



THE
MARYLAND PSYCHIATRIST

WINTER 2019 VOLUME: 43 NO: 1

MPS Holds Psychopharmacology Update

By: Bruce Hershfield, MD

More than 130 people attended the fall scientific meeting of the MPS at Sheppard Pratt on November 17, 2018.

Dr. David Neubauer of Johns Hopkins began with a talk about "Hypnotics: Past, Present, & Future". He mentioned there is a new cooling device for the head that helps people with sleep apnea. He talked about dietary supplements: data exists for "melatonin versus everything else". He described the interaction of the homeostatic sleep drive and circadian rhythms. The majority of people are at their most alert in the evening because of the influence of the latter. He talked about the off-label use of trazodone for insomnia; it can cause morning sleepiness. He pointed out that high doses can cause agitation. He talked about immediate release benzodiazepine-type preparations that can cause sleepwalking. There is now a spray available as an alternative delivery system. Very low dose doxepin – 3 mg or 6 mg – can be effective because of its antihistamine profile. His talk was full of clinical "pearls" in a field that affects most of our patients.

Next, Drs. George Kolodner of the Kolmac Clinic and Sushil Khushalani from Sheppard Pratt gave the first of their three talks: "Medical Cannabis & Cannabis Use Disorders." They pointed out that 9% of cannabis users become addicted. They gave an historic overview of how it went from being an approved medication – till 1942 – to a schedule I narcotic – the most restricted type. Practitioners who have been certified by the state can recommend marijuana, but not prescribe it. There are more than 100 cannabinoids. The most intense preparation – sinsemilla – made of the flowering parts of the infertile female plants – contains 14 – 20% THC. CBD, which is the other famous cannabinoid, is not a euphoriant and can actually counter the psychogenic effect of THC.

Cannabis clearly has some negative effects: lower birth weights and possible teratogenicity, worsening of respiration, and decline in driving performance that causes accidents. It can cause psychosis. Heavy use of it by age 18 can lead to permanent cognitive deficits. Alcohol and marijuana synergistically act adversely to affect driving. They talked about a synthetic THC called dronabinol and a preparation called Sativex that is made up of a 1:1 THC/CBD.

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PSYCHOPHARMACOLOGY UPDATE

(Continued from front page)

Positive effects of cannabinoids include its uses as an anti-emetic and for chronic pain.

The Maryland legislature legalized marijuana for medical purposes in 2013 and '14 and amended the law in 2015. Although physicians comprise the largest component of those who are certified to recommend it, others, e.g dentists, are also doing it. It is not always clear why it is being recommended.

Gloria Reeves, MD of the University of Md then talked about treating children and adolescents. The most commonly prescribed medications for them are stimulants, antidepressant and antipsychotics. She talked about ADHD and told the audience that 40% of patients respond *preferentially* to either Ritalin or amphetamine. Other medications used for ADHD include Strattera, Kapvay (extended – release clonidine), and Intuniv (extended – release guanfacine). It is important to monitor growth and handle any possible hypertension. She said it is important to remember when treating OCD that CBT is superior to medications like sertraline alone; the combination appears to be better than either. Prozac and Lexapro are the only SSRI' s approved for major depressive disorder in children. Off – label treatment should only be used for the treatment - refractory. Common examples are treating PTSD, oppositional defiant disorder/ conduct disorder, targeting irritability and aggression that is not due to autism, and insomnia. Her experience with treating refractory depression is that the dose is sometimes too low or too high. It's important to ask if the child is actually swallowing the medication. Compliance can be particularly problematic when a child is alternately living with two relatives who do not get along with each other.

She went over the retail monthly cost of some commonly prescribed prescriptions: Latuda \$1489, Vraylar 1444, Rexulti 1355, Abilify 745, and generic risperidone 77.

Drs. Kolodner & Khushalani then gave their second presentation, about opioid use disorder. There have been waves of abuse in recent years: first with prescribed opioids, then heroin, and then fentanyl. Alcohol still kills more Americans

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PSYCHOPHARMACOLOGY UPDATE

(Continued from page 2)

than heroin does. At 40-year follow-up, only 22% of heroin addicts remain completely abstinent. Narcan, can now be given parentally or as a nasal spray; it is a short – acting antagonist. Treating fentanyl overdose may require multiple doses because it is so short – acting. We should be sure that our patients are opioid – free for several days before starting them on Revia. When buprenorphine was introduced, overdose deaths plummeted, e.g. by 61% in Baltimore. Overdose deaths then increased after the shift to using more heroin and then fentanyl. It is safer than heroin because there is a “ceiling” as to how much respiratory depression it causes. Buprenorphine causes less – severe infant abstinence syndrome than methadone does. There is now a buprenorphine im-

plant called Probuohine and a subcutaneous preparation called Sublo-

cade. They recommended using buprenorphine at 4 mg per hour until symptoms remit – – averaging 8– 24 mg per day. It eliminates cravings, besides helping with withdrawal.

Dr. Francis Mondimore of Johns Hopkins gave the next presentation-- an introduction to pharmacogenomic testing for psychiatrists. This is a part of the movement towards “personalized medicine” that is tailored to the prevention and treatment of the individual patient. Examples of personalized medicine include getting a family history, looking for genetic markers, searching for serum analytes, and neuroimaging. We’re trying to discover the genes that have to do with how medications work and with their metabolism. An example of the first is the serotonin transporter and an example of the second is the cytochrome P450 system. There are already 285 drugs that have drug – gene interactions listed on the labels; 18% of them are neuropsychiatric ones. Almost all these involve cytochrome P450. He described a couple of different testing systems; some may influence decisions about which medications to choose and others can also flag potential drug –

drug interactions. His final assessment was that we are not “there” yet, but are getting closer to “personalized Psychiatry”.

For the final talk, Drs. Kolodner & Khushalani returned to tell us about Alcohol Use Disorders. Blood alcohol levels decrease by .02% per hour.

One way of managing withdrawal is to use fixed – interval Librium and another is to use it according to indications it is needed. We

were told that it is a good drug to use because it is long – acting and patients do not “like” it and are therefore less likely to abuse it.

Adding clonidine or guanfacine (which is better) can reduce the hyperactive noradrenergic systems. They recommended using a benzodiazepine for alcohol withdrawal for 1 to 2 days, following

up with gabapentin 900 – 1500 mg per day and maintaining that at a reduced dose for 6 to 12 months.

They went

on to talk about Antabuse and how when it is used with alcohol the unpleasant interaction can last up to two weeks. They pointed out that ReVia blocks the euphoric response to alcohol. Campral, which is not metabolized by the liver, helps decrease the relapse rate, though it may take several weeks to work. It is their opinion that medications for alcohol use disorders are under – utilized. For example, only 5.8% of those treated in the VA in 2012 received any medication for it.

It was a well – organized and well-presented program. One could tell from the questions that the speakers were reaching the audience mem-





About My Mother

By: Jimmy Potash, MD, MPH



Jimmy Potash, MD, MPH

Eds' Note: This is a version of Dr. Potash's "Cheers from the Chair" sent to the faculty on 10/26/18

I owe a great debt of gratitude to so many of you for your kindness over the past week in the wake of my mother, Vella Potash's, passing. It has

been comforting and uplifting, and is very much appreciated.

Ten years ago, when I was preparing to make remarks for a ceremony, I asked my mother if it would be okay to tell people that she had had depression. "Yes," she said, "but tell them I was a lawyer who had depression." Mom didn't want to be defined by that illness, which made perfect sense, as she was indeed so much more.

Becoming a lawyer, as she decided to do in 1970, when she was 32, was an even more formidable challenge for a woman then, than it is now. Mom was one of only four women in her law school class. She was deeply dedicated to Women's Liberation and was determined to pursue a career for herself, one that would follow in the footsteps of her father, who had been a very successful criminal lawyer.

That pursuit meant that she didn't spend time making me elaborate lunches for school, like some of the other moms did. There were a couple of times when I was the last kid picked up after school because she had to finish what she was doing at work. But I am extremely proud of what she accomplished. She graduated in 1974 and became an assistant public defender in Baltimore City for several years. She later continued her legal work in Florida, and was on the board of directors of the Family Mediation Association there. Mom provided a wonderful example for

me of the kind of woman I wanted to marry—talented, serious-minded, ambitious. In those ways my wife Sally and my mother were a lot alike.

My mother did struggle for 10 years with depression following her divorce. Her struggles didn't prevent her from coaxing me to become a lawyer. A lawyer friend of hers offered me a summer job during college. I took it, and there came a point near the end of the summer when I was told that my weekly paycheck wasn't ready. "I don't understand," I said. "How could it not be ready?" The unwitting secretary replied, "Because your mother hasn't sent the money in yet this week."

Mom fleetingly thought of writing a book about her experiences with depression. While that book never got written, she did write a memoir, largely focused on her beloved father, called "The Criminal Lawyer's Daughter." She did a superb job with it. It is full of stories—some colorful, some dramatic--of Baltimore at mid - 20th century. For example, she describes my grandfather's client Tilly Tenace, a bar owner, whom mom called the toughest looking, toughest talking woman she had ever seen. Tilly's claim to fame was that she could lift two tables with her teeth, using a rope that tied the tables together. She also described a 1950 case where her father gained acquittal for an African-American cook accused of assaulting a white police officer. The NAACP had asked him to take the case as they believed the officer had struck the cook first. The acquittal paved the way for a larger city government investigation of race-based police brutality.

Thank goodness, my mother did get completely over her depression, and her last 30 years were very pleasant and productive ones. Much of her time was spent in Florida, where she lived with a new partner, a fellow lawyer. She served on the board of the local chapter of the National Organization for Women. She helped children through lending her legal talents to programs that worked on family and child custody

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ABOUT MY MOTHER

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issues. Her devotion to her own children never wavered. For many years I would talk to her on the phone most days as I drove or walked home from work. She was always eager to hear about what was happening, especially with her grandchildren, whom she adored. She spent the last couple of years hoping she could persuade one of them to go to law school.

Last week, as she was nearing the end, she wanted to say her goodbyes. She said many lovely and loving things to me. And then she said, "I'm sorry for those 10 years with depression." I told her it was okay and that I was so grateful for the next 30 very happy years we had had together. "And besides," I said, "without those 10 years I might never have become a psychiatrist." She smiled. I think she truly was pleased to have been able to ultimately influence my career choice.

May my mother's memory be a blessing and an inspiration.

The MPS Presents:

Working With Dangerous Patients

May 1, 2019
MedChi's Osler Hall

6:30-7:00PM

Registration, Coffee/Dessert

7:00-8:00

Working With Dangerous Patients

Donna Vanderpool, MBA, JD, Vice President, Risk Management, Professional Risk Management Services, Inc. (PRMS)

8:00-8:30

Maryland's Extreme Risk Protective Order

Erik Roskes, MD

8:30-9:30

Risk Assessment

Donna Vanderpool, MBA, JD.

Registration materials coming soon!

ECP Evening at Orioles Park

By: Jessica Merkel-Keller, MSc,MD

On Friday July 27, 2018 some of the MPS early career psychiatrists (ECP) gathered for an evening of baseball at Camden Yards Orioles Park. We convened at the Left Field Club and enjoyed food and drink with our families and colleagues, starting at 7pm. Because the opening pitch was delayed by 90 minutes due to thundershowers, we had plenty of time to connect with current Residents and with friends (in some cases not seen since graduation). We talked about our practices and about navigating the shortage of psychiatrists, which has led to an abundance of work. It was a pleasure to share an evening with people who are passionate about what they do.

When the game started, the excitement continued. The Orioles beat the Tampa Bay Rays 15-5.

This evening was made possible by Meagan Floyd, Associate Director of the Maryland Psychiatric Society, who had arranged a grant to facilitate EPC engagement.

We're hoping to hold this fun event again in the summer of 2019.

Happy Hour for ECP Members!

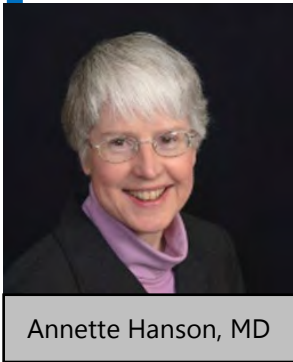
Please Join us on **WEDNESDAY FEBRUARY 27th** at 6pm Birroteca Baltimore! Gather with fellow early career psychiatrists. We'll come together in a casual setting for good wine, delicious food and wonderful conversation. Admission is only \$5 per person, and you are welcome to bring a guest with you to this event.

To register, or for more information please visit [click here!](#)



Two Important Decisions About Civil Commitment

By: Annette L. Hanson, MD



Annette Hanson, MD

Maryland's civil commitment laws, found in Health-General §10-613 to §10-619, allow licensed physicians, psychologists, and psychiatric nurse practitioners to sign certificates for involuntary admission. Following admission, the patient must be given a notice of rights prior to a civil commitment hearing before an administrative law judge within ten business days. This time is known as the "observation period."

During it, patients can be released if the treating physician determines that they no longer meet commitment criteria. Maryland's laws provides civil immunity to clinicians who involuntarily admit patients using this procedure. (1-3) The law was silent on the issue of immunity in cases where doctors decide against admission, or who release patients during the observation period.

Two recent Maryland Court of Appeals cases addressed those issues, and both cases were decided in favor of the psychiatrists.

In 2014 the Maryland Court of Appeals decided *Williams v Peninsula Regional Medical Center*. The case involved a man brought to the emergency department due to suicidal ideation and hallucinations who believed that his ex-girlfriend had placed a curse on him. He had cuts on the inside of both arms. He was released into the care of his mother. That night, after breaking into someone's home, he confronted police while holding a knife to his throat. He demanded to be shot, and was killed by police after he rushed at them. The patient's mother and ex-girlfriend filed a wrongful death suit based upon a failure to admit the patient. The trial court dismissed the suit, stating that the emergency department evaluators were protected by statutory immunity. The Court of Appeals agreed, and held that the clinical evaluators, as agents of a hospital facility, were immune by regulation regardless of the decision to admit. They noted that the immunity provision was adopted in the 1970's, when the legislature was concerned about the rights of people with mental illness and the risk of wrongful admission. They agreed with the lower court's concern that "out of fear of liability, mental health professionals might err on the side of admittance, instead of properly exercising their discretion and following the stringent requirements before taking away someone's liberty." (4)

This past November a second case addressed another aspect. In *Bell v. Chance* a man who had been brought to a hospital following a suicide attempt--and certified and admitted--was discharged two days before his scheduled

hearing as no longer meeting commitment criteria. He had complied with treatment, denied suicidal thoughts or plans, and requested release. Hospital staff documented his clinical improvement. An outpatient treatment plan was set up, he was referred to a partial hospitalization program, and he was then discharged to his mother's home. Tragically, he jumped in front of a subway and died the day after discharge. His mother sued the hospital and the doctor, alleging negligent discharge. A jury found in favor of the plaintiff, but the trial judge vacated the judgment, citing civil immunity per the decision in *Williams v. Peninsula Regional*. The Court of Special Appeals overturned the trial court's decision and stated that immunity under *Williams* only applied to clinicians who signed the initial certificates. The case was appealed to the Court of Appeals to address whether inpatient doctors were protected for a decision to discharge during the observation period.

It found that immunity was in place throughout the evaluation and commitment process:

"We hold that the process of involuntary admission begins with the initial application for involuntary admission of an individual and ends upon the hearing officer's decision whether to admit or release that individual. During that process, if a physician applies the statutory criteria for involuntary admission and concludes in good faith that the individual no longer meets those criteria, the facility must release the individual. That decision is immune from civil liability and cannot be the basis of a jury verdict for medical malpractice." (5)

Med Chi filed an amicus brief in this case, citing the risk of long-term trauma associated with civil commitment as well as the risk of damage to the doctor-patient relationship.

These decisions provide important relief for all emergency department clinicians who make difficult decisions about involuntary treatment.

References:

1. Health-General §10-618
2. Code of Maryland Administrative Regulations (COMAR) 10.21.01
3. Courts and Judicial Proceedings §5-623
4. *Williams v. Peninsula Regional Medical Center*, 440 Md 573 (2014)
5. *Bell v. Chance*, 460 Md. 28 (2018)



Using Biofeedback & Neurofeedback in Psychiatric Practice

By: K. Hogan Pesaniello, MD



K. Hogan Pesaniello, MD

Ten years ago, I added biofeedback and neurofeedback to my private psychiatric practice. The improved results my patients continue to experience have made me realize what a valuable investment this has been.

Why biofeedback and neurofeedback? Like the rest of you, I had patients who were medication-intolerant or resistant, or who wished to be well without meds, but were struggling with psychotherapy alone. I was looking for new tools. Both biofeedback and neurofeedback provide me with other approaches.

Biofeedback is a general term that describes training an individual to be aware of physiologic functions--ordinarily unconscious-- by measuring and providing immediate feedback, therefore allowing more adaptive control over the autonomic nervous system. Examples include training of heart rate variability (a pulse-based measure that improves the dynamic relationship between respiration and heart rate), muscle relaxation, skin temperature, skin conductance, and respiratory rate. My anxious and depressed patients who use very simple peripheral biofeedback tools find they can be easily incorporated into their sessions with me or used at home. One of my handwarming biofeedback patients noted significant symptom reduction with a 15-minute introduction. After one month of diligent home practice with a \$25 hand-warming thermometer (Stress Thermometer ordered from Amazon), the patient was almost symptom-free with regard to his previously intractable vestibular migraines, his panic, and his driving phobia. We could proceed to taper his benzodiazepine and start addressing his PTSD more vigorously. He returned to his next session driving comfortably for the first time in a long while.

Neurofeedback is a subset of biofeedback that uses brain measures like EEG's, typically collected with scalp electrodes. (EEG neurofeedback, brain-wave feedback, or EEG feedback are interchangeable

terms.) Information about targeted frequencies is provided in the form of simple feedback screens. These show patients representations of their brain waves, giving an opportunity to alter them and to see whether they have made the desired changes. I am able to watch the EEG signal as the brain attempts to create the changes. I can --- by adjusting the feedback parameters-- give the brain additional information to ensure it learns more effectively. *PirHEG* neurofeedback (passive infrared hemoenkephalography neurofeedback), is another form of neurofeedback, done by measuring infrared output from the prefrontal cortex with a sensor. Neurofeedback can also be done using fMRI measures, but this is less accessible clinically.

At its core, neurofeedback is behavioral conditioning of brain behavior. EEG neurofeedback protocols target cortical locations, such as the prefrontal cortex, the temporal lobes, and the sensorimotor strip. (The left frontal region is often a target in depression. Bi-hemispheric training -- training the left and right sides of the brain at the same time -- is often used to improve the instability seen in bipolar disorder and migraines.) Protocols can target one or multiple locations, and can be specified to address amplitude of the EEG waves underneath those sites, or communication between regions. Sometimes a *Qeeg* is collected to inform protocol selection, to assess progress, or to contribute to medication decisions. *Qeeg* refers to 19 channels of EEG data, collected for a minimum of 10 minutes open and 10 minutes eyes closed. Clinicians can collect the EEG data, but a certified specialist has to be the one to analyze it.

My first experience with neurofeedback: My first neurofeedback patient—a volunteer-- had been chronically depressed since her teenage years, with dysthymia and superimposed episodic depression. She had been having chronic sleep problems since childhood--mainly early morning awakening and light sleep. The depression had broken through treatment with SSRIs and Wellbutrin on maximum recommended doses. The medications had caused unacceptable side effects. With neurofeedback, she gradually began to show improved energy and sleep, then began to show improvements in body ten-

[*\(Continued on p. 8\)*](#)

sion, social anxiety, and motivation. Eventually, after around 30 sessions, her mood began to improve. All of the symptoms were in remission after 40 sessions. She went off all sleep and antidepressant medication within a few months of remission. It has been 10 years and she has not needed antidepressants, nor has she received any psychotherapy. (She never had any significant psychotherapy.) A few months after the initial training a drop in energy was the only symptom that needed any intervention, and was addressed then and a couple of more times in the next few years with a few refresher sessions. All the other symptoms remain consistently resolved 10 years later.

I was the second person I trained, eliminating my migraines and some mild premenstrual dysphoria. These two early experiences motivated me to learn more.

Relevance of Feedback: Neurofeedback and biofeedback are useful adjuncts and alternatives to the medication and psychotherapy I provide. They help patients previously described as “medication-resistant” and “medication-intolerant”, as well as those preferring *no* medications such as women planning pregnancy, or patients deciding to try *going off* medications despite high risk of relapse. Other patients with multiple diagnoses, along with TBI, PTSD, and Autism Spectrum symptoms, have found it to be useful. Typically, we have had to treat these populations with largely “off label” medications, often polypharmacy at a low level of evidence, because so few—or no—medications are specifically indicated for their diagnoses. We all could use additional tools. Antidepressant “poop-out”, risk of relapse once medications are discontinued, and medication non-compliance are more examples of problems we face. If feedback can take someone to full remission, or be a reasonable first line treatment -- particularly when symptoms are mild or when a non-medication approach is preferred -- we need to consider using it.

A New Tool for Psychiatry: For decades, neuroscience research has been highlighting the significance of the brain’s electrical signaling. As neuroscience offers more information about how training brain waves improves functioning, we now have an additional opportunity to directly impact the brain. Neurofeedback was discovered in the ‘60s through the work of Barry Stermán, Phd. He had done sleep research,

training cats to enhance more stabilizing brain waves by rewarding that brain behavior with milk. After that, when research for the Air Force happened to use the cats he had used in his research (both the ones that had learned to increase their stabilizing brain waves and the ones that hadn’t) it was noted that of all the cats, the ones that had been trained to increase their stabilizing brain waves were more resilient to seizures. From there, he proceeded to use neurofeedback to reduce seizures in humans, then went on to use it to improve symptoms in children.

Neurofeedback: A Well-Established Multi-disciplinary Tool: Over 30 years ago the AMA CPT Code Editorial Panel granted neurofeedback a Category 1 CPT code. (CPT Category 1 codes are for efficacious procedures; Category 3 codes are for emerging procedures that need more research.) This means it was no longer considered experimental. Its use is backed by excellent research, from the first article in *Brain Research* by Dr. Stermán, published in 1967. It has long been found useful in treating epilepsy, migraines, and symptoms occurring in mood disorders, traumatic brain injuries, PTSD, ADHD, addiction, and other psychiatric symptoms. I recall that when I was in residency, we were using anticonvulsants for psychiatric indications, well before it became standard practice. I thought, “If neurofeedback works like an anticonvulsant in stabilizing the brain, wouldn’t it have broad applications in psychiatry?” From its infancy over 50 years ago, neurofeedback has grown to be used across a wide variety of disciplines.

There are two well-established international bodies dedicated to educating and representing practitioners. For more information, see the websites of AAPB (Association for Applied Psychophysiology and Biofeedback) and ISNR (International Society for Neurofeedback Research), and EEG Education and Research, or my website (hoganello.weebly.org). I’m happy to offer more specific information. I can be contacted via hoganello7@gmail.com or at 757 894 3118.

REMEMBRANCE: Mary Roberts, MD

By Bruce Hershfield, MD



Mary Roberts, MD

Dr. Mary Roberts, a former member of the MPS who practiced as a child psychiatrist in Baltimore, died on November 19th.

Originally from Iran, where she graduated at the top of her medical school class, she was given a scholarship by the Shah and chose to use it at Johns Hopkins. After training in obstetrics and gynecology, she had a private practice for several years. She then trained in psychiatry and child psychiatry at Sheppard Pratt and went on to have a private practice in Baltimore for more than 40 years. For many years, she supervised the psychotherapy of Residents in training at JHMI and of Social Workers at Jewish Family and Children's Society.

Her husband, Dr. Paul Roberts, commented, "She was always absolutely devoted to her patients, friends, and family—a bond which could always be clearly felt by those on the receiving end. She had huge stores of energy--not only for relationships--but also for cooking, entertaining, buying clothes, traveling, looking at art, needle-pointing, exercising. She seemed literally buoyant to those close to her, and forever generous and eager to learn."

Contributions in her memory can be made to The Baltimore Museum of Art or Gilchrist Hospice Care.

REMEMBRANCE: Charles Wasserman, MD

By Bruce Hershfield, MD



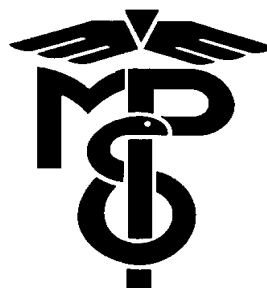
Charles Wasserman, MD

Dr. Charles Wasserman, a psychiatrist who practiced in Baltimore for many years, died on October 12.

A graduate of the Boston University School of medicine in 1969, he trained in psychiatry and surgery at Johns Hopkins after interning at Albert Einstein – Montefiore Hospital. He established a private practice in the northwest area of Baltimore and was on the staff at Sinai Hospital.

Leonard Herzberg, MD said of Dr. Wasserman that he was "a very thoughtful, insightful psychiatrist" who served as a member of the peer review committee for the MPS. He was fair-minded and considerate of all sides of an issue."

Dr. Allan Gold commented, "Charles was warm and engaging, creative in his work with his patients. He was very active in the Rehoboth Film Society and organized and was a frequent presenter at the weekend program "What Makes Us Tick" a series of films discussed by mental health professionals."





Interview: Kostas Lyketsos, MD

Chair, Johns Hopkins Bayview Department of Psychiatry

By: Bruce Hershfield, MD

December 12, 2018

Q: "Please tell us about your work and what you like most about it."

Dr. L: I wear several hats. One is the Psychiatry Chairman at Bayview, which I have been doing for 12 ½ – 13 years. The Bayview department has grown significantly in the last decade to over 60 full time faculty, with multiple general and specialty clinical programs for all ages, a robust research grant portfolio, and expanded education programs including fellowships in consultation psychiatry, geriatric psychiatry, neuropsychiatry, and as of July 2018 training for aspiring psychiatry educators. Here is [our website](#).

What I find most exciting are all the wonderful people on the Bayview team - clinicians, researchers, teachers and staff. They come together in a vibrant, innovative environment. We have some people doing great stuff in education like Meg Chisolm, MD. She has put together a psychiatric academy for physician educators, to train the next generation of psychiatric and medical psychology teachers. We do exciting basic and translation science in the newly named Joseph V. Brady Building. Some is supported by NASA, to look at how space – level radiation influences the brain and, by extension, behavior. Our Behavioral Pharmacology Research Unit (BPRU), now run by Eric Strain, MD is truly the premier such unit in the world. In the midst of an opioid epidemic, and wide use of "medical marijuana" BPRU research is at the forefront. and let's not forget Roland Griffith's pioneering research on psilocybin and related drugs. Our Community Psychiatry Program is one of the best in the country. It is now housed in the 70,000 sq ft 5500 Lombard building that was built for CPP with novel cutting-edge design. Dr. William Narrow, whom we recruited from the APA via New Mexico, will succeed Frank Mondimore, MD, who took over from Anita Everett, MD, as head of CPP. In addition to running the program, he will be setting up our capability to track all our clinical care quality in every patient encounter so that we can demonstrate care quality and value, continue to improve ourselves and conduct outcomes research.



Kostas Lyketsos, MD

Q: "What about the work that you yourself are doing?"

Dr. L: I'm still very focused on Alzheimer's and related dementias. In 2008 we opened the memory and Alzheimer's treatment center that provides care to thousands of patients per year and has spawned the "mind at home" model of memory care coordination that is starting to go national. I have been studying the neuropsychiatric (NPS)/

behavioral symptoms that people with dementia develop. Almost 2 decades ago, we showed that just about everybody with dementia develops NPS over the course of their illness. We are trying to figure out how best to treat them with both pharmacologic and non-pharmacologic approaches. We have been running a very large clinical trial; 26 sites around the USA and Canada to develop a sequential algorithm of a psychosocial treatment followed by escitalopram for agitation. We are very excited about this idea since behavioral symptoms probably are the first indications of Alzheimer's disease in at

least half of people who develop dementia. Obviously, that offers a variety of opportunities for prevention and treatment. I have been, watching the amyloid story unfold. There is the sense that there is one pathogenetic cascade that involves mis-processing the amyloid precursor protein. We have been disappointed in the last 10 to 15 years from amyloid – based therapies. It's possible what we have gotten wrong is that we have been thinking of this as one disease; amyloid therapy might work with some people, but probably won't work with the majority. the next stage will likely be an all-out effort to differentiate the distinct types of Alzheimer's, using a personalized/precision medicine approach.

Q: "That's very important, since so many people are entering the age where they are likely to suffer from it."

Dr. L: That's right. The

[\(Continued on p. 11\)](#)

worldwide projection right now is that there will be well over 110 million by 2070. Just to give you a sense of the scope of the US cost alone, by 2050, if nothing changes, it will cost \$1 trillion a year. It will be the single most costly disease and therefore we need to get better at preventing and treating it. Our interest in treatment development concerns how we approach differentiating the types of Alzheimer's dementia. Some may respond to amyloid therapy, but we think there are at least four or five other types that will dictate a particular treatment. One might be anti-inflammatory. There might be an insulin – resistant type, with obesity without frank diabetes. There appears to be a vascular type."

Q: "Would you tell us some more about Neuropsychiatry and how you became involved with it?"

Dr. L: I have always been interested in psychiatry in medical settings. I played a key role in CL Psychiatry becoming a recognized sub-specialty. I was particularly interested in the concept that brain diseases are an experiment of nature that can help teach us something about psychiatric disorders. When Larry Tune and Marshall Folstein left Hopkins in 1992 – 1994 they left behind a substantial operation at the dementia center. Paul McHugh, MD asked me if I would step in and make something of it. That became the vanguard of a broader neuropsychiatry program. Over the years, we've built up programs in traumatic brain injury and in adults with developmental disabilities that we think is largely a neuropsychiatric condition. We also have a very robust Parkinson's psychiatry program.

Q: "Please tell us about the development of Neuropsychiatry."

Dr. L: I think of it as a branch of consultation liaison psychiatry, focused on neurologic disorders. I think the field has gone in two directions. One is a "neurological" direction, connected with behavioral neurology. There is a universal council for neurologic subspecialties that credentials behavioral neurology/neuropsychiatry program fellowships. We had one of the first. The other path, which I have been more associated with, is within the context of CL psychiatry.

Q: "Please tell us about your involvement with other organizations."

Dr. L: I was involved with the APA Assembly. I was a Member in Training Rep for three years and later represented the Academy of Psychosomatic Medicine (now academy of CL psychiatry). I was deeply involved with the Psychosomatic Academy as a Council member and later as President and led the task force that applied for sub specialization."

Q: "Do you recommend that young psychiatrists consider becoming neuropsychiatrists?"

Dr. L: If you look at the CL annual meeting, it's grown very substantially. Our fellowships are getting very large numbers of applicants. I still think of neuropsychiatry as part of that. There is a lot of interest in what you can learn by studying these "neurologic" patients. I think that their care needs to be grounded in the field of Psychiatry. We are now embedding in the primary care settings, developing pro-active teams, where we don't wait for the consult request to come to us, but we are part of the day-to-day medical/surgical care of the patient. Neuropsychiatry is flourishing from this rapprochement between psychiatry and other medical fields.

Q: "What can the psychiatric community do to support your work?"

Dr. L: I'm more than happy to help mentor people, to talk about the field, make connections. I think I've got a good sense of the field on a worldwide basis. I think it would be wonderful if we had more connection with the psychiatric community around research. One of the biggest challenges we have as clinical investigators is recruitment. Having our colleagues help us get patients into studies and taking care of them can go a long way.

Q: "Any thoughts about the future of Psychiatry and Neuropsychiatry?"

Dr. L: Two-thirds of people with psychiatric illness are not ever seen by a psychiatrist. Our colleagues in internal medicine need our help. I think this integration is the future. We need to appreciate that our colleagues in medicine are thirsting for our expertise and health systems are now preparing to pay for it. Behavioral health is serving as the model for what we believe needs to be done.



LETTER FROM THE EDITORS What's Best To Do?

By: Bruce Hershfield, MD



**Bruce
Hershfield, MD**

The Maryland Psychiatrist has two problems. Not enough writers and not enough readers. What's best to do?

When it began, in the 1970s, it was the newsletter for the society. Meetings were announced and reviewed, comings and goings were properly noted, and some opinions were represented. It ap-

peared in the mail five times per year. In the late 1980s, the society decided to publish a newsletter, *MPS News*, once every month or two. *The Maryland Psychiatrist* (TMP) then became a magazine similar to what the *Baltimore Sun* had every Sunday. In order to save money, the Council voted about five years ago to publish newsletters only on a digital basis, but recently decided to offer readers the option of getting both publications in printed form for \$50 per year.

What does it offer? A record of what we do and what we think. Often, when important people move to Maryland their arrival is noted. Some of our prominent members are interviewed. It's a way to get to know them. When members leave, most frequently because they die, their lives are memorialized. In-between, it's a place where our members *can* express what is important to them.

However, almost no one volunteers to write articles. The editors have been soliciting, or writing, most of them. Editing is the easy part; the hard part is getting people to send in first drafts. Our members write well; look at how eloquent they have been on our email list! Their points of view are worth reading, no matter where they appear. We read what they have to say not only on our e-mail list, but in the *APA News*, *Psychiatric Times*, and *Clinical Psychiatry News*. Local authors have let us reprint versions of what they write in other publications, which we believe is useful (since it's not clear how many of our readers actually read those in the first place they appear). But, it's clear that they don't see TMP as the place where they should be writing first. And, of course, there are many members who *want* to say something and they don't know where they can find someone who wants to publish it. (Now they know.)

What's best to do next? Like in much of the psychotherapy we do, it may take time for the answers to become clear, but our questions should point to the future rather than to the past. And, as in psychotherapy, the answers must come from the only ones who can provide them correctly. The first question we ask in a treatment session -- "How can I help you?" --- often remains the most important one in treatment. How can we make TMP so good that you want to write for it and you want to read it?

BUY YOUR TICKETS TODAY!

MPS Dinner & Movie

March 30, 2019

5:30-9:30PM

Conference Center at Sheppard Pratt

"Suicide: The Ripple Effect" is a feature length documentary film focusing on the devastating effects of suicide. The film highlights the journey of Kevin Hines who, at age 19, attempted to take his life by jumping from the Golden Gate Bridge. The film chronicles Kevin's personal journey and the ripple effect it has had on those who have been impacted by his suicide attempt and his life's work since.

Following a screening of the film, Janel Cabbage, Director of Suicide Prevention at the Behavioral Health Administration, will give a presentation entitled, "Suicide Prevention is Everybody's Business: The Role We Play as Providers."

Please watch your mailbox and email for registration materials.

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of American Psychiatric Association (APA) and Maryland Psychiatric Society (MPS). The APA is accredited by the ACCME to provide continuing medical education for physicians. The APA designates this live activity for a maximum of **2.5 AMA PRA Category 1 Credit(s)**[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.