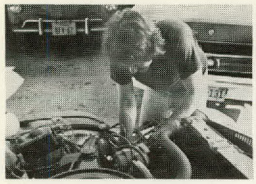
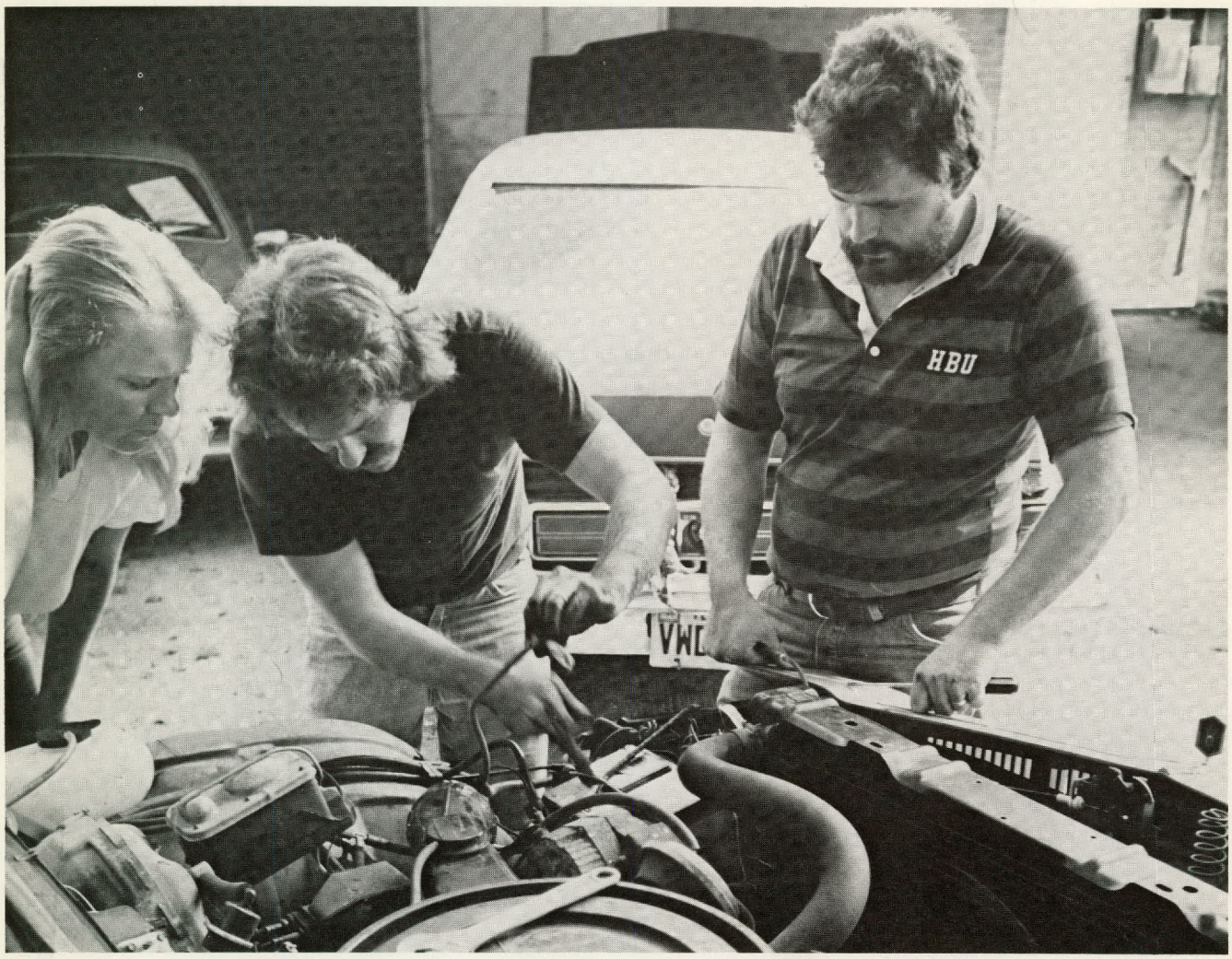
Inside



The Emissary

Texas Research Institute of Mental Sciences, Houston, Texas October-November, 1981



Dr. Schoolar writes

Interaction with other facilities is going and growing

It has been suggested by several groups, the Legislative Budget Board and the TDMHMR Board's Medical Advisory Committee among them, that TRIMS increase its interaction with other departmental facilities. Our services of determining blood levels of prescribed psychoactive drugs for departmental patients, the telephone-transmitted EEG interpretation and consultation, the recent tardive dyskinesia survey of state hospitals, and the autism survey of state school populations are notable as highly useful and successful interactions of the type intended.

The general format is for TRIMS to design the activity and provide core personnel, with each involved facility furnishing additional manpower and working cooperatively with us in carrying out the project.

Such activities may be surveys that aid in future planning; they may be purely consultative; or they may constitute a continuous service to the facilities with monitoring by TRIMS personnel and significant involvement of TRIMS staff.

Several projects have been initiated recently, and they bear brief elaboration. These have to do with psychopharmacological practices of state hospital personnel, the incidence of somatic illness in psychiatric patients, follow-up studies of patients reviewed by the Committee on Manifest Dangerousness, deinstitutionalization outcome studies, prevention, and the identification of non-TDMHMR personnel who may enhance the department's case-finding capabilities.

to study Rusk patients

Recently the commissioner instructed TRIMS to investigate the practice of psychopharmacology at the Rusk State Hospital maximum security unit. Are these patients sufficiently different from those in other facilities to require significant changes in the use of psychoactive drugs? Is the integration of chemotherapy into the overall therapeutic regimen successful enough so that at least part of the program could be carried out in facilities nearer the patient's home? The commissioner asked that, once these initial determinations have been made, TRIMS establish a hotline between TRIMS and Rusk personnel and begin monthly consultation visits with Rusk regarding psychopharmacology.

This project is a part of TRIMS' long-standing interest in the violent-aggressive patient and his or her behavior. Heretofore the core of our approach to this study has been through juvenile delinquents referred to TRIMS by the courts, to assist the court in determining whether or not the individual should be tried as an adult. Demonstrable central nervous system pathology that would account for violent behavior usually meant that such an individual would not be certified as an adult and would be treated in TDMHMR facilities rather than being referred to the Texas Department of Corrections. There is beginning evidence that repeat offenders show significant organizational changes in their central nervous system as compared to normals. This model is the one TRIMS will use in studying adult criminal patients at Rusk State Hospital. Given adequate resources, the TRIMS-Rusk team will also do neuroendocrine studies to help us in describing the overall profile of the violent patient.

Rusk has also been named as one site of a two-facility (TRIMS and Rusk) protocol for examining the incidence of somatic illness in psychiatric patients. Past investigations showed that more than one-half of the department's patients suffer from a previously unsuspected somatic illness. The precise number of patients whose somatic illness directly contributes to their psychological aberration is unknown: obviously such physical illness requires detection and treatment, whether it contributes to the patient's mental illness or not. Studies done in the late 1930s and the mid-1960s can now be updated with modern analytic techniques and computed data analysis. The benefit to patients should be significant.

support for discharged patients

Another matter of paramount concern is the availability of a community support system for outpatients and recently discharged hospital patients. Almost weekly the point is made in TRIMS case conferences that the social support system is the weakest link in the services we provide for our patients. Outcome studies of "deinstitutionalized" patients have been performed by many treatment systems throughout the United States. But most of these studies cannot be applied to Texas and TDMHMR. We intend to develop protocols for outcome studies of the effectiveness of community support programs that may be generally applicable to community mental health systems throughout the state, with a more precise definition of the appropriate role of hospitals and community mental health-mental retardation centers. There is a strong suggestion that the types of patients who seek treatment from community centers are diagnostically different from those who go to hospitals and outreach centers and therefore

require a different application of service by treatment teams of broadly, but differently, trained personnel. Our role is to design studies to examine this question and to carry them out with the help of staff members at each facility.

develop case management system

In no area is the development of a service delivery network of personalized care more important than in geriatric medicine. TRIMS is the site of a federally funded "channeling" project that is designed to demonstrate the salient elements of such a network. Again, one of the most important features of this study is to be its transportability to the various population centers of the state. In proper extension it will define factors needed in rural areas and contrast them with elements most useful to urban populations.

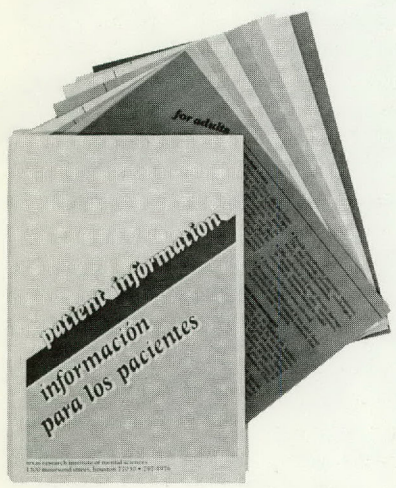
We recognize more and more acutely that the fulcrum, the central element, in making a service available to a patient is the case manager. Money and eligibility for governmentally funded programs are critical elements to a given patient's treatment plan. Some one person must know the patient, his or her needs and eligibility, and must keep up with changes in any and all of those parameters. TRIMS is attempting to design a study characterizing the case manager, as this kind of professional functions best with our patient population.

involve other professionals

TRIMS has long made it a practice to enhance its manpower by capitalizing on our relationship with state universities and medical schools to carry out joint research projects. Highly successful collaborations have been with experts in developmental disabilities, some of whom contribute so much to TRIMS projects as to appear to be members of our staff, except that they are not paid by TRIMS. Another example is the training of area clergy in case recognition and evaluation. This program, already well under way at TRIMS, recognizes that more people in Texas turn initially to their priest, rabbi, or minister for help in solving emotional difficulties than to any other professional. Once our pilot training program is completed, TRIMS will offer the curriculum to other facilities and assist in the establishment of similar programs of patient evaluation and referral by clergy.

Additionally, TRIMS has been asked by the commissioner and the board chairman to investigate the possible use of specific agents in the treatment of Down's syndrome and to reopen the question of the possible utility of dimethylsulfoxide (DMSO). Our review of the literature and discussions with knowledgeable scientists throughout the country is well under way.

All this illustrates the changed emphasis on our relationship with other TDMHMR facilities. The list is incomplete. The commissioner has been asking more frequent and more specific research questions of TRIMS and has been facilitating cooperative programs with our colleagues in the department. All facilities—hospitals, schools, human development centers, and community mental health centers—are included. The TRIMS Research Council is focusing on these issues. This approach will go a long way toward meeting the mandate given TRIMS by the legislature.



The Emissary staff won its third award this year, this time first place among newsletters in the National Association of Mental Health Information Officers' national competition. The publication had placed first in the region earlier this year and received a top award from Women in Communications. The English-Spanish brochure about patient services won honorable mention by NAMHIO.

Impact, the department's magazine, won first place in the magazine category, and the TDMHMR annual report for 1980 got a third.

The Emissary has a new look designed by art director Julie Kavitski of Baylor College of Medicine. We'd be interested in knowing how readers like it.

No car, no job

Drug abuse counselors help kick one of their clients' problems

Two TRIMS drug abuse counselors have been honing their auto mechanic skills at the substance abuse clinic.

It's for a good cause. Robert Knapick, activities coordinator, and Steve Tapscott, outreach coordinator, have conducted four monthly car clinics so far, fixing clients' cars and showing them how to do it themselves next time.

Why treat cars? "To help our clients," Knapick says. "Transportation seems to be one of their biggest problems. Lots of them can't find jobs because their cars don't run." One client had been living in his car because he couldn't find a job. And he couldn't find a job because the brakes on his car weren't working: he had no way of getting to interviews.

The mechanical labor is free Clients pay only for parts. A tune-up, for instance, costs $10 to $15. For some repairs—adjustments, adding Freon—there is no charge. Advice is free too and sometimes pointed: Sell your car. "We can anticipate problems," Knapick says.

automobile I&R

Working under the clinic's carport, the counselor-mechanics can do most jobs. But sometimes the work requires only diagnosis and then referral to another source. A woman who complained that her car's battery was always dead in the morning was sent to a gas station to get the battery checked. "It should be free," Tapscott told her after looking over her car and showing her how to check to see if the alternator was running.

Sometimes clients get involved in their work. Earlier that day Knapick and a client together tuned up the client's car. Another client offered to loan an analyzer which would spot problems in a car's electronic system.

In December the two counselors plan to devote their car clinic to teaching clients routine maintenance like oil and filter changes, tune-ups, putting antifreeze in the radiator as well as "basic trouble-shooting."

could have been mechanic

Knapick, who was being interviewed while tuning up a Gremlin, checking its master cylinder gasket and brakes and adjusting its tappets, said both he and Tapscott had worked on cars since high school. "I almost got a job as a mechanic once," he admits.

By the time of their third car

Once a month Steve Tapscott and Robert Knapick, upper left, diagnose and treat clients' cars outside the substance abuse clinic.

Be a buddy

It helps to know someone when you land in the hospital

If the inpatient unit's buddy system works according to plan, and most of the time it does, never again will a new hospital patient walk off the elevator, scared and confused, to be left alone for hours in a strange room with strange people, and no idea of what happens next.

Since the hospital started its buddy system in April, the weekly roster of patients volunteering to shepherd new arrivals around the unit has always been full.

Lex Kelley is a young but veteran patient and an experienced buddy. He likes the job and says, "The patients get to know you and you can help them. And if there's a difference between the staff and the patient, you can tell the patient who to talk to. You can tell your buddy how to make a telephone call, where to get coffee, what to do at dinner."

Buddies are easily identified by a leather tag made by patients in occupational therapy, and each week the buddies' names are posted on the bulletin boards that tell today's day and date.

Dr. Suzanne Bafus, director of nursing, and Dr. Caryl Smith, acting chief of the inpatient psychology department, designed the buddy system and they will know in a few months how much difference it makes in new patients' anxiety and the atmosphere of the hospital.

Instantly popular, the buddy system also is the subject of evaluative research by Dr. Caryl Smith, acting chief of the inpatient psychology department, and Dr. Suzanne Bafus, director of nursing. Several ideas came together to give birth to the buddy system, Bafus says, not the least of which was the chronic shortage of nursing staff to take care of patients as soon as they arrive.

The most dramatic reason for starting the program was a taped interview with a patient. The tape had been made to let trainees see the hospital experience from a patient's viewpoint.

"We found the interview disturbing but enlightening," says Smith. "The patient talked about having to wait three hours after she arrived on the unit before a staff member could get to her. She was frightened and uncertain of what to expect. She felt a mounting anxiety. We didn't want that to happen again."

First conceived as a welcoming committee, the idea evolved into its present form as a way of introducing new patients "in a warm and effective way," Smith says.

The buddy system helps to give a more communitylike atmosphere to the hospital, Bafus adds, and it gives staff members who ordinarily are not involved in research a chance to participate in that aspect of the project.

before and after

To check out the value of the program, Smith and others administered the Moos Ward Atmosphere Scale and the Spielberger State-Trait Anxiety Scale to patients last March, before the buddy system started. They will do so again in a few months, to see whether it makes any difference.

Although the research is "evaluative and not strictly scientific," Smith says, the program's effect or lack of effect should be clear after the system has run a while.

Some payoffs are already evident. Bafus tells about the patient whom the nurses could not persuade to bathe or comb his hair. The day he was to serve as a buddy, he showed up bathed and groomed, dressed in a suit.

There is a checklist for buddies which, in the section on "getting along with people," gives this advice:

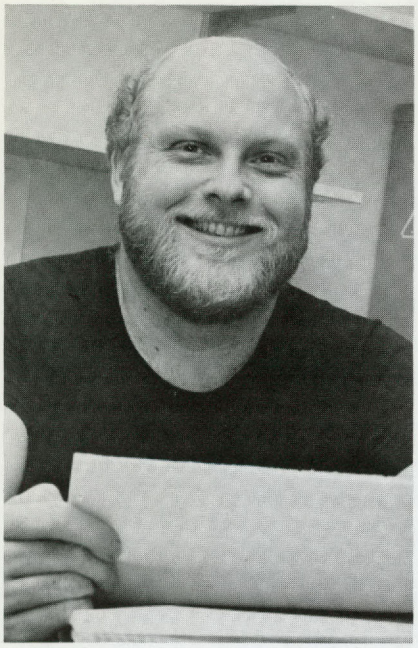
"Most people are friendly and caring, but expect some 'strange' things at times. . . .Remember to be sensitive to how the new patient is feeling (e.g., frightened, confused, angry, etc.). Remember to help them feel comfortable and welcome. Remember to care."

—Lore Feldman

Lex Kelley, showing Marsha Russell Daroush how to operate the inpatient unit's record player

Ward clerk Ruth Gooding and therapist-technician Lovie King, along with other nursing staff members, see that the buddy system runs smoothly.

Who we are what we do



Guy Colahan

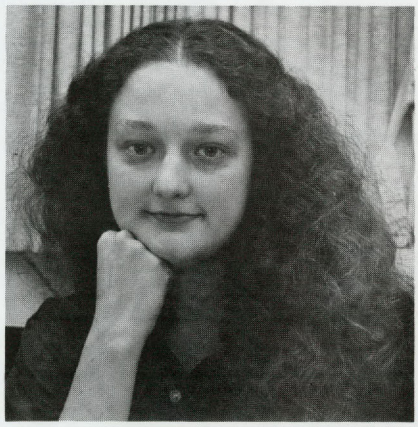
It was the great September office cotillion. And, although property supervisor Guy Colahan shifted the trash and treasure of 100 people into 50 different offices, he was able to say: "By and and large, the people who work here go out of their way to be friendly and cooperative."

The next task Colahan faces is a six-month shift of items valued at less than $100 off the numbered inventory. The stuff will still be accounted for, but it cost more to check it out semiannually than it was worth. "Over the long haul, this will make my job a little bit easier," Colahan says.

At TRIMS for 2½ years, longer than any other property supervisor, Colahan is thinking ahead, perhaps to a job with more administrative responsibility and more challenge. His choice would be veterinary medicine for livestock—he is an Aggie who didn't finish his degree—but so far his bank account doesn't promise to let him go back to school full-time.

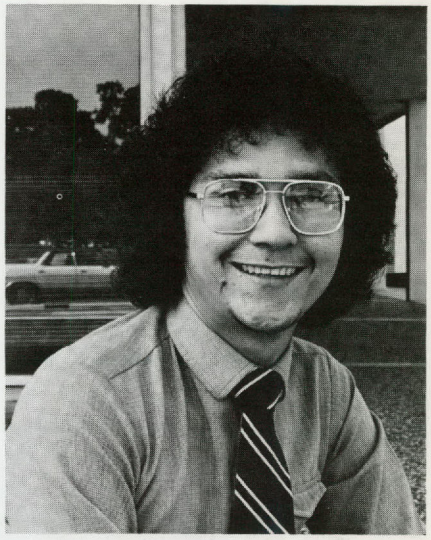
Norma Davidson

Three years ago Norma Davidson decided she wanted to find a job in the Texas Medical Center, where her husband John was a medical student. "A B.A. in English wasn't the hottest degree" for finding work in the medical center, she found. "Science, not language, is in big demand here—I can't understand it." Davidson ended up



interviewing at TRIMS for a job with Dr. Bernard Saltzberg. "I liked him and he liked me, so I enlisted as an administrative technician."

Since then she has been promoted to research assistant. Her job involves computerizing EEG data for studies of epilepsy, alcoholism, and violence, editing and typing mathematical manuscripts, and drawing math, computer, and electronic systems diagrams for Saltzberg's papers and reports. And her boss, Davidson says, is still trying to teach her mathematics, though she's "a reluctant learner." It's hard to overcome her fear of the subject. "It's also hard to overcome Dr. Saltzberg's love of it, so he's still trying to convert me to the true way," she says. "We'll see."

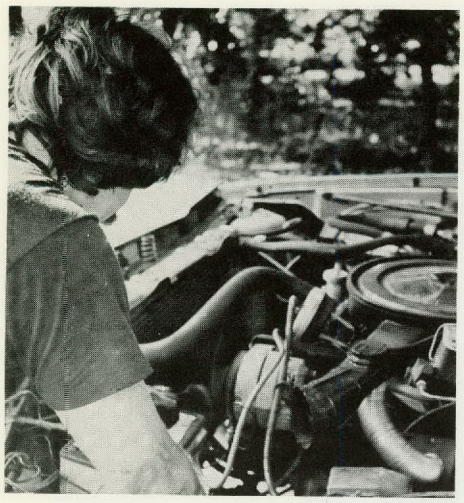


Dr. Victor A. Gutierrez

Dr. Victor A. Gutierrez describes himself as an "emotional man, nostalgic about my past life, but planning for the future as a United States-trained psychiatrist." To make this possible, Gutierrez and his wife, a nurse, had to leave their four-year-old son with his maternal grandparents in the Philippines. Until the family is reunited, "I don't know if we made the right decision," he says.

Now in the second year of psychiatry residency, Gutierrez is resolute about educating his son in the U.S. and practicing here until he retires and returns home. Satisfied with his training and supervision, he says, "At TRIMS you have a good interplay between biological and psychological training. You have a perfect system here—at least I hope so."

Dramatic himself, Gutierrez loves acting. He won several national medals for declamation and was the announcer (also floor washer and tape sorter) for his university's radio station.



c inic the counselors had six cars to work on, twice as many as the two previous months. "In another month or so we should be busy all day," Knapick says. "Word of mouth" seems to be bringing in more clients and their ailing cars.

A poster at the clinic helps with the advertising. "Whether your car is a terminal case or just in need of some crisis intervention, maybe the substance abuse car clinic can help," it says. "Contact your local primary counselor for more information about what we can do for you."

—Karen Hanson Stuyck

Chuang flies to rescue Rio Grande library

Felicia Chuang, right, with Hannah W drig of the Swiss Embassy. In celebration of Houston's Swiss Festival last month, the Swiss government presented the TRIMS library with nine books on Jungian psychology.

Ask a librarian anything, and she/he will do it, find it, borrow it, give it or lend it to you—and that's twice as true for TRIMS librarian Felcia Chuang, who will even fly (no, in an airplane) to do this for distant colleagues.

Chuang spent a day in Harlingen recently, asked by the Rio Grande Center for Mental Health and Mental Retardation staff to help them resuscitate their library which was dying from lack of attention. The center has a new clinical director, Dr. John V. Price, who was determined to revive the library—even if he had to push the superintendent, Blas Cantu, out of his office to create a reading room, which he did, with the superintendent's consent.

Chuang found a lot to do. She started sorting books, of which the center has many duplicates and not many current ones, beginning early in the morning and not "taking a breath" until noon.

She outlined a circulation and record-keeping system, made suggestions for a card catalogue, and gave the center staff ideas of where to buy library supplies and where to get them free.

Chuang is still working on a list of books and journals the center needs. From her modest account of what she did in Harlingen in one day, it's obvious they'd been visited by a lightweight in the physical sense only.

library notes

For her colleagues at TRIMS, Chuang calls attention to two books now available here.

The **DSM-III Casebook—a Learning Companion to the Diagnostic and Statistical Manual of Mental Disorders (Third Edition)** is a collection of case vignettes that focus on information relevant to differential diagnosis.

The Course of Life: Psychoanalytic Contributions Toward Understanding Personality Development is edited by Stanley Greenspan, chief, Mental Health Study Center, National Institute of Mental Health, and George Pollock, director, Chicago Institute for Psychoanalysis. The three-volume work contains conceptual overviews by Anna Freud and Erik Erikson. Pollock, as it happens, was at TRIMS this month to meet with gerontologists and give a seminar.

—Lore Feldman

Publications

James L. Claghorn, Roy M. Mathew, John W. Largen, and John Stirling Meyer. Directional effects of skin temperature self-regulation on regional cerebral blood flow in normal subjects and migraine patients. **American Journal of Psychiatry** 139:1182-1187, 1981.

The article is cited in an editorial in the same issue as describing "a new way for seeing in psychiatry that implies dramatic extensions in our diagnostic, treatment, and research potentials. The authors ingeniously combined two noninvasive techniques; they used inhaled Xe 'scans' of regional cerebral blood flow to visualize intracranial vasomotor changes introduced by biofeedback procedures in migraine and control subjects. They observed both symptomatic and intracranial physiologic changes that clarify the mechanism of biofeedback in vascular headache."

Carlo DiClemente. Self-efficacy and smoking cessation maintenance: A preliminary report. **Cognitive Therapy and Research** 5:175-187, 1981.

fear of death

Dr. Lenore Tate reported her study, "Correlates of death anxiety in elderly black females," to the national convention of the Association of Black Psychologists at Denver. The paper suggests a theoretical model of death anxiety, using demographic, life history, and stress variables. In general, Tate reports, fear of dying is inversely related to psychological adjustment.

brain signals

Dr. Bernard Saltzberg participated in the Third Annual IEEE Engineering in Medicine and Biology Society Conference in Houston, presenting "An alternative to averaging when the number of evoked potentials is small or when stimulus timing is unknown," and "EEG measures of regional neural connectivity." Co-authors for the second paper are W.D. Burton, J.M. Fletcher, R.L. Michael, and N.R. Burch.

Saltzberg reported on "Experimental studies of brain and neck injury" to the 25th Stapp Conference which deals with neurological research on injury to the brain.

psychologists at APA

Who minded the store when the psychologists were at the American Psychological Association at Los Angeles? They contributed much to the meeting.

Kenneth S. Solway, Victor H. Elion, and Linda M. Richardson: "Clinical assessment of psychopathology in violent juvenile offenders."

Harriet Schultz: "Correlates of depression in a clinical sample of children and their mothers."

George Niederehe and Karen Nielsen-Collins: "Depression and age effects in episodic memory—encoding and retrieval."

J. Ray Hays: "Legal/ethical issues in public awareness programs."

Carmen Kaimann: "Aging and the Luria-Nebraska" and "An investigation of the neuro-psychological aspects of multiple sclerosis."

Carlo DiClemente chaired the symposium on "Self-efficacy in health behavior change—smoking cessation and relapse," and Lenore Tate, Cynthia E. Ochs, and Paul K. Chafetz presented a symposium on "Employment opportunities for clinical psychologists with advanced training in gerontology."

'uniformly excellent'

Violence and the Violent Individual, the collected papers of the institute's 1979 symposium, was praised in the hallowed pages of the **New England Journal of Medicine**. Dr. Peter Reich of Brigham and Women's Hospital writes, "The presentations are uniformly excellent. The authors emerge as experienced professionals. Clinicians from all fields are likely to find the material engrossing and enlightening." The volume was edited by Drs. J. Ray Hays, Thomm Kevin Roberts, and Kenneth Solway, with Lore Feldman as technical editor.

With the deaths of Cleo Delaney and Isadora Binderman TRIMS lost two vital staff members last month.

Cleo Delaney, 61, died of a heart attack Sept. 9 at her home. She had joined the staff in 1974, first as a secretary in the inpatient unit, then transferring to personnel where she remained for four years. She knew everyone because she was in charge of time-keeping, and everyone knew her as a person "with a good sense of humor and a lot of concern for others," as one of her chiefs said. Delaney's last position was that of administrative technician in the geriatric clinic, and she continually carried a second job at a department store. A widow, Delaney had one son, Preston Delaney.

Isadora Binderman, who died of lung cancer Sept. 16 after an operation, came to TRIMS to do field work as a social work student from the University of Houston. After she graduated with a master's degree, she became a case worker in the hospital. "Everybody really cared a lot about her," said inpatient social work chief Claire Wingerter. "In a little over a year, Izzi somehow established warm contacts with everyone and became a very important person on our staff. Izzi could do that in a short time."

Binderman was 45 years old. She is survived by her husband David and daughter Judith.

professors, graduate school, various theories of what causes mental illness. All have been to college and one member has several engineering degrees. They all, says Frey, are "very, very bright."

The group, she says, emphasizes socialization, problem solving, and support. Helping members develop better judgment is a high priority; she continually reinforces good intentions and points out inappropriate behavior.

During this group session Peter tells Bob of a job he's heard about and suggests that Bob, who's not working and living at home, might want to apply for it.

Jim says that he's depressed. Before, when he was sicker, he was on a "super high. I was never so happy as when I was crazy."

Scott tells a couple of group members who say they're lonely and bored on weekends to call him, "and we'll go to a movie."

Toward the end of the session, after patients have spent considerable time discussing nutritional causes of mental illness and the use of pets as therapy, Frey tells the group, "What you're all asking me is if there's hope, if you're going to get better."

"I have an answer," Scott interjects before she can finish. "I was sicker than you've ever been," he tells his fellow members, "and I feel great now—except when I drink. And I used to be completely out of it."

—Karen Hanson Stuyck

Marilyn Barber

"Low stress" group teaches social skills

"Steven, are you going to stop acting so silly?" Marilyn Barber gently asks one of her companions.

Barber's resocialization group members are strolling through the zoo in Hermann Park. Steven is bragging—loudly—that he will jump on an elephant, then he will scoop up fish from the pond.

"I thought we were working on that," Barber reminds him.

"I didn't know you were still working on it," he replies.

Unfazed, Barber engages other members in conversation. She checks on a new group member, telling the woman how glad she is that she could come today. Has she ever been to the zoo before? No? "Well, then we'll have to show you," she says with a smile.

The weekly group is "low stress," designed so that very disturbed patients will have something to do each week and learn basic social skills. Group members go on outings, play volleyball, kickball and badminton, learn about etiquette, nutrition, how to shop and manage money.

staying out of hospital

After joining the group, patients who'd been in and out of psychiatric hospitals are either staying out completely or at least for longer periods. The group, says Barber, is "interrupting a revolving door of hospitalization."

Barber, a nurse-therapist, and co-therapist Gretchen Warner a volunteer, try to let members know "how they're coming across, encourage them to open up, and give them support to try things in the world outside TRIMS," Warner says.

"Isn't that a pretty bird?" Barber asks the group, pointing at a king vulture with a vivid red head.

continued on page 12

Group members and co-therapists at the Hermann Park zoo. Outings are a regular act vity for the group.

"No," says Lawrence, a quiet young man. "That's an ugly bird."

Barber thinks it over. "Well, it's kind of pretty and ugly both."

The group, Warner says, is "very pragmatic." At a four-part session on conversational skills, for instance, members learned how to start and end conversations, about appropriate nonverbal behavior, and how to keep a conversation going. They were told if they were talking too softly or too fast, and if they were switching from one topic to the next in a way others couldn't follow.

Feedback on behavior is an important part of the process. A lot of the members have inadequate social skills, Barber says. "One of the reasons they get into trouble is that they don't know what's appropriate and what isn't."

talk and listen

The conversation skills program required members to give a talk and then listen to it on tape, says Bill, who works as a sacker in a grocery store. "We gave ourselves ratings on our tone of voice, the content of the speech, and how we held the audience's interest." His speech was about the beginning and end of **A Tale of Two Cities.** "I said it was a timeless novel, as true today as when it was written."

How had he rated himself? "I didn't like hearing my Southern accent on the tape recorder," he says.

Bill comes "fairly often" to the group, on those Tuesdays when he doesn't have to work. He likes going to different places—the Astrodome, Busch Gardens, the movies sometimes—and he enjoys the group's camaraderie, "getting to meet people and to talk to the same people every week."

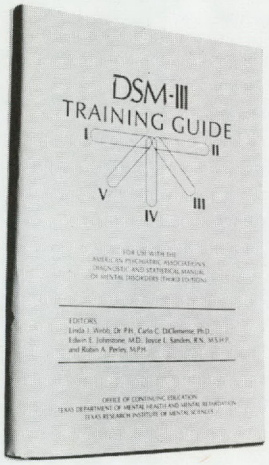
Group members are very supportive of each other, Barber says. "When someone is actively psychotic, the others give him feedback." Rather than rejecting him for acting strangely, they seem to "pull together and try to help more."

—Karen Hanson Stuyck

Training guide for DSM-III turns out to be a hot item

The **DSM-III Training Guide** isn't **Princess Daisy,** but it is threatening to become a bestseller in its own class.

Tested in workshops throughout the state, written and edited and supplemented with audiovisual training materials in a manic three months, the guide to the American Psychiatric Association's **Diagnostic and Statistical Manual of Mental Disorders (Third Edition)** is the product of a large TRIMS team of psychiatrists, psychologists, and educators. They had been teaching the DSM-III classification system around the state, found no teaching materials available, and wrote their own.



Before the book arrived at the publisher's, Brunner/Mazel in New York, more than 500 copies had been sold.

Editors are Dr. Linda J. Webb, chief of the office of continuing education; Dr. Carlo DiClemente, chief of the alcoholism treatment clinic; Dr. Edwin E. Johnstone, director of psychiatry training; Joyce L. Sanders, assistant chief of continuing education; and Robin A. Perley, staff development specialist.

Audiovisual materials, consisting of 140 illustrative slides and a 60-minute videotape which presents five cases, were prepared by former AV chief Mike McGuyer. These are available in a separate package from Brunner/Mazel.

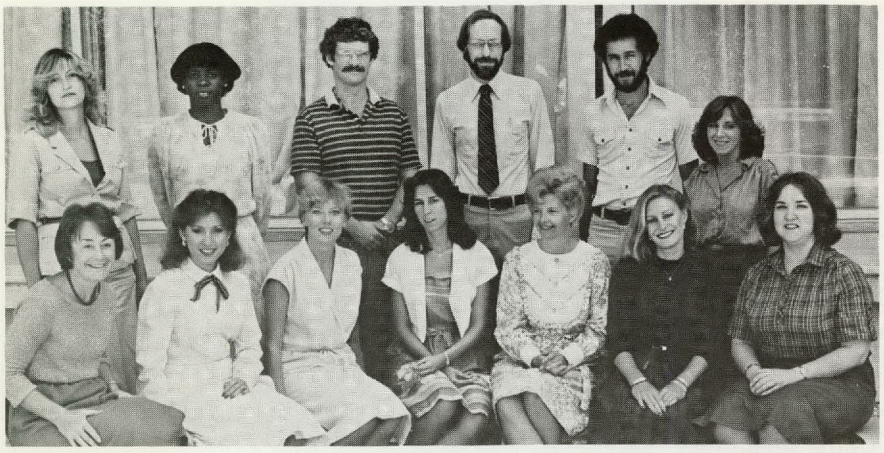
"In preparing these materials, TRIMS has performed a significant service for the mental health profession," Dr. Robert Spitzer and other leaders of the American Psychiatric Association write in their foreword.

The guide is designed to be used both for self-instruction and as a text in continuing education programs in which the DSM-III classification system is taught. It covers the basic concepts and applications of the DSM-III diagnostic system. As a companion to DSM-III, it offers systematic coverage of the major classifications, as well as illustrative tables and case example.

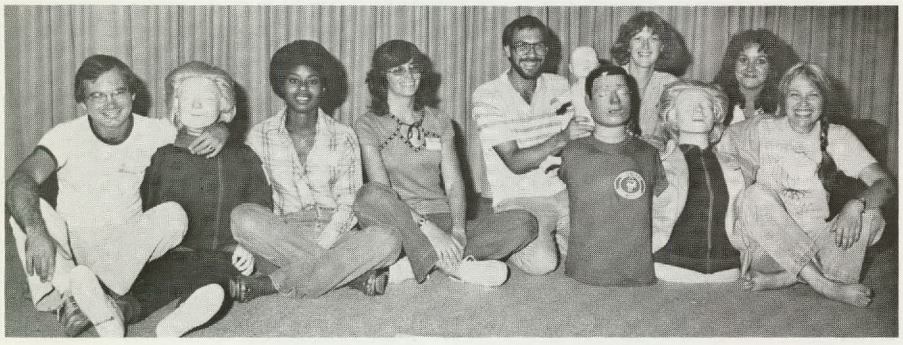
The book costs $10.95 paperbound, $15 clothbound.

Training guide editors: left to right, Dr. Edwin Johnstone, Robin Perley, Joyce Sanders, Dr. Carlo DiClemente, Dr. Linda Webb.

New faces of 1981: the students

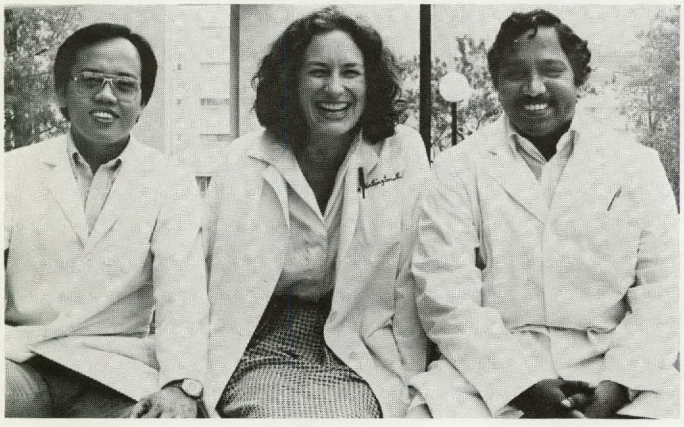


Social workers from the University of Houston: Front, left to right, Ruth Nedelmann, Teresa Sedeno, Lynn Wilson, Marsha Darden, Ferol Johnson, Leslie Weinstein, and Henrietta Wolf. Rear, N.I. Chehayeb, Marsha Richardson, Jaime Raser, Emmett Stevens, Jerry Winter, and Diane Gutman.



First thing the clinical psychology interns had to do is practice cardiopulmonary resuscitation. Left to right: Michael O'Shea with a dumb blonde, Billie Ivra, Carmen Kaimann, Denis Feldman who revived a baby, Anna Palotai, Marie Morell, and Ann Gerike. Not in photo but present in training are Rochelle Levit, Marjorie Stewart, and Jean Benner, psychology practicum students from the University of Houston at Clear Lake.

Fellows in geriatric psychiatry and psychology are Drs. Robert Reichlin and Michele Rusin, psychologists, and Dr. Rafael Lacomba, psychiatry resident.



Drs. Ireneo Espiritu, Marion Worthington, and Pradan Anbunathan started the first year of their psychiatry residencies.

In family therapy training: Wendy Yellen, a social worker, Dr. Kathleen Gallentine, a physician, Dr. David Harvey, a psychologist, and Dr. Manjul Mehra, a TRIMS psychiatry resident.

Dr. Jonathan Malev talks about himself and his practice

Dr. Jonathan Malev is a Houston psychiatrist in private practice who each year acts as a preceptor to a TRIMS psychiatry resident. A graduate of Baylor College of Medicine, Malev taught psychiatry at Baylor for eight years and is now on the clinical faculty.

He was Dr. Robert Rosan's preceptor last year. Asked about Malev, Rosan said:

"What do I think of Jonathan Malev? I think the sun rises and sets on him. I think he's a wonderful guy. He's a great student of life. He is thoughtful and reflective. He has a lot of insight and empathy. In psychiatric terms, he's a good ego ideal for a resident. He has a feeling of what goes on in a resident in training and in a patient, both of whom are a little frightened."

Excerpts from Dr. Malev's taped interview with Lore Feldman follow:

Observations

What does a preceptor do?

Malev: The preceptor notion was put forward by Dr. Johnstone (chief of psychiatry residency) to provide a practical model for the resident in psychiatry. Psychiatrists are, I think, quite different from each other. We're probably more self-conscious about our personalities than are most other members of the medical profession. Ed Johnstone's idea in matching up a resident with a preceptor is to try to make a pretty good fit between their interests and personalities. I participated in it for the first time last year, and the resident was an interesting fellow by the name of Robert Rosan.

What brought you into psychiatry?

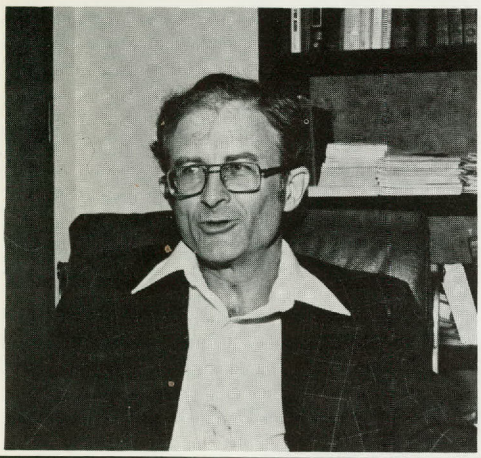
I remember answering that question before, but, at this stage of my life, after 15 years of practice, I probably have a better view. I was always more interested in ideas and in language and more passive pursuits than I was in changing things. I was always more of a thinker than a doer. So all the efforts I made to go through school and medical school didn't come easily or naturally. And of the various things you could do within medicine. . .you might ask, why did you become a physician? I think status had as much to do with it as anything. And I could feel that I was helping. Then why psychiatry?

I conceived of psychiatry as being a more idea-oriented, passive kind of thing where you didn't have to get up real early, where you didn't have to do a lot of things that required mechanical ability, which I don't have. I tried. I'm a self-improver. But I was smart enough to realize that I should go where my already established talents were.

But as time goes on there are rude awakenings: For example, there have been a lot of advances in the field of psychiatry that require—to keep yourself honest—a lot of keeping up with new information and new techniques. So the passivity, of wanting to keep on doing what you've been doing—it's pretty hard to get away with being that kind of a psychiatrist today. I'm talking about keeping up, about study, and making realistic assessments of what it is that you do, and having to change a lot.

Has your work changed, theoretically or practically? What do you think of therapeutic short-cuts?

Not so much my basic theories as some of my methods have changed. For example, some of the behavioral approaches are typically more short-term than the more dynamic ones, and



in that sense those are short-cuts. Short-cuts are important because time and accountability—the question, Am I doing all I can do for this particular patient?—is important for us to ask.

Economic considerations are paramount for almost everybody today, understandably. Cost-accounting and insurance coverage of treatment forced us to check ourselves and each other out. Are we doing quality work? Are the people we hospitalize getting quality care? I have felt the need to try to treat faster, to bring to bear therapeutic techniques that could in a shorter time get people to feel better.

I think that people who are pretty well put together and are able to work on one narrow area can gain a great deal in several months. They might come back from time to time. That's the way you can treat people within a given number of sessions. On the other hand, the more gaps and ego weaknesses a person has, the more personality problems of a long-standing nature, the greater is his or her need to come over a longer period. One way to accommodate that need to a time structure is to gradually increase the intervals between visits. This is done by the general medical profession in treating patients for a chronic illness. I like that idea. It gets away from the more traditional psychoanalytic model.

I'm not a psychoanalyst. I became interested in psychiatry through reading about psychoanalysis and knowing psychoanalysts, even through having some of my own treatment when I was quite young. The influence of psychoanalytic thinking is still everywhere in therapy. Much else has come to be mixed in, but the basic notion of psychoanalysis is the primacy of the individual personality and the conflicts the person has, and a kind of respect for knowing about those, even if you can't immediately help the person do much about some of these conflicts. It's good to know about your own conflicts, your own errors.

Do you think we are more in conflict with our environment than we have been?

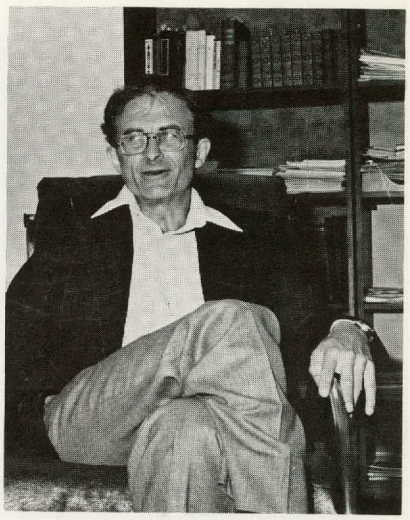
Yes. A lot of it has to do with time and money, the sense of having enough. Again, in the history of a person having enough to satisfy goes back to infancy—the so-called oral phase of development à la Freud, in which the notion of having enough dovetails with the basic notion of having enough sustenance, nurturance, enough security. And the external world's threats of not having enough either for now or later affect everyone.

Is this getting worse as our social supports are getting weaker?

Yes. We're too open to external inputs of all kinds—through the media, through constant contact with larger and larger numbers of other people. A certain amount of insulation and quiet is better at all stages of life.

How about guilt then, about the feeling one should be more involved in community or social action?

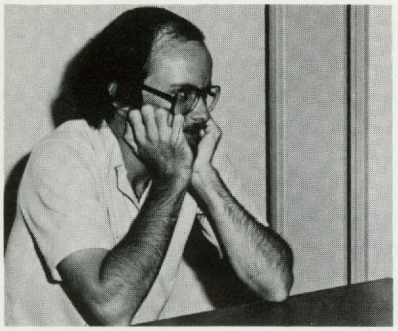
If I'm feeling good, my guilt does not plague me much. I think, Look, I'm doing the best I can. On the other hand, if I'm feeling lousy, then I knock myself on the head and say I'm not doing my bit. I think it's a matter of getting your conscience lined up to where you are. Obviously, someone like me with a private practice makes more money than if I were working in a public agency. But I think that I do better therapy in private practice than I would if I were getting a salary. I'm not saying this is true of everyone, but for me it's true because I have to gear myself up to do my best and be even more available to my patients. I think



you try harder when it's a competitive kind of thing. Private psychiatry is a competitive world—there are a lot of psychiatrists, and more and more very talented psychotherapists who are not psychiatrists. They often charge less.

Do you have a kind of patient with whom you do better than with others?

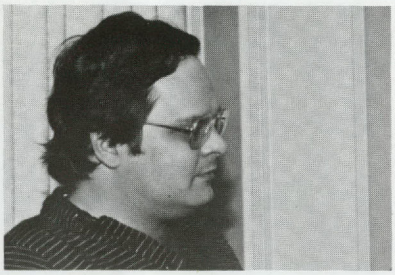
Sure. I have the idea that I do well with people who are idea-oriented, who are pretty cerebral kind of people, who read a great deal. A hypno-therapist named Spiegel and his son wrote a book in which they divided people by personality into three types: the more cerebral person, whom they call the Apollonian, the more emotive person called the Dionysian, and the Odyssean, who needs to succeed in terms of action. I used to and probably still do better with the Apollonian. I can tolerate a lot of obsessing, a lot of intellectualizing, because I have to stand my own.



What they get from therapy

Patients air their views

Asked what they're getting out of their therapy group, the members of Claire Frey's Wednesday night group offer an assortment of viewpoints.



Claire Frey and members of her Wednesday night group

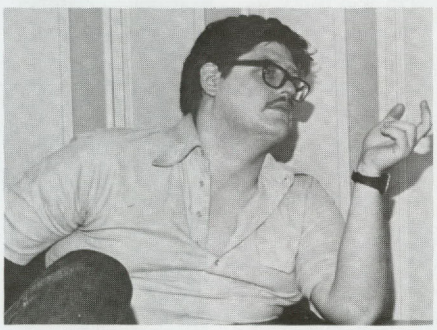
A psychiatric social worker in the adult outpatient service, Frey has been leading groups of schizophrenic patients 15 years. When she started, she says, she and another social worker were among the few people in the country conducting such groups, but now "sometimes group therapy is considered the treatment of choice, and such groups are fairly common."

Group members, she says, are very supportive of each other and "tend to help a member pick up when he's going downhill. If we can keep these people in good remission through support and medication, they can function. They have so much to offer."

John explains that the group is one of his few chances to be with people. He likes the socialization and the "input of other patients. It gives you another perspective on how to solve your problems." Before he joined the group, John went through a "semi-suicidal stage, a lack of will." When someone in the group disclosed that he wanted to die, "I could identify with that," John says. Being in the group has helped him to realize he's not the only person with those problems.

to see men as people

Valerie, a shy, pretty young woman, says that attending the group—she and Frey are the only women—has taught her to "see men as people, not just dates." She'd always felt uncomfortable on dates because she didn't know what to talk about, but now feels relaxed enough to say anything to the men in the group. "They're my friends."



"The group is better when there's male and female input," says Bob. A quiet, intense man, he says he spent his early sessions just listening to other members until he finally felt enough at ease to talk. Bob, says Frey, has made "a dramatic improvement."

Jim is less satisfied with the group. It's "too light," he says. Members should get "heavier about what's on our minds, not talk about teachers, bars, and cars." A different group he'd been in "made you dig, made you get somewhere."

Scott shrugs off someone's label of him as "the one with the best social skills." "I can't really say that anywhere else I'm a star," he says. "Sorry to disappoint you." When Scott first came to the group he was "pretty sick," with "delusions and a high level of anxiety." He's much better now—in fact, Frey tells him, a lot of group members wonder why he's still coming.

Seeing what other members are going through helps him to understand what happened to him, Scott says. It "sheds light on what I used to go through." In the group he also learned how to talk and listen to people. "I learned it's one thing to offer advice or suggestions, and another thing to jump on someone's case."

Although most of the time a visitor wouldn't suspect it, most of these group members have been hospitalized at least once. They're all functioning now and the majority hold jobs.

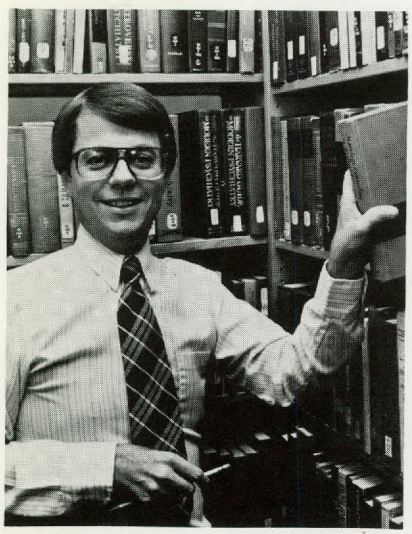
young and articulate

All in their twenties or early thirties, they are articulate and well-educated, dotting their conversations with mentions of Rice

Les Goekler

One week librarian Les Goekler's colleagues attended his going-away party, the next they welcomed him back. "I told everyone I was going to plead temporary insanity." Goekler says of the decision to return after two days on his new job. Although it paid much more, the other library position had kept him in a back room selecting books. "I hated it," he says.

What he likes about the TRIMS job, which he's held for seven years, is that "when someone requests library materials, I have total control from start to finish on the request. I'll see that that person gets it no matter what it takes." This has meant going as far as the British Lending Library to find a journal article, a six-week process. In all requests to other libraries,



listings have to be verified, the Library of Congress number found, and microfiche consulted to determine which library owns the item. In the last two days, Goekler says, he's had 120 requests for material.

Very often staff members call or write to thank him, which is another reward of his job. Goekler is "highly appreciative of the going-away party" and adds that he looks forward to his next party—when he retires.

Gretchen Warner

Gretchen Warner's volunteer work at TRIMS is multifaceted. She is co-therapist with Marilyn Barber of a resocialization group for schizophrenic patients (see related story, page 11). She "listens sympathetically" to callers for information and referral services while the I and R screeners attend meetings. And she will soon start to help hospital patients with occupational therapy.

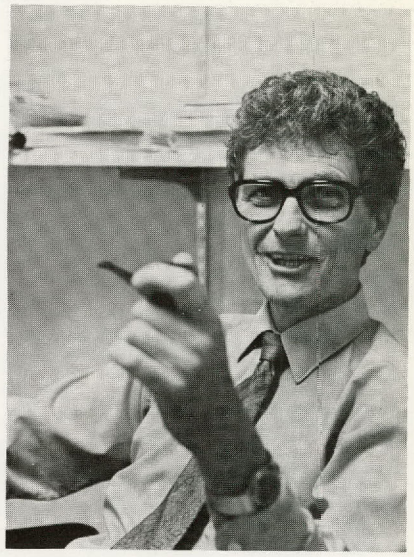
Warner, who has a master's degree in secondary education, has taught at a school for language and learning-disabled children and a residential school for emotionally disturbed girls. A graduate student at the University of St. Thomas, she recently completed course work preparing her to teach emotionally disturbed children and is "two-thirds through" the work for educational diagnostician credentials. Her ideal job, she says, would be teaching children with emotional or learning problems doing diagnostic testing, and working with families.

Warner has "strong feelings about service to the community" and thinks "all members of society are entitled to quality human services." She likes TRIMS because "it seems to me it serves all people, and I like being part of that."

Dr. Jack L. Franklin

Almost directly over his head in Dr. Jack L. Franklin's office are four wide shelves of texts on sociology, program evaluation, health care delivery, and a family of related topics. Should you want to try some aged ploys on him—like, Isn't program evaluation a waste of time and money? Or, Nobody has ever found out how to do it, have they?—please pause.

Franklin wrote an early (1976) text



on program evaluation himself; he taught college courses on evaluative research in Texas, North Carolina, and Illinois, and he practiced what he preached for several state mental health departments, most recently in Austin.

Franklin came here to conduct program evaluation, develop preventive strategies, and do service delivery research. His list of publications is long and practical. Acknowledging in his book that "the emergence of program evaluation as a management specialty has certain elements of slapstick comedy," he believes firmly, and he happens to know, that the effectiveness of services to human beings can be measured if the criteria are "honest and objective."

Ten percent of young retarded in state schools may have autism-like disorders

Probably one-tenth of the young residents in state schools for retarded have pervasive developmental disorders such as autism, in addition to being mentally retarded.

That estimate comes from a preliminary report by Dr. Kay R. Lewis of the TRIMS child development clinic and is the result of six months of evaluation workshops she conducted at 12 state schools during last spring and summer.

In a departmentwide survey, school staffs had identified 412 residents under age 22—from a total school population of about 3,250 aged 22 and younger—as possibly being autistic. From these 412, professionals at each state school then selected four residents to be evaluated at workshops which were also intended to teach differential diagnosis and the characteristics of pervasive development disorders as they are classified in DSM-III, the new **Diagnostic and Statistical Manual of Mental Disorders (Third Edition).**

distortions rather than delays

According to DSM-III, these disorders are "distortions" of basic psychological functions involved in "development of social skills and language, such as attention, perception, reality testing, and motor movement." They are different from the developmental delays typical of uncomplicated mental retardation, and they require additional intervention, Lewis said.

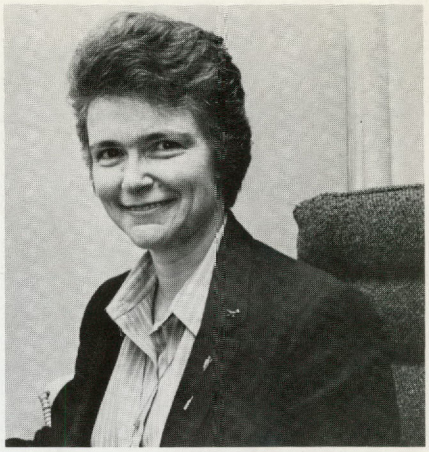
At each state school, the TRIMS team joined other department staff members and consultants in evaluating the selected four residents on the basis of videotapes, personal evaluation, and therapists' reports. Only six of the 48 proved not to have a pervasive developmental disorder in addition to mental retardation, Lewis said.

Though they require further analysis, the data indicate that 85.4 percent of the 412 residents identified in the original survey, and possibly ten percent of the total young state school population, are autistic or suffer from a related disorder.

need hear-see communication

To do their best, these clients require "really tightly structured programs, with special emphasis on behavior therapy, low staff-client ratios, and a total communication program that combines sign and oral language and involves everyone who has contact with that child," she said. "If a child sees a thing as well as hears it, the child is more likely to understand and feel less frustrated."

Dr. Kay R. Lewis



Gilbert Hanke, a speech pathologist and director of habilitation at Mexia State School, had demonstrated that the incidence of aggressive outbursts among emotionally disturbed, mentally retarded children can be reduced by a total communication program, Lewis said.

The workshops were attended by 678 staff members and showed "how really concerned the people at each mental retardation facility are about appropriate diagnosis and programs for their residents," Lewis said.

Texas Research Institute of Mental Sciences
1300 Moursund Street, Houston 77030
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Joseph C. Schoolar, Ph.D., M.D., **director**
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Karen Hanson Stuyck, **associate editor**
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