membership-governed, transparent, and responsive organization that reflects the values of our profession, backed by the credibility, resources, and reputation of the American Psychiatric Association. The CSAP Board of Directors are all psychiatrists directly appointed solely by our District Branches. APA is now poised to recognize CSAP as the APA State Organization. As SCPS members, we will have the voting power—and veto power—to make sure that our issues are taken seriously. CSAP is directly accountable to us. We don't simply suggest advocacy actions—we initiate them.

Besides uniting the California District Branches, CSAP brings another great strength to our advocacy efforts. CSAP contracts for advocacy services with one of the largest and most respected advocacy firms in California—SYASL (Shaw, Yoder, Antwih, Schmelzer, and Lange). This is the same group that also represents the California Medical Association and the California Association of Child and Adolescent Psychiatrists. SYASL has unmatched access to legislators across California. It works with them to craft and sometimes sponsor legislation on many critical issues. The firm's deep links with many California counties and cities (including the cities of Los Angeles and Santa Monica) ensure that it can additionally guide SCPS on some of our local advocacy efforts.

Key to our relationship with SYASL is that we as APA psychiatrists—and nobody else—determine the content of the advocacy. SYASL assesses and discusses the political landscape with us and suggests the best options to reach our goals. But SYASL and CSAP never presume to make our choices for us. There are no unaccountable decision-makers in the CSAP structure. For both SYASL and CSAP, clear and transparent guidelines and reporting to SCPS assure that advocacy decisions are not covertly influenced by political opportunism or drug company, insurance company, or other industry support.

SCPS advocacy efforts have come a long way since SCPS President Ijeoma Ijeaku re-invigorated our SCPS Government Affairs Committee (GAC) last year. The committee brings together members with interests in private

practice, public practice, managed care, residency and early career issues, diversity and cultural concerns, and psychiatric subspecialties to forge legislative positions. These positions will now directly determine what CSAP advocates at a state level.

But SCPS has done more. In the years since CPA dissolved, SCPS strengthened our local connections with non-APA psychiatric lobbyists, LACMA, NAMI, training programs and county mental health departments. We intend to continue working closely and collegially with them to forward mutual goals. After all, many SCPS members actively participate in these associations as well.

Advocacy works when we productively ally with all groups seeking to improve our practices and the lives our of patients. It works when we have a true and effective voice in setting our agenda, backed by the know-how to make things happen. CSAP doesn't just "have our back." As was CPA, it's actually part of us.

Please stay tuned to our progress and provide feedback. SCPS members will soon be receiving informative and thought-provoking weekly advocacy updates from Paul Yoder, a principal of SYASL who is recognized across the state for his expertise, experience, and effectiveness in the legislative process. And please, as an SCPS with new connections to powerful statewide advocacy, take advantage of our expanded opportunities to participate directly in setting and initiating our new and stronger advocacy efforts. SCPS GAC, reachable immediately via our executive director Mindi Thelen, quickly acts on all membership concerns and will keep us all informed about developing local issues.

SCPS Joins the California State Association of Psychiatrists (CSAP)

Paul Yoder

Andrew Antwih

Priscilla Quiroz

SCPS has joined the California State Association of Psychiatrists (CSAP) and will now be partnering with three of the other four district branches in California on legislative and regulatory matters. CSAP is now fully established in state public policy making circles through the strength of its membership (now over 2500 psychiatrists strong!) and through the services provided by the ten lobbyists at Shaw Yoder Antwih Schmelzer & Lange (SYASL). Governor Newsom and his key staff, legislative leaders on behavioral health policy (such as Senators Wiener and Eggman), and other influential advocacy groups such as the Kennedy Forum and Steinberg Institute all now recognize CSAP and SYASL as the voices for organized psychiatry in California.

There are three SYASL lobbyists principally working on CSAP issues: Paul Yoder, Andrew Antwih and Priscilla Quiroz. With decades of experience, this powerhouse team brings an intimate understanding of policymaking, with a proven track record of integrity, professionalism, and success. Paul Yoder, who is the lead lobbyist for CSAP, has been advocating on behavioral health issues for over thirty years and has "seen it all" during his career – from the original 1991 Realignment of mental health services to the counties to the enactment of recent parity-related legislation SB 885, SB 221 and now regulations under development at the Department of Managed Health Care. With conservatorship reform such a hot topic right now in the Legislature (Senator Eggman alone has introduced 9 bills; the Chairman of the Assembly Health Committee, Dr. Wood, has also introduced AB 2275 regarding possible changes to the LPS Act), it is worth noting that SYASL (Paul) collaborated with Senator Wiener on the con-

servatorship pilot legislation for San Francisco, San Diego, and Los Angeles Counties, which was the last notable change to conservatorship law in California.

SYASL was founded in 1978 and still retains its first client. The firm has ten lobbyists (one of the few firms in California to have this many), and seven legislative assistants, and is located just blocks from the State Capitol. SYASL is perennially ranked among California's Top Ten advocacy firms. It's lobbyists annually rank in Capitol Weekly's Top 100 Influencers in California. SYASL is also one of the few firms in California that not only provide both advocacy and association management (the day to day running of statewide organizations) but both at such an elevated level and seamlessly. SYASL is also one of the few firms that can sponsor and defeat legislation and also work both the legislative process as well as the state budget process.

One of the advantages to SYASL is that they also work for over twenty counties in California and several large cities (Los Angeles and San Francisco), which produces a deep understanding of how the public behavioral health system works, and the intersections with private practice psychiatry as well as the challenges that cities face in addressing homelessness, especially the mental health and substance abuse issues that can be so prevalent in this population. SYASL (mainly Andrew) also does contract advocacy work for the California Medical Association which provides CSAP and now SCPS will a deeper understanding, a more "inside baseball" perspective, on pressing medical issues in California. Lastly, for years, the firm (Priscilla) has represented the California Academy of Child and Adolescent Psychiatry (Cal-ACAP), which is currently sponsoring SB 528

Paul Yoder is always available to all members of SCPS. His email is paul@syaslpartners.com. Members who have already reached out to Paul and his team will tell you how happy and impressed they have been with the information provided on the spot as well as the follow up from the SYASL team.

SCPS members will definitely want to check out the CSAP website, which is updated every week and includes in a very transparent and useful way the letters that the association has sent on various topics, especially bills as they move through the legislative process.

These are critically important times for psychiatry in California, and SCPS joining with three of the other four district branches is vital. As CSAP Board Chair, Roula Creighton, stated upon receipt of SCPS's decision, "Our CSAP GA Committee, Board representatives and lobbyists have worked tirelessly to establish a strong advocacy team that is an effective voice in Sacramento. We are excited to announce that the Southern California Psychiatric Society has chosen to join us in this effort. We welcome their active involvement as we jump into a remarkably busy legislative year. With the coordinated efforts of the Northern California, Orange County, San Diego and Southern California District Branches of the APA in representing almost three thousand Psychiatrists in California, we can realize true change for the mental health of Californians."

Trauma: Keeping the Score

By Kavita Khajuria, M.D.

Friends of the Semel Institute and the Resnick Neuropsychiatric Hospital Board of Advisors for an Open Mind recently hosted a discussion with Bessel van der Kolk, MD, considered a pioneer of post-traumatic stress studies and the founder of the Trauma Research Foundation in Boston. He was joined by Robert Pynoos MD from the UCLA Trauma Psychiatry Program and later by Dr. Alexander McFarlane from Australia.

This was a discussion, not a presentation or Q &A. Discussants reflected on experiences from the past 30+ years and shared personal opinions. Dr. Van der Kolk cited the body as the carrier of emotions, with interpretations and effects on all bodily systems. He noted this as often primed from childhood, further illustrated by the medical hospitalizations of victims of abuse from priests. Long term effects of trauma were noted to include difficulties with initiating or cultivating friendships, and interpersonal relations, including problems with dating. Noting a child to fear one's own physical effects from trauma, they stressed the importance of teaching kids to overcome the past by acknowledgement, then to 'reset' the body. Dr. Van der Kolk encouraged clinicians not to take insults personally, rather - to sit back, perhaps with irreverence and more lightheartedness, to ask, "what happened?" rather than risk a diagnosis of Oppositional Defiant Disorder. The journey of recovery was noted to be potentially complicated, requiring time and patience. Establishment of safety was cited as crucial, with space to allow for finding words for the unspeakable.

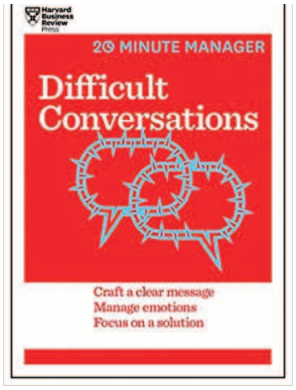
Reflections included some thought provoking, if not provocative opinions. Dr. Van der Kolk noted psychologists and psychiatrists to be poor at making people feel good about themselves, adding that they could take a lesson from kindergarten teachers who know how to help kids feel safe. Other topics included the use of psychodrama, and the importance of positive modelling and learning about child development. Home visitation programs for young mothers was described as crucial, and the need to treat the system and address the environment. Cultural changes over the 30+ years were also discussed, including parents not wanting to be blamed for the mental illness of their child. Dr. Van der Kolk expressed his approach to treatment to not necessarily include pills and shared an unfiltered opinion on the DSM, noting his inclination to be towards a developmental and experiential approach. He noted the benefit of starting the professional day with yoga, and to end with singing.

Dr Alexander McFarlane subsequently joined the conversation; topics included the evolution of PTSD on the map, noting how psychiatrists have been unaware of the pervasiveness of the extent of stressors including domestic violence. They noted trauma as deeper than a memory, a mistake to codify and commented on traumas ability to change one's perception of reality – "it (trauma) chooses who you are". Alexithymia was referenced, and how a person can get lost in the "soup" of trauma. Dr. Van der Kolk expressed disappointment at the current situation, yet lack of surprise. Politics were acknowledged as inevitable, given the birth of PTSD from suffering veterans and political issues. They noted the disappearance of community psychiatry, and the need for awareness of long-term studies - with a focus on best outcomes, subjective experience, and complexities, not on alignment with certain camps or schools of thoughts, given a loss of wisdom with a loss of the case study approach – and called on the importance of mental processes and detailed experience "to regain the soul of psychiatry". The benefits of discussing failure, thinking through, and the ability to learn from experience and mistakes was encouraged. Dr. Van der Kolk illustrated this by noting the importance of M&M experience during his training, with rich lessons learned that could encourage one to see how things could be done differently. He eventually shared the motivation behind his book and emphasized the importance of inspiration.

The video is available at www.friendsofnpi/open-mind-videos on You Tube with the Open Mind Programs.

Difficult Conversations
Harvard Business School Publishing Corporation
130 Pages
$25.00 Hardcover; $3.00 Kindle
ASIN: B012BLTJGG

Book reviewed by Kavita Khajuria, MD



Authors explain what make conversations so difficult, exploring friction and difficult conversations at work. They note the difficulties to include differing views, styles, core values and/or a lack of trust. How does one decide if speaking out is actually worth the risk? Hypothetical scenarios illustrate the points and pose necessary questions. Authors cite self-awareness as the leader in emotional intelligence when it comes to work related success and to efficiently navigate difficulties. Tools and guidelines are shared on how to maneuver and become a better communicator. Readers are guided through the preparation, conduct, and the eventual follow-through of a difficult conversation. The book is informative and educational – it concludes with a list of recommended articles, books and classics. It may help one navigate through the more common conundrums and enhance professional adaptability and resilience.

Council Highlights
January 14, 2022
Haig Goenjian, M.D., *Secretary*

Outline of Notable Meeting Events and Discussion

The meeting was called to order by Dr. Ijeaku at 7:01 PM.

Minutes from the previous April meeting were unanimously approved without addendum.
1. President's Report
A. APA Notification to CA DBs: Topic regarding the APA's letter to SCPS regarding concerns of our compliance to APA's procedural code as it relates to having a state advocacy arm. Discussion circulated around understanding the letter and how to respond. No conclusions made. The highlight of the importance was noted. We have till March 15th to respond to the letter.

B. Mini Documentary Series Project: Updates provided and in general council noted that this appears to be well received by the psychiatric community. We had our 5th Video with Dr. Ochoa. Next is with Dr. Gary Tsai. We encourage members to share the link, which is available through our Newsletter.

IV. GOVERNMENT AFFAIRS COMMITTEE Dr. Shaner
A. GAC Report: GAC had both CSAP (Paul Yoder) and PPAC representatives (Randal Hagar and Jim Gross) come to their meeting. They also sought feedback from each DB. Their highlights were outlined. PPAC allowed SCPS to allow for a Board Member.

Motion 1: 19 yes, 1 no, 2 abstain (from gac report regarding advocacy—in Council packet)
Motion 2: Passed unanimously (from gac report regarding advocacy—in Council packet)
Motion 3: Presented by Dr. Goldenberg: Motion: The SCPS council should direct the sub-committee on contract development to send a letter to PPAC. The letter will request that PPAC provide, the SCPS Government Affairs subcommittee on contract development, the opportunity to review copies of the current PPAC contracts with its advocacy staff in order determine contractual provisions for assessing and managing potential conflicts of interest that advocacy staff may have in regard to their non-PPAC clients, and to also assess related contractual costs incurred by PPAC for services provided to SCPS.
Passed Unanimously

V. NEWSLETTER COMMITTEE REPORT Dr. Goldenberg
The January Edition is on the Alternative Crisis Response and was co-edited with Dr. Wood. Next month is in honor of Black History Month, and will focus on diversity. To be guest edited by Dr. Okoye.

VI. TREASURER'S REPORT Dr. Goldenberg
A. December Financials:
Regarding Income: For the month, we are over budget by approx $11,735. For the year, we are over budget by approx $77,705 (reserves).
Regarding Expenses: For the month, we are over budget by $568. For the year, we are over budget by $35.
Overall we are approx $71,123 over cash on hand as compared to last year. Largely reflected by the overall mutual fund gain of $71,127. Per Dr. Goldenberg's report, "we are ending the year exactly where we were one year ago..we did, however, we did return 10k to reserves."

Passed Unanimously

VII. ASSEMBLY REPORT Assembly Reps
- Highlights include discussion that the next Assembly Meeting for Area is January 31st.
- Dr. Red gave education on how action papers work and notified council that the Assembly is open to receiving new Action Papers. SCPS members are encouraged to send Action Papers to Council.

VIII. MEMBERSHIP REPORT Dr. Ijeaku
A. Membership Report 9 new, 7 GM, 2 RFM
Current Active Membership –904
(December 879)

IX. PROGRAM REPORT Dr. Gales
Committee is working on an effort with APA to get CME credit for our Programs. There have been issues and we may look in the future to accredit ourselves.

X. NEW BUSINESS Dr. Ijeaku
- none

XI. OLD BUSINESS Dr. Ijeaku
- none

The meeting was adjourned by Dr. Ijeaku at 9:20 pm.

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Full and half-days available Mondays, Wednesdays, Fridays, as well as Thursday evenings, in office in professional building, The Larchmont Medical Building, in Hancock Park.

Eighth floor office with spectacular views of the Hollywood Hills/Hollywood Sign. Single office with private waiting room, separate entrance/exit, call-light, fiber optics internet, HEPA filter. Street or lot parking. Rental fees dependent on number of days/hours.

Contact Dr. Bell, 323-464-3823;dr.ilenebell@gmail.com

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