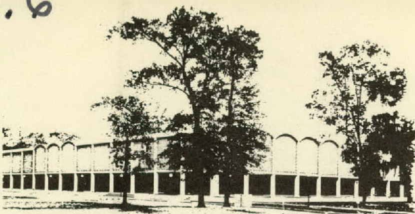
R1775.6
Em43
12/7



texas research institute of mental sciences □ houston □ aug.—sept. 1980

the emissary

Government Documents
SEP 18 1980
Dallas Public Library

photo by Marc Meyers

dr. schoolar writes

were the staff cuts equitable? could we improve communication?

At a recent meeting of the public responsibility committee several concerns of the staff were brought out that bear comment. One statement had to do with the recent five-percent reduction in personnel, saying, in essence, that it was a foregone conclusion that most personnel cuts would occur in the lower echelons. As to working hours, the "chiefs" were privileged to come and go as they pleased.

These statements are not true. The reduction in force was as follows:

Salary Group	Number of Positions Reduced
3	1
7	2
8	1
9	1
11	1
15	2
18	1
exempt	6 (5 psychiatrists, 1 research specialist)

Not only was the cut well distributed among classified positions, the *preponderance* of the reduction was in the higher ranks.

Many of our professionals are not employed full-time by TRIMS. Some psychiatrists, psychologists, social workers and others work seven-eighths, three-quarters, or even half-time. In addition, both full- and part-time employees may arrange their working hours to meet the institute's and their own needs. They must, of course, work the prescribed number of hours, and the schedule must benefit TRIMS. Requests for change must be approved by the employee's supervisor and filed with the personnel office. But if one meets those requirements, one may work other hours than the traditional 8 to 5, so that an employee may indeed appear to be coming and going on an irregular schedule. That does not mean that the staff member is not discharging his or her responsibilities to TRIMS and to the state.

yes, communication could be better

The other statement was that there is insufficient communication between senior TRIMS personnel, particularly me, and staff members at or below the section chief level. That's probably true. TRIMS has a large and active staff, two conditions common to complaints of poor communication. Further, regularly scheduled activities (research rounds, staff meetings, clinical grand rounds) and travel cut deeply into my "free" time. And although this is regrettable, these activities are necessary and a fact of life.

We therefore turn to other methods of interchange, and though they suffer from a degree of impersonality, I believe they are helpful. The monthly division and section heads' meeting is designed as an information-sharing event, at which each person is encouraged to bring up matters of general interest. The weekly seminars are open to the entire staff, and much of the discussion there is in the nature of interdisciplinary communication. This column is an attempt to inform, as well as to editorialize a little, and my annual report to the staff is as comprehensive as possible within the time allowed. Then, too, there are smaller gatherings, committee meetings, clinic meetings, and the like. I meet with the psychiatry residents regularly, and the fact that it is an evening meeting allows time for more informal exchange. I continue to maintain an open-door policy for all employees.

there are problems

Yet there are limitations and shortcomings in communication, and I recognize many of them. Too often the discussion is one-sided; time pressure is a factor; and lack of agreement may be taken as superficial or faulty communication.

Many of these concerns, it strikes me, are simply in the nature of an organization; although we generally reach a consensus, there simply cannot always be agreement. Although any employee may walk into my office to make an appointment, staff members should go first to their section chiefs and division heads, or else our organizational structure will be in shambles in a short time.

Given these realities, however, we can do much to improve communication. Recently we formed an employee relations committee, which is one approach. I plan to meet with the committee from time to time, and informally with the staff, as the committee may suggest.

Until a chairperson is announced, staff members should write the employee relations committee, in care of my office, about issues the committee should address.

cover

Psychology intern Dee Goldwater admires a picture Jason Hix drew after their group session at the University of Texas M.D. Anderson Hospital and Tumor Institute. The weekly group, for children being treated for cancer, gives the young patients a chance to express their feelings about their illness "without making someone else feel sad." The pediatric unit is a place for living. For story about the interns' work at Anderson, see next page.

emotional support for sick children

psychology interns help young cancer patients deal with fears

It's a setting where sick children are encouraged to talk about pain, their illness, and their fears of death.

The children are cancer patients at the University of Texas M.D. Anderson Hospital and Tumor Institute. Three TRIMS psychology interns work there part of the week, helping to lead therapy groups of children and adolescents, and counseling family members and individual patients.

Dr. Donna Copeland, a clinical psychologist and director of the mental health division in Anderson's department of pediatrics, supervises the interns. A former TRIMS psychology intern herself, Copeland last year asked Dr. Kenneth Solway, chief of the psychology internship program, whether TRIMS would be interested in sending interns to M.D. Anderson. "I thought it would be a good rotation for them, and I could use the help too, particularly with family and child therapy," she says.

All of the department's patients—who range in age from birth to 18—are encouraged to attend a weekly group for children or adolescents, Copeland says. TRIMS intern Dee Goldwater is co-therapist for the children's group, and intern Douglas Dunlap helps lead the adolescent group.

Both groups, Copeland says, "provide a setting for the children to express their fears, doubts and frustrations in a nonthreatening situation—one where they don't have to worry about making someone else feel sad." Many of the children worry about their health and about dying, and sometimes they can't talk about this with their parents. "We're training the children to be more expressive and to deal with their illness." There are also two groups for parents, and the sick child's sisters and brothers are encouraged to attend either the adolescents' or children's group.

total treatment concept

Each hospitalized child has his or her own primary physician, nurse, and mental health professional, usually a social worker. The pediatrics department has a "total treatment concept," Copeland says. "Cancer is so invasive that, for the child to be totally cured, other needs besides the medical have to be given attention." The child's mental health counselor provides supportive therapy and might also help the family with such things as finding a place to stay. Copeland says only when a child seems particularly disturbed or upset is she called in to help.

This help can take many forms. Copeland and the interns do therapy with children individually or with the whole family. Dee Goldwater used hypnotherapy to help a child overcome her fear of needles and to help her through a painful bone marrow test. Intern Bill Friedrich used hypnotherapy with other kinds of therapy in treating a teenaged boy with inoperable osteosarcoma. The hypnotherapy greatly reduced the boy's pain, Friedrich says. He visited the boy at home five days before he died. "I was upset by his death. But the boy's mother told me that his last couple of weeks had been much easier because I made him realize the freedom that death could bring."

Death is a subject the interns must deal with at Anderson. Although the majority of pediatric patients live, the children worry about death. "We encourage the children to talk about it if they are concerned about it," Copeland says. "We get them to express their ideas about death and their fears. Often we find their fear is really of being separated from the people they love, and we can reassure them that they won't be alone."

continued on next page

Intern Douglas Dunlap plays "Hi-Ho! Cherry-O" with Karazahn Smith, 9, in M.D. Anderson's pediatric department.

photos by Marc Meyers

place for living

The pediatric unit is a "a place for living, where the quality of life is attended to," Copeland says. Over half the children who have cancer now live, and much of the work in the unit focuses on helping the children to lead normal lives. Children attend school (the Houston Independent School District sends two teachers to the unit). When they're not able to attend, the teacher will come to their beds for lessons. Meals are served in the pediatric dining room, and the children are encouraged not to eat in bed.

"One of the main purposes of the therapy groups is to help children adjust to the disease with as little disruption as possible to their normal family and social lives."

deal with family problems

In family therapy, the interns often deal with family problems "just like at TRIMS," Copeland says. "The illness seems to accentuate problems that already are there." They might deal with issues such as control—the child complains because his parents try to do too much for him and won't give him his say—or behavior problems like a child's hyperactivity, or resisting treatment. Adolescents are more likely than younger children to resist treatment. "They're more disturbed about the illness and about how they look; they don't like to be different from their friends."

One parent is allowed to stay in the hospital with each pediatric patient, and almost all parents choose to stay, Copeland says. With the parents living on the ward, "you have a lot of group and family dynamics that you wouldn't necessarily have in other treatment settings."

Copeland chairs the weekly staffing conference. A patient and his or her family are selected to discuss their case in a conference attended by the staff members who have had contact with them. This includes—in addition to the physician, nurse, and mental health worker—nutritionists, chaplains, school teachers, physical therapists, and a child-life worker. The staff reports on the child's treatment, and Copeland interviews the family, eliciting suggestions and complaints, sharing information. "It's often very therapeutic for the family; they usually leave calmer and more confident," she says.

may teach and do research

If they're interested, the interns may teach and do inservice training at Anderson. Friedrich is collaborating with Copeland on research projects on psychological adjustment to disfiguring illness and treatment and on how Hispanic groups differ from Anglo groups on emotional dimensions.

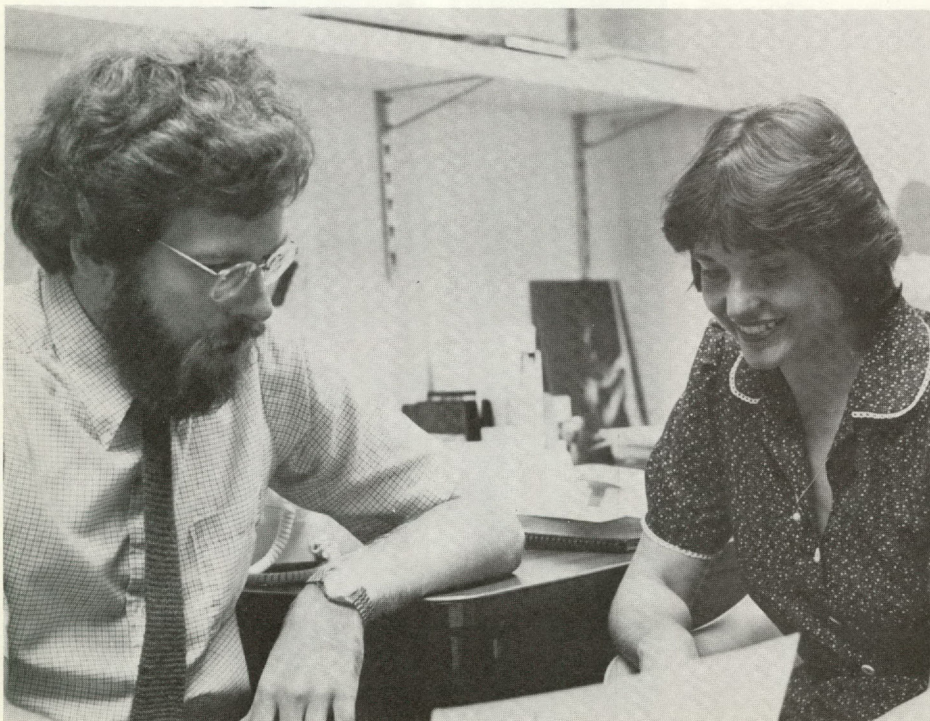
Once a week there's a mental health meeting, which Copeland supervises. Groups and individual patients are discussed. Goldwater says the meetings are an opportunity for expressing feelings and for mutual support among the mental health team.

Goldwater chose the rotation at Anderson "to learn something about the psychological impact on a child and family of dealing with severe, life-threatening illness." Working on the unit, she's found, "has so much meaning. Watching these families deal with death and dying—you learn so much from them."

Dunlap, who's just started working at Anderson, says he chose to work there because "it's something I'd never done and it scared me." He says he's glad he chose the rotation and now feels "less scared."

"I'm sure those kids taught me more—in the way they dealt with their illness in such a victorious way—than I helped them," says Friedrich, who plans to continue working with pediatric cancer patients. "Some of the parents were really admirable. After reading the research literature I thought that families who had children with chronic diseases showed a lot of disruption, but I was surprised at the number who showed a lot of strength."

—Karen Hanson Stuyck



Psychology intern Bill Friedrich works with Dr. Donna Copeland, director of the mental health division in Anderson's department of pediatrics, on two research projects.

flowers for child therapy graduates

Parents, spouses, and colleagues filled nearly every seat in the auditorium July 1 when eight early childhood therapy trainees graduated from two-year TRIMS internships and the master's degree program in child development at Texas Woman's University.

Suitably enough, little children made unscheduled noises during the brief speeches. Barbara Gardner told each of her classmates what special qualities she treasured in her or him, and all the graduates—Claudia Anderson, Sandra Gilbert, James Viola, Lynn Wilson, Betty Andress, Debi Klein, Jane Heatherington—received one long-stemmed apricot rose with their certificates.

Andress and Klein are staying at TRIMS to help clinic director Dr. Mae F. McMillan supervise the next class: Mary Urmeneta, Sandra Medina, J.J. Go, Maria Sodek, Charles Streat, Harlan B. McCartney, Virginia Hargrove, Kathy Reeves, Betty Suarez, and Janet Rothschilds.

Dr. Hilde Bruch, emeritus professor of psychiatry at Baylor College of Medicine, made the speech that summarized, briefly and precisely, the work the graduates had chosen. *(See next page)*

Top: Dr. Mae McMillan at party that followed graduation. Left and above: the graduates, and McMillan with Debi Klein.

Marc Meyers

...and a special gift from Dr. Bruch

Dr. Hilde Bruch wrote *Don't Be Afraid of Your Child: A Guide to Perplexed Parents*, *Learning Psychotherapy: Rationale and Ground Rules*, *Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within*, *The Importance of Overweight*, and recently, *The Golden Cage: The Enigma of Anorexia Nervosa.*

A psychotherapist and teacher of worldwide fame, she was introduced at the child therapy trainees' graduation by clinic director Dr. Mae McMillan as a person of "scholarship, diligence, and singleness of purpose who is always available to her colleagues." Dr. Bruch said:

psychotherapy demands skill and discipline

With that introduction I can't go wrong. I had expected a small gathering of eight people, and that we would have a seminar. Since I am not prepared for a formal lecture, I will say exactly what I had planned to say to an informal gathering. The theme we agreed on was the demands made on the psychotherapist.

Psychotherapy is the skilled and disciplined effort to be of help through the use of the interpersonal relationship. It is the situation of two people who try to come to an understanding of each other, with the explicit goal that something positive will be achieved for the complaining person, the patient. To be more specific would be to introduce artificial parameters. The demands on the therapist are those of being capable of listening with the intent of hearing what the other person tries to say. Listening with what has been called the "third ear"—for the implied word—takes a good deal of skill and awareness and sensitivity on the part of the therapist.

People who come for psychotherapy, particularly children, are in considerable distress, often because of fear of what will take place. Therapists vary in their background, their ambitions, their capacity for introspection, their sensitivity. Part of the training is to help the future therapist become aware of his or her inner functioning.

The patient's complaints usually are symptomatic. Empathy for what truly troubles a person is part of the innate but also trained sensitivity of the therapist, in addition to the ability to listen in a way that conveys to the patient that she or he has been heard and understood.

ability to tolerate anxiety

The therapist needs patience. Ideally, one would think that once something is clear, the symptom would disappear and the child or grown-up would live happily ever after. It is not quite as simple. There are many stages at which something is clarified and everything looks fine, but next week it is gone and something new has happened. The therapist needs the ability to tolerate delay and anxiety, because she or he will be troubled by questions: What did I do wrong? What did I miss? What would an experienced person have done? These questions are justified, but if they make the therapist excessively anxious and therefore more uncertain, the problem will not be solved.

freedom from preconceived notions

There are many causes and reasons for abnormal behavior. The conditions I consider accessible and amenable to psychotherapy are related to misdirected early experiences. The personality develops out of interaction with other people. This is essential for acquiring the ability to communicate, to observe, to have foresight, to learn from experience. If these processes miscarry or are inadequate or unrealistic in certain areas, the growing child will be deprived of necessary organizing experiences that make him capable of communicating and relating to other people. It is to the extent that this misdevelopment is clarified that true growth can proceed. Though I stress the importance of the theoretical frame, I would like to add the need to be free from rigid preconceived notions. It is better to have a more general framework, with alertness to what has miscarried in a patient's development, and freedom to resolve the contradiction or conflict, than to have too rigid a concept of what must have taken place and to try to fit the patient into the preconceived notion.

This open-mindedness applies not only to theoretical beliefs or assumptions, but to many other areas. We need to be aware of, if not free from, moralistic attitudes. The changing sexual habits of young people dramatically illustrate the need for open-mindedness. Something that would have been unacceptable twenty years ago is now daily routine. The therapist who sits there with conceptions of a previous generation and tries to superimpose them on modern adolescents will be in trouble.

open-mindedness about self

Probably the more difficult aspect of psychotherapy is the therapist's need to become aware of his or her own problems and unresolved conflicts. She needs to have the courage to be open-minded about herself, not in the sense of communicating her troubles to the patient, but to be aware of where her own personality is slanted, is oversensitive, is blind-spotted, so that she cannot hear what the patient says or what the patient's needs are.

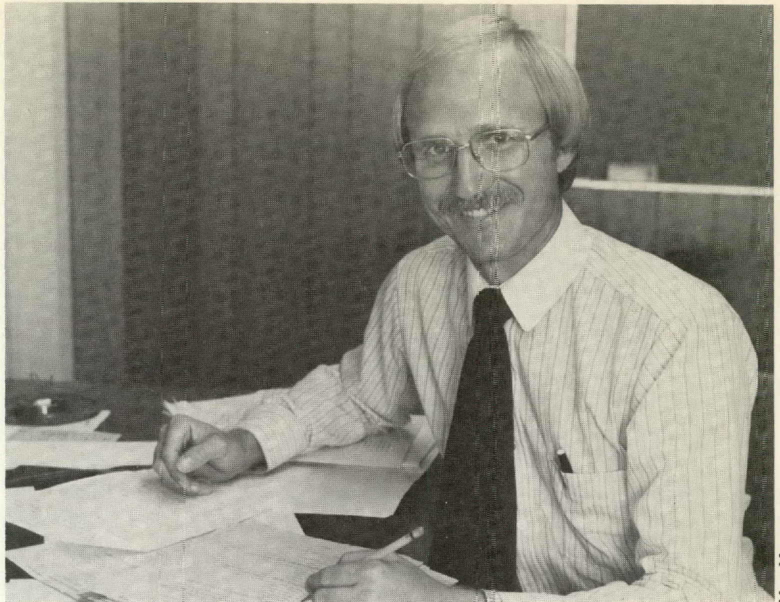
The therapist needs to be aware of her own competitiveness, even with a small child. More important is to recognize jealousy, rivalry, or envy, of being irritable when the patient doesn't follow through on what one dreams for the patient. There are two sides to this. One needs to have an image of the patient as functioning better, of what this adult or child would be like if he or she were not troubled. But there is a grave danger that one might form too ambitious a picture for the patient and to expect more resolution or more development than the patient is ready to undergo. To have a positive orientation without superimposing one's own ambitions on a child or adolescent is necessary, and the therapist needs to be aware of the difference.

succinct, clear language

There is another danger—of seeing things through the glasses of one's own experience, slanting therapy in the direction that will satisfy the therapist but may be inappropriate for the patient. The positive ability that develops out of life experiences and training is the disciplined, skilled way of using the relationship for the patient's growth. Even the beginner has one great advantage, of seeing things that are confusing and painful to the patient in a clearer way. One part of the therapist's task is to reformulate for the patient, in succinct, clear language, issues that were confusing and contradictory. It is in this recognition of contradictions in the other person that a big step toward clarification takes place.

Sometimes it takes a few pointed, well focused interviews, sometimes it takes a long time. But the reward of this work is to see the maturing of a handicapped, blocked, interfered with, maldeveloped person into someone who is capable of fulfilling his or her own dreams and expectations of what life has to offer. And I wish you luck in your career.

they found four-day week good for work and morale



Dr. Rick Allen led four-day week pilot project.

Marc Meyers

The comments speak for themselves: The four-day week "seems to be a better management of time and energy."

"Permitted evening group sessions. Patients did not have to lose much time from work or school."

"I saved on gas. Traffic is lighter in non-peak hours. I felt more productive and motivated to work since this schedule seemed like a privilege; good for morale."

"The best benefit I've received at TRIMS. Allowed me to accommodate both my work life and my personal goals without in any way interfering with my job performance."

Twenty-six TRIMS employees participated in a four-month trial of the four-day work week. With their supervisors' and division heads' approval, employees could work four 10-hour days a week from January through April. Generally participants worked from 7 a.m. to 6 p.m. or from 8 a.m. to 7 p.m.

At the end of the trial period Dr. Richard H. Allen, principal investigator for the project, sent questionnaires to both participants and their supervisors to help evaluate the experience. The response to his questionnaire gave him his first indication of the interest in the schedule. "In most mail-out questionnaires, the best you can expect is a 50-percent return," he said. "But we got a 96-percent return from participants and a 90-percent return from their supervisors without any follow-up contact."

The two main things Allen wanted to find out were the effects of the four-day week on work performance and employee morale. He also wanted to determine the social impact the schedule would have if it were used throughout TDMHMR: Would employees be pleased with the additional time at home? Would there be savings on gasoline and child care costs?

work quality same or better

What he learned was that most participants rated their productivity during the four-day week as the same or better (88 percent of the respondents) and the quality of their work as either improved or the same (96 percent). All supervisors said the quantity and quality of participants' work was at least the same, if not better. Fifty percent of four-day workers said their job satisfaction was much higher during the trial period, while 25 percent said it was somewhat improved, 21 percent said it was about the same, and 4 percent said it was somewhat reduced.

Ninety-six percent of participants and all supervisors felt that working a four-day week did not interfere with their ability to fulfill their duties at TRIMS. Seventy-nine percent of participants and 67 percent of supervisors said the work schedule improved the employees' ability to complete their work. The reasons cited for the improvement were that a 10-hour day gave workers two hours of uninterrupted time, participants were able to see patients and their families after work, and they enjoyed having a larger block of time for finishing projects.

To the question, "Would you say that working a four-day week improved your ability to complete your duties at home?", 67 percent of participants said yes. Most of these respondents said that they used the extra week day to handle personal matters, such as errands or doctors' appointments, or that they enjoyed the extended weekends. Eight percent of participants said the new work schedule interfered with their ability to complete their home duties because of too little time after they left work.

What did these employees do on their extra day off? Aside from errands and appointments, they said they cooked for the entire next week during the extended weekend, did housework when no one else was at home, and did landscaping, car repairs, household projects, and hobbies.

did not suit everybody

Not everyone was completely happy with the new schedule. One participant had trouble arranging a carpool. One said, "In my present position the work is intense, and sustained effort for 10 hours was difficult." Another said she terminated the four-day week early because "I felt I needed to be here five days—was pleased with the three-day weekends, however." Still another said her case load decreased during the trial period. But she added that she had always worked a lot of overtime, and still did. Since she wasn't here on the fifth day, her extra hours had decreased.

Allen compared the turnover rate and absenteeism of the four-day workers with the rest of TRIMS employees. He found average sick leave time was about the same for both groups—22.46 hours for participants compared to 22.35 hours for TRIMS employees as a whole during the four-month period. "Probably the persons working four days missed fewer days," Allen said, "but they missed a tad more in hours." Only one person in the trial left his TRIMS job—an annual turnover rate of 11.6 percent versus 31.5 percent for the rest of the staff (though that figure may be misleading because of the five-percent staff reduction, Allen said). No one in the trial group took leave without pay—another indicator of absenteeism—compared to an average of three hours' leave for the rest of TRIMS employees.

gas savings

Allen calculated that the 24 participants who answered the questionnaire saved a total of about 340 gallons of gasoline by not working the extra day. (He figured that on their day off participants would drive about one-third of the miles they drove on a work day.) "If 10 percent of TRIMS employees—55 people—were to go on a four-day week, it would mean a savings of 2,300 gallons of gasoline annually," he said. "And if 10 percent of department employees, or 2,700 people, were to work four days, it would be a savings of 115,000 gallons of gasoline."

Probably more TRIMS employees would choose to work four-day weeks if they knew this would be their permanent schedule, Allen said. Some people couldn't rearrange their lives for four months. Then, too, many section heads would not allow their employees to participate in the trial.

In response to a questionnaire sent out last November, 12 section heads said they wouldn't allow a four-day week. Reasons ranged from expected employee fatigue to the section's having too much work. ("They didn't seem to recognize that it's 40 hours, no matter how you measure it," Allen said.) Others said their sections were too small to allow adequate coverage on the day an employee was absent.

Who joined the trial? The majority of participants were married (75 percent) and childless (71 percent). Of those who had children, less than half—12.5 percent of the total group—were paying for child care.

Many said they hoped the four-day week would continue. "In a time of budget cuts and five-percent reductions, I think TRIMS should consider instituting the four-day week as a permanent option for employees," wrote one. "It is, in my opinion, an invaluable benefit."

When asked whether TRIMS employees could continue to work a four-day week, Dr. John J. Kavanagh, commissioner, quoted State Law 5165a. While state employees, he wrote, are required by law to work 40 hours a week, in institutions "where the administrative head of the agency deems that efficient operation will be aided thereby, he/she may assign certain personnel to a 40-hour, four-day work week."

Much of Allen's work on the four-day week project was done in collaboration with the personnel office under the direction of Coy Nolley.

—Karen Hanson Stuyck

outpatient clinics start monthly conferences

A series of clinical psychiatry conferences designed to help staff members keep abreast of the latest clinical issues has begun at TRIMS, organized by Dr. Mohsen Mirabi, chief of adult outpatient services.

"At TRIMS we see almost every disorder you'd find in a comprehensive psychiatry textbook," Mirabi says. The monthly clinical meetings "provide an opportunity for everyone to exchange ideas and become acquainted with new developments in clinical psychiatry." Each conference includes case presentations followed by a panel discussion.

Started in June, the conferences so far have dealt with forensic psychiatry and legal issues in patient care, and changes in psychiatric classifications from *DSM-II* to *DSM-III*. Panelists for the forensic psychiatry conference were Drs. J. Ray Hays and Roy Varner; Drs. Vivi Daniel and Mirabi presented cases. Drs. Carlo DiClemente, Edwin Johnstone, and Mirabi were the *DSM-III* panelists.

Topics for upcoming conferences will be convulsive disorders and their psychiatric implications, movement disorders and psychotropic drugs, schizophrenia, alcoholism and drug-induced psychosis, treatment modalities, psychosomatic illnesses and depression, and psychopharmacology. Panelists will come from both inside and outside TRIMS, Mirabi says.

Persons attending all conferences will receive 18 hours of continuing education credit. Open to all clinical staff and trainees, the meetings are 3 to 4:30 p.m. in the Kahn Room on the last Tuesday of every month.

---

we can help

The Public Responsibility Committee composed of volunteers from the community has been established to assist in protecting the rights and interests of every patient in the care of the Texas Research Institute of Mental Sciences (TRIMS).

Complaints, questions, concerns or suggestions may be made known by writing to:

Chairman
Public Responsibility Committee
P.O. Box 20391
Houston, Texas 77025

Drs. Gaitz and Gordon move on up

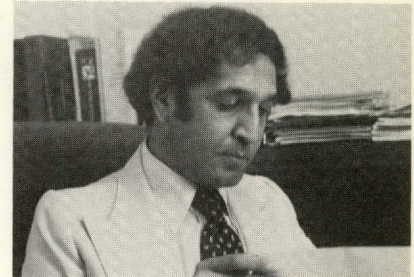
Dr. Charles M. Gaitz and Dr. Jack R. Gordon were appointed to higher administrative posts last month by Dr. Joseph C. Schoolar, TRIMS director.

Gaitz, head of the clinical services division since 1978 and founder of the institute's geriatric clinic and gerontology research section, became assistant director in charge of special services. At that rank he joins Dr. James L. Claghorn, assistant director and head of training.

Gordon took on leadership of the clinical services division, which includes children's, adolescent and family, adult, geriatric, drug abuse, and inpatient services.

Dr. Mohsen Mirabi, chief of the crisis clinic and information and referral services, succeeded Gordon as chief of adult outpatient services. In addition to the two clinics he directs, Mirabi has supervisory responsibility for Service A, headed by Dr. Sebastian Cos; Service B, headed by Dr. Jon Reck; the psychosomatic unit under Dr. Roy J. Mathew; and the substance abuse service under Dr. Timothy Sharma.

In other administrative changes, Dr. Jack Fletcher was appointed chief of the newly established neuropsychology research section. Linda Sohns, chief of admissions and claims, was promoted to head the enlarged medical records, patient data and admissions section.



Top: Dr. Jack Gordon and Dr. Charles Gaitz. Right: Dr. Mohsen Mirabi

legal note

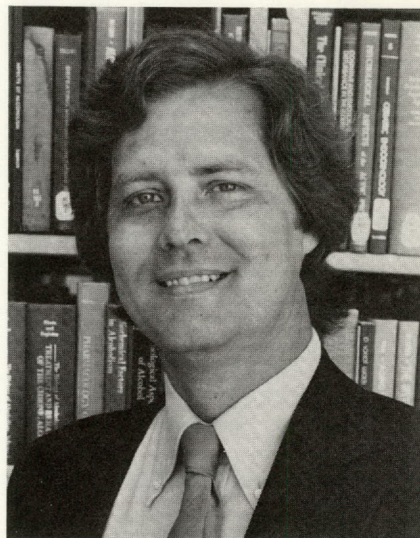
minors must consent to hospitalization

by J. Ray Hays, Ph.D., J.D.

The attorney general clarified one part of the Texas Mental Health Code in a recent opinion (MW-180) concerning whether or not a minor must consent to be hospitalized. The relevant statute is Article 5547-23, which provided that the application for admission of a person to a mental hospital as a voluntary patient shall be in writing, signed by the patient if he/she is legally of age, or by a parent, guardian, or the county judge, with the patient's consent, if the patient is not legally of age.

The question raised by the commissioner of TDMHMR was whether the minor's consent was necessary only when the minor was admitted upon application of the county judge or also when the parent or guardian made the application. The department had for many years interpreted the statute as requiring the consent of the minor under any of the three conditions.

The department's interpretation goes much farther than did the Supreme Court of the United States in granting rights to children. The court in *Parham* v. *J. L.* did not choose to rule that minors should have some say in the hospitalization process through either their assent or consent. The Texas legislature and the department is to be commended for their recognition of the rights of minors. In his opinion, the attorney general of Texas stated that the *Parham* decision set only the minimum constitutional standard for admission of a minor to a hospital. Since the department had a much stricter standard, the *Parham* decision had little relevance to Texas.



Dr. J. Ray Hays

consent at what age?

The question was raised also as to the age at which a child could give consent. The statute is silent on this issue. The attorney general then gave the burden of assessing the child's capacity to consent to the mental

continued on page 12

In new positions: Linda Sohns, left, is chief of medical records, patient data and admissions. Dr. Gary V. Sluyter, center, is assistant to the director. Dr. Jack Fletcher, bottom, was appointed chief of neuropsychology research.

Gordon hopes to strengthen clinic-research teamwork

The tasks facing Dr. Jack Gordon as head of the clinical services division are to "work continually toward improving the quality of care we give, and to incorporate more research in the major psychiatric disorders into our clinical work."

For this he hopes to strengthen collaboration between clinicians and researchers at TRIMS, he says.

Gordon took over leadership of the clinical services division from Dr. Charles M. Gaitz, who was promoted to an assistant directorship. Gordon had been chief of adult services since last year, when he came to TRIMS from private practice. He had been a consultant to Big Spring State Hospital, and the Devereaux Foundation School, Citizen's Memorial Hospital, and Gulfbend Clinic for Children in Victoria. At TRIMS he organized an alcohol research and treatment service which, because of restricted resources, is "still in its infancy," he says.

The need for services is "boundless, but we are limited in what we can do. Our staff is being stretched to its capacity. To give more service, we need more tools. One of the things we must try to do is to bring salaries up to at least competitive levels within the medical center, especially for the nursing and administrative support staffs."

This will become especially critical when, about a year from now, the inpatient unit and other services move into new and larger quarters in Center Pavilion Hospital. The building was recently bought and will be remodeled by Harris County.

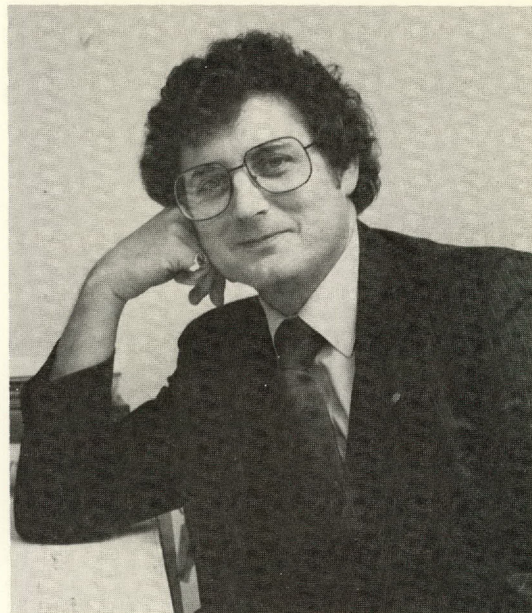
Gordon hopes to apply for an alcoholism grant, but the service needs to establish a track record first, he says.

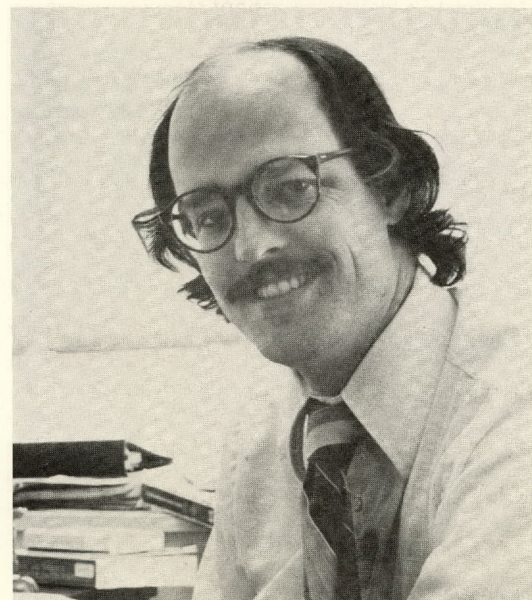
drug-free clinic

Another project may be a clinic in which chronically ill patients will be treated without neuroleptic drugs. "Because of the long-term side effects of drugs, this would be important for management of chronic patients. The opportunities for rehabilitation are better without drugs," he says, "but these patients would have to be followed very carefully to avoid relapses."

Gordon received his medical degree from the University of Texas Medical Branch at Galveston and served his psychiatry residency at Baylor College of Medicine.

Dr. Joseph Schoolar, director, calls him "a superb clinician with rare administrative skills who thoroughly understands the necessity of going on several fronts at once—good patient care and research and training."





study finds cerebral blood flow reduced in depressed patients

In a pilot study of 13 depressed patients and an equal number of normal volunteers, researchers in the psychosomatic unit have found a relationship between depression and cerebral blood flow.

Dr. Roy J. Mathew, chief of the research unit, hopes to study a larger number of people to confirm the finding that depression is associated with reduced blood flow in the anterior brain region believed to be the control site for cortical tone. Cortical tone is the degree of activation of the brain. It is low in nondreaming sleep, high in manic states.

"The reduced levels of blood flow we found in depressed patients are quite in keeping with what we expected," Mathew said. "If we could prove conclusively that lower blood flow is tightly correlated with depression, the data would have a wide range of implications.

"The information could help us to verify diagnoses and to prognosticate, differentiate various types of psychiatric disorders, identify people who are at risk of depression, and evaluate the efficacy of antidepressant drugs and treatments."

The research group used the noninvasive method of measuring blood flow developed by Dr. John Stirling Meyer, professor of neurology at Baylor College of Medicine and chief of the regional cerebral blood flow laboratory at Veterans Administration Medical Center.

Research participants inhale a mixture of 133-xenon, an inert radioisotope, and air through a face mask for one minute. They wear a helmet on which 16 probes record the desaturation curve of radiation from which regional cerebral blood flow is calculated. Blood flow values are instantly recorded and printed out by a computer, together with normal values, on what looks like a map of the brain. The technique is harmless and causes no discomfort, Mathew said.

both sides at once

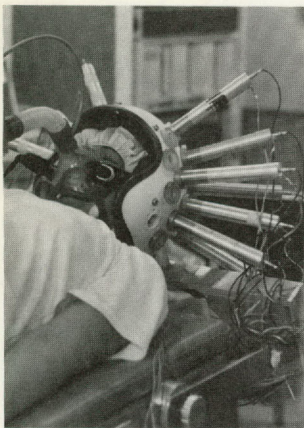
Measuring regional cerebral blood flow with this technique is different from previous methods in that blood flow from both sides of the brain, including the brain stem, is recorded. The validity and reliability of the technique, Mathew said, was established in Meyer's laboratory and several other research centers.

The TRIMS research group is seeking volunteers to enable them to repeat the study with a larger number of participants. One question they hope to answer concerns the contribution of anxiety to blood flow changes. "Depressed patients are also anxious," Mathew said, "and we are not certain whether the lower blood flow we found is also a function of anxiety."

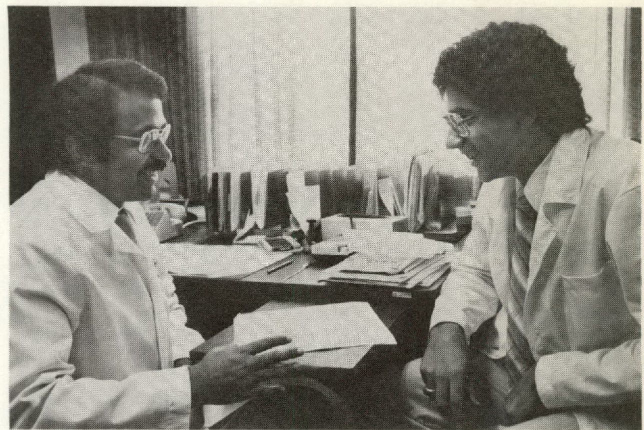
Eventually the researchers hope to study regional cerebral blood flow in schizophrenic patients as well. European researchers have found reduced cerebral blood flow in schizophrenic patients, but diagnostic criteria in Europe are different from those in the United States. If such a study is to be repeated here, Mathew said, it has to be done with the diagnostic criteria and rating scales for schizophrenia used in this country.

Mathew's coworkers are David Francis, predoctoral fellow, Dr. Maxine Weinman, research specialist and statistian, and Karen Semchuk, nurse.

—Lore Feldman



Left: Volunteers in cerebral blood flow study wear helmet with sixteen probes. Right: Dr. Roy Mathew and David Francis.



legal note. . . *continued from page 10*

health professionals involved in the child's treatment. The professionals must determine the competency and maturity of the child to give effective consent. Should the child, because of immaturity or lack of mental ability, not be able to consent, voluntary hospitalization would not be possible. The parents, guardians, or mental health professionals would then have to seek involuntary commitment through the courts.

The opinion thus requires the same procedures for children as for adults when the minor, for any reason, does not have the capacity to consent to voluntary hospitalization. Texas takes a much more humanitarian position in recognizing the rights of children than does Georgia where the *Parham* case developed.

The opinion addresses the need for written consent. The statute does not require the child's consent to be in writing. The application must be in writing and signed by the parent, guardian, or county judge. The method for obtaining and documenting the consent is not outlined in the statute. It would seem best from the standpoint of documentation if the consent were in writing and signed by the minor whenever possible. When that is not possible, admitting professional staff should note the capacity of the patient to consent, and that consent to hospitalization was received from the patient. That seems to be the most prudent course when children are "voluntarily" admitted to our hospitals.

program: Biology of Anxiety

November 5-7, 1980
14th annual symposium
presented by psychosomatic research unit
Texas Research Institute of Mental Sciences
at Holiday Inn-Medical Center, Houston

sponsored by office of continuing education
Texas Department of Mental Health and Mental Retardation
program director: Roy J. Mathew, M.D.
chief, psychosomatic research unit

Wednesday, November 5

7:00-5:00 registration

8:00 *Welcome.* John J. Kavanagh, M.D., commissioner, Texas Department of Mental Health and Mental Retardation

8:10 *Introduction.* Joseph C. Schoolar, Ph.D., M.D., director, Texas Research Institute of Mental Sciences

Session 1: Physiology of Anxiety

8:30 *Diagnosis of anxiety and its differentiation from depression.* Max Hamilton, M.D., F.R.C.P., F.R.C. Psych., F.B.P.S., emeritus professor of psychiatry, University of Leeds, England

9:15 *Stress, arousal, and anxiety.* Malcolm H. Lader, D.Sc., Ph.D., M.D., F.R.C. Psych., professor of clinical psychopharmacology, University of London, England

10:30 *Endocrine manifestations of acute anxiety.* Robert Rose, M.D., professor and chairman, department of psychiatry and behavioral sciences, University of Texas Medical Branch at Galveston

Session 2: The Anxiety-Prone Personality

1:30 *Genes and environment in the causation of anxiety.* Gregory Carey, Ph.D., department of psychiatry, Washington University School of Medicine, St. Louis

2:15 *The effect of prenatal stress on the infant.* Lorraine Roth Herrenkohl, Ph.D., professor of psychology, Temple University, Philadelphia

3:30 *The effect of postnatal stress on the infant.* Victor H. Denenberg, Ph.D., professor of biobehavioral sciences and psychology, University of Connecticut, Storrs

Thursday, November 6

8:00-5:00 registration

Session 3: Pharmacological Treatment of Anxiety

8:30 *Possible neurotransmitter mechanisms for the central effect of benzodiazepines.* Salvatore J. Enna, Ph.D., associate professor of pharmacology and neurobiology, University of Texas Medical School at Houston

9:15 *Inhibition of monoamine oxidase in treatment of anxiety.* Alexander Nies, M.D., professor of psychiatry and pharmacology, Marshall University School of Medicine, Huntington, West Virginia

10:30 *Beta-adrenergic blockade in the treatment of anxiety.* Ferris N. Pitts Jr., M.D., professor of psychiatry, University of Southern California School of Medicine, Los Angeles

Session 4: Nonpharmacological Treatment of Anxiety

1:30 *Regional cerebral blood flow and relaxation.* James L. Claghorn, M.D., assistant director; and Roy J. Mathew, M.D., D.P.M., M.R.C. Psych., chief, psychosomatic research unit, Texas Research Institute of Mental Sciences

2:15 *Biofeedback treatment of anxiety and anxiety-related illnesses.* Edward Blanchard, Ph.D., professor and director of clinical training, department of psychology, State University of New York, Albany

3:30 *Biochemistry of relaxation.* Beng T. Ho, Ph.D., chief, neurochemistry and neuropharmacology research section, Texas Research Institute of Mental Sciences

Friday, November 7

8:00 registration

Session 5: Psychosomatic Manifestations of Anxiety

8:30 *Psychosomatic manifestations of anxiety.* Chase P. Kimball, M.D., professor of psychiatry and medicine, division of biological sciences, and professor, department of psychiatry, University of Chicago

9:15 *Psychobiology of hypertension.* Herbert Weiner, M.D., professor of psychiatry and neuroscience, Albert Einstein College of Medicine, and chairman, department of psychiatry, Montefiore Hospital and Medical Center, New York City

10:30 *Arousal and migraine.* Roy J. Mathew, M.D.

Session 6: Sleep

1:30 *Anxiety and sleep.* Robert L. Williams, M.D., professor and chairman, department of psychiatry, Baylor College of Medicine, Houston

2:15 *Sleep and psychosomatic illness.* Harvey Moldofsky, M.D., professor, department of psychiatry, University of Toronto, and psychiatrist-in-chief, Toronto Western Hospital, Canada

3:30 *Evaluation and treatment of insomnia.* Ismet Karacan, M.D., (Med.) D.Sc., professor of psychiatry and director, sleep disorders center, Baylor College of Medicine, Houston

Accreditation

As an organization accredited for continuing medical education, the Texas Research Institute of Mental Sciences of the Texas Department of Mental Health and Mental Retardation designates this continuing medical activity as meeting the criteria of 17 credit hours in Category I of the Physicians' Recognition Award of the American Medical Association.

Registration

Biology of Anxiety Symposium
Texas Research Institute of Mental Sciences
1300 Moursund, Houston, Texas 77030
Att: Business Office

name and degree________________________

affiliation____________________________

street_______________________________

city______________state______zip_____

phone__________STS number__________

______$100 (before Oct. 5)
______$115 (after Oct. 5)
______$50 (student fee)
______TDMHMR staff (no fee)

Please return this form and check to above address and make checks payable to Texas Research Institute of Mental Sciences.

who we are what we do

He's in "the love business," the **Rev. John De Forest Jr.** says. As assistant to the rector of the Church of St. John the Divine, De Forest spends much of his time counseling parishioners, especially for alcohol and drug abuse and family problems. He is a consulting member of the public responsibility committee and sometimes refers church members to TRIMS. Another TRIMS connection is his son Bill, who several years ago was a psychology fellow here. A graduate of the New England School for Alcoholic Studies, De Forest has run a home for alcoholics, and he started both the San Antonio Council on Alcoholism and an annual retreat for alcoholics in the Episcopal diocese. In Houston he's organized a diocesan commission on alcoholism, which Dr. Joseph Schoolar chairs. He believes more people are seeking counseling for drinking problems today because alcoholism is now considered a disease. De Forest also brings communion to parishioners in retirement homes, trying, he says, to fullfill their needs for "humor, faith, and someone to care."

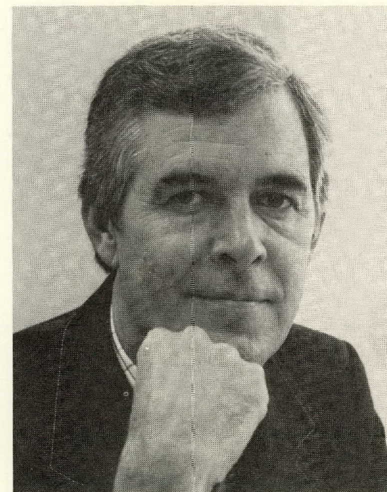
When **Toni Shippenberg** came to TRIMS she wasn't sure whether she wanted to go into medical or another kind of graduate training. As a neuroscience major at Colgate University, Shippenberg had written Dr. Harold Altshuler about a job "because I was interested in his research." She accepted his offer of a research technician's position in the neuropsychopharmacology laboratory and now, a year later, has made up her mind about school. "I decided I wanted to do research," she says. "I realized I'm interested most in finding out the answers to questions—why everything happens." She has just started in the Ph.D. program in pharmacology at Baylor College of Medicine and is a candidate for a TRIMS predoctoral fellowship. Shippenberg is working on a project to see whether rats can discriminate between alcohol and an alcohol metabolite, with hopes that the results might help clarify some reasons for addictive drinking. She'll present her report to a Society for Neuroscience conference in November.

Gail Estes' job as secretary in the neurobiology of aging section is not her first, but it's her first experience in a medical setting, "where something new is going on all the time, and you can never predict how the day will go." Estes enjoys sharing work with others. She is learning laboratory techniques, handling mice, helping to develop and print electron micrographs—"there is no limit to what anyone will teach you here." In her other jobs, she says, "people were afraid you would learn their work and move up into their spots. Here everyone seems secure and willing to teach." Dr. Thaddeus Samorajski "has got to be the best boss I've worked with," she says. "All his secretaries have gone on to train for other things." Estes plans to go to law school after completing prelaw courses at Houston Community College. She's carrying six hours of evening courses and keeping up her grades.

Dr. Renu Thapar entered her TRIMS psychiatric residency at the second-year level. She had served residencies in pediatrics and internal medicine, and was an assistant professor of anatomy at University Medical College in New Delhi, India. She studied in England on a commonwealth scholarship, learning electron microscopy and researching protein-calorie malnutrition at the University of Glasgow. Her first American post was at a Maryland hospital. Married to a pediatric cardiologist, Dr. Thapar came to Houston when her husband accepted a teaching post at Baylor College of Medicine. This year she has been working in the children's and crisis clinics; next year's program includes geriatric psychiatry. "There is a lot of guidance here," she said, "We have seminars each morning, weekly special topics conferences, monthly journal club. People here are eager to teach and supervise. The library staff go out of their way to find what you need. The only thing I miss at TRIMS is a good cafeteria." Dr. Thapar has even found an opportunity to follow her research interest, working on fetal alcohol syndrome with Dr. Corky Rosan.

Sue Crommelin-Dell's training as a family therapist and Jungian analyst is "more compatible than you might expect, at least to me," she says. Instead of seeing people as "containers of attitudes," Jungians view the personality as preparing to go forward. Family therapists look at family members as part of a system getting ready, or refusing, to change. "The two theories work well together," she says. Social worker in the adolescent and family clinic, Crommelin-Dell teaches a course on structural family therapy with Dr. Sergio Henao, and she belongs to the treatment team for a group of extremely disturbed families. "Such families tend to gobble you up," to pit therapists against each other. Working as a team, with simultaneous coaching from behind a one-way mirror by telephone or ear transmitter, is a "powerful tool for learning family therapy at a gut level," she says. Having trained in the children's and adolescents' psychiatric clinics at UT Medical Branch and Texas Children's Hospital, she is happy to be at TRIMS in a mixed disciplinary setting.

A consultant in clinical neurophysiology, **Dr. Robert Maulsby** manages EEG services for clinic and hospital patients. At TRIMS since May, Maulsby is involved in several research projects. One concerns the effects of haloperidol, an antipsychotic medication, on the brain's electrical activity. The other is a comparison of electroencephalograms of delinquent and nondelinquent youths. If there are differences, they might provide clues to some causes of delinquency. Maulsby was most recently a professor of neurology at Wayne State University and director of the Holden neurophysiology laboratory of Harper Hospital in Detroit. His return to Houston brings him to the site of his medical school training and his first teaching position at Baylor College of Medicine as an assistant professor of physiology. Maulsby is also a consultant to the clinical neurophysiology service at Baylor.



community affairs dept. updates facts about children and youth

Facts change, and FACS is keeping up with them. FACS, the family and child statistics information system produced by the children and youth services division of the Texas Department of Community Affairs, is now available with a new update. This is current information on 150 items concerning children and their families in each Texas county and the state as a whole—information on health, education, income, services, and other topics.

FACS data are particularly useful to local and regional planners, service providers, and professional and volunteer groups for planning, public education, proposal writing, and advocacy. They are effective tools in alerting citizens to conditions that exist in their communities.

To request a free copy of a county's 19-page profile or to learn more about the children and youth services division's other free informational services, call Terry Foster at 1-800-252-9642 (toll free) or at 475-5833 in Austin. When writing, address inquiries to FACS, Texas Department of Community Affairs, Children and Youth Services Division, P.O. Box 13166, Austin, Texas 78711.

seminars

Mental health training seminars, Friday mornings 11 to 12:15 in TRIMS auditorium.

sept. 5 • migraine headache—the psychosomatic angle
Roy J. Mathew, M.D.
chief, psychosomatic research unit
TRIMS

sept. 12 • fear of crime
Victor Elion, Ph.D.
clinical psychologist
behavioral research section
TRIMS

other topics to be announced

texas research institute of mental sciences
1300 Moursund Street, Houston 77030
(713) 797-1976

Bulk Rate
U.S. POSTAGE
PAID
Permit No. 4
Houston, Texas

address correction requested

the emissary aug.-sept. 1980
vol. 12, no. 7

Newsletter of the Texas Research Institute of Mental Sciences, the research-training-patient care facility of the Texas Dept. of Mental Health and Mental Retardation, an equal opportunity employer.

John J. Kavanagh, M.D., *commissioner*
Joseph C. Schoolar, Ph.D., M.D., *director*
Lore Feldman, *editor*
Karen Hanson Stuyck, *associate editor*
Keith Jackson, *art director*
Marc Meyers, *photographer*

Produced by medical illustration and audiovisual education, Baylor College of Medicine.