

THE MARYLAND PSYCHIATRIST

Winter 2015

Dr. Sally Waddington, MPS President, 2014-15

Dinah Miller, MD Page 2

New Chair at UMMS Professor Bankole Johnson, DSc, MD...

Kathleen Patchan, MD Page 4

Reflections & Photographs of Barbara Young, MD

Barbara Young, MD Page 8

Geetha Jayaram, MD, MBA, wins International Award

Paul McClelland, MD Page 12

Celebrating Rappeport

Bruce Hershfield, MD Page 14

Awakening to Addiction: New Appreciation of an Old Illness

Neil Sandson, MD Page 15

In Memoriam

Stanley Platman, MD

Thomas E. Allen, MD Page 17

John Urbaitis, MD

Paul McClelland, MD Page 19



Barbara Young, MD, THE BLUE ROOM, 1971

What a wealth of diversity we have in our membership! This edition of *The Maryland Psychiatrist* highlights MPS President, Sally Waddington; new Chairman of Psychiatry at the University of Maryland, Professor Bankole Johnson; analyst and accomplished photographer, Barbara Young; and award-winning international leader, Geetha Jayaram. We have more thought-provoking clinical reflections from Neil Sandson. We celebrate Jonas Rappeport's 90th birthday and his many contributions to psychiatry in Maryland and nationally. And finally, we mourn and commemorate the loss of two longtime, beloved members-- Stan Platman and John Urbaitis.

The MPS Editorial Advisory Board welcomes articles from any member. In addition, we encourage artistic contributions by members: poetry, drawings, paintings, etchings, photography, cartoons, other. Contributions may be addressed to Meagan Floyd at mfloyd@mdpsych.org, or to me at either nwahls@sheppardpratt.org or nkwahls@msn.com.

Nancy K. Wahls, MD
Editor

Meet Dr. Sally Waddington, MPS President, 2014- 2015

Don't serve fish sticks and beets...

Dinah Miller, MD



If you are thinking of inviting MPS president Sally Waddington for dinner, I would like to make a few suggestions. Dr. Waddington is a wonderful dinner guest, but don't serve fish sticks and beets – she had her fill on Friday nights in a Catholic girls' boarding school in Ireland. Broccoli, cucumbers, green beans, and watermelon are also on the taboo list, but it is not quite as clear why. And you may want to stick to weekends for your invitation – Dr. Waddington is busy watching Jeopardy! at seven on week nights, and rumor has it she's quite good.

Dr. Waddington is the oldest of four children, and her father was a pilot. She notes, in a sweetly

self-effacing way, "I am not an interesting person." She then goes on to elaborate, "But, I did have an interesting childhood. I lived in a lot of places– Sudan, Nigeria, Zambia, Germany, Kuwait." She notes that her parents lived in Kuwait while she was studying at Trinity College medical school in Dublin and she visited them for a summer, first working as visa clerk at the British Consulate, then doing a rotation in radiology at the hospital there.

"I am not an interesting person, but I did have an interesting childhood; I lived in a lot of places– Sudan, Nigeria, Zambia, Germany, Kuwait."

Her move to the United States was prompted by her marriage to Henry Willett in 1989. Sally met Henry the summer before her last year of medical school in an Irish bar in Atlantic City. She was visiting a friend, and Henry was working as an

"After years of living here– and not quite losing her Irish brogue– Sally became a United States citizen in 2012."

investigating agent for the Immigration and Naturalization Service. After years of living here – and not quite losing her Irish brogue-- Sally became a United States citizen in 2012. Sally and Henry have a daughter, Ciara, who is an

admissions officer at St. Mary's College, and she has two step-daughters and one adorable step-grandson. When she is not leading the MPS, Dr. Waddington has a private practice in Laurel. She also enjoys traveling, gardening, yoga, biking; and she is an avid reader.

“The membership committee was great training, and Joanna Brandt trained me well; I think it helped me understand some of the problems we have because I talked to members and heard their complaints and concerns. It gives me a good idea of what the issues are.”

Dr. Waddington's entrée into MPS leadership began in a serendipitous way. One day she learned she was on the Membership Committee. She had not signed up to be on the committee (at least not intentionally), and she never did figure out how she was put on it. However, Sally went with the flow, and she faithfully attended the meetings, called member after member regarding their unpaid dues, and came up with ways to attract new members. “The membership committee was great training. Joanna Brandt trained me well,” she said, “I think it helped me understand some of the problems we have because I talked to members and heard their complaints and concerns. It gives me a good idea of what the issues are.”

Dr. Waddington eventually became committee Chair, and then was elected to the MPS Council. When the Nominations & Elections committee met, she was a natural choice for the Executive Committee. Three months into her term as president, Sally says that the summer, as expected, has been fairly quiet. “I expect it to get

much busier in the fall and during the legislative session.” The Executive Committee (EC) has been following the progress of the DHMH work group as they formulate recommendations for the legislature regarding involuntary outpatient commitment. The EC has also been working on revisions of the Uniform Treatment Plan forms – see the President's column in the September issue of the MPS News for more details about that.

When asked about her vision for the MPS, Dr. Waddington responded: “To maintain our fiscal health and our advocacy for all our members. I am approaching it from a membership perspective since that is where I came from. I want to hear what members have to say, and I am more than open to members calling me. We are hoping to start a new initiative, hopefully with grant funding, to get the Hopkins residents on board. We are looking at ways of retaining early career psychiatrists, which is where we lose a lot of our membership. I would welcome any suggestions from any of those quarters. We are waiting to hear from the APA about a pop-up grant to help.” Dr. Waddington notes that women are sometimes

“I want to hear what members have to say, and I am more than open to members calling me.”

hesitant to get involved in MPS leadership positions. “I think women feel anxious, like they don't have the skills; they don't feel confident enough. And there is also a sense that the leadership is made up from institutions; but in fact, we have a lot of private practice psychiatrists.”

If you'd like to chat with Sally Waddington, do feel free to call, or even to invite her to dinner; but do get clearance on the vegetables. 🥬

New Chairman of Psychiatry at University of Maryland

Interview with Professor Bankole Johnson, DSc, MD, MBChB, MPhil, FRCPsych, DFAPA, FACFEI

Kathleen Patchan, MD

KP: What made you first interested in psychiatry?

BJ: I became interested in neurological mechanisms of the brain, specifically as they relate to addiction. Much of my research has examined how genetics affect alcoholism by looking at allelic differences on genes. I've also focused on targeting specific serotonergic pathways and serotonin transporters to treat alcoholism. Historically, many studies have looked at behavioral approaches to treat alcohol use disorders. For example, certain medications, such as Antabuse, penalize patients if they ingest alcohol. My work is to develop medications that don't punish patients but target specific markers that can tailor treatment to the disorder.

KP: What made you interested in coming to the US?

BJ: I was invited to give a lecture tour in the United States, and one of my stops was the University of Texas in Houston. When I returned home to England, I received an offer to join the faculty at the University of Texas believing this to be a short-term appointment. Now-- 23 years later-- I am still in the United States and loving it, especially here at the University of Maryland.



KP: Did anyone serve as a mentor to you? If so, what personal qualities made their presence so influential?

BJ: There was a chap at Oxford called Dr. Philip Cowen. He was a good example of a physician-scholar. He worked on grants and did research and had some clinical tasks to do. He was very kind, generous of his time, and was engaging and interested in seeking answers to questions.

KP: Why were you interested in coming to the University of Maryland?

BJ: I was interested in coming to the University of Maryland because of its focus on the brain and mechanisms of the brain. This focus was developed by former Chairs and is one of the reasons that the Maryland Psychiatric Research Center has focused on schizophrenia research. My research background in psychopharmacology and treating addictions made it a good fit. Also, I am interested in working with pharmaceutical industries in the field of substance abuse. This is something I would like to promote at the University of Maryland School of Medicine.

KP: How has your experience in Maryland been so far?

BJ: The Chair for the Department of Psychiatry was recently endowed by the Taylor family.* Also I've been named Director of the Brain Science Research Consortium Unit. <http://medschool.umaryland.edu/BSRCU/>. This initiative has been good because it brings together different Department Chairs, faculty, and prominent leaders across the School of Medicine to discuss the underpinnings of the brain and specifically pathophysiology, including neural inflammation.

KP: Where do you see the Department heading over the next five years?

BJ: I want to see the Department study different medications and treatments and advance those treatments into clinical trials. We recently had a retreat which will allow us to develop programs, projects, and grants for the University to find a cure, or what I would call stable and highly efficacious treatments for a wide range of neurological brain disorders and neuropsychiatric disorders.

“We recently opened the Clinical Neurobehavioral Center in Waterloo Crossing. This center is the first facility in the region to conduct... clinical trials, specifically with a focus on... alcohol use disorders.”

We recently opened the Clinical Neurobehavioral Center in Waterloo Crossing, which is devoted to clinical studies of the brain, neurological as well as neuropsychiatric disorders. <http://patch.com/maryland/columbia/new-center-columbia-research-alcohol-drug-disorders-0> This

center is the first facility in the region to conduct clinical trials specifically with a focus on impulse and behavioral disorders, such as alcohol use disorders and gambling. This catchment area will recruit patients from northern Washington, DC, Columbia, and west Baltimore.

My hope is that this will be a landmark clinical site for doing high-end, top-notch, state-of-the-art clinical studies in neuropsychiatric disorders, neurological disorders, and all disorders related to the brain. The first study that we'll focus on is continuing the work on the genetics of alcoholism and looking at pharmacogenetic treatments for alcohol use disorders. We'll then probably do some work that involves a combination of magnetic imaging to see the abnormalities in the genetics to understand the underpinnings of the abnormality.

KP: On a personal note, what are your goals for residents in the Department?

BJ: We've introduced certain new programs into the Department. One of my goals is for residents to have a lot of international exposure.

There will be a rotation at the Centre for the Resolution of Intractable Conflict in the United Kingdom. Residents will work with a psychiatry colleague of mine, Dr. Alderdice. This colleague uses psychiatric techniques to tackle counter-terrorism. I think this is something that residents and fellows would not get the experience with at home.

The second is a child program rotation in Costa Rica. I just signed the Memorandum of Understanding. This is at the Hospital De Niños in Costa Rica, and our residents and fellows will get great experience with integrative care there. Their psychiatry child fellows do pediatric clinical care, even working on child ICUs and with families, while doing child psychiatry. Most of their practice is outside the hospital because they actually see patients in the home. I thought this would be a great model of integrative care, to practice pediatrics and provide support for the whole family in the home.

We also are beefing up Grand Rounds and will have a lecture series of six to eight new external speakers, which the

department is funding. I'm hoping to have a big drive for education.

Research-wise, we're working on a mentorship program, whereby residents and fellows who start off and want to have a career in research can find a mentor. We're trying to make the residency program more scholarly, interesting, and variegated.

KP: Aside from your role as a Department Chair and researcher, what would you like people to know about you?

BJ: I'm very keen on life-work balance, even though with this new job there's so much work. It's important to make sure that people look out for their families and are supported by their families and work in an environment where they feel they are part of a larger family or second family.

KP: Given renewed health policy interest in Psychiatry, what policy changes do you expect or hope to see in Maryland?

BJ: We're working to try to encourage the Department of Health and Mental Hygiene to fund one of our vision projects to start an urban violence prevention program. This is particularly pertinent since we received the sad news that we lost somebody at the university due to random violence. If we are able to get support for this, it would be extremely important for us to work on conflict

“There will be a rotation at the Centre for the Resolution of Intractable Conflict... in the United Kingdom. Residents will work with a... colleague of mine [who] uses psychiatric techniques to tackle counter-terrorism.”

“[There will be] a child program rotation in Costa Rica... at the Hospital De Niños, and our residents and fellows will get great experience with integrative care there...”

resolution and decrease violence in the city of Baltimore. We want to work with other Departments and other schools; we want this to be city-wide.

KP: Where do you see the role of psychiatrists heading over the next several years?

BJ: Psychiatrists are becoming more important to the health system in general, primarily because of changes brought about by the Affordable Healthcare Act. Psychiatrists will now become more involved in hospital care; we're expanding and focusing our consultation-liaison service to that effect. Psychiatrists are becoming more involved in reducing length of stay and in following up with patients so that they do not get readmitted to the hospital.

Psychiatrists are going to become more involved in the new wave of general health care planning and integrative care. So, I think that the role of psychiatry and the clinical practice of psychiatry are very different than they were five years ago. The role of research psychiatry will be fundamentally different as we move more and more into the world of personalized medicine and domain-based treatments of psychiatric disorders.

KP: How do you think the Maryland Psychiatric Society (MPS) can be helpful to you and the department?

BJ: I think it would be important for all of our residents and fellows to take part and become involved in MPS and to be involved in the APA; I strongly encourage them to be members of both. It's very important for psychiatrists to develop a true esprit de corps in Maryland and to know who their colleagues are in order for us to work as a community and for us to tackle projects together. 🐼

"...it would be important for all... residents and fellows to... become involved in MPS and to be involved in the APA..."



*Dr. Johnson is The Dr. Irving J. Taylor Professor and Chair of Psychiatry at the University of Maryland School of Medicine.

Creativity in the life of an Analyst

Barbara Young, MD Barbara Young, MD

I was born ambidextrous, but was taught to write with my right hand. That intellectual half of myself functioned well enough to get me through medical school, but it was not the full true me. My creative half first emerged when I started treating patients during my psychiatric residency. Adjusting the treatment to meet the needs of the patients came naturally, and I was fortunate enough to have Dr. John C. Whitehorn as a professor. He had funds available to keep patients in the hospital for months, if necessary, for the benefit of residents' education.

Jamie was a Peabody student who was having musical hallucinations and who walked in front of a streetcar. She was born after her father died, and her mother gave her to an aunt. When Jamie was a year old, she was put in an orphanage. There she managed to call attention to herself by being "Little Mary Sunshine;" but, at 12, when she saw a smile on the face of the woman who was beating her, she escaped the orphanage and returned to her mother. With no real bond to her mother, she took up her father's violin and taught herself to play. The violin became a "mother figure" that would not abandon her. Finally, accepted to school at Peabody, she collapsed.

This is when I learned that, if a patient has suffered such severe trauma as an infant, she must have the opportunity in the hospital to regress and actually re-live that agonizing longing in order to get better. Each night when I made my rounds, I spent some time visiting with her and gave her a hug. Yet when I tried to go out the door, she had my leg locked in her embrace. As time passed, she was able to come to my office, where she sat on the floor rocking a pillow as though it were a baby. Jamie recovered, worked, married, played in a regional orchestra and



Self Portrait, 1969

several chamber groups. When she approached her death, she left money to Hopkins so that others could have the opportunity she had been given.

After I started my private practice, Dr. X was sent to me with a diagnosis of schizophrenia. I disagreed with the diagnosis. He was severely suicidal. We discovered that there remained a symbiotic tie with his father who had raised him so that all his actions were automatic. He was living a false life to keep from having his true self destroyed. From the couch, he asked me to keep silent, but to stay with him as he literally struggled to speak in his own voice. Before he left he was actually talking *with* me.*

“What I would like to emphasize is the importance of creativity: how a violin, a cello, a camera, a pen or computer can be a substitute mother or supportive father figure...”

What I would like to emphasize is the importance of creativity: how a violin, a cello, a camera, a pen or computer can be a substitute mother or supportive father figure that serves as a solid foundation enabling us to survive. I floated through my lonely adolescence on my cello until I got to medical school and met young people like me. In college I had a glimpse of the joy that was to come. Our string quartet was practicing. The violin teacher put the second movement of a quartet by Anton Rubenstein on our music racks. It was simple enough that we could play it all the way through without rehearsing. When we had finished, we looked at each other: “Did we actually do that?”

Many years passed. When I finished my analytic training and was in private practice, I developed spring allergies. Knowing how hard I was working, my wise internist, Dr. Charlotte McCarthy, advised me: “You are depressed. Eat lunch with your friends. Don’t talk a long time on the phone. Each evening, take a walk.” After dinner I listened to Beethoven’s late string quartets. *If he could suffer and surmount that suffering, so could I.*



Twilight Parade, 1965

Charlotte could not have realized how appropriate her recommendations were. On my evening walks, I reconnected with the world of nature—the world I had shared with my father. (As a child

some of my happiest times had been going to the woods to see the wild flowers; watching the red-headed woodpecker swooping over the road ahead; sitting beside him unselfconsciously singing a song I was making up, with no awareness that he could hear). We have to assume that the left-handed half of myself—my creative half—has its roots in my love of my father and his love for me.

“For the first time in my life I feel like I’ve had enough to eat!’ Finally that left-handed part of me—the real me who had been perpetually hungry, unfulfilled—had found a way to be satisfied.”

I began to identify the trees in my neighborhood. I watched the mischief of the cats. I visited with my neighbors. Planning my future, I would be like Henry James. If the tenement is haunted, go abroad. I went to the international analytic meetings in Paris. When my friends returned to Baltimore I was lonely. With a map in hand, I headed for the Impressionist paintings in the Jeu de Paume, and there I felt something springing to life inside me. I wanted to cry out with joy. I then rested for two weeks on the Riviera. As I was swimming lazily on my back in the calm sea, the tide drifted me into the rocks. Shaken, I sat on a rock contemplating my future. *Can I retain this contented joyful feeling when I get home?* A story came to my mind: “How Much Battering can a Body Stand?” I ran up to my room and wrote. I was fully alive. I would take more time off from my practice to write. Within a year, a camera replaced the pen. There were many ‘Ah-ha’ moments as I wandered around Harbour Island in the Bahamas. The light. The colors on the houses. My study of those friendly people as they went about their daily lives lasted 40 years.

My patients accepted my long absences. After my second summer safari, I wrote to a friend, “For the first time in my life I feel like I’ve had enough to eat!” Finally that left-handed part of me—the real me who had been perpetually hungry, unfulfilled—had found a way to be satisfied. Without realizing it, I had played a vital role in my parents’ and my patients’ lives. Did I have a right to use some of this energy for myself? At the beginning of my photographic career, I must have questioned this because—after an exhibition in which my work was being acknowledged— I stepped in front of a car. If my friend had not pulled me back, that would have been the end of the photography— and me.

At the time I discovered that no gallery carried color photographs, I was referred to Edward Steichen, head of photography at the Museum of Modern Art. He asked for *Golden Leaves* for their permanent collection. On February 21, 1962 he wrote me: “*Golden Leaves* did give the feeling of what might be behind a troubled mind as expressed in the twisted turbulences one finds in nature.” And, when I showed my photographs to the head of Magnum in Zurich, Rosselina Bischoff, she caressed them gently and likened them to the Zen Buddha gardens in which nature is arranged to represent various life forces.



Golden Leaves, 1959



The Blue Room, 1971

When I am taking a picture, I am so busy setting the camera to capture what I see that it does not occur to me what significance the picture may be conveying to me or to the viewer. In 1971, my friend Dr. Hugh Davis was dismantling three row houses near Johns Hopkins Hospital. He “saw” the photograph and urged me to come right away to capture it. Teetering on the insecure floorboards, I set the Hasselblad on a tripod so I could get as much depth of field as possible. *The Blue Room* is my most popular image. The light and shades of blue attract. Then I began to see the row of rooms as a journey—my journey. The discarded bathtub and radiator in the first room represent the poverty of the Great Depression I left when I began my journey from Illinois; the narrow slit of light at the end of row of rooms is actually a view of the Johns Hopkins School of Medicine where I arrived in 1942.

There are times when a voice inside commands me to seek out a picture—when I am in need of a photograph to heal myself. In the summer of 1965, I was incorrectly diagnosed with cancer of the ovary. The surgery was major. I returned to work. There was no time to face what I felt at being so close to death. When I arrived at

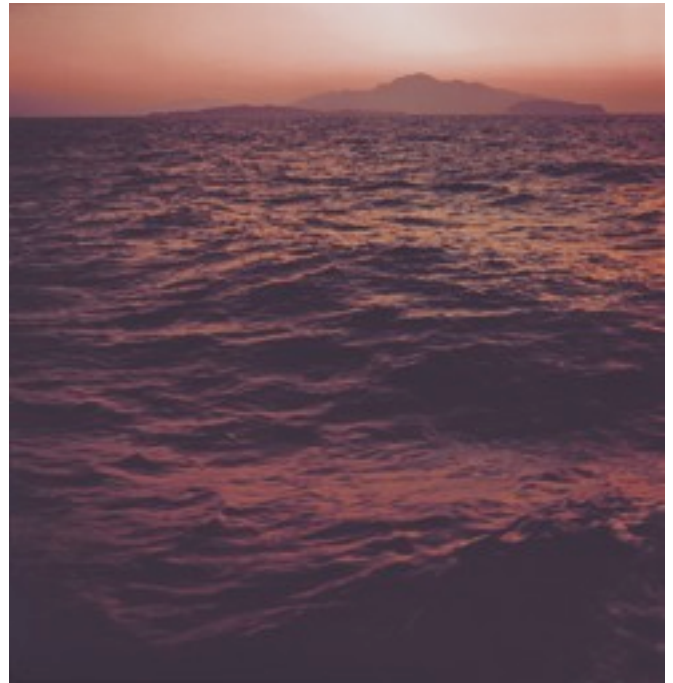
Harbour Island in 1966, a voice told me to put black and white in the camera and go right to work. Walking down a narrow sidewalk towards the beach, I was attracted by two trees—one deciduous and one evergreen—that were arching across the walk, the delicate tendrils of each tree intertwining with the other. As I crawled around the tree trying to get the best angle to capture this intimate connection, I began to shake. Death is forever entwined with life. When I arrived at my island refuge the following year, I went immediately to check on my trees. The one I had thought was deciduous was gone—sawed off at the ground. It *had* been dead. The stark photos of the Bahama trees that I call *Kiss* and *Loss*, exist to remind me of my close encounter with death.



Kiss, 1965/66



Loss, 1966/67



The Wine-dark Sea, 1968

I turned 94 in October. I can no longer travel; but one look at *The Wine-dark Sea*, and I am sailing into the Greek island of Santorini. I can revisit France, England, Italy, Spain, and Harbour Island any time I chose. Now, with a little camera, I record the views from my windows-- the sculptural march of the trees in my backyard. And I am hoping that two recent photos, *Vanishing Sun* and *Dancing Shadows*, will perform the same magic as *Kiss* and *Loss*, and buy me some time so I can finish the therapy with my few remaining patients and and can hold in my hand the book I have recently written: *The Persona of Ingmar Bergman: Conquering Demons Through Film*, which is soon to be published by Rowman & Littlefield.



*For more regarding the case on page 8, please reference-- "Rebirth at Forty: Photographs as Transitional Objects." *International Journal of Applied Psychoanalytic Studies*, V. 1, No. 2, 2004.

Maryland Psychiatrist Abroad

Geetha Jayaram, MD, MBA, wins International Award

Paul McClelland, MD

Maanasi* is a remarkable humanitarian project that offers care to six million households in an impoverished region of Southern India. It now serves as an international model for integrated medical and psychiatric care. Its creator is Dr. Geetha Jayaram, whose remarkable career serves as a model for physicians everywhere.

Dr. Jayaram has been recognized for this project and her many other achievements-- including teaching in India, Australia, and the United Kingdom-- by being named the 2015 winner of the Rotary Foundation Global Alumni Service to Humanity Award.

Maanasi ("of sound mind" in Kannada, the predominant local language) was profiled by Eve Bender in Psychiatric News [<http://psychnews.psychiatryonline.org/doi/full/10.1176/pn.41.6.0024>] and has also been captured in a film.

The program targets indigent women and children with mental illnesses and is funded by donations from Rotary clubs from America, India and elsewhere, as well as by other donations. Treatment and outreach services are provided free of charge in villages and homes, as well as in a clinic in Mugalor. The clinic is a joint effort of the Departments of Medicine and Psychiatry at St. John's Medical College in nearby Bangalore and provides integrated medical and psychiatric evaluations and care. Four outreach staff members travel throughout the region to provide

follow-up care and medication supervision for over 1600 active patients.

Dr. Jayaram was invited to present on Maanasi at last year's meeting of the WHO's Mental Health Gap Action Program. The program is now twelve years old and thriving. Capitalizing on Bangalore's reputation as the software capital of Southern Asia and the fact that over 80% of rural homes have a cell phone, a telemedicine

component is now being developed. Bender's article and the film provide a moving account of the cultural and other hurdles overcome in the preliminary survey of 12,000 households in 25 villages.

Dr. Jayaram was born and raised in Bangalore, where her parents were deeply committed to public service. She volunteered in Rotary projects during her undergraduate and medical school education at St.

John's College and Hospital in Bangalore. She completed her residency training (1981) and a fellowship (1982) at Johns Hopkins, after which she worked in community mental health clinics in Laurel in order to be more available to her two young children. While doing this, she succeeded in promoting community involvement, finding resources for transportation, and developing other creative solutions to overcome funding limitations. She then returned to Johns Hopkins, where she worked in the Community Psychiatry Program before joining Dr. Jeffrey Janofsky as co-attending on the Community Psychiatry's inpatient unit.



Dr. Jayaram is now an Associate Professor of Psychiatry at Johns Hopkins and the author of two books, with a third to be published soon, and many articles on an unusually broad range of topics drawn from her work in this country and in India. She has also served a term as the MPS Representative to the APA Assembly.

When their two children were grown, Geetha and her husband moved to an extraordinary home of their design in western Howard County. Both remain very active members of the Rotary, having recently organized the Rotary Club of Howard West. The Rotary is an international service organization, which originated in Chicago, where members “rotated” meeting sites among their offices. It has the unique credential of using only nine per cent of donations for fundraising and administrative expenses. Its Global Alumnus Award is granted annually to one of its 1.3 million members for achieving professional distinction and performing sustainable service that positively affects the international community. Recent recipients have included Maya Ajmera, who founded the Global Fund for Children, and a group of individuals who played a leading role in eradicating polio in India.



Dr. Jayaram was honored for her 15 years of work organizing and leading Maanasi, but also for many other accomplishments. For example, she has also led an international research project associated with the Indigo Foundation, the results of which were published in Lancet in November 2012. 🇮🇳

*Interested readers can contribute to Maanasi by sending checks to the Rotary Club of Howard West Foundation.

Eyes Wide Open: Celebration of an Icon

Jonas Rappeport, MD, turns 90

Bruce Hershfield, MD

On October 18th, 2014, about 130 people gathered at Broadmead in Hunt Valley to congratulate Dr. Jonas Rappeport on his 90th birthday. The attendees included about ten of his former Forensic Psychiatry fellows, many of his friends, colleagues and neighbors, and his three daughters and their spouses and most of his grandchildren.



Some of the attendees spoke up about the influence that he has had on their lives. A few of the people have known him since elementary school or high school. Some commented on what he has done for psychiatry locally and others on the influence he has had on forensic psychiatry throughout the country and the world. One person said that Jonas has been like a father to him.

Dr. Rappeport had a speech prepared, but felt so overwhelmed that instead he said something like, 'I thank you for all the kind comments you have made. It makes me feel like this could be a

memorial service, but I'm lucky enough to have my eyes open.'

There are indeed many people who are happy to celebrate that Jonas Rappeport still has his eyes open— and that he is still able to show us how much good one person can do in the world. 🌟



“Some commented on what he has done for psychiatry locally and others on the influence he has had on forensic psychiatry throughout the country and the world.”

Awakening to Addiction:

New Appreciation for an Old Illness

Neil Sandson, MD



About three months ago, I lost a little bit of my innocence. Here's what happened.

I was treating a 26 year-old man who had returned from Afghanistan a few years ago. He had an escalating drug habit. Cannabis was his drug of choice, but opiates, benzodiazepines, and cocaine also played significant roles. Curiously, he did not care much for alcohol. He was recently married and had a 3 month-old son. He had presented himself for inpatient treatment due to escalating paranoia, menacing behavior, and anxiety. He portrayed his drug use as a maladaptive attempt at self-treatment for PTSD symptoms. Initial history additionally suggested a bipolar diathesis co-morbid with his substance use. With a few days of abstinence and initiation of an atypical antipsychotic, his paranoia completely remitted. His anxiety was significantly reduced. He was admitted on a Tuesday, stayed through the weekend, and on Monday I had been planning to transfer him to a sub-acute unit for longer-term inpatient treatment, followed by a residential substance abuse rehabilitation program.

Prior to meeting with him on Monday, my social worker received a call from his wife, who informed us that she was concerned about some Facebook entries her husband had made from our unit over the weekend. He had reportedly conveyed to a friend his intention to "hang with him and smoke some blunts." We briskly arranged for the wife to come to the unit, and we had a family meeting that same Monday morning. I made my pitch for transitioning into the long-term treatment track, about which he had earlier expressed interest; but he then revealed that he felt he didn't need that—he missed his son, and he wanted to return home with a plan to begin outpatient care in earnest. I shared with him my concern that he was

responding to cravings to use and that he seemed likely to relapse and fall through the cracks if he made this choice. At that point, he dropped all pretense of investment in treatment and made it clear that he now felt better, could "handle it", and just wanted to leave. Just to be clear, there was no longer any endorsement of the notion that he needed to get high to numb his pain; he just wanted to have a good time. Right on cue, his wife made it clear to him that, if he made this choice, he was not welcome back in their home and would have to be separated from her and their son.

I was ready for this. This was when tough love and the realization of the magnitude of the choice before him would work their familiar magic, and he would agree to a meaningful course of treatment however grudgingly. This time, however, the other shoe didn't drop. In an utterly indifferent manner, as if he decided to go with the turkey club rather than the chicken salad, he said, "I can live with that."

Perhaps some of you think I shouldn't have been surprised, but I was. Following the births of my children, oxytocin hit me and hit hard (three cheers for the prairie voles!), so I have a particular blind spot when it comes to hurling one's own children under the bus. I often find it hard to imagine and understand what enables someone to make a choice like this. Probably he didn't have a strong and/or positive sense of self; probably on some level drugs did make his life more tolerable; but more than anything else he did not seem pushed to drug use by his distress and discomfort, but rather he seemed drawn to use by the neurochemical rewards. Of course we are all aware that euphorogenic drugs foster addictive behavior, but we are so familiar with this basic truth that I suspect we don't often reflect on just

how profoundly drugs can undermine essential aspects of what make us human. I remember being taught in college about a particular rat experiment, in which rats were separated from familiar rewards by an electrically charged grid. They had to cross the grid to access the reward. There was a magnitude of current that would suffice to keep a starving rat from a known food source. But take that same rat, addict it to cocaine, separate it from the known cocaine source with the same grid and current, and guess what? Yup, it crosses, and readily at that.

When I think of what separates us from most animals beyond cognitive complexity, I think about moral sense, awareness of right and wrong, principles, what we aspire to— that sort of thing. What I see so often in my addicted patients is that they are able still to discern what they “should” do, but they consistently fail to make choices consistent with these understandings and beliefs. Does addiction strip them of the ability to make these choices? In most cases, I think the answer is somewhere between “no” and “not quite” although addiction certainly presents challenges to the reliable exercise of volition. But sometimes, albeit infrequently, I think the answer is “yes.” I don’t have much counter-transference trouble with those who struggle unsuccessfully with addiction. Troubled people are grappling with something much bigger than they are, and we collaborate with them in this struggle. Setbacks are inevitable, but with patience and appropriate expectations we can guide and support our patients on their complex and sometimes treacherous paths to recovery. What I have a hard time with, in my gut and heart, are the unambivalent addicts. I believe them to be comparatively less common, but these are folks who are generally drawn to drugs by the rewards and not driven to them to escape from or otherwise numb various forms of discomfort and distress. If they had the wherewithal to do so, they would gladly be high and stay high as often as possible. That is their passion. That is what

they live for. That is what they love, to the exclusion of all else. When they do present for what we then euphemistically refer to as “treatment,” it has more to do with avoidance of adverse consequences arising from their behavior or in some other way encountering the non-sustainability of their behavior. As soon as they can do so, they return to using, without any regret or remorse.

When I am “treating” one of these folks, I find myself either becoming emotionally disengaged, frustrated and/or angry, or consoling myself that they are so fundamentally lesioned as to be operating on the level of that poor addicted rat, and thus not able to fully access the range of moral decision-making that makes us quintessentially human.

Am I right? Is this a defense I’ve adopted so I can spare myself the full brunt of my own frustration and anger? They’re not mutually exclusive, I suppose. I do know this. I don’t like feeling helpless in the face of my patients’ psychopathology. Neither do I enjoy regarding my patients as something less than fully human.

I don’t have any easy answers as to how to navigate this quagmire. But it seems to me that from the standpoints of pervasiveness and devastation, of all the evils that people inflict on each other, the facilitation of addiction is surely one of the worst. Sadly, this is not a cause célèbre, even within the mental health world. It is too much a disorder of doing versus being to generate the sympathies upon which funding often depends; but that is small consolation to the addicted and those whose lives are wrecked as collateral damage. I wish I had something profound and inspiring with which to end.

Albeit late in my career, I have finally recognized how important the struggle against addiction truly is. Although it is a daunting task, I know I’m in good company. 🌟

Stanley Platman, MD, 1934- 2014

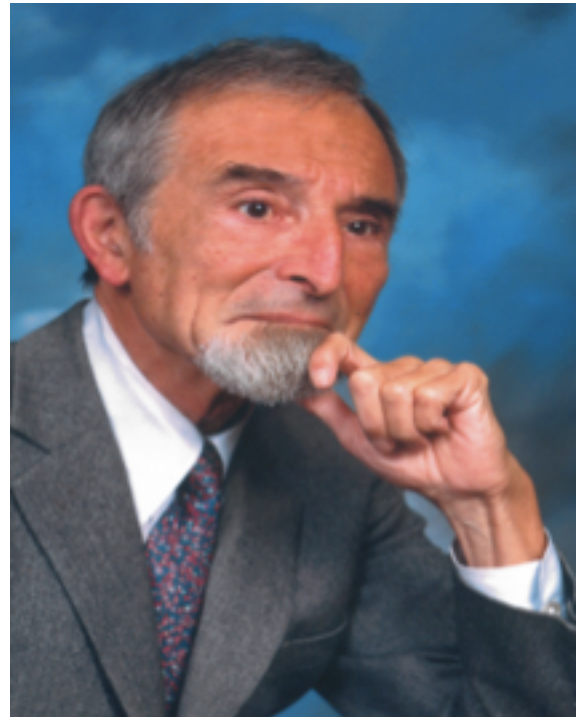
Thomas E. Allen, M.D.

“I think try not to get caught up in doing something for the rest of your life straight away. Get some experience. I think you need to travel. I think you need to look at various different sorts of populations and functions. I think too many young psychiatrists only train. They get their boards, and they are suddenly seeing patients. And they practice for the rest of their life. That’s, I think, an extraordinarily narrow way of growth, and I think you grow by experience. Certainly helped me grow.”

This was Dr. Platman’s answer to Dr. John Buckley’s question December 12, 2011, during the oral history interview on what advice he would give to a young psychiatrist. It is advice that he lived by fully.

Stan was born in England; went to medical school there at the age of 17; and graduated from a six-year medical program at age 23. He was interested in research, and, during medical school, he spent six months in Israel studying thyroid disease. After medical school he was “called up” by the government and joined the colonial service instead of the Armed Services. He was sent to Swaziland in South Africa where he provided very basic primary care services. He was a trouble-maker there, and the Governor sent him away to work in a psychiatric hospital in South Africa; and he became a psychiatric resident at the Witwatersrand University in Johannesburg. It was a good experience and afterward he returned to London where he qualified in Internal Medicine. He then took a fellowship in the United States at Columbia University doing research on thyroid disease again and its relationship to psychiatry. When that fellowship ended he was going to return to England, but instead he got a fellowship running the Metabolic Unit at the Psychiatric Institute at

Columbia. This is where I first met him. He was working on a project trying to understand how lithium worked and what metabolic effect this salt was having on the body. He was working under a psychiatrist who was one of the American pioneers in the use of lithium for manic patients. He continued working on that project for six years; then he was recruited by a senior psychiatrist who was opening a new psychiatric hospital in Brooklyn in 1969 to do research in the area of service delivery. It was just at the time when some of the Kennedy mental health initiatives were bearing fruit, and



Stan took the job. During that period, he was contacted by Christchurch University in New Zealand and was offered the Chairmanship of its Psychiatric Program, which he declined, with later regrets.

Shortly afterward, he was offered the Directorship of an integrated Community Mental Health Center and State Hospital, and he was excited to run such an experimental

program-- something relatively new at the time. He was soon asked to become the Western Regional Director of Mental Health for the State of New York and finally was offered the job of Deputy Commissioner of Mental Health for New York State in 1976. He decided not to take it, but instead that year took an offer from Maryland to become Assistant Secretary for Health and Director of Mental Health, Mental Retardation and Addictions. He also joined the Hopkins School of Public Health. He continued in these roles for eight years, but left when Governor Donald Shaefer appointed Adelle Wilzak to the position of Secretary of Health. For the first time he did not have an institutional affiliation or employment. He became a consultant to mental health systems in other states and to private psychiatric facilities in South Africa and tried to mitigate the effect of Apartheid, a policy that appalled him. He also began to practice and became Chair of the Psychiatry Department at North Charles General Hospital and consulted at Rosewood. Later Hopkins took over North Charles and Wyman Park Hospital, and Dr. Platman became chair of both psychiatric departments. Then Hopkins abruptly decided to close both hospitals as managed care put pressure on hospital bed utilization. Dr. Platman fought this and got the health planning commission to rule that they could not close the psychiatric units unless they provided funds to open another psychiatric unit in the area. This led to the psychiatric unit at Union Memorial Hospital.

In 1990, the President of Med Chi, a colleague who was familiar with Dr. Platman's work, appointed him to chair the Physician Rehabilitation Program at Med Chi. This was a volunteer job that required many hours of work over many years and was really a model for programs in other states. In a quirky trick of fate, the legislature in 2003, despite positive reviews by outside consultants, decided to put

the authority and funding of the program under the Maryland Board of Physicians. The Board and Executive Director at that time issued an *RFP* which threatened the privacy of non Board-referred participants in the program. Dr. Platman, in an MPS News article in 2004, informed MPS members about this threat. Med Chi and the MPS rallied around Dr. Platman's courageous struggles to preserve something very important. It led for a period of time to two programs, one run by the Board and one run by Med Chi under Dr. Platman. Eventually the Board discovered the costs of running the program were higher than they expected. It also found that physicians did not choose to self-refer, and that federal and state regulations restricted the disclosures that could be made to the Board thus preventing the direct access into participant files that the Board had deemed desirable. The Board and Med Chi reached an agreement in 2010 that has proved satisfactory to both parties, creating two programs: one for Board-referred cases and the other for non Board-referred cases to which the Board does not have access. This was largely due to the skilled work of Dr. Platman and to his very highly developed ethical sense.

In later years he continued to keep an exhausting pace despite early Parkinsonism. He was devoted to all of the patients with whom he worked, and he always had an open mind and great compassion. People who worked with him, as I did, felt it was a privilege to do so. He will be missed, and psychiatry has lost a "man for all seasons." 🌸

John Urbaitis, MD, 1941- 2014

Paul McClelland, MD

Dr. John Urbaitis died unexpectedly August 14, 2014, at the age of 73, while attending the annual music festival in Edinburgh, Scotland. He has been an outstanding leader of the Maryland Psychiatric Society for decades, while also making many contributions to the American Psychiatric Association, Sinai and Johns Hopkins Hospitals, the Mental Health Association of Maryland, and elsewhere. He will be greatly missed by his many friends, colleagues, and patients.

Dr. Urbaitis graduated from Cornell University Medical School and completed an internship in Internal Medicine in Brooklyn before spending two years of military service at the National Institutes of Health's Clinical Research Center in Kentucky. In 1969 he came to Baltimore to undergo residency training at Johns Hopkins. He then led psychiatric emergency services for two years before being appointed director of its Community Psychiatry Program.

Dr. Urbaitis left Johns Hopkins in 1977 to become the Associate Chief of Psychiatry at Sinai. He would remain there until his retirement last year, serving as Chief of Psychiatry from 1991 through 1996. A gifted

clinician and researcher, he was a leader in the treatment of psychiatric emergencies, publishing a book, book chapters and papers on this subject. He also published studies of drug dependence, depression and neuropsychology.

A longtime advocate for community mental health, Dr. Urbaitis was the founding director

of the Maryland Council of Community Mental Health Centers. He served for many years on the Board of Directors of Fellowship House, a rehabilitation center for those with severe and persistent mental illnesses. He was elected president of that Board in 1990, while also serving on the Board of the Mental Health Association of Metropolitan Maryland.

John played many essential roles with the MPS over several

decades, including serving as President in 1988 and being a key member of the Maryland Psychiatrist's Editorial Advisory Committee. In the latter capacity he wrote many articles and served as a mentor for several other writers. For many years he served as an MPS representative in the American Psychiatric Association's Assembly. He went on to become a member of the Board of that organization.



Dr. Urbaitis' many contributions have been recognized both locally and nationally. He was a Distinguished Life Fellow of the APA and the recipient of that organization's Ronald Shellow Award for his service to the Assembly. He was named as Mental Health Professional of the Year by the Mental Health Association of Metropolitan Baltimore. In 2005 he was awarded the MPS Lifetime of Service Award.

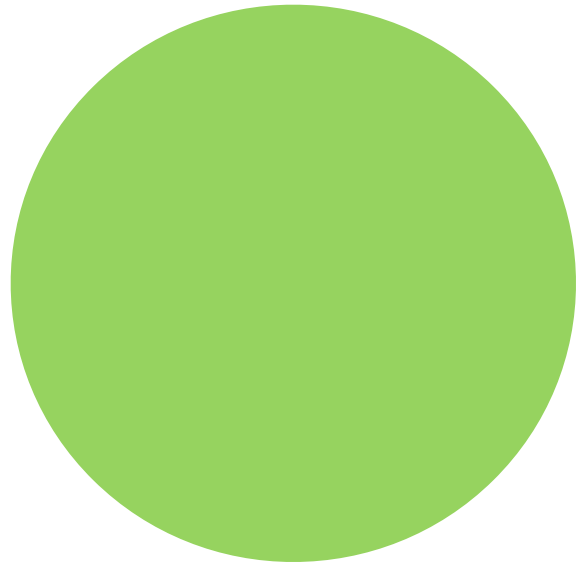
A Memorial Service was held on October 4th and served as a forum for many shared remembrances by his large circle of friends and colleagues, including many from the MPS. Dr. Bruce Hershfield provided a humorous, but inspiring, account of his interactions with John, whom he described as a gentleman who "knew everything," but remained modest.

Previously, Dr. Steven Daviss said, "John was the first person I worked for after fellowship training. He was chair at Sinai at that time. I learned a great deal from him – especially his approach to patients and the art of using a team approach. I admired his commitment to patient care, and to the responsibility of professional organizations to embody and protect our professional values. He was one of the giants of Maryland Psychiatry and will be greatly missed."

"He had a far-reaching influence on Psychiatry, both in Maryland and at the national level, and he is greatly missed," said Heidi Bunes, associate director of MPS.

Dr. Steven Sharfstein, President of Sheppard Pratt Hospital and former President of the APA said, "Dr. Urbaitis is someone who is admired throughout the country for his psychiatric leadership."

John is survived by his wife of 49 years, Barbara Matheson, PhD, a renal physiologist, and by his daughter, Jessie Chapman, an architect. 🌿





The Editorial Advisory Board

John Buckley, MD

Devang Gandhi, MD

Jesse Hellman, MD

Bruce Hershfield, MD

Vassilis Koliatsos, MD

Paul McClelland, MD

Jessica Merkel-Keller, MD

Kathleen Patchan, MD

Nancy Wahls, MD

John Urbaitis, MD, is greatly missed.