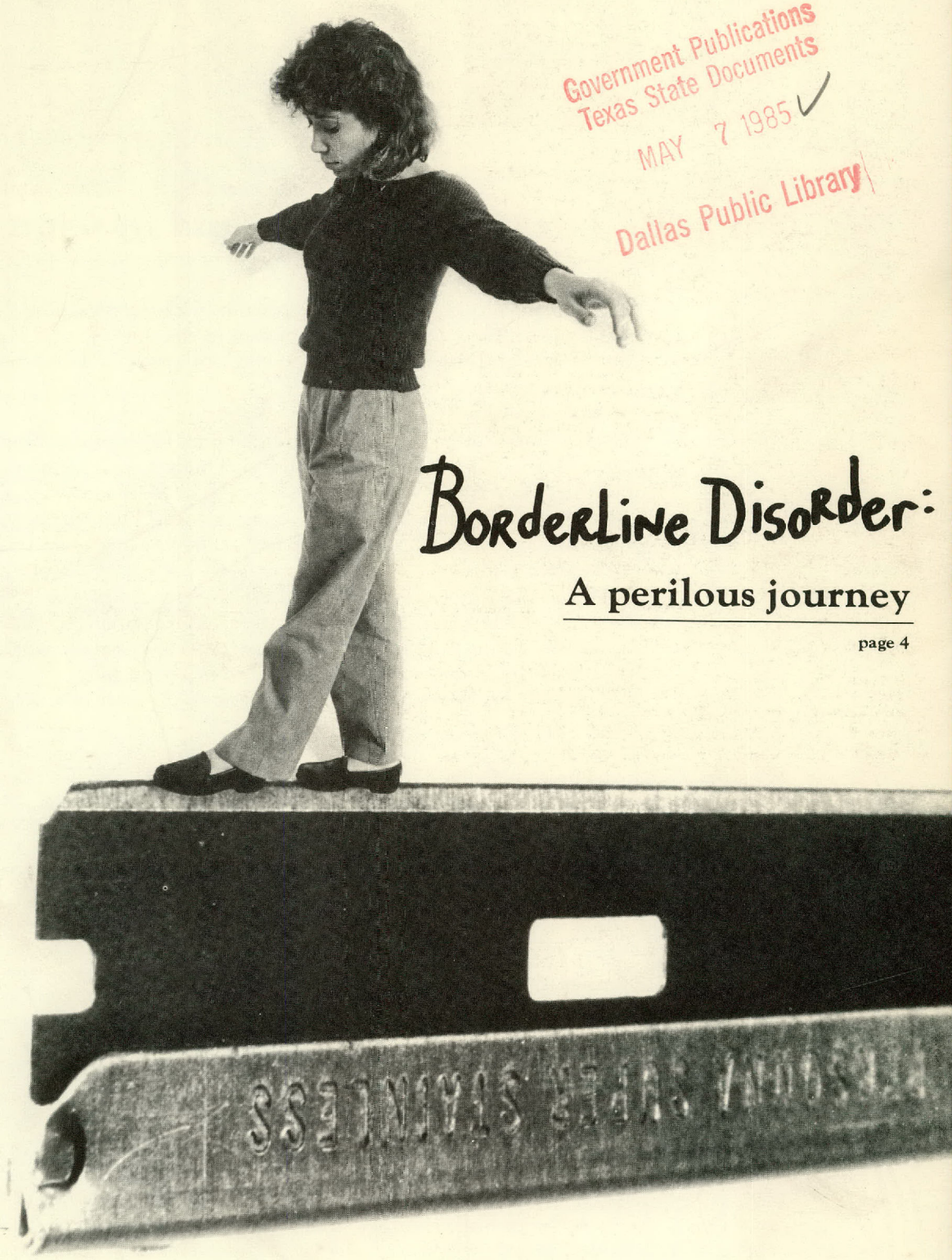
The Emissary

Texas Research Institute of Mental Sciences, Houston April-May 1985



Borderline Disorder:

A perilous journey

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(Below) TRIMS staff members crowded into the auditorium to listen to director Dr. Joseph C. Schoolar (left) discuss the future of the institute.

Dr. Schoolar writes

Will TRIMS continue—and in what form?

In an enormously crowded auditorium, with people lining the walls and sitting on the stage, I reported to the staff Feb. 27 about the proposed transfer of TRIMS to the University of Texas Health Science Center.

That same day, the budget and oversight subcommittee of the Texas House Public Health Committee voted to eliminate funding for TRIMS. The proposal was to use our budget for staffing the new State and County Psychiatric Hospital in Houston, improve staffing ratios in state hospitals to comply with U.S. District Judge Barefoot Sanders' orders, and to equalize the funding of community centers.

We do not know which one of these two possibilities will happen. Nearly every day brings us different information. We are doing everything possible to retain our funds to continue working as part of the University of Texas Health Science Center.

The excerpts below are from my report to the staff Feb. 27. They express our best efforts and hopes.

We are all here to discuss the proposed transfer of TRIMS to the University of Texas Health Science Center at Houston, a change that has been talked about for many years. Dr. Miller, our commissioner, called me last week to say the transfer was indeed going to occur, and a rider to the appropriations bill had to be written.

Dr. Miller and I agreed on the salient points; this is what I asked for:

- that TRIMS be transferred as a whole and not divided among health science center facilities
- that all TRIMS patients be assured of continued care
- that TRIMS employees be transferred without loss of benefits
- that we be given an opportunity to continue our research.

I will tell you about the first draft of the rider but I must emphasize that there will be many changes and we do not know what the final version will be. Furthermore, the transfer may have to be accomplished by new legislation, not merely a rider. Essentially, the reasoning is expressed in this draft:

On September 1, 1985, the Texas Research Institute of Mental Sciences should be transferred to the University of Texas Health Science Center at Houston.

Such a move will be a cost-effective method of consolidating Texas Department of Mental Health and Mental Retardation functions in Houston in the new State and County Psychiatric Hospital, which will open in late 1986 or early 1987.

Using the resources of the University of Texas Medical School in conjunction with the research and training resources of TRIMS would give the state an effective and excellent vehicle for exemplary research and training.

Such a consolidation of resources for the new State and County Psychiatric Hospital will allow the state to save a significant amount of money in the coming biennium.

The transition team set up to take a look at this includes Dr. Charles Mullins, executive vice president

of Health Science Resources, University of Texas System; Bob Inge, University of Texas health facilities developmental specialist; John Darrouzet, legal counsel for the UT System; Dr. Louis Faillace, acting dean of the University of Texas Medical School at Houston; Charles Schotz, executive assistant to TDMHMR Commissioner Dr. Gary Miller; and myself.

Our calculations are that the transfer would save about $4 million and make available money and staff resources to plan and begin the training of personnel for the new hospital.

This means that the TRIMS budget of $13 million in 1986 and $11.25 million in 1987 would be transferred to the University of Texas Health Science Center, present research activities would be maintained, our training budget would be combined with that of the State and County Psychiatric Hospital, and part of our outpatient budget would be used partially in the new hospital's staffing budget, the rest to maintain selected outpatient programs.

Significant savings would be achieved by combining TRIMS administrative and support services with those of the University of Texas.

Our inpatient service would become part of the new hospital.

That is where we stand at the present time, but strategies for transferring TRIMS to the UT system are under continuous discussion. I have to say again that we don't know whether or not this will happen, or what the final structure will be.

If it should occur, the aspect for which I am responsible is to accept the change as a challenge. You share this responsibility with me. The TRIMS staff, I believe, will benefit from the transition. We will have new duties in the new hospital, while our research will shift to different clinical problems.

My intention is to carry TRIMS forward in the best possible way—to the time of transfer or nontransfer—and to make sure that the interests of our patients and our staff are protected.

- We have treated an average of 5,000 patients each year since TRIMS was established in 1960.
- We currently have 531 staff members who have many "firsts" to their credit: the Gerontology Center and Texas Project for Elders, the "stages of change" treatment system for alcohol abuse, the automated analysis of electroencephalograms, the multiphasic assessment of new patients, just to mention a few.
- Our basic research speaks for itself, both in quality and quantity. We are moving ahead in clinical research in such areas as mental retardation and developmental disabilities.
- We are among the country's leading training centers for psychiatry residents preparing to serve in public facilities, for psychology interns, and for psychiatrists and psychologists who want to specialize in treating elderly patients.

We are proud of our accomplishments and want to be able to continue our work in as united a fashion as possible. I will keep you informed about our situation.

Correction

The printing of two illustrations of chorionic villus tissue on page 7 of the February 1985 *Emissary* was a violation of copyright. We did not know this at the time and apologize to the publisher, Wolfe Medical Publications Limited, London.

The entire collection of illustrations appears in *Color Atlas of Life Before Birth: Normal Fetal Development.* A set of 50 slides (designed for nurses, midwives, biology and science teachers) and a 200-slide set (for embryologists, anatomy teachers, and libraries) will be available this year from Year Book Medical Publishers, 35 East Wacker Drive, Chicago, Illinois.

Tom Scott, 1914-1985

Tom Scott, a janitor at TRIMS since 1965, died of heart failure Feb. 16 at Hermann Hospital. He was 71 years old.

Although Scott retired in 1981, he stayed in touch with his coworkers by visiting once in a while and through his niece, Leola Burks, a laboratory technician in the multiphasic clinic. Scott lived with Burks and her two daughters.

"He was popular with everybody because he was a kind, lovable man," says plant engineer Wallace Ragan, Scott's long-time boss. "He had his routine. He'd do anything to help people."

His death, Burks says, "has made our house awfully quiet. My daughters called him 'our noisy little toy.' He was such good company, the life of our house."

Burks thanks all her colleagues for their expressions of sympathy and support.

The name fits, but what is it?

Borderline personality disorder is like living in no-man's land

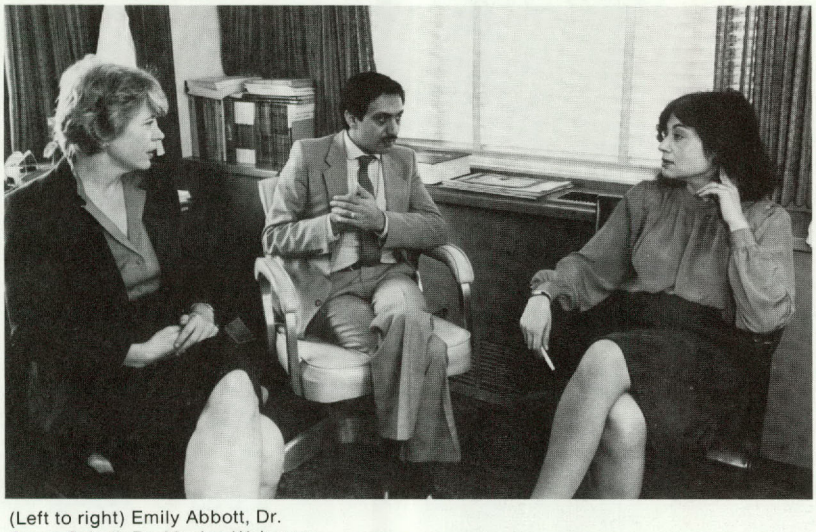
They are adults who act as if they never left the terrible twos.

To them, people are either good or bad, loving or hateful, but never a combination. They fear aloneness, but their tantrums, unpredictable behavior, and exhausting crises alienate the people who might care.

Fierce emotional pain sometimes drives them to slash their arms or burn themselves, often in a desperate effort to scream for help. But they usually resist hospitalization and, once admitted, may lash out at those who treat them, complain to administrators, and demand to be discharged.

People with borderline personality disorder, as defined in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), are not easy to treat.

Without necessarily intending to, they may draw their therapists into a vortex of crises, manipulating, frustrating, and finally defeating them.



(Left to right) Emily Abbott, Dr. Cyrus Sajadi, Dr. Maxine Weinman.

"They are the number one patients psychiatrists do not want to treat," says Dr. Cyrus Sajadi, chief of the TRIMS inpatient unit. Which is precisely why Sajadi is interested in them.

"Public institutions like TRIMS will become the prime place where they are likely to be treated." He estimates that as many as 20 percent of adults referred to TRIMS have a borderline personality disorder and that the number is growing as more patients are identified.

Sajadi and a team of therapists and investigators are studying the disorder to:

- identify common characteristics of the patients, like job stability, history of illness, family ties.
- see if certain characteristics relate to and can predict how well patients will do in therapy.
- determine what kinds of medication help these patients most.

The research team consists of Sajadi, who first requested the study; Dr. Maxine Weinman, who designed the study and a rating scale for borderline personality disorders; and therapists Emily Abbott, Dee Pizzitola, and Laura Wolff, who collaborated on research development and treatment planning.

According to *DSM-III*, people with borderline personality disorder are impulsive or unpredictable, have intense, often volatile relationships, and cannot control their feelings of anger and rage. They despise being alone, feel chronically empty or bored, and are confused about their identity.

"A typical feature of a person with a personality disorder may be acts of self-destruction and self-mutilation," says Abbott. Such a person frequently shows up when he or she is in the midst of a crisis. Attempted suicide is not uncommon.

"Borderline personality disorder is probably one of the most controversial issues in psychiatry right now," Abbott says. Although the disorder has been given a name, mental health professionals are still not sure what they are dealing with.

The definition of borderline syndrome represents a wide range

of psychopathology. The controversy, Abbott says, focuses on questions like: Who is a borderline patient? How do we diagnose her or him? What is the best form of treatment? And what is the etiology of the disorder?

"This is what makes borderline patients so challenging to work with. It's still a new frontier in psychiatry," Abbott says.

Fifteen patients so far

The team has admitted 15 patients to the study and hopes to see at least 20 more. Patients are screened with the Diagnostic Interview developed by Dr. John Gunderson, and administered the Premorbid Scale, a test designed by Weinman to examine patient characteristics (work history, stability of relationships, drug use, and other mental health problems). They are then placed in short-term (three-month) therapy.

In therapy the patients deal with issues of trust, identity, self-esteem, and interpersonal relationships. They are tested monthly to see whether or not their symptoms are improving and they have complied with therapy.

"We're looking at who drops out early, who quits after three months, and who wants to continue therapy. We want to see if we can predict anything from the premorbid scale," Abbott says.

The severity of the symptoms borderline patients experience falls along a spectrum between neurosis and psychosis. Sajadi believes that patients who come closest to resembling schizophrenic patients may do well on antipsychotic drugs. Those whose symptoms are closer to an affective disorder may be helped by mood-stabilizing drugs like lithium carbonate. Later in the study, he plans to test his hypothesis.

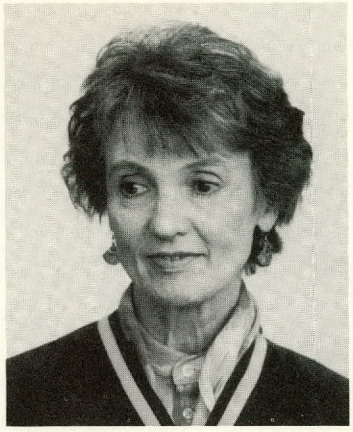
The two-year study, now one-third complete, is important to TDMHMR, Sajadi says, because borderline patients tie up a great deal of resources and time with very little therapeutic success. "It is so important to find out what kind of therapy can be most helpful and to determine whether we can offer it or should refer these patients elsewhere."

Kathleen Kimball-Baker

Nothing wrong with stepfamilies that time and patience can't cure

Psychologist Emily Visher says she is not particularly fond of the newest labels for stepfamilies, words like blended or reconstituted.

"They sound like a bunch of people running around in a blender. Names like that came about because stepfamilies have such a negative image. But I say, 'What is so bad about stepfamilies that we have to change the name?'"



Emily Visher

Visher and her husband John, a psychiatrist, are founders of the Stepfamily Association of America. They have been counseling families for eight years, with wisdom grounded in experience. When they married 25 years ago, they each had four children whose ages ranged between five and 16.

In a recent visit to the Texas Medical Center, she recalled the chaos of those years. "We used to call it our accordion family." she says, pretending to play the musical instrument. "Sometimes we had six kids at home, the next day two, and the next day eight."

Stepfamilies were more of a novelty in those days, she says. But today, with the ever-increasing divorce rate and the high incidence of remarriage, stepfamilies can hardly be considered "alternative" families.

Their numbers are growing rapidly. An estimated 1,300 new stepfamilies are formed each day. By 1990, she says, single-parent households and stepfamilies are projected to outnumber biological families.

Stepfamilies face tumultuous adjustments, she says. "It is so important to have realistic expectations. You must understand that it takes time to start new traditions and to develop relationships. Stepfamilies are families without a history."

"Tribal rites" like how to fix spaghetti and whether or not to put marshmallows into the hot chocolate are different for each family. New traditions and ways of doing things need to be worked out, she said.

If parents and children understand that problems will arise and solutions take time, the snags will be easier to handle, she says.

"It's like Dr. Spock and his book on children. Before he told us about the terrible twos, a lot of parents got quite upset when their children acted up. But after Spock told us it was normal, we didn't feel like throwing up our hands," she says.

Visher offered these suggstions to stepfamilies:

- Stepparents, like new parents, need time to get to know each other. The temptation is to feel guilty about the children's feelings and to try to cater to them. But like a biological family, the best thing stepparents can give the children is a happy marriage. The children need a model of how a good relationship works.
- Get to know the stepchildren away from their biological parent. Take them out and form new relationships.
- Make sure each child—step or biological—has some time alone with each parent, even if only to run to the store or to read a story.
- Children need to learn to share, but if they know that they will definitely have a turn at something, the waiting will be easier.

Kathleen Kimball-Baker

DOWN but not out

How therapists feel about their chronically ill patients

More than two years ago, members of a TRIMS research team patrolled the entrance to a symposium on chronic mental illness like guards at the Tower of London.

Participants (psychiatrists, psychologists, social workers, scientists, nurses) were allowed to enter the meetings only after they had completed a short questionnaire on their views about patients, the current state of treatment methods, and the direction of research.

It is no surprise, then, that 87 percent of the 502 symposium participants completed the survey and that the results are so provocative that *Hospital and Community Psychiatry* is publishing them this month (April).

"The chronically mentally ill: A survey of professional attitudes," was written by Drs. Mohsen Mirabi, Maxine Weinman, Sandra Magnetti and by Kathleen Keppler.

The answers to the 23-item survey reflect a frustration with state-of-the-art treatment of chronically mentally ill people, a hope that research in biological psychiatry and neuropharmacology may one day offer practical answers, and the wish for cooperation between practioners of all mental health disciplines.

The survey also solicited comments. "Their answers are so genuine and sincere and they reflect how much effort and commitment it takes to work with chronically mentally ill patients," says Mirabi, assistant head of the clinical research division.

"They (patients) do not reward our efforts by getting 'better' within an easily observable period of time, or, if they improve, they backslide and we can begin to feel much as they do about the hopelessness of their situation," one therapist wrote.

More than three-fourths of the answers came from people who work in the Texas Department of Mental Health and Mental Retardation. Of those who responded, 18 percent were psychiatrists; 17 percent, psychologists; 16 percent, social workers; 14 percent, caseworkers; 7 percent, psychiatric nurses; the rest were allied mental health professionals.

Not favorite patients

Eighty-five percent of the respondents agreed that chronically mentally ill people are not preferred patients in mental health agencies. Professionals tend to avoid such patients because working with them brings few rewards. Two-thirds of the respondents believe most clinicians do not receive adequate training to deal effectively with these patients.

Although 86 percent of the respondents find working with these patients intellectually challenging, an almost equal number saw burnout as a common problem.

The majority agreed that the patients' lack of compliance with medication gave them a feeling of helplessness and that cooperation from the patients' families was not good enough.

Particularly frustrating to the respondents were lack of resources for treating patients, discontinuity of care, and a failure to combine different treatment strategies to meet all the patients' needs.

Forty-one percent agreed that most clinicians are not optimistic that current therapeutic regimens relieve symptoms or can stabilize patients.

For biological research

Almost half of the respondents said biological psychiatry is the single most important area of research for providing practical answers. Social approaches were considered relatively important by 33 percent. Psychoanalytical theories were rated as important areas of research by only one percent.

Despite their optimism about research, respondents also said they believe that research protocols are more likely to be funded than treatment programs.

Mental health professionals today work with a much different population of chronically mentally ill patients than they did 20 years ago, Mirabi says.

"Deinstitutionalization combined with financial cutbacks and system overload has fragmented the once static population of chronic patients in public hospitals into a variety of subpopulations who have contrasting service

Drs. Maxine Weinman, Mohsen Mirabi, Sandra Magnetti

needs. These conditions have created feelings of hopelessness and frustration."

New patient generation

Patients today, says Magnetti, don't accept the system as did patients who spent their lives in institutions. Today, they are more transient and outspoken about their civil rights.

"We're dealing with the baby boom population. Their rejection of the system is pervasive. They have never been institutionalized for long periods and travel from place to place. In the 60s that kind of rejection was the norm and young chronic patients blended in with the 'hippie' generation. But their rejection is not one of ideology, it is part of their thought disorder. Now that society has shifted to more conservative patterns, these patients have become more apparent."

Added to that, says Mirabi, is the problem of fragmented services. "You find yourself dealing with so many obstacles. Each government—county, state, city—has a different set of rules and regulations to contend with."

"The survey tells us that we need to do much more long-range planning and training and not ignore one another's contributions to the field. There is a danger in becoming obsessed with one treatment approach," he says.

"We need to look at ongoing management of the patient's chronic mental illness, not just treat him or her during the crisis phase. You wouldn't just treat a diabetic patient for insulin shock and send her on. You need lifelong planning to manage the person's disease."

In the clinical research division, Mirabi says, the survey is one of several projects focused on this group of patients. In other studies Weinman, Magnetti and social worker Claire Frey are looking at homeless patients and living arrangements for schizophrenic patients. Mirabi, Magnetti, and social worker Andrea James are studying mentally retarded people who are also schizophrenic.

—Kathleen Kimball-Baker

Comparative Services Research Section

Half a dozen projects at once

The comparative services research section, where paper seems to reproduce itself and the computer needs a nap, has its own kind of revolving door: questions in, information out.

The section, headed by Dr. Jack Franklin, was set up last year to research problems of immediate, practical concern to the state mental health system.

Acting as an information source for organizers of preventive programs throughout the state is one part of the job. Although the section has only five staff members—researchers Franklin, Dr. Jane Simmons, Brenda Solovitz, Dr. Toni Alterman, and administrative assistant Myrna Harlan—their agenda of current studies is long. Part-timer Wen Lu, a University of Houston student, helps with data analysis.

Franklin, a sociologist, directs a group that tackles new problems almost weekly, responds to new questions daily, and looks for collaborators and financial supporters all the time. The longer-term projects the researchers work on are complicated and often have a background of tragedy.

Death of discharged patients

One study concerns differences in mortality rates of patients discharged from Texas state hospitals between January 1979 and August 1982. This period coincides with the department's changeover from diagnosing patients according to the American Psychiatric Association's *Diagnostic and Statistical Manual—II* to using the *DSM-III*. The newer manual, Franklin explains, makes sharper distinctions among psychiatric disorders, and these may correlate with differences in documented causes of death.

The question is important because certain diagnostic groups—manic depressive patients, for example—are at greater risk of suicide and accident than patients diagnosed as schizophrenic.

One serendipitous finding is that a higher than expected number of patients discharged during 1980 died from pneumonia and influenza, "preventable illnesses," Franklin says.

The two diseases account for 10.4 percent of deaths among the mental patients, compared to 2.4 percent among the state's general population. Franklin is not ready to attribute the abnormal death rate to the former patients' homelessness, poverty, or lack of support, yet that is the suspicion.

Nearly 54,000 patients were discharged from state hospitals during the

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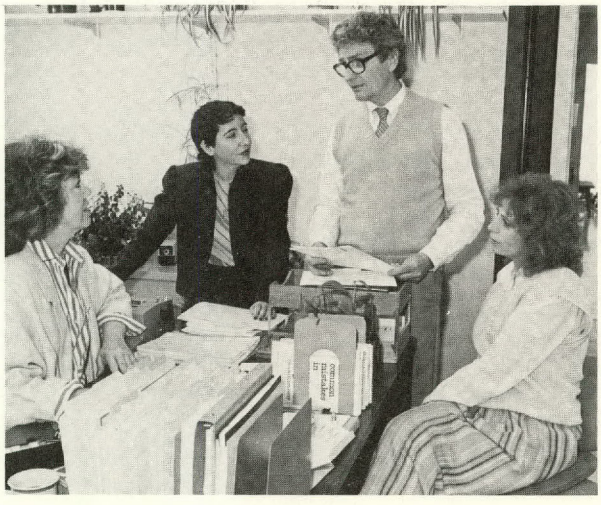


(Left to right) Myrna Harlan, Brenda Solovitz, Drs. Jack Franklin and Jane Simmons.

Comparative Services Research Section

continued from page 7

period studied and 2,117 died—3.94 percent. Heart disease, accidents, pneumonia and influenza, cancer, and suicide were the five leading causes of death.

The study, not yet finished, has implications for the evaluation of psychiatric illnesses in relation to death risk, and especially for discharge planning and follow-up, Franklin points out.

His collaborators are Mark Mason in the TDMHMR central office and Dr. Robert Markusch of the University of Alabama Medical School.

Suicide among adolescents

Using Texas Department of Health records, the section will conduct a statistical study and "psychological autopsy" of suicides among adolescents, younger children, and young adults to try to clarify events that led to "cluster suicide." Tragedies of this kind recently occurred in Clear Lake City and Plano, but it is possible, Franklin says, that there have been others in Texas that have not received public attention.

The TRIMS researchers will review the literature and statistics of violent death among adolescents and the younger and older groups. Some accidents and homicides may actually be suicide, the researchers believe. The adolescent suicide rate more than tripled between 1950 and 1980, and suicide is now the third leading cause of death among 15- to 24-year-old persons. The younger children are included in the study because they have so many fatal accidents other than in automobiles.

The study is supported by the federal Centers for Disease Control and by the Adolescent Suicide Task Force headed by Dr. Betsy Comstock of Baylor College of Medicine and the Veterans Administration Medical Center. Task force members represent the Mental Health and Mental Retardation Authority of Harris County, the University of Texas Medical School and School of Public Health, and Texas Children's Hospital.

Area newspapers will be studied to see whether or not the timing of press attention, or its absence, seemed to influence the events. Relationships among the young suicide victims are part of the study, as are the young people's social profiles and those of their schools and communities.

Genetics education

In a program evaluation project typical for the section, the researchers are helping the Genetics Screening and Counseling Service staff in Denton analyze the value of their education materials. Do people know more about prevention of birth defects and help for handicapped children after they've read and seen GSCS pamphlets and slides?

GSCS education director Jeanne Nicholas and Simmons will do telephone surveys on pre- and post-contact attitudes and knowledge among the agency's families.

"Our profession has a lot of experience with field research and sampling methods. We expect to help the genetics staff with the evaluation, not tell them how to do it," Franklin says.

Stress among mental health workers

Two other studies are well along. Solovitz is working with the staff of San Antonio State Hospital to investigate stress among mental health workers, who have notoriously tough jobs and low salaries. She is asking such questions as: Do mental health aides in acute-patient wards feel less stressed than those working with chronically ill patients who may not improve much? Does this mean they have more disagreements with supervisors or take off more time in sick leave? The study is Solovitz's dissertation for a doctor of public health degree from the University of

Results show 1-on-1 links 'make sense'

Hard data about the success of case management in Tarrant County are not yet in because second interviews with the project's 417 clients won't be finished until this summer.

Section chief Dr. Jack Franklin said, however, that the study has already shown that clients who have case managers gain access to a wider variety of recreational, medical, social, and psychological services than do clients without this kind of help.

The tougher questions—Does case management keep former state hospital patients from going back? How much does case management cost?—have to wait a while for answers from researchers in the TRIMS comparative services research section and their partners, the Tarrant County Mental Health and Mental Retardation Services in Fort Worth.

Meanwhile, the Fort Worth Star-Telegram headlined a story, "1-on-1 effort slows the 'revolving door'" and reported that case managers "are forming active one-on-one links with dozens of the most needy mentally ill....If a client needs food, a case manager helps him or her get food stamps. If a client needs a place to sleep, a case manager helps to negotiate the bureaucratic maze to get federal rent assistance."

This study represents the first time that services are

being documented and evaluated in terms of the clients' quality of life. Everyone in the study has been discharged from a hospital at least twice. Two groups, those helped by one of seven case managers, and a similar group negotiating the community services system alone, were interviewed last year. Interviews are being repeated now as a second stage before data analysis, and Franklin admits it's not easy to locate all the people who joined the study earlier.

He and researchers Dr. Jane Simmons and Brenda Solovitz at TRIMS and project manager Dr. Kathleen Jordan in Fort Worth already know, however, that the case management clients are using at least 158 different services outside the community center. These include hospitals, physicians, psychologists, legal aid and law enforcement people, self-care groups, leisure activities, and shelters.

The case managers, Franklin said, are "brokers. They make sure clients get what they need from services scattered throughout the community."

As consultants and data analysts, the TRIMS researchers are connected to their Tarrant County collaborators by computer and telephone instead of highways and flight paths.

"Later this year," Franklin said, "we will answer questions about case management costs, and the clients' hospital readmissions and living conditions in the community. But we know that case management makes good sense."

—Lore Feldman

Texas School of Public Health.

Another dissertation project is Pamela Lewis's study of the job-seeking behavior of chronically mentally ill people, an issue important to patient follow-up. Lewis, who is not a TRIMS staff member, will receive a Ph.D. degree from the same school.

Evaluation for NIMH

The section has been asked by the department to work with the National Institute of Mental Health on evaluating child and adolescent services funded by block-grant "set-asides" (meaning specified money) to the states. Chances are, Franklin says, that one such project will be in the Rio Grande Valley and one in the Houston-Galveston area.

The section's latest proposal is to work with Dr. George Niederehe and Nancy Wilson of the Gerontology Center to find out how effective and costly it would be to provide care for mentally ill people in nursing homes.

Nursing homes resist admitting mentally ill elderly people because they are difficult to care for and because psychiatric treatment usually is not part of nursing home care.

"What would it take for the state to provide long-term psychiatric supervision in nursing homes so that elderly patients could live in their home communities instead of state hospitals? What if the $35 a day the state pays for community care were applied to nursing home costs?" Franklin is asking.

The study would not be done in Houston, he says, because nursing home care in this city is atypical. More, though not many, psychiatrists work in nursing homes here than in small Texas communities, and the Houston research data would not be useful elsewhere.

Franklin and his staff always have half a dozen projects going at once. They are as excited about the ones that will take a week as about those that will take a year or two.

—Lore Feldman

Library tips

The second volume of *Aging 2000: Our Health Care Destiny—Psychosocial Issues* follows the first one, *Biomedical Issues*, by only a few months.

Volume II (Springer-Verlag, 1985) is edited by Charles M. Gaitz, George Niederehe, and Nancy L. Wilson. While volume I contains the 1983 TRIMS symposium's more technical papers, volume II authors explore the social, financial, and moral issues of health care for the aged in the future.

"A salient theme running through Volume II is the mention of moral and ethical issues that will be part of the future health-care scene. Ageism, in the form of negative attitudes and biases against active treatment and rehabilitation of the aged, will remain an issue to be combated among health-care providers, and in society at large," the editors write.

The book opens with overviews by Robert H. Binstock, Terrie Wetle, George C. Myers and Kenneth G. Manton, then goes on to sections on health and changing concepts of the life cycle, emerging trends of working and health, future directions in cognitive assessments, health care and physical environment, social supports in the future, care delivery in a state mental health-mental retardation system, rehabilitation, long-term care, future financing of health care, legal and ethical concerns, visions of aging and culture, "squaring the suffering curve," and health care in the next century.

The two volumes together contain as wide a view and as thorough a discussion of health care this generation of gerontologists can possibly pass on to the next one.

Young and old geriatric troupers get together

When 115 assorted social workers, directors, and community referral whizzes came from all over Texas to the Winter Gerontology Center Forum in Houston, they acted like members of a far-flung family getting acquainted for the first time.

It was the first time the Texas Research Institute of Mental Sciences' Gerontology Center held a conference not starring famous experts. That kind of meeting is coming in April.

The one in late January had its own glow because the participants found they had a common history, shared ideas, and loved the same people—the older folks in their communities.

"Once you get a taste of working with the aged," said J.C. Thomas, deputy director of the El Paso Center for MHMR Services, "you never get rid of it. They are a fascinating group of people."

Like many others, Thomas talked about patched-together services and "missing coordination." The legislature has to be persuaded to put money into services for the aged. "Some high-level policy decisions have to be made," he said. The TDMHMR regions must find ways to get together, eliminate red tape and coordinate their geriatric services with those of state departments of human services and of aging, and with their "triple A's," the city and county area agencies on aging.

Trials and errors

In describing the history of their programs—in many cases three or four staff members try to serve elderly people in as many as 14 counties—the participants described their successes, their trials and errors. Their successes come from doing a lot with a little. They use volunteers for a home maintenance program in El Paso for example, have Waco university students visit clients at home, make behavioral principles work in Terrell State Hospital's geriatric unit, and do practical, applicable research in Houston.

Sometimes they start a family service and nobody comes. Other times they run up against their rural communities' belief that counseling means you're crazy, and if you allow a mental health worker inside your door, your next stop will be the mental hospital or the nursing home.

Below (left to right), Gerontology Center Forum panelists Ron Cookston, James E. Smith, and J.C. Thomas.

Right, Dr. Charles M. Gaitz and Howard Rabinowitz.

The panel on treating mentally ill elderly with limited resources was moderated by Howard Rabinowitz, conference organizer and training coordinator for the TRIMS Gerontology Center, and led by Dr. Ranjit Chacko, Mental Health and Mental Retardation Authority of Harris County; Howard Gruetzner, Heart of Texas Regional MHMR Center; Dr. Richard Hussian, Terrell State Hospital; and Marge Sherwood, El Paso Center for MHMR Services. They and their audience said:

- Funding is short, and we already know what the most critical needs are—food and housing. To give health and mental health care, we must work with others like a "family of agencies." We can't do everything for everybody.
- The aging are in double jeopardy, loaded down with the stigma of mental illness and myths of aging. We must raise community awareness of mental health, work with aged people and their families wherever they are, at home, in nursing homes and community hospitals, and do "a lot of follow-along."
- Outpatient clinic staffs must include people who have a special interest in geriatric patients, and in state hospitals currently used inservice training does not prepare staff members to work with the elderly.

Fit programs to retarded elders

Panelists Richard Browder and Pam Parks of San Angelo State School, and Dr. George Foelker, a TRIMS geriatric psychology fellow, bravely attacked the topic of managing and treating elderly people who are mentally ill and mentally retarded. Among a multitude of ideas, experiences, and statistics were these:

- Retarded people go through the same aging process as others, sometimes in an accelerated way. Their training programs must encourage them to stay active, but in accord with their age and intellectual function. If elderly state school clients say they are retired and don't want to work any more, they should be persuaded at least to maintain skills and physical function.
- Elderly patients diagnosed as retarded early in their lives might not be retarded according to newer tests. Intelligence tests are still not standardized for the elderly. Further, we tend to overdiagnose retardation in the elderly and neglect psychological deficits: medication effects, lack of motivation, slowness, and the testers' lack of skill often lead to misdiagnoses of retardation and, on the flip side, failure to note psychiatric problems.
- As elsewhere, three percent of the state's population is believed to be retarded, which means that if the Texas population grows to 20 million in 1990, the state will have 2.7 million retarded persons. Today, only 1.3 percent of the elderly retarded are served by the TDMHMR system. One reason for this is lack of services, but also the run-around families get when they try to find programs.
- We need case management, a "one-stop shopping system." This point was made clearly and often, but obstacles are some agencies' unwillingness to share costs and give up "power bases."
- Staff members working with these clients should be sensitive and understanding. Mandated activity standards often do not fit the clients. Many sheltered workshops require more speed than elderly workers can muster.

Know the turf

Jim Brittnacher, TDMHMR coordinator of the liaison worker program and a man with at least three other jobs, moderated the panel on consultation and education with Dr. Ron Cookston of the Sabine Valley Regional MHMR Center, James E. Smith of Vernon State Hospital, and J.C. Thomas.

That Brittnacher can spend only 15 percent of his time on aging programs was proof enough that the department's "interest" in aging is usually in response to some crisis. But the aged are now considered a priority population in the budget and that will make some difference in the future," Brittnacher said. The panel stressed:

- Knowing the turf and respecting the communities' culture, especially in rural areas where there "might be more cattle than people."
- Offering preventive services like daily phone calls and using "natural helping networks" of neighbors and families.
- Treating elderly people with the dignity and respect they deserve—not saying "we've come to save you."
- Integrating programs instead of doing everything piecemeal.
- Caring for people in the least restrictive environment, which cannot be done without more funds for community programs. We can't discharge hospital patients saying, "Here's a dollar for bus fare, good luck."

"The sort of energy expressed at this meeting," Brittnacher said, "may never be greater than it is right now. I'm excited about this event. The people in this room have the possibility of networking, and perhaps that is where we need to go. There is no excuse for lack of communication. We have a golden opportunity to accomplish some things, and we need to begin working on them."

Dr. Charles M. Gaitz, head of the TRIMS Gerontology Center and sponsor of the meeting, offered the center's help in keeping up what had been started.

—Lore Feldman

Case managers helped 692 frail elders, they want to keep doing it

Four years ago the TRIMS Gerontology Center's Texas Project for Elders won a national "beauty contest" and became one of the country's pathfinding case management programs to connect frail, elderly people with the services they need to live at home.

Houston's "long-term care channeling," as the case management demonstration is called, is funded through April by the U.S. Department of Health and Human Services.

February 25, with two months of federal funding to go, the project's smart, beautiful people—founders, staff, volunteers, allies and consultants in the Texas Department of Human Resources—met to look at their future and past.

Trying hard to keep sadness out of the meeting, they reported on what they have learned so far and talked about how the program might continue.

Before the Texas Project for Elders started, director Nancy Wilson, a social worker, had spent a year in meetings with experts in the community to devise a program to enable sick, elderly people to live at home with as much independence as possible.

In three years, project staff members did this for 692 clients.

They wove a network of services, recruiting medical and social support from other agencies or providing it themselves. Through their caregiver support groups, TPE case managers bolstered the elderly clients' family members, neighbors, and friends to keep them from becoming worn out from caring for the old people they wanted to keep close by.

Flourish at home

TPE showed beyond a doubt, Wilson said in an interview with the *Houston Chronicle*, that many frail, elderly people can flourish at home with the proper help and support. "The program has been cost-efficient, and it has proved that a coordinated, comprehensive team approach is the best way to meet the clients' many needs."

TPE clients have many impairments. Twenty percent need to be fed. Many need homemaker services and special medical equipment, which TPE paid for with an additional government grant. Among the project's clients, 25 percent are 85 and older, and 42 percent are between 75 and 84 years old.

Sixty-one percent live on less than $400 a month, 20 percent have between $400 and $600 a month. "We served an economically and physically impaired group of clients, and we used family resources and resources in the community to make an effective care plan for each one," Wilson said.

Couple together again

Jane Corinne, assistant project director, told *Chronical Lifestyle* reporter Claudia Feldman about a typical client, a woman in her late seventies who suffers from such severe arthritis that she can barely walk. When her husband was placed in a nursing home, she limped to the nursing home every day to take care of him.

"We got her a brace for her leg. We listened when she said she wanted her wheelchair-bound husband with her. She said it would be easier for her to care for his many problems herself than make those long, lonely treks to the nursing home."

Sharon Boatman and Nancy Wilson

The TPE staff arranged this. They brought the man home, than hired help so that his wife would have some backup in dealing with his daily needs.

"Everyone benefited financially. The couple saved the money they had been pouring into the nursing home, and they no longer needed assistance from the state. Most importantly, the couple is living together again. They began to relax. Some of her stress and some of his confusion disappeared. He began walking again.

"It was one of those magic situations all the way around," Corinne said.

Could see, move around

Another seemingly miraculous happening, case management supervisor Bonnie Marsteller reported, was the home care the University of Houston College of Optometry gave TPE clients. With eye care and glasses, many people could read again or even step outside their doors.

Now Wilson and her staff, with help from the state human resources department and the Area Agency on Aging, are trying to continue the program by seeking grants from public and private sources.

Funding for two staff positions has been promised at TRIMS. From Washington they hope to get a Medicaid waiver, which would mean that sick, elderly people

would have the choice of using federal funds to go to a nursing home or stay at home with help from a program like TPE.

Better lives

Wilson and Sharon Boatman, assistant project director of the Texas Long-Term Care Demonstration Project, reported on research data from the nationwide project's first six months. The final report will not be ready for months, but early data show a significant improvement in the clients' "quality of life"—their medical care, more comfortable life at home, the ability of couples to stay together.

The U.S. Department of Health and Human Services funded two kinds of programs throughout the country—the "no-frills basic case management program," as Wilson called it, in Houston, Baltimore, Eastern Kentucky, New Jersey's Middlesex County, and southern Maine. Model 2, the "financial control model," was funded for Cleveland, Greater Lynn, Massachusetts, Miami, Philadelphia and Rensselaer County in New York State. Model 2 differed from the basic model in that its managers had more money and more discretion on how to fill gaps in services.

Evaluation of both models is going on now, with data coming on costs, the clients' well-being, comparisons between research and control client groups, their use of nursing homes and hospitals, use of formal and informal community services. Throughout the country, client and control groups were evaluated at six, 12, and 18 months after the programs began.

Families don't desert

However the research data turn out, TPE staff members know one thing for sure. "Families do not abandon their sick, old relatives," Wilson said. Family members were the Texas Project for Elders' unwavering partners.

Helping them get some time off, giving them information on care, creating a place for them to talk and encourage one another to keep going were some of the project's most satisfying ingredients.

Corinne's book, *Aging Living & Caring—A Handbook for Elders, Families & Friends* and the laminated resource list will stay in clients' and caregivers' homes no matter what happens to the project.

But meanwhile, though all staff members received awards from the state for their work and Wilson tried not to water her flowers with tears, working for the Texas Project for Elders during these last two months is hard. If federal funds come through, the project will continue.

Bonnie Marstellar

Jane Corinne

Staff stayed together

The staff has stayed on, Wilson said, even though many of these talented, dedicated people have received job offers. Wilson thanked volunteers and state agency supporters, and especially Dr. Charles M. Gaitz, head of the Gerontology Center, for his administrative backup and counsel throughout the life of the program.

"I don't think many of us have a chance in a lifetime to engage in as far-reaching a project as this one," Boatman said. "We hope that we have advanced the art of working with frail, elderly people. It's obvious that case management works. I have never before worked with such wholly dedicated people."

—Lore Feldman

Women AT WORK

by Linda J. Webb, Dr.P.H.

Q *I am having a problem with a woman who is my peer in our clinic. In meetings we always end up arguing. I know some of the men have conflicts but they never seem to argue openly. I feel angry and competitive with this woman because I end up looking out of control and incompetent. What should I do?*

A Your question seems to pose two problems. One has to do with how you feel and the other with your behavior. You indicate that you *feel* "angry and competitive" with your female colleague, but *think* that you should not. Actually, identifying your reaction is a step in the right direction. Women often try to deny their competitiveness. We think that we should have a natural alliance with other women at work and are surprised by less than supportive feelings.

It is natural to feel competitive with some of your female colleagues. The question is how to deal with these feelings without guilt and in a nondestructive manner.

Continually arguing with this woman in staff meetings is not productive for you or the group. Interestingly, the other staff seem to be comfortable with letting you and your colleague monopolize the group's time. My guess is that your arguing serves a function for the group. By letting you two do all the fighting, other group members don't have to express disagreements, conflicts, or competitiveness they might have with each other or with the supervisor of the clinic.

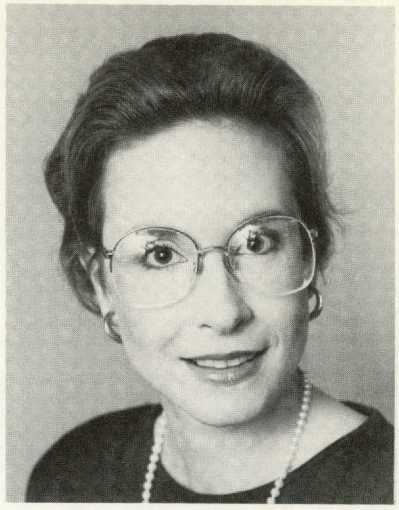
Keep quiet for awhile, "bite your tongue" if necessary, but do not argue with anyone. Given sufficient time, other group members will begin to express some of their disagreements and you, in turn, may not feel such a strong need to argue.

You might confront the woman privately, admit your competitive feeling, and discuss your desire to find a more productive way to work together.

Dr. Webb invites questions from readers. Please send your letters to Dr. Webb, Director, Office of Continuing Education, 1300 Moursund Avenue, Houston, Texas 77030. Your confidentiality will be protected.

Honorabilia

Susan Tipery Deter



Dr. Kate Loveland

Profile of courage

Susan Tipery Deter is one of 12 people featured in a brochure entitled "Profiles of people with multiple sclerosis." In the collection of vignettes, prepared by the President's Committee on Employment of the Handicapped, the featured people discuss their battles with the illness and their ability to be productive employees.

National recognition

Two employees of the Genetics Screening and Counseling Service have been selected "Outstanding young women of America." They are Imelda Salinas in Corpus Christi and Teresa Gallegos in Edinburg. The award is given to exceptional young women for outstanding personal and professional achievements.

Lights, cameras...

Felice Cohen appeared on a public television documentary about pedophilia called 'Child at Risk.' She talked about the use of art therapy in treating children who have been sexually abused, and the artwork she has collected in her research was part of the program. Coincidentally, the South Texas Art Therapy Association recently chose Cohen as a life member.

Expo expert

Dr. Albert Moraczewski is a consultant to Expo 85 in Tsukuba, Japan. He was asked to consult on "To Think," a 10-minute color motion picture to be shown in the U.S. Pavilion. Expo 85 deals with science and technology in the service of humanity. The U.S. Pavilion is titled "Artificial Intelligence: Exploring the Human Mind."

Good review

A review in the January 1985 issue of the *Journal of Nervous and Mental Disease* called the TRIMS-produced *DSM-III Training Guide* a "useful adjunct to the *DSM-III* and the *DSM-III Case Book.* The training guide was produced by Dr. Linda J. Webb, Dr. Carlo DiClemente, Dr. Edwin E. Johnstone, Joyce Sanders, and Robin Perley.

Lectures, presentations

Dr. Anita Woods spoke on psychosocial assessment of the elderly and Dr. T. Samorajski talked about the biology of aging at one of Baylor College of Medicine's geriatric psychiatry seminars.

Samorajski discussed "New directions for molecular and clinical research involving studies of Alzheimer disease" at Texas Woman's University in Denton.

Dr. Pamela Yu presented "A social problem-solving intervention as a treatment alternative for children in an outpatient psychiatric clinic" at the American Psychology Association convention in Austin.

At a Boston University conference on language development, Dr. Kate Loveland reported on her and Dr. Susan Landry's research with autistic children. She discussed "Joint attention behaviors in autism and language delay."

In publications

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D.L. Taylor, P.B. Silverman, & B.T. Ho ((1984). Effects of 6-methoxy-tetrahydro-beta-carboline on serotonin binding in rat brain. *Journal of Pharmacy and Pharmacology 36,* 124-127.

D.L. Taylor, R.J. Mathew, B.T. Ho, & M.L. Weinman (1984). Serotonin levels and platelet uptake during premenstrual tension. *Neuropsychobiology 12,* 16-18.

S. Landry, J.M. Fletcher, C.L. Zarling, L. Chapieski, & D. Francis (1984). Differential outcomes associated with early medical complications in premature infants. *Journal of Pediatric Psychology 9,* 385-401.

Victor Molinari & George Niederehe (1984-85). Locus of control, digression and anxiety in young and old adults: a comparison study. *International Journal of Aging and Human Development 20,* 41-52.

George Niederehe and Ernest Frugé (1984). Dementia and family dynamics: clinical research issues. *Journal of Geriatric Psychiatry 17,* 21-56.

K. Loveland (1984). Learning about points of view: spacial perspective and acquisition of "I/you." *Journal of Child Language 11,* 535-556.

Who we are

Jarek Aronowski

Jarek Aronowski

Jarek Aronowski would be convincing as a ballet dancer. Maybe he's too tall, but he is graceful and definitely European.

He admits readily that he is a fan of ballet, classical music, and theatre as well as soccer and other sports. His true love is sciences: neuropeptides, to be exact.

Aronowski, a young Polish scientist, has been in the United States for three months now and is splitting his time between TRIMS and the University of Texas Medical School.

At TRIMS he works with Dr. T. Samorajski, investigating the role of neuropeptides (brain substances made up of amino acids which are involved in regulation of the central nervous system and other biological processes) in Alzheimer disease. His work at UT is with Dr. Nachum Dafny, a professor of neurobiology and aging, with whom he is studying the effects of narcotics abuse.

Aronowski comes from a line of scientists. His grandfather was the first professor of pharmacy in Poland, and his father is an expert in electroacoustics.

After writing a rough draft of his dissertation at the Medical Academy of Warsaw on the influence of opiates on the central regulation of blood pressure, he decided this was a good time to visit the United States.

Aronowski says he is impressed with scientific equipment in the United States, particularly the use of computers in research.

"But more than this," he says, "I appreciate the openness and friendliness of my American colleagues."

Joanne Wenman

People usually grow and fit themselves into their jobs, but Joanne Wenman is that rare person whose work seems designed exactly for her—like a Nipon dress, which would look good on her too. She is a thin, graceful person with persuasive eyes.

Wenman has a bachelor's degree in communications (she was a copywriter for Panasonic in New Jersey and a freelance writer in San Diego), and a master's degree in counseling (which she has done for a women's clinic and in private practice). She uses these skills now as a research psychotherapist in adult outpatient services.

"It's as if this job were tailor-made for me," she says.

Her writing experience helps her collaborate in research proposals with Dr. Mohsen Mirabi, assistant head of the clinical research division. Her counseling training has brought her into several research

Joanne Wenman

and treatment teams—one dealing with schizophrenic retarded people who are taking two different neuroleptic drugs, the other planning to evaluate the well-being of former drug clinic clients who are no longer taking methadone.

Wenman has been coordinating the lithium clinic and setting up therapy groups for manic-depressive patients. In the trial group led by Wenman and nurse-therapist Tillie Koch, these patients participated much better than they do in mixed groups, with patients who have other mental disorders.

"The manic-depressive patients seem curious to learn from each other," Wenman says. "There is a sense of sharing and caring, and their treatment compliance has improved. I'm impressed by their sensitivity and support for one another."

Wenman's many other activities include helping Mirabi coordinate a symposium, "Depression in persons with mental retardation: A team approach to diagnosis and treatment," for the American Association on Mental Deficiency meeting in May. She is helping Mirabi edit a book on psychiatric aspects of mental retardation.

Xyna Bell

Xyna Bell

The data for Xyna Bell's dissertation are stored neatly on a computer diskette which is buried safely under a pile of magazines.

It's not that she's lost interest in the project, but working as a TRIMS psychology intern has left her little time for anything else. And she doesn't seem to mind that at all.

"I chose the TRIMS internship because it gives a broad-base look at different areas of psychology. It also gives me a chance to work with minorities, something I hadn't been able to do," she says.

Bell, a native New Yorker, earned a bachelor's degree in psychology from the State University of New York at Stony Brook. Her master's degree in psychology is from Pennsylvania State University and she will complete her doctoral degree there.

She researched self-change in quitting smoking and came across the work of Dr. Carlo DiClemente, chief of the addictive behavior and psychosocial research section.

After corresponding with him, she decided TRIMS would be a good place for her internship.

She hopes to treat adult patients and families in a community setting and continue to participate in research when she finishes her education.

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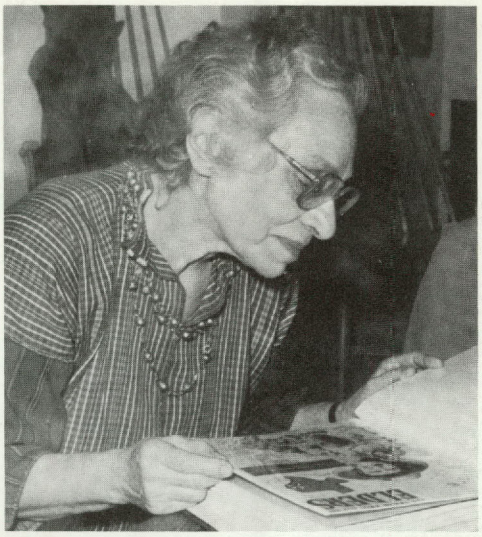

Saying good-bye is one of my least favorite things to do. I think Lore Feldman, TRIMS information director for 16 years, liked it even less. She wouldn't write this column, so I am.

March 15 was Feldman's last day at TRIMS. She has retired from here, but not from work. She is now editing scientific manuscripts at the University of Texas M.D. Anderson Hospital and Tumor Institute. Editing is her favorite thing to do. She's awfully good at nurturing gardens, friends, and publications too.

When she came to TRIMS in 1969, Feldman was put in charge of an in-house publication printed on duplicating equipment and distributed throughout the institute. Under her habitual clear-thinking, foresight, and compulsion for deadlines, *The Emissary* grew into a prize-winning newsletter with an internal and external circulation of about 3,600.

She also made a whole bunch of friends.

We miss her and wish her the best.

—Kathleen Kimball-Baker

Federal funding for the Texas Project for Elders is ending but staff members are still working to preserve some of its components. (See story, page 12) Gathered for a recognition ceremony are TPE members (left to right) Ruby Salazar, Fred Hebinck, Hasu Patel, Eva Grimes, Yvette Stallworth, Nancy Wilson, Sharon Kahn, Paul Ulrich (back), Jane Corinne, Delores Garcia, Bonnie Marsteller, Robin Kennedy, Margaret Silva, Libby Lieberman, and Sharon Boatman.

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