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President's Column

Crisis and Disaster Psychiatry

Ijeoma Ijeaku M.D.



A crisis is a situation that arises from an overwhelming negative event that is not responsive to the usual coping strategies that an individual has at their disposal. A crisis usually follows an acute stressor and is considered a threat to the individual's pursuit of important life goals. The situation is usually so threatening that it is a matter of life-or-death options. Among crisis theorists, there is recognition of the concept of *cognitive key* as possibly the most important determinant predicting outcome following a crisis. The cognitive key is the story one is telling oneself about the crisis. This is important as it affects the meaning one ascribes to the crisis and the mobilization of tools to deal with it...

The initial attack on Ukraine from Russian forces was on February 24, 2022, amidst denials from Russian officials of an imminent attack up to 1-2 days before. In the last month plus, the war on Ukraine has been raging leading to deaths, casualties, displacements, refugee situations and a new global crisis. As world leaders rally round to develop tactics to curb the negative effects of this war, millions of Ukrainians are actively affected and struggling with their basic needs of food, clothing, and shelter. Many more are worried about the ongoing onslaught on their overall wellbeing. The crisis is active and current as the situation is still unfolding and not under control. This is particularly concerning because the world has been dealing with a different global crisis since 2020, the issue of the pandemic. The real issue therefore is not just an acute situation of a war and its attendant consequences. The complexity of the moment is the superimposition of an acute situation on a chronic or subacute situation stemming from the pandemic and the fact that individuals have been under unusual stress for the past 2 years and do not have the usual reserves to deal with this crisis.

Beyond the issues faced by those primarily affected by the war are the many individuals affected vicariously through their social media engagement in the wreckage caused by the war. In a 2013 study from UCI, individuals who watched TV for at least 4 hours per day in the week following September 11 were at increased risk of developing PTSD. That study looked at data from 2001 with limited social media influence. According to a Time.com report dated 3/8/22, there were 600 million views of TikTok videos with #ukrainewar. This is indeed a different time as far as the ease with which individuals access information in real time. Also, people have been dealing with the stress from the pandemic and its attendant consequences. In other words, our patients, family, friends, and others are susceptible to the effects of this war happening so far away from them through the power of the media. These effects are particularly concerning given the many stressors that individuals have dealt with in the last 2 years.

As Psychiatrists trained to deal with the mental health of individuals and as humans watching the upheaval created in the lives of our fellow humans, we are bothered, and some have found ways to meaningfully engage those affected and contribute towards their upliftment. Within the APA, the global mental health caucus has been quite active. There have been multiple resources shared about how to get involved and there have been trainings to educate and equip those interested in offering their services. These resources at the national level have helped members feel connected and productive in their crisis intervention roles. Locally, the SCPS Disaster Relief Committee has shared resources about ways to get involved.

Necessity is said to be the mother of invention. The Disaster Relief Committee of SCPS has been active in the last few years following the southern CA fires. The pandemic brought its work to the limelight as it worked hard to keep members updated about resources available to them; from resources for serving others in need to resources regarding vaccine allocations to town hall meeting for member check-in. As the committee engaged with other agencies at the local and state level working on the development of a crisis intervention mental health model, it has become more apparent that other agencies do not usually know what role psychiatrists can play. We have not been involved in disaster and crisis work perhaps because existing disaster relief agencies have been limiting in their definition of our role or others assume that we are not interested, or we have not really considered disaster psychiatry a real concept or it is none of the above. Whatever the case, our colleague Erich Lindemann who is credited with authoring the first papers on crisis intervention wrote in 1944 that several types of crises share the same basic features, and most do not require any formal interventions. Psychiatrists must learn to embrace crisis intervention and disaster psychiatry work bearing in mind that the *cognitive key* of the individual in crisis is the most important aspect of the work. Between the fires that happened locally, the COVID 19 pandemic that is now past its 2-year mark and the threat of another global crisis with the Russia-Ukrainian war, this is the time for SCPS members to get involved in disaster psychiatry work and a time for SCPS to help redefine the psychiatrist's role in crisis intervention...

SCPS committees serve as focused work groups with specific charges that work on behalf of the council to serve our membership. Our SCPS committees give members opportunity to be heard as issues can be deliberated with colleagues and recommendations can be made to council to help shape SCPS positions regarding various issues. If you are interested in redefining the psychiatrist's role in disaster psychiatry work, consider contributing your time, effort, expertise to the Disaster Relief Committee by reaching out to our most devoted executive director Mindi Thelen @ socalpsychiatric@gmail.com



<https://youtu.be/x3m2wAAw3a0>

Danielle Chang, MD, MSW is originally from New York and received her undergraduate education at Dartmouth College. Post-college, she was awarded a Public Interest Fellowship through Princeton University's Project 55, where she developed an arts-based after-school program for special needs children at the Association to Benefit Children. Through this experience, she fostered an appreciation for social work and went on to receive her Master of Social Work from New York University. As a social work intern, she founded the Preventing HIV/AIDS in the Next Generation Program, which gave HIV positive clients the opportunity to challenge stigma by sharing their stories with high school students and other at-risk populations in New York City.

Dr. Chang attended medical school at Michigan State University and trained as part of the Leadership in Medicine for the Underserved and Vulnerable (LMUV) program in Flint, Michigan. She received her Doctor of Medicine (MD) degree in 2015 and was inducted into the Gold Humanism Honor Society.

Dr. Chang completed her internship in psychiatry at the UCLA San Fernando Valley Greater Los Angeles VA. She completed her residency training in psychiatry at UCLA Olive View Medical Center, where she served as a chief resident during her fourth year and received the Outstanding Graduating Resident Award. Dr. Chang became involved with the Southern California Psychiatric Society (SCPS) as a Resident Liaison and received the SCPS Outstanding Resident Award, Psychiatric Education and Research Foundation Excellence in Psychiatric Education award, and an SCPS Presidential Commendation for her work as Chair of the SCPS Disaster Relief Committee. She represents SCPS on the California Disaster Mental Health Coalition and is an SCPS liaison to the American Psychiatric Association Psychiatric Dimensions of Disaster Committee. She has continued to serve as an SCPS Council Member representing the San Fernando Valley for past three years.

Dr. Chang currently works as a psychiatrist at Olive View Community Mental Health Urgent Care and teaches residents as a UCLA Health Sciences Clinical Instructor for the Olive View Medical Center Psychiatry Residency Program. She is a psychiatric consultant for the Los Angeles County Office of Diversion and Re-entry, providing psychiatric services to patients enrolled in a Department of State Hospitals incarceration diversion program. Dr. Chang is passionate about providing services to patients who have limited access to care and is looking forward to being involved in developing a specialty clinic for LGBTQIA+ patients at a new outpatient mental health clinic at Olive View Medical Center.

Ukraine Edition:

By Newsletter Editor
Matthew Goldenberg D.O.



Happy April!

Several weeks ago, we all received an email from SCPS about the war in Ukraine, which was written by our colleague Alex (Oleksandr) Trofymenko MD.

As a follow up to that communication, for this month's newsletter, nothing seemed timelier than discussing the [ongoing war](#), [refugee crisis](#) and the [mental health implications](#). Dr. Trofymenko has been gracious enough to serve as this month's guest editor.

Dr. Trofymenko is a PGY-IV at the UCLA/VA Greater Los Angeles Psychiatry Residency Training Program. He is originally from Ukraine and his family moved to Arizona when he was in high school. He considers several places to be "hometowns" including Sumy (Ukraine), Tucson and Phoenix (AZ).

I want to thank him for his contributions to this month's newsletter and for sharing his personal story and perspectives.

It is my hope that this month's articles help our colleagues and our field facilitate critical thinking and a discussion of how we can help those who are suffering and impacted by the ongoing war and the resulting humanitarian and public health crisis.

There are resources and links from the APA here: <https://www.psychiatry.org/newsroom/news-releases/apa-statement-and-resources-on-the-mental-health-impact-of-the-war-in-ukraine>

In addition to these important articles related to Ukraine, I also want to, once again, thank Dr. Shaner and Dr. Soldinger for the very thoughtful and informative article which they submitted. It provides important details about SCPS's and CSAP's advocacy efforts and goals.

[If you missed it, please read [their article from last month](#) for more details on SCPS's decision to join CSAP].

Dr. Shaner and Dr. Soldinger are both longtime leaders of advocacy in California and are both former SCPS presidents. They currently serve as SCPS State Legislative Representative and Federal Legislative Representatives respectively.

I hope Dr. Shaner's and Dr. Soldinger's article helps all SCPS members to better understand the advocacy services they are receiving as SCPS members and why the SCPS Council felt that CSAP was the best option for SCPS to reach its advocacy goals in 2022. As a reminder, in 2022, SCPS has

continued to prioritize advocacy and has allocated 31.5% of its dues collection to support advocacy activities.

If you have questions related to your current advocacy member benefits, as an SCPS member, please reach out to Mindi.

Advocacy has never been stronger or more top of mind at SCPS. The Government Affairs Committee was dormant for more than a decade and Dr. Shaner and Dr. Soldinger have revitalized and rejuvenated it.

SCPS joining CSAP has not only reunited the California District Branches of the APA, but it has also given all SCPS members a voting representation when it comes to advocacy in California.

If you hear otherwise, please reach out to Mindi and/or come get involved with SCPS and see first-hand how strong advocacy efforts are in 2022.

Continue to stay safe,

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

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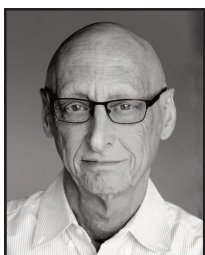
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Shaping Psychiatric Advocacy:

Legislative Advocacy Update

By: Roderick Shaner, M.D., and Steve Soldinger, M.D.

Co-Chairs, SCPS Government Affairs Committee



No exaggeration: This is arguably California's most important year for mental health and medical insurance legislation in decades. Our votes about psychiatric advocacy are too critical to justify delegating decision-making to unaccountable parties.

As psychiatrists, we must intelligently determine organized psychiatry's position on new legislation. One efficient way to do this is to follow the informative weekly advocacy update from the California State Association of Psychiatrists (CSAP). It comes into our email inboxes every Friday. Here's the link to last week's edition: [CSAP Newsletter March 25 2022 \(mailchi.mp\)](#). Through SCPS, we can determine organized psychiatry's voice.

But, first, what is CSAP? CSAP is the successor APA membership-driven organization to CPA, reuniting four of the five APA district branches in California and over 90% of APA psychiatrists in California. That unity and strength gives us, through CSAP, the resources to employ one of the most powerful respected advocacy groups in California to sponsor bills, the same group that works with CMA and the California Association of Child and Adolescent Psychiatry.

Just as important, CSAP is transparent and composed of APA members only. We vote on every advocacy decision. CSAP doesn't just solicit our input, it is us. As such, it is an incredible source of talented and accountable leadership. Just like APA and SCPS. (Or CMA, for that matter.)

So, please, if you haven't already, review the CSAP newsletter. You'll find a concise and thoughtful analysis of CARE Court, Newsom's revolutionary proposal to reshape the role of Courts and mental health bureaucracies. It affects the lives of our patients and our professional options. You might like some parts. You may be disturbed by others. After a transparent discussion at CSAP, we'll determine which elements we should support or oppose, and what marching orders go out to our advocacy specialists. Patient lives and billions in state funding hang in the balance.

The 2022 legislative session is also awash in a matrix of LPS reform bills. These bills change definitions of grave disability, alter procedures for LPS conservatorships, and rejigger permissible treatment. The CSAP newsletter covers this, too. Once again, our voices and votes are necessary.

CSAP isn't about "advocacy" as an abstraction. It's about advocacy for what we as APA psychiatrists believe is right, as determined by our votes. This accountability is important enough to justify the commitment of some 31.5% of SCPS membership dues to the enterprise. And that sum from our roughly 1000 members is then augmented by proportionally similar contributions from the other roughly 2000 additional members from NCPS, OCPS, and SDPS. The alliance creates unmatched advocacy power through economies of scale. Surely, it's a bargain—especially when it includes having a real say in advocacy, a partnership with our fellow California District Branches, a talented and experienced team of advocacy specialists, and strong connection with APA.

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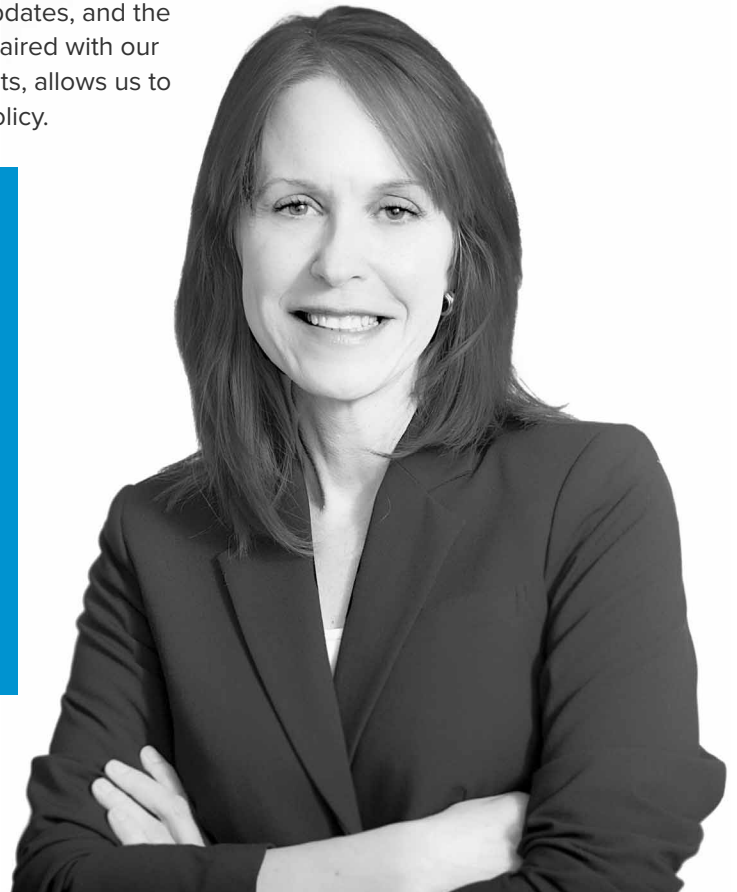
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Letter from the Guest Editor

Oleksandr Trofymenko, M.D.
PGY 4 - GLAVA



I originally wrote this letter from a state of utter shock and disbelief. I was born in Sumy, Ukraine and came to the United States when I was fifteen years old. Only a month ago my wife and I were discussing when would be the best time for our kids to visit Sumy for the first time. Roman, my oldest, was born right before the pandemic started and we have not been able to visit his grandmother and my home country. As my wife and I talked about when would be ideal time to visit, I imagined taking him to this tiny private airport, where I got to go during my last trip. Roman loves heavy machinery and it would bring him immense joy to explore the small planes and helicopters parked nearby. I also pictured taking him to the river where I used to play as a child with my grandmother.

And then it happened. The day I woke up to the video footage of my hometown plundered with gunfire forever burned into my memory. I saw the streets leading to the airport covered in smoldering rocket shells with tanks and heavy artillery parked right in the middle of what once was a busy intersection. I had tears running down my cheeks and a heavy knot in my throat. My grandmother, who still lives in Sumy, may not get a chance to meet my children. I could never have imagined such terror inflicted on people, who, like most of us, just wanted a better life for themselves and their children. My hope for peace ended after seeing these frightening images of my home.

Two weeks ago was the first time that I felt a glimmer of hope. I learned that my uncle Mykola, a retired firefighter, was still alive. He and his wife live on the outskirts of Sumy in Vorozhba, a tiny Ukrainian village that had a misfortune of hosting a battalion of Russian tanks and other armored vehicles on top of their fields. I remember him as a comedian with huge heart; always happy and eager to show around the firetruck and let me ride in the front seat of his old car. As happy as I was that he is a live, my mind wonders into dark places. For how long does he have to be a hostage, living with his elderly wife in a basement of his own house, while Russian soldiers are ransacking and destroying his home?

Now I am sitting here with a heavy heart, trying to figure out what I, a Ukrainian-American, a father, a son, and a doctor can do. I am in my final year of psychiatry residency, and my first thought is to make sure that I am okay. I deeply cherish all the well-wishes from everyone who has reached out offering their support. The love that I experienced from others has once again sparked some hope in me.

My second thought is with the brave men and women who took up arms to defend Ukraine against Russian aggression. They know what they are facing, and their heroic sacrifice gives me even more hope. It is no metaphor to say that Ukrainians are not only fighting for their country, but also for the fate of freedom and democracy itself.

The calamity caused by Putin's regime is creating a massive humanitarian crisis, that has not been seen in Europe since World War II. Like my grandmother, millions of older people as well as children, currently in Ukraine, are unable to leave or have nowhere to go. The damage inflicted by ongoing Russian bombardments of large Ukrainian cities leaves people without food, water, or shelter. My mother shared the footage from the streets of Mariupol that has been deleted from YouTube. The 15-second recording showing rows after rows of lifeless bodies piled up on top of one another on both sides of the street made me shiver. I cannot see this again. I also must do everything in my power to stop the genocide of Ukrainians.

Many Ukrainian and non-Ukrainian mental health professionals have answered the call to be help in multiple creative ways. As Ukrainian prime news channels joined into a unified 24/7 online tele-marathon, several prominent local psychologists take turns to go live and discuss various immediate high-impact strategies to deal with acute stress and grief reactions. A special interest channel for psychological help for Ukrainians via Telegram (popular messaging app) has been created to connect both providers and patients via live chat. Organizations like Vibrant have shared free online psychological aid training in Ukrainian and Russian via YouTube. The organization has also been actively recruiting volunteer mental health providers for telehealth work. Various international humanitarian agencies like Red Cross have directed their efforts to address mental health as an important component of aid to displaced populations of Ukraine.

This is a dark hour, not just for Ukraine, but for humanity itself. But, regardless of the message that Russian propoganda is displaying about the invincibility of their military, Ukrainian soldiers are successfully fighting back. The enemy can and will be defeated.

Let's not let the next 21st century tyrant get away with terror. Ukraine needs all the military, humanitarian, and economic help right now to mount an effective resistance for weeks or even months to follow. Aside from contacting my representative I made a choice to sacrifice badly needed income, delay our financial independence, and donate a significant portion of my earnings to Ukrainian military. They will need the money for as long as mass murder continues to happen and for a long time afterwards.

I urge you all to speak with your representatives about additional aid to Ukraine and putting further sanctions on Russia. There are many worthy causes to get behind, this is one where the time to act is NOW. Your financial contribution can provide desperately needed humanitarian aid. The money received can also go towards hiring full-time local medical and psychiatric providers. Lastly, supporting Ukrainian military may not jive well with some physicians, but this is one way to prevent the bombs from ever reaching the cities and killing civilians like my grandmother.

Knowing everything we know; this IS our fight. We have a moral duty to do our part to ensure Ukrainian victory, which, after a month of brutal terror appears to be the only way Ukrainians can survive.



Moral injury and the war in Ukraine

By Hannah Roggenkamp, M.D.



Over the past several weeks we have all read news articles, seen the images and videos coming out of Ukraine, often recorded by Ukrainian soldiers and fighters, that show the hard-fought war they are waging against Russian forces invading their country. As a VA psychiatrist who specializes in combat PTSD, almost all my combat-exposed Veteran patients have expressed dismay over the war in Ukraine in recent appointments and voiced a clear desire to be able to go and fight against the Russian forces in support of Ukraine and the Ukrainian people, at the expense of their own life and limb. How do we understand this, especially given the fact that these patients all have PTSD from their combat experiences and have varying levels of physical problems related to their military service? The answer is simple – from a *moral* standpoint, volunteering to fight for Ukraine is the right thing to do. These patients have high moral standards of what is ‘right and wrong,’ and they see the ‘wrong’ that is being done in Ukraine as personally salient and something for which they would be willing to die if there is a chance that further suffering can be prevented. This selflessness is admirable; but what drives my patients to want to fight to the point that one Veteran’s spouse had to hide his passport to prevent him from buying a plane ticket and traveling to Poland?

One of the ways our military prepares soldiers (who typically are between the ages of 18 and 24 during their training) to be able to kill and go to war is by stressing high moral values and standards – avoiding civilian casualties, only killing the “bad guys,” treating prisoners of war fairly, not engaging in torture, protecting their fellow soldiers from harm, as well a focus on personal responsibility for one’s actions and job duties, crucial in high stakes situations. It is the situations in which soldiers are *unable* to uphold those high moral values and end up engaging in something that was ‘wrong’ that can trigger mental health problems such as posttraumatic stress disorder (PTSD) as well as depression and substance use. The term for this type of experience is *Moral Injury*, a term first coined by psychiatrist Jonathan Shay in 1995, and defined by Litz and Carney in 2018 as “*the lasting psychological, biological, spiritual, behavioral and social impact of perpetuating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations.*” Moral injury is increasingly recognized as a major driver of mental health problems such as suicide in the Veteran population; the concept is considered separate and distinct from PTSD (see Bryan et al, 2018), though the actual ‘mechanisms’ of moral injury are not fully understood. Ironically, those service members who are most ethical, most moral, are at an increased risk of experiencing a morally injurious event. Years after the fact, they see themselves as ‘monsters’ who have stepped over a forbidden threshold with no chance of redemption, despite being able to name countless other acts of moral behavior and self-sacrifice.

Those who are willing to fight and die for others tend also to wish to do so for a ‘righteous’ cause, clear right and wrong; unfortunately, the post-9/11 conflicts in which the United States military engaged were complicated, leading the moral correctness of those wars to come into question for many soldiers, similarly to the war in Vietnam. World War II, with the overt ‘Nazi Germany vs. everyone else’ division is often lauded as a ‘just war’ by combat Veterans, who perceive similar moral clarity in Russia’s invasion of Ukraine. A leader who is dependable, willing to put themselves in the same risky situations as the soldiers, and who advocates for the needs of the soldiers, can be a further protective factor against the development of moral injury, and the Ukrainian president Volodymyr Zelenskyy, ever-present and proactive during this conflict, is a great example of leadership under which soldiers can thrive, and for whom they would be willing to give their lives.

Moral injury has been increasingly used in popular press and research on non-military traumas but is not

a term that should be used lightly, so as not to discount and trivialize the severe experiences our services members had that still shake them to their core. Those of us in healthcare have all experienced moral challenges and moral stressors, leading to moral frustration and moral distress. No doubt many of the mental health challenges that healthcare workers, including us psychiatrists, have faced because of the COVID-19 pandemic, are related to moral challenges – lack of sufficient PPE, a populous that places personal convenience over the lives of the most vulnerable, etc. One approach to helping patients with moral injury is encouraging them to engage in acts that ‘fill the morality bucket’ such as volunteering for those less fortunate. Perhaps my patients’ desire to go to Ukraine to fight for the innocent is a desire to refill their own moral buckets. Hopefully this brief article encourages the reader to reflect on their own moral code and on ways in which the reader can strive to hold themselves to the highest of moral standards.

References and further reading:

Bryan, C et al. 2018. Moral injury, PTSD and suicidal behavior among national guard personnel. *Psychological Trauma: Theory, Research, Practice and Policy*, 10 (1): 36-45.

Litz B et al. 2009. Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*, 29: 695-706.

Litz, B & Carney, J. 2018. Employing loving-kindness meditation to promote self- and other-compassion among war veterans with posttraumatic stress disorder. *Spirituality in Clinical Practice*, 5 (3): 201-211.

Litz, B & Kerig, P. 2019. Introduction to the special issue on moral injury: Conceptual challenges, methodological issues, and clinical applications. *Journal of Traumatic Stress*, 32: 341-349.

Shay, J. 1995. *Achilles in Vietnam: Combat trauma and the undoing of character*. Simon & Schuster.

Refugees and Displacement

By: Samantha Stewart



It is impossible to ignore the fact of refugees and displacement in the here and now with the sudden imagery of Ukrainians fleeing for safety as their country is assaulted by Russia. Many have commented that our media and our alarm bells have registered it more deeply because of the visual similarity of the Ukrainians and the lives they are leaving behind. The reality is that UNHCR estimates that 84 million people from over 150 countries were forcibly displaced in 2021 fleeing war, gang violence, sanctioned or ignored violence against women and gay people, political instability, environmental catastrophes and economic impossibilities around the world. You can explore the UNHCR data pages (<https://www.unhcr.org/refugee-statistics/>) to try to comprehend the array of situations that have led to displacement at higher rates than at any other point in history.

Tucked among the rest of world news it can be hard to take in these stories and the numbers that feel too large for our hearts and minds to grasp. But like much of psychiatry, one at a time, the individual stories become lives that are open for navigation and in which our listening and conferred authority can make a small but real difference. Previously I worked full time for the Bellevue/NYU Program for Survivors of Torture providing mental health care alongside medical care and social and legal services to refugees and political asylum seekers. It is no longer my primary job but there are many ways I have found opportunities to continue to work with refugees and asylum seekers since moving to Los Angeles.

International work close to home: In Los Angeles we are very close to a border which serves as a point of entry for refugees and political asylum seekers from around the world. The long history of documented and undocumented crossings of Mexicans at the southern border has often led to a reductive

representation of the migration at this border as an economic problem which racism and politics further transform into a kind of white noise. But beginning in 2017 with the news of caravans of Central Americans and the visible surge in both crossings and deportations again in 2021 after Biden came into office, it has been made clear that multitudes of people from around the world are seeking entry to the United States a few hours from where we live and work.

In the last year I have evaluated or supervised evaluations of individuals from Nicaragua, Ghana, Nigeria, Haiti, Honduras and different regions of Mexico. Most of this work has been providing evaluations for political asylum applications. Pro bono lawyers reach out to physicians and residents trained by Physicians for Human Rights to perform and write up these evaluations. I have worked with both the USC-Keck Human Rights Clinic (<https://sites.usc.edu/keckhumanrights/>) and the UCLA Psychiatry Asylum Clinic (<https://communitypartnerships.ucla.edu/program-search/ucla-psychiatry-asylum-clinic>). Both campuses have provided PHR trainings at least annually. (There is an asynchronous training opportunity coming up in April! <https://phr.org/issues/asylum-and-persecution/asylum-network-trainings/>). Lawyers highly value the evaluations of psychiatrists because the mental health sequelae of torture and flight trauma is harder to visualize and describe for non experts. The title psychiatrist bears tremendous authority in the courtroom. When we restate the events and describe the mental status and how it relates to PTSD or other diagnoses we are translating those overwhelming numbers into an individual, comprehensible story that helps urge a courtroom to protect that one person.

Field work: Quickly after the first large caravans arrived, there were activists from many backgrounds who headed to the border imagining they could be of help. One group that organized and remains there is Refugee Health Alliance or RHA (<https://www.refugeehealthalliance.org/>). The group, originally composed primarily of medical students and residents, continues to run a daily clinic to provide preventative and urgent care to migrants waiting at the border. They also have mobile clinics that enter the many shelters that have been set up near the border. They are staffed by volunteer clinicians who drive down and spend days or hours there and they collaborate with other organizations that are helping to facilitate asylum applications and humanitarian parole letters now that most applicants, post Title 42 (a health screening preventative measure), are required to apply from Mexico rather than entering the United States to seek asylum. I have spent a day working in the clinic, using the donated pharmacy formulary of antibiotics and pain killers, hydroxyzine to sleep, and writing referrals that allowed a haitian woman to get an ultrasound to check her pregnancy. It was a very concrete reminder that people at the border must continue living and surviving every day with minimal resources. I have also led resident groups to participate in asylum evaluations in Tijuana. Crossing there and back in a day not only permits the evaluation to take place but better teaches the evaluators what the conditions are and what the psychological implications of being stopped right there might be.

Although I spent several years in New York City working with asylum seekers, many of whom had spent time in detention and who described detention as an additional point of trauma in their journey, I still managed to imagine detention as something more benign and passive than imprisonment. When I had the opportunity to join a group of clinician-advocates and politicians on a Human Rights First arranged visit to Adelanto Detention Center I blocked my day at work in order to join. (<https://www.humanrightsfirst.org/press-release/la-mayor-garcetti-human-rights-first-visit-detainees-adelanto-immigration-detention>) Seeing the detention setting first hand and speaking to migrants dressed in color coded uniforms in concrete rooms forever changed my understanding of the asylum experience. Detention is the condition of being imprisoned. Witnessing this clarified how the system exacerbates and adds to existing traumatic experiences, treating individuals appealing for asylum as criminals. Entering the settings and systems in which refugees navigate their migration is an important way for psychiatrists to better understand and advocated the mental health implications of displacement. And collaborating with human rights and legal advocacy organizations is another ways psychia-

trists can use their influence.

Remote work: Because of the confluence of high need and Covid, remote evaluations are becoming more acceptable. The enormous backlog of individuals seeking asylum and the reluctance to continue flow through the border at the same rate during covid has led to a new way to try to permit the most urgent cases to cross into the United States. When it is matter of acute safety or medical or psychiatric urgency, individuals can seek “humanitarian parole.” A medical or psychological letter is used in the setting of dire need for treatment and lack of available services to advocate for the asylum process to take place in the United States where the individual may seek appropriate treatment. Through RHA I have been connected with individuals who I video call on Whatsapp to review their history and symptoms and write an abbreviated evaluation recommending permission to cross when the situation does in fact appear urgent. These appeals are often refused but allow us to join in the continual navigation of an overloaded and often hostile entry system.

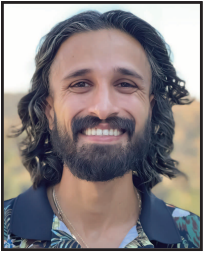
Storytelling/activism: A hard part of this psychiatric work is that most of us are organized around providing treatment and relief. One of the basics of training for asylum evaluations is learning to rein that instinct in as you may never see the individual you are advocating for again. You are trained to not make promises or provide too much certainty or hope as that would be inaccurate. You are only able tell the individual you will be listening to their story to write a report that will help the lawyer explain the case for asylum. You explain to them that some of the questions may be difficult and you can offer them breaks, water, nods of support but no immediate relief from their situation. You can pass on recommendations to the lawyer but this helpful helplessness is a different position than we often sit with. Instead our usefulness is in witnessing the story and translating it into an official language to declare, Yes, these experiences harm people in countless ways the court can't see. Yes, it is hard to tell these stories and both easy and normal to get overwhelmed. And, just as easy to dissociate and appear unaffected. We use our skills to explain an individual's response to extreme stress and in this way become psychiatrist-activists rather than psychiatrist-treaters.

Collaboration: Another interesting piece of this work is the opportunity to collaborate across career paths. The relay of lawyer handing off to psychiatrist, handing back to lawyer and into the courtroom feels important. We get a strong taste of what we know and we get to experience a teamwork that connects the missions of varying career paths. At the border many of the doctors and lawyers are medical students, law students or early career lawyers and doctors—it is a reminder of the big picture in our vocations and in the collective effort of being humane.

Finally, *Resilience:* At Program for Survivors of Torture, I loved the work because it was easy to sit humbly and curiously with people from such different lives and places. The majority of individuals would have never seen a psychiatrist if they had not fled for their lives. Firstly, because most came from countries where psychiatry was minimally available and secondly, because most were functioning members of their communities who's beliefs or identities or general societal chaos led them to drop everything and leave for their safety. They were individuals with functioning attachment and reality testing, stable moods and brave, more often than anxious temperaments. I don't say this to diminish the patients who come seeking psychiatric care in mental health clinics but to shine light on one of the striking experiences of meeting with refugees: It is very often a re-encounter with human resilience. People will face many unimaginable scenarios to stand up for their beliefs, protect their loved ones and to preserve a sense of self. As a psychiatrist I am grateful for the moments I get to bear witness to the strength of humans amidst the turmoil that surrounds us.

Afghanistan: The Trauma Continues

By: Ismatt Niazi, M.D.



“Afghanistan was a peaceful country... People were very peaceful, comfortable, they did not know war or the tragedies that follow”. “Life had so much joy and richness, that you wouldn’t even wonder what else was out there in the world”.

These are quotes from my father and mother, respectively, when describing their home country. My parents were displaced from Afghanistan in the late 70s, after the Soviet-Afghan War. A war that threw Afghanistan into constant chaos and destroyed my parent’s version of Afghanistan and their dreams to ever return.

My parents were among the more fortunate to leave Afghanistan.

My mother traveled to the United States, to help her eldest sister with childcare, when my grandfather told her she could not come back home, forcing her to seek political asylum. A vacation turned staycation, forever.

My father was in America, literally chasing my mother (what a love story!), when the war broke out. He was able to leverage his contacts and his medical doctorate to get a visa and eventually was also granted asylum.

My parents did not experience imprisonment, torture, war, or having to flee the country emergently. They were saved from many of these, unfortunately common, pre-migration traumas.

But they were not saved from loss.

Resettlement does not represent a conclusion to trauma and hardship. My Mom describes keeping busy to distract her from ruminating on all she lost: her favorite vacation spots, her house, her parents, her siblings, her friends, her job, *her life*... all back home. Even today she stays busy, all day, every day. I don’t think she knows how to relax, there are too many demons to run from.

My father battled status dissonance his first many years in America. A proud physician back home, having practiced in Afghanistan, Germany, and Iran, he was now back to studying and having a series of exams to pass to regain the ability to practice medicine. Worst of all, he was unable to work and support his family. Culturally, this is more painful for an Afghan man than any amount of time studying pathology slides and medical textbooks. After years of studying and passing his exams, he finally got his reward, a chance to repeat residency as a foreign medical graduate with an accent, dark complexion, in Omaha, Nebraska, in the 80s.

Life was overwhelming for my parents, as they learned to perfect their English, how to drive, new cultural norms, and how to negotiate raising their family in a culture very different from the only one they ever knew. The later being a common source of tension in many first generation households serving as a vector to spread trauma and abuse.

My parents were lucky.

They were not imprisoned and tortured for opposing governmental oppression. They did not have to flee the country, spending hours hiding in the back of transport vehicles hoping to sneak past govern-

ment check-points into surrounding countries. They did not have to wait for days, outside the Kabul airport, just for a chance to board a plane with the hope, not promise, of safety. They did not have to witness bodies hung from buildings or public killings to install fear and submission for all the opposition. They did not have to duck and cover from bombings and gunfire while they tried to eat dinner. They did not have to see their family members being forcefully escorted out of their home to an unknown location for an indefinite amount of time.

Most Afghans do not share the same fortune as my parents.

Since the Spring of 1978, Afghanistan has been in a near constant war state. From the Soviet-Afghan war, to the resultant Civil War in the 90s, to the US-Taliban war of the 2000s, and the resultant Taliban led state currently in power, Afghanistan has been stripped of many of the qualities *our* parents described to us first generation Afghan-Americans. "*Our Parent's Afghanistan*" is no more.

On August 16th, 2021, the Taliban captured the capital of Afghanistan, Kabul, essentially taking control of the country. Weeks later, after a 20-year occupancy, the United States withdrew the last of its troops from Afghanistan. It is estimated that roughly 130,000 Afghans were evacuated. During the past 20 years, it is estimated that over 300,000 Afghans were directly involved in assisting US forces. These are the Afghans at highest risk for harm to themselves and their families. Simple math suggests that most of these Afghans remain internally displaced, continuing to look for safety in a country on the brink of widespread famine, universal poverty, the COVID19 pandemic, and record setting droughts and natural disasters from climate change.

For those "lucky" enough to leave the country, the hardships do not stop. California has the highest amount of resettled Afghans, with estimates of greater than 5,200 Afghans being resettled since August. Afghan Americans in the area have been leading efforts to help secure social services, basic appliances, transportation, housing, and medical care. Despite these volunteer efforts, resettlement has been difficult, putting added pressure on an already stressed system.

At one point there were 300 unaccompanied children spread across the United States, with variable access to interpretive services, multiple moves from one site to another sometimes with only minutes warning, and with no clear direction on where they would go next. Children, half way across the world from their families, with infinite questions and no answers.

The trauma continues.

History repeats itself, and for Afghanistan it has repeated within a lifetime. If there is a silver lining to such a tragic tale, it may be that there are many Afghan-Americans who can serve to mentor this new generation of resettled Afghans and ease the post-migration stressors that can derail generations. I have proudly witnessed my Afghan colleagues lead evacuation efforts, start relief organizations, and donate their time and services to help in any way they can. Survivor's guilt can be a strong motivator, and the Afghan diaspora is filled with survivors who have a passion to preserve the Afghanistan described to us by our parents. "*Our Parent's Afghanistan*" will live on forever.

The Sky Is Falling!!! – Now What?

Disaster Psychiatry: It's Not Just PTSD

By: Leslie Gise, M.D.



Like a lot of disaster psychiatrists, I got involved with Disaster Psychiatry after September 11th and joined a number of disaster preparedness and response organizations which gave trainings and drills.

Disaster Psychiatry is different from Traditional Psychiatry. The slide below is from Josh Morgenstein, Chair of the APA CPDD (Committee on the Psychiatric Dimensions of Disaster) and Deputy Director of CSTS (Center for the Study of Traumatic Stress) at USUHS (Uniformed Services University of the Health Sciences).

Broad Focus

<u>TRADITIONAL PSYCHIATRY</u>	<u>DISASTER PSYCHIATRY</u>
Individual	Populations
Disease/Disorder	Wellness
Treatment	Prevention
Medical Consultation	Leadership Consultation
Interpersonal Comm.	Crisis & Risk Comm.
Fixed/known facilities	Whenever & wherever

Disaster Psychiatry deals with

populations, not individuals

wellness, not disease or disorder

prevention, not treatment

leadership consultation, not medical consultation

crisis and risk communication, not interpersonal communication

whenever and wherever, not fixed known facilities like inpatient and outpatient psychiatry settings.

Disaster psychiatry is a synthesis of many fields. If you are involved with Emergency Psychiatry, Trauma, Community Psychiatry, Consultation-Liaison Psychiatry, International Psychiatry, Preventive Medicine, etc, there is a place for you in disaster preparedness and response work, and it does not have to be deployment. Almost everyone can play a role and be part of the solution. This slide below is also from Josh.



A core practice of Disaster Psychiatry is Psychological First Aid (PFA).

There are several different versions of Psychological First Aid, but they are all basically the same. The 5 principles are Safety, Calming, Connectedness, Self and Community Efficacy, and Hope.

I taught Psychological First Aid for the Red Cross for 10 years, but in March 2020 at the onset of the covid pandemic, I found that I had to teach it to myself! Checking in on oneself, self-care, and checking in on fellow disaster responders is part of the job of disaster mental health workers.

Disaster response work is stressful and addictive. Responders typically overwork and experience distress. If you are not in good shape, you can't do your best helping others. First responders are one of the vulnerable populations for psychological distress and trauma and are at risk for "compassion fatigue", which is similar to "burnout". "Taking care of yourself" is a major principle of Psychological First Aid.

The APA has a Disaster Listserv which is opened to all APA members. 1/3 of DBs have a DB Disaster Rep and several, like SCPS, have a Disaster Committee. The APA website is being re-designed with a dedicated page for Disaster Psychiatry and resources. And the APA Disaster Course at the Annual meeting is free this year, both in-person and online, and it's in short attendee-friendly segments.

Outreach is a cardinal principle of Disaster Mental Health work. This is sometimes called “walking around therapy” or “the tissue and water brigade”. Even just standing quietly with a survivor who just lost their house and bearing silent witness with them can be calming and foster connectedness. Or if they are watching their house burn down, you can take them out of the direct line of sight which fosters a sense of safety and calming.

In many communities the Red Cross is the major local response organization. Typically there is a call for more Disaster Mental Health Volunteers. As Mental Health Lead for the Maui Red Cross for 20 years, I mostly took call from home. Response workers who were concerned about a survivor's behavior could call and get advice. They would often give the survivor's phone number for follow up the next day. Distressed survivors were generally much better the following day. 90% of people who have symptoms of Acute Stress Disorder, are better within one month.

Besides the Red Cross, there are many other ways to become involved:

MRC, The Medical Reserve Corps

VOAD, Voluntary Organizations Active in Disaster

Hospital and Clinic Disaster Committees

Vibrant Emotional Health, www.vibrant.org

The Physicians Support Line, (888) 409-0141, www.physiciansupportline.com

The new National Suicide Prevention Lifeline 988 going live 7/16/2022

Risk Communication and Messaging

In conclusion, disasters are increasing and there are many ways that psychiatrists can become involved. Disaster preparedness and response work is very rewarding.

Leslie Hartley Gise MD, leslieg!@maui.net, (808) 283-9095

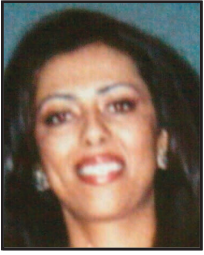
Member APA CPDD, Committee on Psychiatric Dimensions of Disaster

APA HI Assembly Representative

Clinical Professor, John A Burns School of Medicine, University of Hawai'i, Honolulu, HI

Psychiatry & Public Service

By Kavita Khajuria, MD



After a one year pause due the COVID surge, the city of Anaheim resumed its annual two day Health Fair from November 6 -7, 2021, held at the Anaheim Convention Center. Over a thousand members of the public received free mental health, medical, dental, vision, mammogram, acupuncture and chiropractic services, as well as flu and COVID-19 vaccines for adults and children. The number of attendees exceeded the expectations, although perhaps not so surprising, as this was an only chance to see a doctor this year for many of those without insurance.

The public arrived from various parts of southern California, including San Bernadino. As the psychiatry consultant, this was an excellent opportunity for me to meet the public, underserved communities, and learn or refresh knowledge about community conditions and dilemmas, given that most of my clinical practice is behind bars in corrections.

Topics ranged from prolonged bereavement, to childhood OCD, family discord, PTSD, ADHD, psychosomatic conditions, evolving dementias, and parental concern about childhood technology addiction with predictions. Other issues included stormy situations with menopause and involuntary hospitalizations. Some questioned the effects of methamphetamines on the brain, expressed uncertainties about psychiatric medication resumption, or questioned the impact of maternal abuse on adult parenting. The traumatic impact of prisoner release on victims of assault was a riveting and sobering discussion. Consultations included assessments, patient education, support, and provision of referrals and resources, including, but not limited to APA brochures on various mental disorders and afflictions. Contact information for the Lestonnac Free Clinics were provided for follow ups. A group of high school student volunteers asked about the career pathway to becoming a psychiatrist, although the request to shadow evaluations was turned down for obvious confidentiality reasons.

Over 250 medical professionals and other volunteers provided their time and services for this event. For those interested, information on future events can be obtained from the Mayors Office of Anaheim or Anekant Community Center.

Council Highlights

February 10, 2022

Haig Goenjian, M.D., *Secretary*



Outline of Notable Meeting Events and Discussion

The meeting was called to order by Dr. Ijeaku at 7:02 PM.

Sub-agenda topics: (APA- Erin Philp/Kathy Orellana 45 minutes)

Key APA positions, initiatives, and activities (APA SGR)

- APA representatives attended the first part of the meeting, where they provided an update on how they are working with DB's both at the Nationwide and Statewide levels.

1. Nationwide State Government Issues - Led by Erin Philps

Erin Phelps, of the APA's State Relations branch, discussed different ways in which APA worked with DB's on Government Issues. One example she focused on was State Legislation for the collaborative care model, where a primary care provider works with psychiatric clinicians. She offered this type of support to our DB. The APA is also working on eliminating prior authorization with states such as NJ and Maryland. Philp's team can help draft legislation regarding such issues for DB's or State branches of APA.

Another topic she discussed was AB988, the Suicide Hotline, and CA legislation. APA is concerned about all the states in general as only 8 have passed legislation. 988 goes live in July 2022.

Lastly Philp discussed "Scope of Practice." Non physician groups are trying to get the same authority to practice as physicians. She mentioned APP is at minimum looking for a physician safety net for the non-physicians. "If things go wrong...that you or other physicians are available." Philp spoke of psychologists prescribing, up to 10 states may have legislation. APA is working with an outside PR firm to develop materials that will be helpful in those 10 states and nationally. One poll found that 78% of people nationally think a physician should be the ones doing the prescribing for psychiatric medications. This info will be rolled out to the DBs.

2. California

Led by Kathy Orellana Regional Manager of Region 1

Kathy Orellana led the discussion. She began with an example of how the APA has been working with OCPS for the past 2.5 years. She has been working with CSAP as well. Working on model legislation e.g with collaborative care, prior auth, coordinated special care.

Another example is of expanding access to care e.g for young adults with early psychosis - they drafted a bill, they took it to CSAP, and are working on introducing this bill at the next session. Orellana states she believes CA is a leader in health policy. She would like a more intentional relationship with DBs/state chapters. Another example she gave was of Psilocybin legislation concerns. In sum, these were examples used to highlight the point that APA State Government Relations services are available as support to all DBs.

Dr. Shaner asked the representatives regarding the No Surprise Act. The representatives deferred a definitive response, but the below resource is available:

<https://www.psychiatry.org/psychiatrists/practice/practice-management/no-surprises-act-implementation>

tion
 Dr. Goldenberg asked the representatives how to get the best benefits for our members e.g. of our GAC. Philp said they will act when there is agreement amongst the DBs within a state, when asked. Dr. Silverman asked about relations with CMA. Philp mentions APA maintains relations with AMA, e.g they are on the board of scope of practice group. Philp encouraged DB's/APA to work with State MA.
 Dr. Shaner asked if APA had a system in place to do bill tracking across the States. Philp's response: We are backups, not primary, and are staffed with only 4 people for 76 DBs.

Kathy Orellana also offered to be present at GAC meetings.

PRESIDENT'S REPORT

Dr. Ijeaku

A. APA Notification to CA DBs

- Dr. Ijeaku has been in touch with Mary Jo Fitz-Gerald of the APA regarding recent letter to council related to questioning our support of an APA aligned state advocacy group. Clarification by Mary Jo provided and in Drop Box. Our deliberations tonight may affect and influence the APA's response.

B. Mini Documentary Series Project (D+C)

Proceeding well. We have two interviews left.

NEWSLETTER COMMITTEE REPORT

Dr. Goldenberg

Dr. Goldenberg thanked Uchenna Okoye who guest edited the recent Black History Month - Diversity and Inclusion Newsletter.

Next month will be guest edited by Janet Martin and Kristine Eipl And will be the theme of Women and Psychiatry.

TREASURER'S REPORT

Dr. Goldenberg

A. January Financials and Cash on Hand Report

- Income for the month - Loss approx 14k in mutual funds but over budget for dues collection by approx 17.5k. Overall about \$260.00 over budget for January.
- Expenses for the month - Under by approx. 8k
- Total: Approx 79k over cash on hand as compared to last year. This reflects mutual fund gain of 60k, including the 14k loss in January.
- Passed unanimously

PROGRAM REPORT

Dr. Gales

Advances in Psychopharm was on January 29th. The speakers were received well. It was recorded and it will be available for a fee online.

GAC REPORT

Dr. Shaner

After a detailed discussion of the proposed agreements with PPAC and CSAP, the details of the provisions of the competing proposed agreements and the APA's stated concerns about political advocacy on behalf of its members in APA Area 6, it was moved, seconded and passed by a vote of 18 in

favor, 2 opposed and no abstentions, to enter into the proposed agreement with CSAP.

COMMITTEE UPDATES

Chairs/Thelen

A. Disaster - presented by Dr. Chang

Dr. Chang reported on the last event put on with Dr Shepper discussing their experience with disaster work. Upcoming events include Dr. LoAllen – Psychiatric Evaluation of Asylum Seekers. And also one on Psychological First Aid Training.

B. LGBTQI - presented by Mindi

- 1.5 hour program on Sunday march 12th or 27th on Transgender Issues
- Speakers are: Madeleine Lipshie-Williams and Rebecca Gitlin.

C. Alternative Crisis Response - Dr. Wood

- The subcommittee is looking at new updates coming from the state level. Dr. Wood also highlighted that the ACR subcommittee is working closely with NAMI.

D. Access to Care - Gillian Friedman

- Last meeting was a brainstorming session and she is helping spearhead this relatively new subcommittee.

E. Managed Care - Mindi

Dr. Burchuk is reinvigorating the committee. He did put on a presentation last week. There was keen interest with members who are in managed care that were present. Dr. Burchuk is the sole member of the committee and Mindi noted he could benefit from support.

MEMBERSHIP REPORT

Dr. Ijeaku

A. 9 RFMS, and 3 GMS brought in last month. Dr. Ijeaku is hopeful that with the reconciliation of the DB Window, we will have an increase in our membership.

Current Active Membership –923

(January 904)

New members approved unanimously

Meeting adjourned at 9:02 pm by Dr. Ijeaku

On Communication

By Harvard Business Review

Harvard Business School Publishing

208 Pages

\$ 24.95 Paperback

ISBN-13: 978-1422189863

Book reviewed by Kavita Khajuria, MD



Ten articles explore the multifaceted necessities of communication utilizing interesting descriptions of personalities to illustrate the points. Turns out that being an enthusiast, skeptic, follower or a controller - could have implications far beyond the obvious. Authors cite 5 styles of behavior and decision making - revealing for an institutional employee or those in academic facilities, regardless of rank. Other topics include the power of persuasion, the benefits of voluntariness, personal commitment, credibility and reason – while acknowledging the long term consequences of childhood experiences.

Gender and cultural considerations include discussions of linguistic styles, conversational rituals and cultural differences. And bygone are the days of dictatorial hierarchy – nowadays employees and students ask for reasons, rather than lists. Authors encourage emotional stability, flexibility and integrity. And if in doubt as to whether to keep quiet or speak out - the pros of speaking out appear to outweigh the costs of keeping mum.

Other encouragements include taming the grapevine, transmission of values and self-assessment. Personality characteristics are described - including those of 'pitchers' and 'catchers' – an oddly interesting analysis. And for those stressful conversations - authors share their personal perspectives and cite clarity and temperance as essential building blocks. They concede no single method of communication to be golden - what works in one situation could be disastrous in another. Despite the use of labels ('show runner' and 'neophyte' to name a few), information and tools translate as helpful to navigate the potentially nebulous maze of management communication in any field, including psychiatry.



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