M1000.6
m7
9/3

IMPACT

Government Documents
DEC 26 1979
Dallas Public Library

Vol. IX, No. 3 • Texas Department of Mental Health and Mental Retardation • September/October 1979

The Broken Taboo:

Exploding Myths About Incest

By Blair Justice and Rita Justice

★*The Harry Lewis* family struck people as having a lot of togetherness. The father, a college-educated middle manager in the computer industry, came home after work each day and spent the rest of the evening with his wife and two daughters, 9 and 12. The mother kept a neat house. The family went to church together, took vacations together and did yard work together. On the surface, they seemed healthy and happy.*

★ *Dianne Smith's father was an architect whose work was in much demand. She and her three brothers and sisters and her stepmother lived in a big house in the best part of town. All the children were achievers, but Dianne was outstanding in school. Her father thought she was brilliant. She tried hard to please him. The neighbors considered the Smiths a successful family and the father a real asset to the community.*

★ *Dan and Lynn Davis had a teenage daughter who was going through the "adolescent rebellion" stage. She would argue with her parents about their being "too strict and old-fashioned," but the worse thing Lisa did to rebel was to sneak out of the house occasionally with her friends when they were spending the night. Even then, her mother knew she was gone, and Lisa was always back in an hour or two. For the most part, Lisa was cooperative, did average work in school, and seemed to enjoy hanging around with the kids at the church the whole family attended.*

**All names are fictitious.*

These three families share a number of features---nice house, good neighborhood, "devoted" parents---but what they have most in common is a problem of growing magnitude in America: incest. These three families serve to explode one of the myths about incest, that it is a problem found only among the poor and "depraved." Another myth is that people who commit incest are sick and crazy, and no one in the three families fits this stereotype either.

Incest is defined as any ongoing sexual activity between nonmarried members of a family. Estimates are that at least one in every 20 families is involved in some form of incest. It is another myth that incest is rare.

Contrary to what most people believe, many incestuous families present on the surface a picture of being stable and cohesive. Like Harry Lewis, the father may seem family-centered and the mother home-oriented.

It is not unusual for the incestuous family to present this kind of profile: They are middle-class people. The parents have some college, if not a degree in their background. They have been married more than 10 years. The father is in his late thirties; the mother is slightly younger and does not work. There are three children; the oldest daughter is reaching puberty. In short, from a distance the typical incestuous family looks like a typical American family.

But an incestuous family is *not* the typical American family. So why does incest happen in some families and not in others? As reported in our new book, *The Broken Taboo: Sex in the Family* (Human Sciences Press, 1979), we surveyed 112 families in which incest had recently occurred. We treated 20 of the families plus 10 young women who had incestuous experiences as children. Why incest happens is one of the questions we addressed. Basically, incest is not a matter of sex. Rather, incest grows out of people's attempts to meet their needs for warmth, nurturing and closeness through sex.

Incest is a form of child abuse, and the underlying motivations are similar in both physical and sexual abuse: a parent under stress turns to a child to try to meet his or her needs. In physical abuse, violence is the means by which a parent tries to force compliance and nurturing. In incest, the parent uses sex and seduction. In both cases, the needs of the child are being sacrificed to those of a parent.

Sadly, the exploited child is likely to become an abusive parent as an adult, for like physical abuse, incest passes from generation to generation. As one woman who had been sexually abused said: "I believe my mother was abused sexually to have married my father who abused me. I also believe that if I didn't deal with where I was with men and my anger toward men that I would have picked a man who would have abused my children because those were the only kind of men that I knew how to relate to."

Besides investigating what incest is, who commits it and why it occurs, we also focused on the cues and consequences of incest and what can be done about the problem.

"Role reversal" is one of the signs suggesting incest in a family. This occurs when the parents are functioning more like kids, and the kids are forced to assume the role of parents.

Other cues of father-daughter incest are a father's being over-possessive of his daughter, not wanting her to date or spend much time with her peers. The mother in the family may act as a rival to her daughter, showing jealousy at her husband's attention to their daughter. The cues in the victim vary with the age of the child. With adolescents, depression, secretiveness and seductiveness may be signs. Cues in pre-puberty children can include bedwetting, hyperactivity, phobias or excessive masturbation.

The consequences to a child involved in incest are often long-lasting. To what degree incest is damaging depends on many factors: how the incestuous relationship began, the child's age, the emotional context, how the family reacts, how the incest comes to light and many other elements.

The most pervasive long-term consequence of father-daughter incest is the effect on the daughter's self-image. Many have a low self-image, feeling dirty and bad, and they suffer guilt and depression all their lives. This self-image affects their relationships with people, especially men.

In addition to feeling worthless, the daughters grow up with a confusion between sex and affection, and they do not know how to receive or show affection in nonsexual ways. As a result, they have great difficulty in establishing loving relationships and may end up involved in promiscuity, divorces and miserable marriages. While not every person is devastated by an incestuous experience, few emerge without some permanent scarring.

Fortunately, rehabilitation on both an individual and family level is possible. In families we have worked with in therapy, the parents have learned to meet their own needs without turning to their children, and the children, in turn, have learned that they can be children and still have their needs met. The marriage, as well as the family, is strengthened, and the incestuous experience, for families who receive help, is converted into one of growth rather than destruction.

However, in order for more families to receive help, there will have to be more treatment programs and training of professionals in how to do therapy with incestuous families and with adults who were victims of incest as children. Professionals all too often are uninformed about the causes of incest and the means to effective treatment. They may miss picking up on the cues of incest because of lack of knowledge and their own discomfort with facing the issue of incest.

Although incest continues to be a taboo, the taboo has not prevented the behavior from occurring. It simply has kept people from discussing the problem, recognizing how extensive incest is and taking corrective action. Because the taboo has served to keep the subject so hidden, children are left vulnerable in terms of not knowing where to turn for help.

Meanwhile, the problem continues to grow. As families experience more and more stress and find it harder to meet their emotional needs, the potential for incest goes up.

As for prevention, one of the most important steps is to bring the subject out in the open and to remove the taboo against discussing it. We cannot begin to make prevention a reality until we deal with the subject openly and recognize it for what it is. ■

Blair Justice, Ph.D., and Rita Justice, Ph.D., are the authors of The Abusing Family *and* The Broken Taboo: Sex in the Family. *He is a professor of psychology at The University of Texas School of Public Health in Houston and she is codirector of the Southwestern Institute for Group and Family Therapy.*

El Alcoholico

By Rolando Garza

The high birth rate among residents of Hispanic origin, coupled with an astounding tide of immigration, has made the Spanish-speaking population of the United States the fastest growing minority. The presence of los Chicanos, Hispanics, the Spanish-speaking, La Raza, the Mexican-Americans, Cubanos or Puerto Ricans, or whatever the designation, is having a broad impact on the social, economic and cultural life of all Americans. The tide of immigration, unequalled since the turn of the century, can be seen in the vivid Chicano murals adorning buildings throughout the country, heard in the Latino-flavored salsa music sweeping all disco lovers off their feet and tasted in the abundance of Mexican restaurants. To some political observers, Hispanics are the political movement of the '80s. To others, the growth of the Hispanic population represents an irresistible force in search of expression.

Unfortunately, an increase in alcoholism and alcohol abuse among Hispanics appears to be matching the population growth. Estimated at approximately 11 million, the alcoholic population of our country includes a large portion of Hispanics. Increasingly, the issue of alcohol abuse and alcoholism among our people has received concern and attention.

What is alcoholism? A good working definition is the following: "It doesn't make any difference whether a person drinks whiskey, gin, champagne or beer, whether he drinks before breakfast or waits until after dinner, every day or on weekends only, alone or with others, at home or abroad. If drinking continues to disrupt an individual's life, he is an alcoholic." Unfortunately, for too many Hispanics alcoholism remains an embarrassment that affects "the other guy." This is a tragic misconception.

But whether the individual is a skid row bum or a white, middle-class business executive, un hombre o una mujer, Anglo, Hispanic or Black, the individual who suffers from alcoholism is afflicted by a progressive yet treatable disease that yearly devours the lives of millions of Americans. It is the basic understanding of alcoholism as a disease, una enfermedad, that the Hispanic population has not yet completely accepted. This is indeed a major concern to anyone involved in the alcoholism field. It is a true tragedy for the Hispanic people.

The nature and severity of the problem are not often confronted among Hispanics. The many cases of child abuse, battered women, homicides, suicides, drunk driving are some examples of what is seen in our barrios but seldom related to the true root of the problem: alcohol abuse and alcoholism. Consequently, alcohol problems continue to spread unnoticed.

The Hispanic population has for too long maintained wrong ideas and attitudes about drinking, excessive drinking, alcohol abuse and alcoholism. The problems are compounded by pressures from cultural differences, low socio-economic status, and cultural and communication problems in dealing with existing services or personnel.

Although more and more professionals dealing with alcoholism are becoming sensitive to the problems of Hispanic alcoholics, there are not enough of them and the urgency of the matter requires more Hispanic involvement. Most alcoholism awareness and education efforts through the media are in English and either do not reach or do not appeal to our Spanish-speaking population. The lack of bilingual/bicultural prevention and treatment programs along with the lack of services located within or near Hispanic barrios remains an obvious concern.

Initial studies reflect a need for treatment modalities that will involve the entire family. An understanding of the roles that Hispanics assign to men and women could be of value in exploring drinking habits of both sexes. Alcoholism counselors must become sensitive to the cultural uniqueness of the Hispanic and, wherever possible, confront the client in the native language. Traditional therapeutic techniques must not hinder explorations into the value of curanderismo in addressing alcoholism and alcohol abuse problems of Hispanics.

Professionals must explore the psychosocial and cultural factors affecting Hispanic women in their drinking behavior and patterns of drinking, because National Institute on Alcohol Abuse and Alcoholism (NIAAA) figures show that one out of every three alcoholics is a female. What effects do machismo (manliness), compadrismo (the kinship between the godfather and parents of a child), commadrismo (the kinship between the godmother and parents of a child) and carnalismo (brotherhood) play in influencing women to drink? How can the Hispanic family help in the rehabilitation of the female problem drinker or alcoholic?

According to Juan Chavira, assistant professor of Clinical Social Science with The University of Texas Health Science Center in San Antonio, for too long Mexican-Americans have been left out of the mainstream of the health services delivery system. "The Mexican-American is outside the realm of medical care services because he is outside the realm of social services," he says.

Reinforcing this belief are two employees of the Austin-Travis County MHMR Center: Rudy Zapata, unit director of the East First Human Development Center, and Ed Valdez, alcoholism counselor at the center. Zapata and Valdez point out there is a definite need for the Hispanic popula-

tion to examine, define and interpret its drinking attitudes, values and behavior patterns because these factors are important in developing treatment modalities for the Hispanic alcohol abusers and alcoholics.

Zapata says the Hispanic family unit often protects the Chicano alcoholic by laughing at his problem, hiding it from others and even denying that the individual does in fact have an alcohol problem. This type of protection can be fatal, because the progressive nature of the disease makes treatment and rehabilitation harder to accomplish as the individual enters the chronic stages.

The problem of alcoholism in the barrio is an issue Ed Valdez has dealt with more than two years. The alcoholism counselor is quick to point out that "La Raza simply does not believe alcohol consumption or abuse can make one a sick person and even cause death."

Valdez is adamant in his concern for a thorough education campaign that will dismiss the many stigmas and misconceptions that Hispanics hold about alcoholism. "It concerns me that many young Chicanos feel strongly that drinking beer can not cause alcoholism. As a result, many are experiencing the effects of too much beer at earlier ages."

Hispanics must come to terms with their own drinking habits and patterns. One effort designed and implemented by barrio residents in Austin is "Culture: A Means of Primary Prevention," a three-year program funded by NIAAA and under the leadership of Bob Lawrence, a doctoral candidate in anthropology at The University of Texas at Austin.

At the end of the first year of the program, community leaders, neighborhood service providers, individuals who assisted in gathering community information through interviews and questionnaires and any interested community volunteer will review the data collected. Out of the information will emerge a primary prevention strategy that will not assume that all concepts of responsible drinking resemble middle-class America. Instead, the prevention programming will reflect the ideas and attitudes that help to reinforce cultural values in the community and not destroy them.

The harsh reality of admitting that our own father, mother, aunt, uncle, brother or sister has a drinking problem is not an easy undertaking. But we have ignored "el alcoholico" for too long. The consequences of continued apathy could result in shame for the entire race. The Hispanic community is a place for our legacy of pride to be stored and transmitted to future generations. For the sake of our children and our children's children, we can not, we must not leave behind the legacy of a people destined for great accomplishment but hindered by the staggering effects of alcohol abuse and alcoholism. ■

Rolando Garza is a public information specialist for Austin-Travis County MHMR Center. Formerly he was an information specialist with the Texas Commission on Alcoholism.

Resource

Guide To Alcohol and Drug Abuse Audio-Visual and Print Sources about the Spanish Speaking---in Spanish, English or Bilingual, by Joseph V. A. Partansky (Nov. 1977, 64 pages). Charge only for postage and handling: U.S. and Mexico, $.50, Central and South America, $1 U.S. International money order. Send to Do It Now Foundation, P.O. Box 5115, Phoenix, AZ 85010.

The author would like to receive sample copies of recent or excluded items to add to future revisions. Send to Partansky at 704 Superba Ave., Venice, CA 90201. ■

To See Ourselves...

By Hanaba Noack

VERNON---"To see ourselves as others see us" is one of the aims of video therapy being used at Vernon Center Adolescent Drug Abuse and Addiction Service.

"Video gives immediate feedback to the clients showing them how they come across to other people," says Jerry McLain, information director. "It's therapeutic in that it gives the client a greater understanding of himself that may lead to a better self-concept and a healthier emotional attitude."

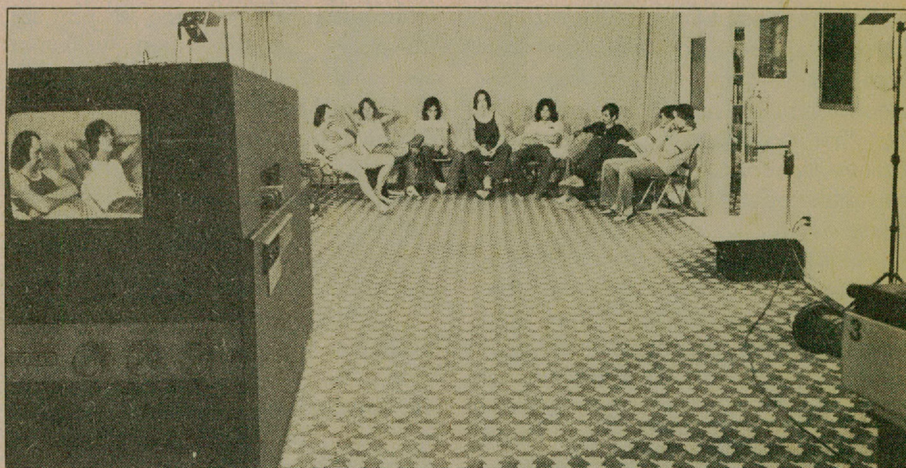
Both one-to-one and group therapy sessions are taped in the audiovisual studio in settings designed to create a relaxed nonstudio atmosphere.

Groups usually are taped for about 30 minutes. The clients then view a playback of the whole session. McLain sometimes, unbeknown to the clients, tapes the group while they are viewing the playback so they can afterward see their reactions to seeing themselves---a double dose, as it were.

A video switcher allows McLain to utilize split screen images, corner inserts and other special effects to capture group interactions. For example, two clients talking to each other from opposite sides of a group can be placed face to face on a vertically split screen. McLain also zooms in on individuals in the groups---"not only facial expressions," he says, "but also body language---gestures and other nonverbal forms of communication, a foot tapping nervously or hands gripping a chair."

The center also uses the video equipment to produce tapes for employee orientation and departmental training. McLain plans to use a video editing system to produce tapes of clients (with their consent) showing their emotional development from admission to dismissal. The tapes would be restricted to use in certain segments of inservice training. ■

Hanaba Noack is information officer for Vernon Center.



Video therapy provides immediate feedback. Photo by Hanaba Noack.

...As Others See Us

By Joan De Rooy

EDINBURG---"I never was *that* bad!"

So says the alcoholic client a couple of days after he has been admitted to the hospital for detoxification. "I know some guys who are really 'out of it' because of alcohol, but not *me*. I want some help controlling my habit, but don't tell me what bad shape *I* was in when I was admitted."

These common, and sincere, feelings on the part of many alcoholics prompted the alcohol counselors and their support team at Tropical Texas Center for MHMR to begin their intake videotape procedure.

With the client's permission, a short videotaped interview is conducted as part of the initial intake interview for use in several ways. First, the tapes are helpful to the alcoholism team in diagnosis and evaluation of the new client. They also allow those members of the team not present at the time of intake to observe the client.

But the application that has the most therapeutic impact on the client is the opportunity for the person to see his or her actions in a way no report from someone else could make possible. The ability to see what happens as a result of alcohol abuse can be a "sobering" sight.

The videotaping strategy is only one facet of Tropical Texas Center's 10-day alcoholic detoxification process. Another project has been the development of Spanish language curriculum packets of alcoholism information to better serve the monolingual and bilingual clients.

Alcoholism clients Buddy Garza and Fred Pena developed the program with the support of caseworkers Bob Giles and Juan Rodriguez; Thelma Longoria, supervising counselor; Edna Labbe, occupational therapist; Dan Trussell, psychologist; and Emma Jean Sanders, R.N.

Modern technology and staff concern are allowing clients to truly "see themselves as others see them." The acceptance of what they see, coupled with a desire to change, which is bolstered by a supportive alcoholism team, is giving alcoholic clients new fuel in their battle against alcoholism. ■

Joan De Rooy is director of consultation and education for Tropical Texas Center for MHMR. If you write her at P.O. Drawer 1108, Edinburg, TX 78539, she'll share with you the outlines and lists of sources used in developing their Spanish language curriculum packets of alcohol information.

"No one is paid to be a hero."

It is Linda's second week as a mental health worker in the geriatric unit. She is just beginning to sort out the bewildering jumble of names and faces which have been thrust upon her in the past days. From down the empty hall a heavy-set woman in her sixties approaches her. Linda tries to remember if she is Mrs. Ellis, the widow who is so terribly depressed, or is she Mrs. Ellers, the lady who was admitted recently after suffering a psychotic break.

Linda chances a tentative greeting. With no warning, and surprising swiftness and strength, the elderly woman reaches and grabs a fistful of Linda's long hair. Panic and pain take over and Linda lashes out wildly. Reacting to Linda's hysterical defense, the woman strikes back frantically. By the time another staff member can intervene Linda has lost a hank of hair, several patches of scratched-away skin and all the self-confidence she had managed to build up.

Was Linda's experience unique? The statistics say no. In the third quarter of fiscal year 1979 staff members at the 13 state schools suffered 3,349 injuries. Of that total 1,783 were inflicted by clients. Although similar systemwide data from the state hospitals are not available, those facilities, too, are struggling with the problem of abuse of staff by clients.

Staff injuries are rarely serious. Only 98, or less than three percent of the 3,349 injuries reported at the state schools, required hospital treatment. Still, the bites, scratches, sprains and cuts which a few of the system's 17,000 residential clients will at some time wreak upon the bodies of a fraction of frontline workers are inevitabilities which frighten new staff members and unnerve veterans.

Over the past decade, as both clients and employees alike have become aware of their rights, the department has explored a number of responses to aggressive behavior. In 1967 Mexia State School began to develop a set of guidelines to help staff determine when it would be legitimate to subdue residents. San Antonio State Hospital's inservice training program has prepared a manual of "Techniques for Managing the Disturbed, Acting-Out or Aggressive Patient." A number of other facilities have developed their own programs. And an even greater number have trained staff members through programs, films and modules from a variety of other sources.

One of the more popular of these programs is Client Management Techniques (CMT), devised and instructed by consultant David Mandt of Richardson. In a recent refresher course Mandt taught to a portion of the 18 Austin State Hospital employees he had certified as trainers last year, he introduced his techniques with an anecdote illustrating the program's philosophy.

"There was a nurse," Mandt recalled, "who had her own invariable way of dealing with troublesome patients. 'Tie their butts up,' she'd order. No matter what the person was doing, it was, 'Tie their butts up.'

"That was her attitude. Then this nurse's father had a stroke and suffered some brain damage. He was sent to her unit. Suddenly, instead of 'Tie his butt up,' her attitude changed to, 'That could be my father.'

"That is what your attitude should be with every patient---That could be *my* father, or *my* sister, or *my* brother.' And you should treat the patients accordingly, even if they are being aggressive."

This philosophy accounts for Mandt's insistence that instructing staff in techniques which utilize pressure points and pain to subdue assaultive clients is totally inappropriate to the field. He explains that oftentimes a client who is psychotic or heavily medicated can have a pain threshold vastly different from the normal. A

Gene Graham (left), Austin State School staff training specialist, instructs a class of new employees in Client Management Techniques (CMT).

client may not give any of the usual signals of pain---flinching, screaming, retreating---and the staff member who is using the wrestling hold, come-along grip or limb hyperextension he was taught could do serious harm to the pain-tolerant client.

What Mandt advocates in place of techniques which rely upon pressure points and pain are a "graded system of alternatives." He contends that this system encourages the use of the least amount of external control necessary so that the internal control used by the client is reinforced. These external controls start at the gestural, verbal, body positioning level and escalate to touch, holding and forcible movement only when the first three have proved ineffective.

"The idea," says Steve McArthur, Austin State Hospital training officer, "is that using the least amount of external control reinforces the client's own use of internal control. The staff person is not supposed to be king of the block. It is not a win/lose situation. The attitude that staff has to always be in control at any cost is wrong. No one here is being paid to be a hero."

McArthur cites two obstacles he faces in implementing Mandt's program: a 99.5 percent annual turnover rate among frontline workers and the increasingly higher proportion of more severely disturbed clients with whom they work.

The second factor is one of the major causes of a growing departmental interest in staff abuse and how to handle it.

Pat Craig, Ph.D., chairperson of the departmental Committee on Behavior Therapy Modification and liaison to a task force directed to develop a standardized Protective Management of Aggressive Behavior (PMAB) curriculum, says, "Everybody recognizes that staff must have some way to protect themselves."

This recognition, says Dr. Craig, is tempered by the task force's concern that should they adopt a standardized PMAB curriculum, it has the potential of turning into a vehicle for abuse.

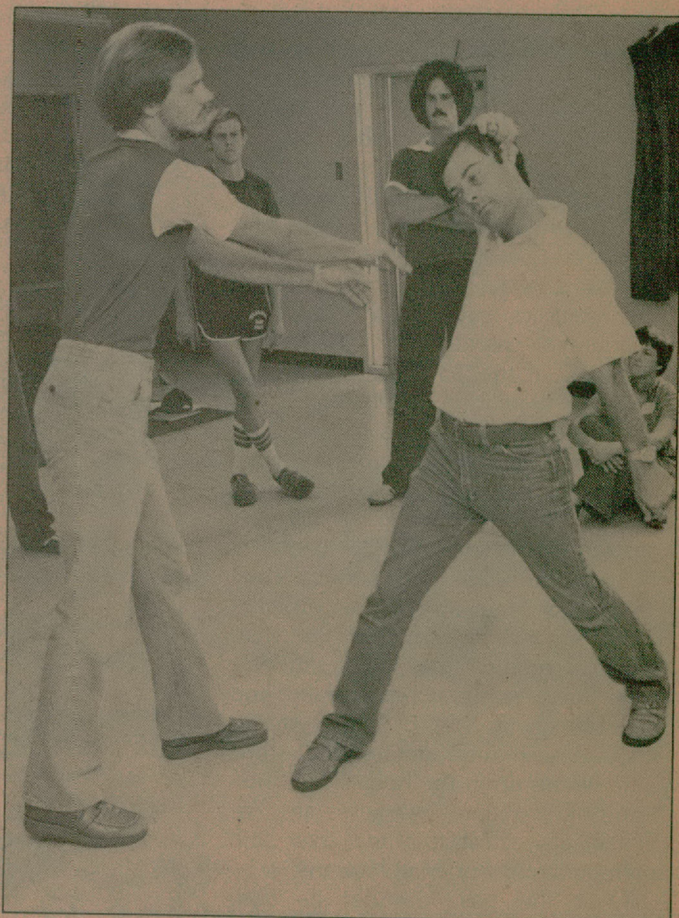
The other obstacle---turnover---is one which McArthur would attempt to overcome by training the constant stream of new employees to deal with aggressive clients before they are ever sent out to their frontline positions.

Uvaldo Cantu, program coordinator for Austin State Hospital's Center for the Deaf and a man with 22 years of service in the mental health field, agrees with McArthur's solution.

"For their first three or four months on the unit new workers never know if they're going too far or not far enough. First Staff Development pumps client abuse to them, which is all to the good, but they end up not knowing how tight to hold on to patients and what they can and can't do. They used to show them films on wrestling holds and pressure points. Boy, they were really bad. They were out to hurt the patients."

Cantu says he always, instinctively,

Acting as the client, Graham demonstrates that it is not necessary for the staff person to control every situation. In this case the student learns that if she presses the client's hand tightly to her scalp her pain is minimized and she can simply follow his hair-pulling lead.



CMT emphasizes de-escalating potentially violent encounters by maintaining a nonaggressive stance. Here Graham breaks out of a choke hold with his right arm carefully tucked over his head rather than held aloft in a more threatening posture.

has used CMT---talking with clients, de-escalating potentially volatile situations, avoiding force. He does, however, recall one particularly dramatic incident when force was unavoidable.

"This was years ago," Cantu begins, "and we had this new admission. He was six-foot six, weighed 300 pounds and had size 16 feet. This guy was big! I was getting him settled in and, for no apparent reason, he looked at me and says, 'I'm gonna whip you!' I had no idea on earth how I was going to salvage myself.

"Finally we had to come after him with a mattress when he started swinging. He grabbed that mattress though and bent it back like it was made out of paper. It took 10 guys to pin him down."

Cantu, a CMT trainer, adds that "in those days if a client became angry or struck you, you just had to fend for yourself. It was you and him until other staff came, then everyone jumped in for their lives.

"From experience I found that those harsh techniques don't work. With CMT you don't always have to be right. For me it is the ideal program and long overdue. It tells how to protect yourself *and* your client."

Another equally enthusiastic supporter of Mandt's program is Bill Connelly, fire and safety officer at Austin State School. His meticulously-kept employee injury records provide the cause for his enthusiasm.

"The percentage of client-inflicted injuries to the total number of employee injuries per quarter decreased nearly three times (42.1 percent) after the Client Management program was instituted," Connelly's records report. "Likewise, the percentage of injuries each quarter that were client-inflicted decreased from 51.3 percent to 32.2 percent in the same period."

Gene Graham, Austin State School's CMT instructor, acknowledges there were some reservations about the program. Staff Development personnel worried that by teaching new employees the techniques they would alarm them unnecessarily and possibly create a staff more given to physical intervention. Neither possibility materialized and Graham is now a wholehearted supporter.

However, he does point out a basic limitation inherent to CMT and any other program: "None of them will make anyone six-foot four and weigh 200 pounds."

"If you think that just because you've taken my course," Mandt tells his students, "that you're never going to get hurt, you're wrong and you're in the wrong business. My program is *not* self-defense. What we're teaching is how to minimize injuries to yourself and to your client."

Or, as McArthur puts it, "CMT is just another tool that an effective staff person needs to have. It is one which will protect both staff and client without pitting one against the other. With CMT clients can feel like the staff is on their side, that we're all on the same team." ■ *S.B.*

Graham becomes a smiling blur as he attempts to unloose a particularly tenacious grip. Photos by Sarah Bird.

EL PASO: CULTURAL CROSSROADS

The destiny and character of few cities have been determined so dramatically by geography as that of El Paso. Isolation in an awkwardly extruded pocket of the state has been one determinant. The Franklin Mountains knifing the city in two also have played a role in making El Paso the distinctive city it is. But the dominant geographical factor is El Paso's location on the U.S.-Mexico border.

The Rio Grande, threading its concrete-walled way between Juarez and El Paso, is the most permeable of borders. From each side of the river stream influences which insinuate themselves into every aspect of life on the opposite bank. No arena, from the cultural to the economic, is immune to these frontier-proof infiltrations, but the area where they exhibit perhaps the most unexpected effects is on the city's mental health service system. A look at some of the divisions within the El Paso Center for Mental Health and Mental Retardation Services will illustrate many of these influences and a few surprising effects.

CENTRAL OUTPATIENT SERVICES

The workers, documented and otherwise, who flow more regularly across the bridges from Juarez to El Paso than water will ever run in the conduits below, have had an enormous impact on center services. Central Outpatient, located in the impoverished San Juan barrio, is the mental health facility closest to the river.

"We serve the poorest of the poor," says unit coordinator Sandy Johannson of the 750, predominantly Mexican-American, clients who comprise the caseload of the 10-year-old facility. Of those 750 clients, Johannson estimates that 10 percent are Mexican citizens.

"It is a constant problem for us," she says, referring to the sticky issue of treating nonresidents. "I'm a real humanist. I don't care what a person's nationality is, if they come to us and they are hurting, they're a person who needs help. We don't ask for citizenship proof."

The problem continues to expand when, added to it, are those Mexican nationals who forsake their former citizenship to take up permanent residence in this country. While El Paso might seem like the most Mexican of American cities to us, Johannson reports that Mexicans continually remark on how American, how fast-paced, it is.

The stresses associated with acculturation are myriad---financial problems, abusive employers, pay scales ruled by backbreaking quotas, family disruptions, mushrooming expectations---and Central Outpatient is where they are dealt with.

"I can clearly trace several psychotic breaks to the stresses of migrating," says Johannson. She adds that, although the unit's 10 professionals see more women than men, acculturation takes a far heavier toll on the transplanted males.

"The woman is the symptom-bearer in the family," explains Johannson. "Although she is more protected from abusive employers and the like, the Mexican woman, like women in most cultures, has more permission to show problems. That is really true here since it is heightened by machismo in the Mexican culture. By the time a Mexican man will come to us, his problems are severe, more severe than the woman's."

The wealth of possibilities suddenly available to them is what places the greatest strain on the migrating women, says Johannson. She estimates that they come from Mexico with a third-grade education and few expectations. In America those few expectations multiply dramatically. "In Mexico," says Johannson, "the women were content. Here they get angry. If they had stayed in the pueblo they never would have known what they were missing."

Acculturation is something best measured in degrees, ranging from the totally Americanized to the client with a rural Mexican background whose emotional fears are expressed in terms of witchcraft and "mal ojo," the evil eye. Central Outpatient deals with such problems within a cultural framework, often referring them to curanderos, native healers, for doses of manzanilla and other teas soothing to the "nervios," the nervous complaints which rural Mexicans often present.

The strong family solidarity so traditional to Mexican families is another fact of life at Central Outpatient. Johannson describes it as a "double-edged sword," explaining that families are often so close it is quite common for a married woman to spend time daily with her mother. This closeness can be suffocating if the woman has problems which are fueled by constant contact with a disturbed parent. On the other hand, Johannson doesn't see many Mexican families rejecting a member with emotional troubles. She explains that there is no cutoff point when a child turns 18 or 20 like there is here. "A son or daughter, or any family member, is theirs for life."

NORTHEAST OUTPATIENT SERVICES

Cultural diversity seems to be the major byproduct of El Paso's geographical location. It is seen in abundance at the center's Northeast Outpatient Services. Unit coordinator Larry Gauna describes the 110,000-person northeast corner as "El Paso's stepchild," since it is cut off by the Franklin Mountains and further isolated by an inadequate transit system. The isolation has not prevented an incredibly heterogeneous group from finding its way to this outpost.

Fort Bliss makes generous contributions to the caseload with clients who are connected with the base but not eligible for military benefits. A major percentage of the clientele has been discharged from Big Spring State Hospital. A large number of transplanted Midwesterners, Easterners and retired persons from points all over the map, drawn to the city where "the sun failed to shine only 23 days in the last 14 years," also find their way to Northeast Outpatient. In addition, there is a large contingent of clients more tied to Juarez than any point north---those moved from their former neighborhood in a south side barrio to federal housing at the other end of the city. Add to this mixture some aviators from the nearby German Air Force training base and you come up with quite a cultural hodgepodge.

"We see a wide variety of problems," says Gauna, "and they are exacerbated by the transience in this area. A person typically has few, if any, support systems. This intensifies problems."

The challenge to staff members in dealing with the unit's 150 to 200 active cases, says Gauna, is always to remember their values are not any worse or any better, only different. He cites an instance when this nonvalue orientation might become difficult to achieve.

"We had a client from Central America, a woman. She came from a male-dominated society where the man runs the house, makes all the decisions. We come from several decades of Susan B. Anthony propaganda, so we think the first step in treatment is to get the client on an equal footing

with her husband. But then we have to ask ourselves, 'Is it our job to change her values, to make her less conservative, less passive-submissive?' "

Dealing with questions such as these, and the additional burdens they impose, causes Gauna to remark that "staff burn-out is not just a word, a popular term. It's an experience.

"People don't come in here often and say, 'Gee, the sun is shining and I feel great and I just wanted to tell you.' No, it's 'God, my sister just blew her brains out and I'm coming apart.' " This is why, in hiring staff, Gauna searches for people with a sense of humor. "There are too many problems, too many acute problems here, for someone who wants to be a saviour."

El Paso's geography conspires to compound those problems. With her unfailing sun attracting snow weary Northerners and her permeable border drawing those from the south, the city has an unemployment rate which runs more than 10 percent and peaked last summer at 14 percent. Along with the expected strains unemployment places on mental health service clients come some unexpected frustrations as well.

EMILIO FERNANDEZ WORKSHOP SERVICES

"El Paso's mentally retarded persons have to compete with the illegal job market," reports executive director Lee Yudin, Ph.D. "The motels, for instance, are closed to us." Director of Mental Retardation Carmen Quesada elaborates: "A lot of the companies which might employ the mentally retarded in El Paso go across the border instead and subcontract the work. We have to bid at $2.90 an hour. They can have it done in Juarez for $1.40."

Lehr Martin, marketing coordinator, grappled with the problem of placing the mentally retarded in a market glutted with unskilled labor and managed to turn it to his advantage by incorporating the twin plant concept into his thinking. This concept has been developed by large manufacturers

Randall Lee, a member of Emilio Fernandez Workshop's grounds maintenance crew, sees to it that the area around G. T. Lenkurt's firm is kept litter-free.

John Estrada, coordinator of the drug abuse program, delivers a blood sample from a methadone client to the county health department.

like General Electric and General Motors who set up shop along the Rio Grande. By law goods cannot be finished completely south of the border without paying excessive import duties. So twin plants are established. On the Juarez side products are assembled partially, then hauled across the river to a twin plant for the finishing touches. They are packaged and shipped around the country from El Paso.

Convertors, a hospital supply company, employs this concept. The surgical toweling they manufacture is sewn and assembled in Juarez. Their employees in El Paso then cut, sterilize and ship the towels. Seventy of those employees are clients of the Emilio Fernandez Workshop.

"The mentally retarded are capable of doing anything their supervisors are capable of teaching them," believes Martin. The team of workers he has placed at Convertors bear him out. Dressed in disposable tunics and caps, they put in a six-and-a-half-hour workday unpacking and reinspecting shipments of substandard towels. They then remove defective towels, refold those which can be saved, repack and send the towels to be sterilized.

This salvage operation has resulted in a considerable savings for Convertors and a new life for those employed in it. One who went on to even bigger things is Victor Navarez.

The 23-year-old started as a towel folder with the workshop crew, but his inspection rate of between 500 and 600 towels a day, compared with the regular employee's average of 275-300, quickly drew the floor supervisor's attention. Whenever extra help was needed in moving boxes or conducting inventories, Navarez' able assistance was sought and given without any prospect of financial remuneration. It was rewarded though when, six months ago, the firm took him on as a full-time regular employee earning $3.30 an hour as a materials handler.

Household lawn maintenance, a traditional source of employment for the mentally retarded, would seem, at first glance, closed in El Paso with her arid climate forcing substitutions of pebbles and cacti for mowable lawns. Yet here again Martin turned an obstacle into an advantage for the workshop by contracting with large firms like G.T. Lenkurt, the Chamizal National Memorial and a 150-unit apartment for grounds maintenance. A five-man crew with supervisor is now fully booked five days a week keeping clients' Southwestern landscaping pebbles in place and grounds litter free.

DRUG ABUSE SERVICES

El Paso's location on the United State's southern boundary has still other implications for mental health services. Among them is the ready availability of cheap liquor. "El Paso is the kind of town," says executive director Lee Yudin, Ph.D., "where everyone has a wet bar and they meet you at the door with a drink." More serious, however, is the availability of drugs, hard drugs.

"In the fifties and sixties there was an abundant, pure supply of heroin. It was going for $3 a hit," says John Estrada, coordinator of the center's methadone treatment program, explaining the unit's large percentage of older addicts. Back then, continues Estrada, there was consent at the governmental level to the illicit flow of heroin across the river. Supply lines were pinched during the sixties when the counterculture moved heroin out of the slums and barrios and into a position where it began to threaten mainstream American society. This is not to say though that heroin no longer filters through El Paso. "It is one of the major ports of entry," reports Estrada, pointing out that while a few years ago most heroin came from the Orient, the major source now is Mexico.

El Paso's border location contributes two other complicating elements to the addiction syndrome---unemployment and poverty. Those are two vital factors if we make the contention that drugs are an escape, for, as Estrada says, speaking for his clients, "No matter how alone, or how desperate you are, heroin is always there, especially in El Paso."

CRISIS SERVICES

Probably no social problem points up so dramatically the many unexpected ramifications and special dimensions which mental health care workers must be attuned to in El Paso as does rape and the response to it. John Fuller, program coordinator for Crisis Services which subsumes the center's Rape Outreach program, explains that the less acculturated a Mexican-American woman is, the more difficult it will be for her to report a rape for fear of how her relatives, friends and husband will react.

Central Outpatient Services' Sandy Johannson confers with Lee Yudin, Ph.D., executive director of the El Paso Center for MHMR Services.

Guadalupe Tarin constructs an ojo de dios at the Day Treatment Center with the Franklin Mountains serving as a backdrop. Photos by Sarah Bird.

Least likely of all to report a sexual offense is the illegal alien. "Reports are very rare," says Fuller, "and even if we do get an initial report, the victim usually disappears. There are so many aliens working in homes, in factories, in restaurants, in motels where abuse is on a daily base and is tolerated as a condition of remaining here and not having papers."

A case tried several months ago, however, has gone a long way toward eradicating this deplorable situation. For the first time an illegal alien prosecuted an American citizen for rape and saw that citizen convicted.

"Many people feel they can abuse, violate, an illegal alien," says Fuller. "Now they see that something *can* happen. This conviction changes the focus from an illegal alien to a person who has been violated."

The complexities of this, and a host of other problems faced by center personnel, are understood best within a cultural context. Caregivers have to remember in dealing with rape victims, for instance, that the Mexican-American woman still may have her emotional roots in Mexico, a country where rapists can avoid prosecution by marrying their victim.

Whether, as Gauna pointed out earlier, this value is better or worse is not for center staff to decide. What is undeniable is that it is different. Dealing with those differences is just one of the distinctive challenges presented by a unique geographical situation to the community mental health and mental retardation center in the country's largest border town. ■ *S.B.*

MHMR Services in Texas:
The Price Tag

Texas cares for the mentally ill and the mentally retarded in its state facilities at less cost than most other states.

That is the report from Jack L. Franklin, Ph.D., chief of Program Analysis and Statistical Research for TDMHMR.

Dr. Franklin's cost analysis report on TDMHMR expenditures from 1970 to 1978 was prepared for the Texas Board of Mental Health and Mental Retardation.

"While the operating cost of TDMHMR facilities has increased appreciably over the past eight years, the fact is," said Dr. Franklin, "Texas ranks near the bottom of the list of states in expenditures for the mentally impaired."

He noted that Texas ranked 42nd among the states in expenditures for mental health services in 1976, the most current year for which complete state rankings are available.

In 1978 Texas' per capita expenditure for mental health services in state hospitals and community MHMR centers was $11.07.

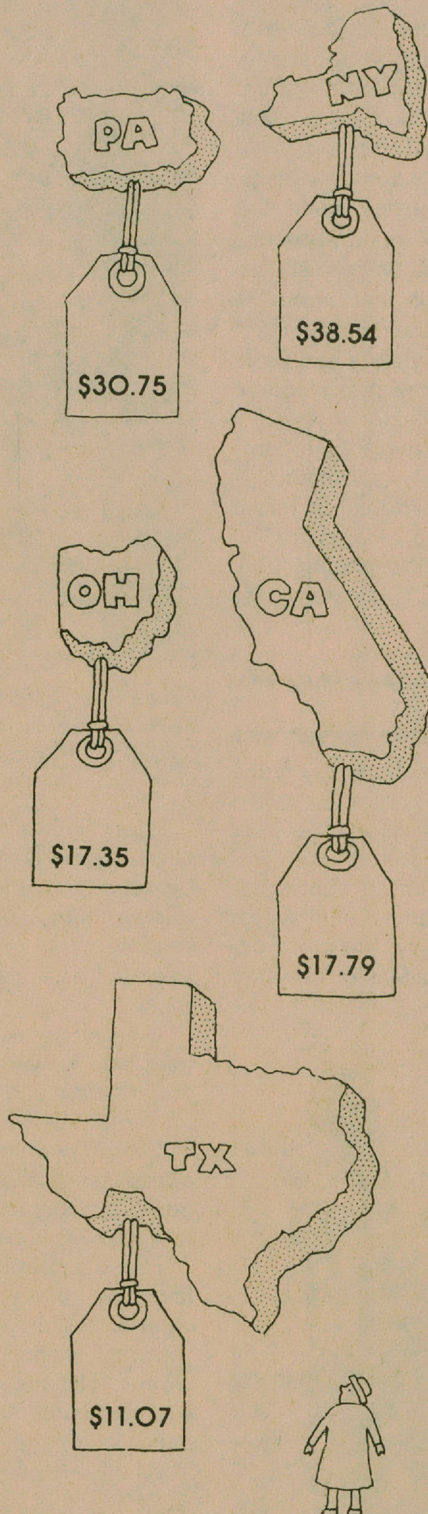
New York heads the list of large states in 1978 per capita spending for mental health with an expenditure of $38.54. Other large states and their per capita expenditures are: California, $17.79; Pennsylvania, $30.75; and Ohio, $17.35.

The national average daily cost for a state mental hospital patient is $37.54. In Texas the average daily cost is $26.56. The cost in other leading states: California, $45.58; New York, $37.08; Pennsylvania, $46; Illinois, $57.21; Ohio, $32.57; and Michigan, $57.99.

Statistics on per capita expenditures for mental retardation services are not available from other states, said Dr. Franklin.

However, his report does show that Texas is far below the national average for the daily or per diem cost for a resident of a state school for the mentally retarded. In Texas the cost averages $35.86. The national average is $50.10 a day.

Texas ranks 37th among the states in this category, far below the other states with large populations, such as California, New York, Pennsylvania, Ohio and Michigan.



In 1978 Texas had the lowest per capita expenditure for mental health services of all the large states.

Operating costs for Texas' state mental hospitals have climbed from $39.8 million in 1970 to $109 million in 1978. The cost of operating state schools has increased from $35 million to $149 million in the eight-year period.

However, Dr. Franklin points out, much of the increased cost, approximately 39.2 percent, is the result of inflation and the decreased purchasing power of the dollar.

Another point Dr. Franklin makes in his report is the fact that the state hospitals and state schools also collected funds during the eight-year period, money that came from participation in federal programs and payments from those who could afford to pay the state for the cost of services.

In 1970 the state hospitals deposited $9 million in the general revenue fund. The amount was $11 million in 1979. For the state schools, the collections totaled $10 million in 1970 and $52 million in 1978.

"This means," said Dr. Franklin, "the state schools returned to the treasury approximately 35 cents for every dollar spent on operating costs in 1978.

"The state hospitals returned approximately 10 cents for every dollar of operating costs during that year. Cancellation of the Medicare program accounts for the small amount in state hospital revenue. The Medicare program has been reinstituted, which means the hospitals will collect more revenue in the future."

Dr. Franklin's report also shows that Texas' state mental hospitals operate with fewer physicians, psychologists, nurses and direct care personnel than most other states; have fewer admissions per 100,000 population than the national average; and operate at less cost than most of the states.

"When you compare Texas' services to the mentally impaired with that of other states, the cost is not excessive," concluded Dr. Franklin. ■ *H.P.*

Dollars Allocated to Community MHMR Centers

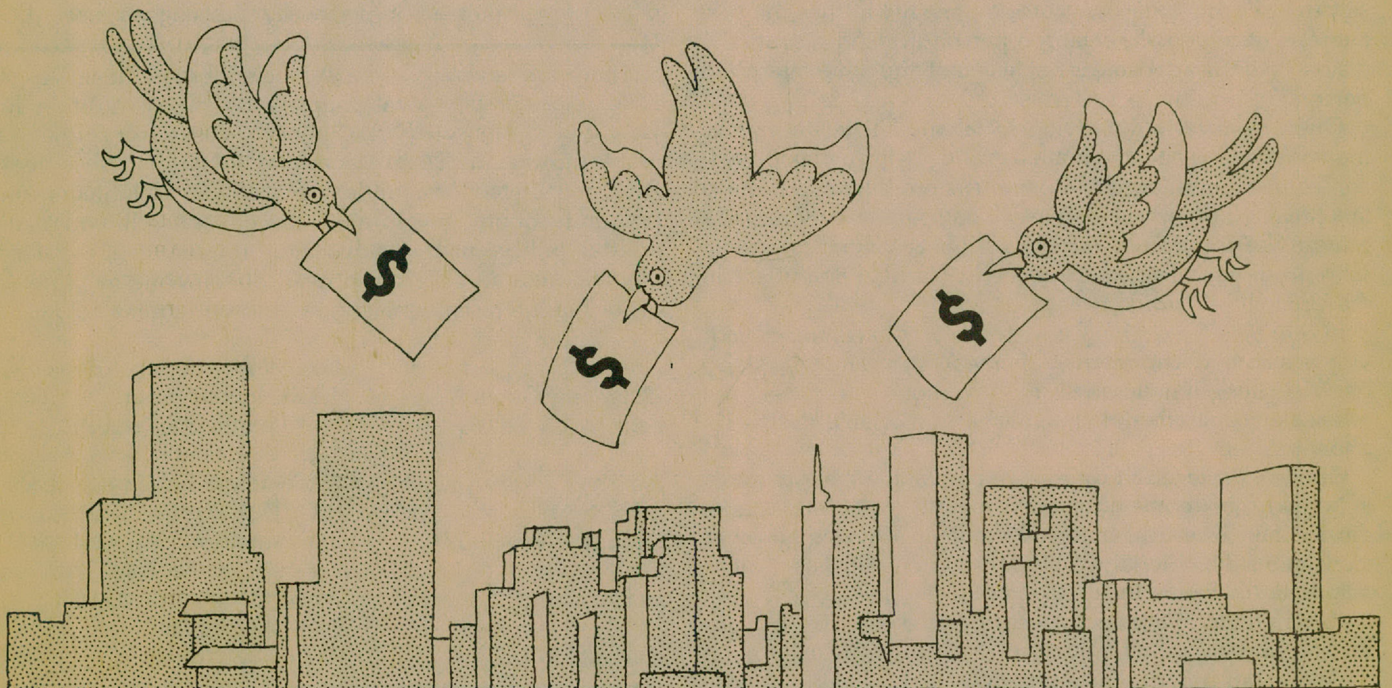
Allocation of $47,131,898 in state grants-in-aid to 30 community MHMR centers was approved by the Texas Board of Mental Health and Mental Retardation, meeting in Austin Aug. 17.

Included in the allocation was a grant to the Navarro County MHMR Center of Corsicana, which on Sept. 1 became Texas' 30th community MHMR center.

The grants represent $46,829,898 in state funds appropriated by the 66th Legislature for fiscal year 1980 and $302,000 in federal funds.

The centers and the amount each received in grant-in-aid are:

Center	Amount
Abilene Regional MHMR Center	$791,011
Amarillo MHMR Regional Center	$1,361,268
Austin-Travis County MHMR Center	$2,309,366
Bexar County MHMR Center, San Antonio	$3,593,326
Brazos Valley MHMR Center, Bryan	$914,822
Central Counties Center for MHMR Services, Temple	$1,201,290
Central Plains Comprehensive Community MHMR Center, Plainview	$706,916
Central Texas MHMR Center, Brownwood	$504,856
Concho Valley Center for Human Development, San Angelo	$532,925
Dallas County MHMR Center	$6,200,538
Deep East Texas Regional MHMR Services, Lufkin	$1,189,159
MHMR Regional Center of East Texas, Tyler	$1,009,981
El Paso Center for MHMR Services	$1,676,626
Gulf Bend MHMR Center, Victoria	$680,884
Gulf Coast Regional MHMR Center, Galveston	$1,711,104
MHMR Authority of Harris County, Houston	$7,996,265
Heart of Texas Region MHMR Center, Waco	$1,259,433
Lubbock Regional MHMR Center	$1,241,788
Navarro County MHMR Center, Corsicana	$82,948
North Central Texas MHMR Services, McKinney	$309,784
Northeast Texas MHMR Center, Texarkana	$566,134
Nueces County MHMR Community Center, Corpus Christi	$1,843,584
Pecan Valley MHMR Region, Stephenville	$371,510
Permian Basin Community Centers for MHMR, Midland	$1,019,528
Sabine Valley Regional MHMR Center, Longview	$690,714
MHMR of Southeast Texas, Beaumont	$1,467,109
MHMR Services of Texoma, Denison	$580,914
Trinity Valley MHMR Authority, Fort Worth	$3,136,079
Tropical Texas Center for MHMR, Edinburg	$1,443,442
Wichita Falls Community MHMR Center	$738,594



Citizen Advocacy: Friends In Deed

"An advocate is not an adversary," insists Carol Kruhl. As public information coordinator for Citizen Advocacy in Austin, Kruhl has many opportunities to make that point for those unfamiliar with the group's work.

"The group" currently consists of 120 matches between adult volunteers called "advocates" and mentally retarded children and adults called "proteges." Each pair's relationship is personal, based on the needs of the protege and the interests and abilities of the advocate.

"An advocate is just an outside person who has the best interests of a mentally retarded person in mind," Kruhl explains, "but the advocate is not in lieu of any other interested person."

One advocate may provide social advantages to expose the protege to new situations and help develop self-confidence. Another may monitor the program of a protege in a private residential facility, seek educational services for a child in the community or help a 40-year veteran of a state school arrange telephone service in his new apartment in the city.

In one match a clothing store manager offers financial advice to a couple who married after leaving a state school. By helping them handle their money more effectively, the advocate enables them to maintain a comfortable lifestyle on a low income.

Another protege is a withdrawn boy of five. He's enrolled in an early childhood education program of the local school district, but his stark home environment provides no other stimulation. His friend is a young mother who has a mentally retarded child herself. By introducing new experiences and running interference to secure added services, this advocate provides the early intervention so critical to the development of a mentally retarded child.

Before a match is made, a Citizen Advocacy caseworker becomes acquainted with the prospective protege and interviews and trains the aspiring advocate. Then the caseworker joins the pair on several get-acquainted visits to test the match. If everyone is satisfied, the advocate sets goals for the relationship and contracts with the protege (or family) to try to reach them.

By extending friendship and speaking up for those who cannot, advocates across the country champion the rights and needs of their proteges in personally satisfying ways. ■ *J.O.*

There are several Citizen Advocacy programs in Texas, all connected with local chapters of the Association for Retarded Citizens (ARC). Support comes from Title XX grants through the Texas Department of Human Resources, ARC and United Way funds, use of VISTA Volunteers, and city and county government contributions. If you're interested in becoming an advocate, or if you want to refer a mentally retarded person in need of someone to promote his or her interests, contact one of the programs below.

Austin Citizen Advocacy
2818 San Gabriel
Austin, TX 78705

Abilene Citizen Advocacy
1717 S. 11th
Abilene, TX 79602

Dallas Citizen Advocacy
2114 Anson
Dallas, TX 75235

Fort Worth Citizen Advocacy
1300 W. Lancaster
Fort Worth, TX 76102

San Antonio Citizen Advocacy
P.O. Box 10210
San Antonio, TX 78210

Waco Citizen Advocacy
P.O. Box 7172
Waco, TX 76710

Just Another Student

By Sally Gardner

FORT WORTH---"I wish we had more homework."

"I like the homework and the worksheets."

The students with these refreshing attitudes toward study are participants in a new program in higher education in Tarrant County named Project REACH (Regional Educational Action for Community Health).

The Institute of Urban Studies at The University of Texas at Arlington is the regional coordinator of REACH. Tarrant County Junior College (TCJC) and Trinity Valley MHMR Authority (TVMHMRA) are the cosponsors. Except for four students who are residents of Fort Worth State School, the students in REACH all are developmentally disabled adults who are living independently or with their families in Fort Worth, Arlington and surrounding areas.

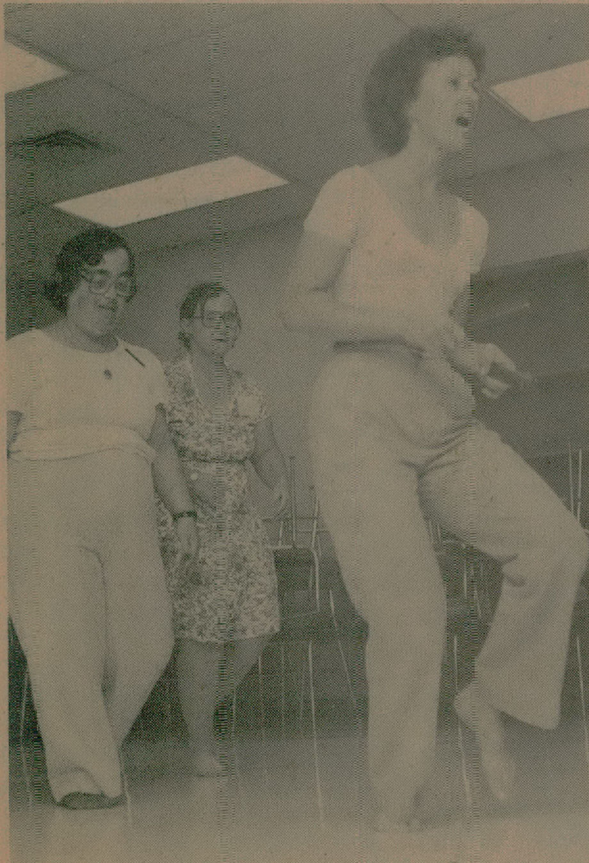
Classes were designed around the ideas expressed by the TVMHMRA clients in a survey done as part of the project. The summer semester courses include reading (the most popular), arts and crafts, music and dance. Fifty-nine students are enrolled. Classes conducted on the TCJC campus are small, courses are custom-designed and faculty all have special education certification. Otherwise, nothing distinguishes these young adults from the other college students.

REACH was developed as a demonstration project funded by the U.S. Department of Health, Education and Welfare as a way of opening community college campuses to nontraditional or underserved populations. Now that TCJC knows how to meet the special needs of these citizens, more courses can be offered to them. And now that TVMHMRA clients and other developmentally disabled people know they can successfully go to college, perhaps many more will enroll.

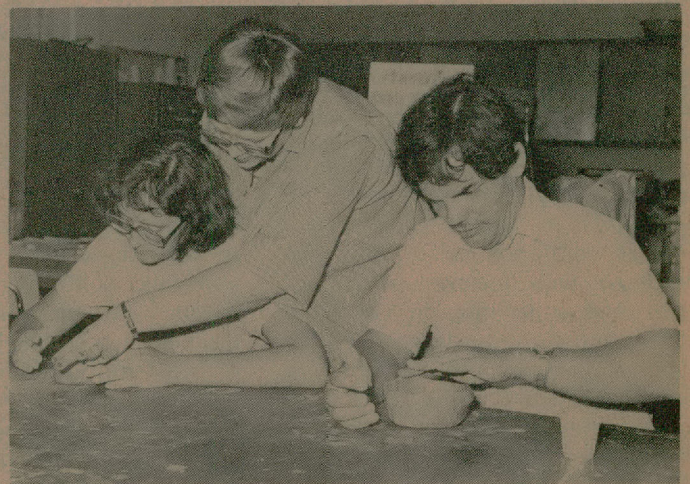
And the classes are a success, because as one student explained, "Well, I wouldn't come if I didn't like it. And I'm here." ■

Sally Gardner is planner for Trinity Valley MHMR Authority.

Reading was the most popular summer class. Here teacher Karen Fontenot assists Clyde Walker.



Higher education for Annette St. Marie (left) and Bettie Braucht (center) meant a chance to follow the high-stepping dance steps of teacher Bonnie Teed.



Teacher Bunny Hastings (center) checks the progress of Cheryl Moughon and Walter Smith in their arts and crafts project. Photos by Ben Head.

The Angry Child

Handling children's anger can be puzzling, draining and distressing for adults. In fact, one of the major problems in dealing with anger in children is our difficulty in handling the anger that their feelings stir up in us. It has been said that we as parents, teachers, counselors and administrators need to remind ourselves that we were not always taught how to deal with anger during our own childhood. We were led to believe that to be angry was to be bad, and we often were made to feel guilty for expressing anger.

It will be easier to deal with children's anger if we forget this notion. Our goal is not to repress or destroy angry feelings in children---or in ourselves---but rather to accept the feelings and to help channel them to constructive ends.

Parents and teachers must allow children to feel *all* their feelings. Adult skills can be directed then toward showing children acceptable ways of expressing their feelings. Strong feelings cannot be denied, and angry outbursts should not always be viewed as a sign of serious problems; they should be recognized and treated with respect.

What Is Anger?

To respond effectively to overly aggresive behavior in children, we need some idea what may have triggered an outburst. Anger may be a defense to avoid painful feelings; it may be associated with failure, low self-esteem and feelings of isolation; or it may be related to anxiety about situations over which the child has no control.

Angry defiance also may be associated with feelings of dependency, and anger may be associated with sadness and depression. In childhood, anger and sadness are close to one another and it is important to remember that much of what an adult experiences as sadness is expressed by a child as anger.

Before we look at specific ways to manage aggressive and angry outbursts, we should distinguish between anger and aggression. Anger is a temporary emotional state caused by frustration; aggression is often an attempt to hurt a person or to destroy property.

Anger and aggression do not have to be dirty words. In other words, when we look at aggressive behavior in children, we must be careful to distinguish between behavior that indicates emotional problems and behavior that is normal.

In dealing with angry children, our actions should be motivated by the need to protect and to teach, not by a desire to punish. Parents and teachers should show a child they accept his or her feelings, while suggesting other ways to express the feelings. An adult might say, for example, "Let me tell you what some children would do in a situation like this...." It is not enough to tell children what behavior we find unacceptable; we must also teach them acceptable ways of coping, and ways must be found to communicate what we expect of children. Contrary to popular opinion, punishment is not the most effective way to communicate to children what we expect of them.

Responding to the Angry Child

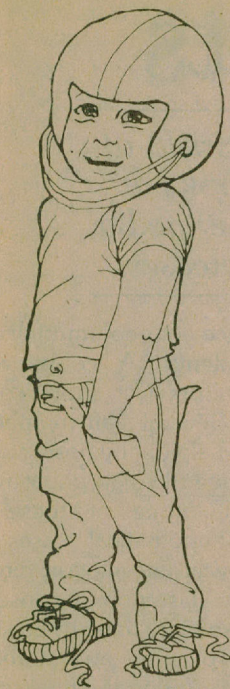
Some of the following suggestions for dealing with the angry child were taken from *The Aggressive Child* by Fritz Redl and David Wineman.

Catch the child being good. Tell the child what behaviors please you. Respond to positive efforts and reinforce good behavior. An observing and sensitive parent will find countless opportunities during the day to make such comments as, "I like the way you come in for dinner without being reminded;" "I appreciate your hanging up your clothes even though you were in a hurry to go out to play;" "You were really patient while I was on the phone;" "I'm glad you shared your snack with your sister;" "I like the way you're able to think of others;" and "Thank you for telling the truth about what really happened."

Similarly, teachers can positively reinforce good behavior with statements like, "I know it was difficult for you to wait your turn, and I'm pleased that you could do it;" "Thanks for sitting in your seat quietly;" "You were thoughtful in offering to help Johnny with his spelling;" and "You worked hard on that project, and I admire your effort."

Deliberately ignore inappropriate behavior that can be tolerated. This doesn't mean that you should ignore the child, just the behavior. The "ignoring" has to be planned and consistent. Even though this behavior may be tolerated, the child must recognize that it is inappropriate.

Provide physical outlets and other alternatives. It is important for children to have opportunities for physical exercise and movement, both at home and at school.



Manipulate the surroundings. Aggressive behavior can be encouraged by placing children in tough, tempting situations. We should try to plan the surroundings so that certain things are less apt to happen. Stop a "problem" activity and substitute, temporarily, a more desirable one. Sometimes rules and regulations, as well as physical space, may be too confining.

Use closeness and touching. Move physically closer to the child to curb his or her angry impulse. Young children are often calmed by having an adult nearby.

Express interest in the child's activities. Children naturally try to involve adults in what they are doing, and the adult is often annoyed at being bothered. Young children (and children who are emotionally deprived) seem to need much more adult involvement in their interests. A child about to use a toy or tool in a destructive way sometimes is stopped easily by an adult who expresses interest in having it shown to him. An outburst from an older child struggling with a difficult reading selection can be prevented by a caring adult who moves near the child to say, "Show me which words are giving you trouble."

Be ready to show affection. Sometimes all that is needed for an angry child to regain control is a sudden hug or other impulsive show of affection. Children with serious emotional problems, however, may have trouble accepting affection.

Ease tension through humor. Kidding the child out of a temper tantrum or outburst offers the child an opportunity to "save face." However, it is important to distinguish between face-saving humor and sarcasm or teasing ridicule.

Appeal directly to the child. Tell him or her how you feel and ask for consideration. For example, a parent or a teacher may gain a child's cooperation by saying, "I know that noise you're making doesn't usually bother me, but today I've got a headache, so could you find something else you'd enjoy doing?"

Explain the situation. Help the child understand the cause of a stressful situation. We often fail to realize how easily young children can begin to react properly once they understand the cause of their frustration.

Use physical restraint. Occasionally a child may lose control so completely that he has to be restrained physically or removed from the scene to prevent him from hurting himself or others. This may also "save face" for the child. Physical restraint or removal from the scene should not be viewed by the child as punishment but as a means of saying, "You can't do that." In such situations, an adult cannot afford to lose his or her temper, and unfriendly remarks by other children should not be tolerated.

Encourage the child to see his strengths as well as his weaknesses. Help the child to see that he can reach his goals.

Use promises and rewards. Promises of future pleasure can be used both to start and to stop behavior. This approach should not be compared with bribery. We must know what the child likes—what brings him pleasure—and we must deliver on our promises.

Say "NO!" Limits should be clearly explained and enforced. Children should be free to function within those limits.

Tell the child that you accept his or her angry feelings, but offer other suggestions for expressing them. Teach children to put their angry feelings into words rather than fists.

Build a positive self-image. Encourage the child to see himself as a valued and valuable person.

Use punishment cautiously. There is a fine line between punishment that is hostile toward a child and punishment that is educational.

Model appropriate behavior. Parents and teachers should be aware of the powerful influence of their actions on a child's or group's behavior.

Teach children to express themselves verbally. Talking helps a child have control and thus reduces acting out behavior. Encourage the child to say, for example, "I don't like your taking my pencil" or "I don't feel like sharing just now."

The Role of Discipline

Good discipline includes creating an atmosphere of quiet firmness, clarity and conscientiousness, while using reasoning. Bad discipline involves punishment which is unduly harsh and inappropriate, and is often associated with verbal ridicule and attacks on the child's integrity.

As one fourth grade teacher put it: "One of the most important goals we strive for as parents, educators and mental health professionals is to help children develop respect for themselves and others." While arriving at this goal takes years of patient practice, it is a vital process in which parents, teachers and all caring adults can play a crucial and exciting role. In order to accomplish this, we must see children as worthy human beings and be sincere in dealing with them. ■

Adapted from "The Aggressive Child" by Luleen S. Anderson, which appeared in. Children Today *(Jan.-Feb. 1978). Reprinted with permission and available as a pamphlet from Harley Pershing, Director, Arts, Graphics and Educational Services, TDMHMR, P.O. Box 12668, Austin, TX 78711.*

Taking the *Snap* out of Snapshots

Protecting TDMHMR clients' right to privacy is an issue of interest to all department employees. This article looks at how information directors, the facilities' link with the media, deal with one aspect of that responsibility: photo releases.

As any MHMR information director will tell you, photo releases can be a monumental headache. For instance, in which of these four situations would you think a consent form is required:

a) A reporter from the local paper has come to your facility to do a feature on an innovative program that you are particularly proud of. The photographer tagging along with her shoots off "a few quick ones, just to show the program in action." The photographer assures you that the clients in the photographs won't even be named in the captions. Are photo releases needed?

b) The crew in Staff Development is working on a videotape to help train new aides. No one outside your hospital will ever see the tape. Are releases needed for the clients who have agreed to be taped?

c) The superintendent of your state school is hosting a dedication ceremony for the opening of a therapeutic park recently constructed entirely with volunteer funds. You snap a picture of him locked in a handshake with a visiting dignitary for use in a brochure you are preparing which explains volunteer activities. After you have the print developed, you discover that a resident had wandered into your photograph. But he is in the background behind the flesh-pressing bigwigs. Does he need to sign a photo release?

d) You are producing a slide show to introduce your community center to area residents. A couple of your planned shots will show counseling sessions. Several staff members have agreed to help out by posing as clients. Do they need to sign photo releases?

Probably none of these all-too-possible hypothetical cases slipped past any wily information director: In all but the last one a consent form would absolutely *have* to be signed by the client pictured and stored in the client's file. And in the final situation a consent form *should* be signed by the staff members.

Attorney W. Kent Johnson, chief of the TDMHMR Legal and Claims division, explains why: "Generally the disclosure of any information which

would directly or indirectly identify a person as a client of a TDMHMR facility should not be made without the consent of the client or his authorized representative."

In reference to the opening illustrations, Jim Herod, staff attorney, points out that, where it might be possible to adjust names and facts in written material enough to prevent any confidentiality of information conflicts, pictures showing a client's face are always identifying. Therefore, it makes no difference if a photo (or a videotape, slide or film) from which a client can be identified

a) is to be used without an identifying caption,

b) is intended strictly for use at your own facility,

c) pictures that client in the background,

a consent form must be signed and kept on file.

As for the last situation: Usually the staff member's verbal consent to be photographed is sufficient after you have explained, in the presence of a third party, how the pictures are to be used. However, cautions Herod, it is preferable to have the staff member sign a release too. It is possible that your subject could change his or her mind at an inopportune time, like the day after your witness leaves the country. A signed consent form could prove to be valuable protection.

The immediate purpose of all this caution is, of course, to avoid lawsuits. It is based, however, on something a bit more edifying---the protection of an individual's right to privacy. All citizens enjoy the constitutional right to privacy. State statutes, federal regulations and voluntary standards further protect TDMHMR clients from being publicized as mentally disturbed or mentally retarded with a shield called confidentiality of information.

There are exceptions to the confidentiality of information rulings which cover clients' records and histories as well as their likenesses. These exceptions are made when the information is to be used for approved research at the facility, for state or federal audits, for medical emergencies, or when disclosure is ordered by a court of competent jurisdiction. And then there is that one time you never have to worry about releases---when the photo is to be used by the facility for identification purposes. But the exception which most concerns us is when a client, or someone authorized to act for him or her, consents to the disclosure of information, whether fact or photographic.

The job of explaining confidentiality of information restrictions frequently falls to the information director. Most news people are used to dealing primarily with two groups who are virtually free game in the publishing jungle---public figures and people involved in newsworthy events. An explanation of the department's duty to protect its clients will help visitors understand the necessity for what might otherwise seem like a flurry of news-smothering protectionism in the form of photo releases.

The nature of these forms is being affected by a set of guidelines which the department voluntarily has chosen to follow. They are set out by the Joint Commission on Accreditation of Hospitals and require more than state and federal statutes demand. Currently clients sign general consent forms. Under the proposed form changes clients will consent only to the release of their photo for a certain purpose or specific publication. It has been recommended that these forms be made renewable every two years at the client's discretion. These revisions are expected to be ready soon.

The department's philosophy of requiring more than the law demands is largely a preventive measure, and an effective one; TDMHMR has never been sued for unlawful disclosure of information. The one tiny drawback this sterling record carries with it is that it forces the department to operate in something of a gray area. In the absence of court decisions to provide guidelines, TDMHMR must maintain a conservative approach and hope that the record will remain untarnished.

As mentioned earlier, however, something more than the avoidance of lawsuits is at stake. Herod expresses it this way: "We have to protect the clients' rights because oftentimes they are not in a position to do it themselves." ■ *S.B.*

The aim of this article has been to cultivate a basic awareness of the significance of consent forms. If you have specific questions or complications regarding photographic consent, Central Office's Legal and Claims division will be happy to help you sort them out.

Conference Calendar

Oct. 23-26
American Assn. on Mental Deficiency
Region V conference
Held in Wichita, Kan.
Contact: Betty St. Louis
Parsons UAP
Parsons State Hospital and Training Center
Parsons, KS 67357
316-421-6550

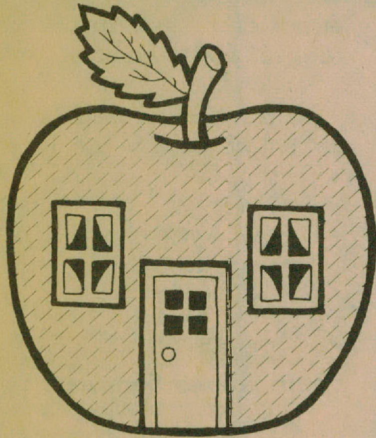
Oct. 25-26
Child Abuse Seminar
Held in Arlington
Sponsored by Texas League for Nursing
Contact: Texas League for Nursing
6225 Hwy. 290 E.
Austin, TX 78723
512-459-6070

Nov. 9-11
National Society for Autistic Children
Southern regional conference
Held in Fort Lauderdale, Fla.
Contact: Barbara Slawson
NSAC
1234 Massachusetts Ave. N.W., Suite 1017
Washington, DC 20005
202-783-0125

Nov. 16
Parenting Today Seminar
Held in Austin
Sponsored by Texas League for Nursing
Contact: Texas League for Nursing
6225 Hwy. 290 E.
Austin, TX 78723
512-459-6070

Jan. 16-20
International Transactional Analysis Assn. Inc.
Annual winter congress
Held in San Antonio
Contact: ITAA
1722 Vallejo St.
San Francisco, CA 94123
415-885-5992

★ PEOPLE & PLACES ★



School Programs Hit Home

"It is more efficient in work with children to include the family and school as well as the child," says Jim Exum, director of **Terrell State Hospital**'s Ellis County Outreach Center.

Center staff member John Hain proved it when he developed two programs last year on inhalants and communication in cooperation with the Ennis Police Department and the Ennis Independent School District.

Hain and juvenile officer Greg Joyce met with more than 2,800 students from grades 7 to 12 in small classroom groups. Each class had different needs and interests, so the pair learned quickly to evaluate the students and tailor each presentation.

The program on inhalants resulted in an immediate decrease in reported problems. The outreach center, for example, previously had opened one or two cases per week related to inhalant use; three months after the presentations, the figure was zero. Reports to police and school officials dropped from more than two per day to a combined total of only 11 during the next three months. A check after six months showed little increase from those figures.

To involve the students in the presentation on effective communication, Hain and Joyce sometimes asked them to role play how to avoid a physical fight at school or a conflict at home with parents. This program showed results too, but the effect was more difficult to evaluate.

The outreach center staff is convinced that working within the school is not only a time-saving measure, but it is more likely that family members will become involved when they don't have to seek services from the agency. Dan Mitchell, psychologist, and Joyce Ancell, social worker, are working with several local schools, including group therapy at Waxahachie High School and Junior High.

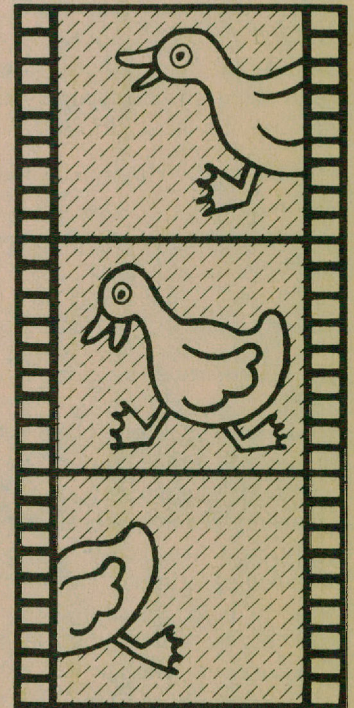
"We feel that these types of programs are innovative, especially in rural areas," explains Exum. "They do work when operated properly, but take a great deal of planning and coordination, motivated staff and interested and cooperative schools."

Continuing Education Team

The department's Continuing Education office, which moved from Austin to **Texas Research Institute of Mental Sciences** (TRIMS) in Houston, is now fully staffed.

Continuing Education director Linda Webb, Dr.P.H., has recruited as staff development specialists Gary V. Sluyter, Ph.D., management consultant who was superintendent of **Corpus Christi State School,** and Joyce Sanders, R.N., M.S., former coordinator of nursing inservice training at **San Antonio State Hospital** and lately assistant director of nursing at TRIMS.

Dr. Sluyter is planning statewide training in management and Sanders is designing interdisciplinary training programs for patient-care personnel. Mildred Dobson, administrative secretary, and Ira Mae Sam, administrative technician, complete the new Continuing Education team.



Free Films

Funds from the Mental Health Services division of Central Office have made possible the purchase of new films for loan to Texas citizens.

The popularity of several films already in the library required the purchase of extra copies to meet the demand for their use. New titles added are these:

Aging, a discussion of some of the life styles followed by older people.

Child Abuse: Cradle of Violence, a documentary utilizing interviews with abusing parents to show the causes of child abuse and illustrate ways parents can learn to react to normal child behavior without becoming violent.

Managing Stress, a presentation of current research and information about how to recognize and cope with stress.

Parenting Concerns: The First Two Years, an exploration of com-

mon but perplexing childrearing situations from birth to age two.

Parenting Concerns: Preparing Your Child for Kindergarten, a selection of suggestions for meeting the challenge of raising children from ages two to five.

Teenage Turn-On, an investigative film report providing facts about the use and abuse of alcohol and other drugs among teenagers.

The Wild Goose, the tale of a mischievous old man who escapes from his nursing home, raising questions about the values of our society concerning old age and old age institutions.

To schedule a maximum two-week loan of any of these films, or to request a complete film catalog, write Film Library, Texas Department of Health, 1100 W. 49th, Austin, TX 78756.

Singled Out

★The appointment of two facility administrators was approved Aug. 17 by the Texas Board of MHMR.

Named as superintendent of **Rusk State Hospital** was Robert Story Glen, M.D., of Dallas. Charles H. Locklin of Austin was named director of **Waco Center for Youth.**

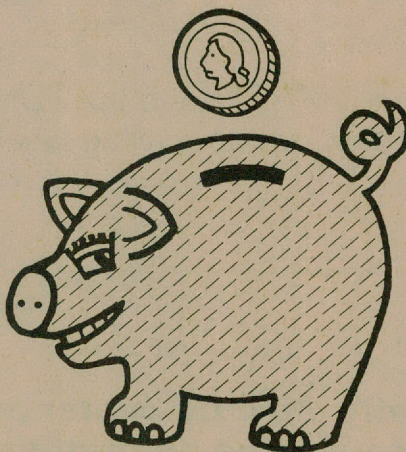
Locklin, who served as program consultant for the Quality Assurance and Standards Compliance section at Central Office, took over his duties Sept. 1.

Dr. Glen, a private psychiatrist, succeeds Paul I. Kaufman, who recently announced his resignation as acting superintendent of Rusk State Hospital to return to private hospital administration in Houston. Dr. Glen's appointment is effective Oct. 1.

★A Certificate of Significant Achievement was presented to the **San Antonio State Hospital** (SASH) by the American Psychiatric Association for the institution's innovative program in rehabilitating the long-term psychiatric patient.

The SASH honor was selected from hundreds of entries from government and private mental hospitals throughout the country at the 31st Institute on Hospital and Community Psychiatry in New Orleans in September. SASH was the only Texas institution to receive an award. The winning program is described in the October 1979 issue of *Hospital & Community Psychiatry*.

SASH was commended for its survival skills training which prepares chronic patients to live and work together in the community. In addition to saving the taxpayer approximately $20,000 per year per person, the innovative training proves the chronic psychiatric patient can be helped significantly, says Robert M. Inglis, M.D., superintendent.



Money for Children

Communities interested in helping their youngest citizens---children from birth to age 6---are being offered a chance to do so through a new project of the Children and Youth Services Division of the Texas Department of Community Affairs. The department is making funds available to city and county governments and public and private agencies in communities throughout the state to develop local programs to serve youngsters in need and their families.

In a request for proposals issued Aug. 24, the division specified four areas in which funds are available: parenting services, primary prevention, child development staff training, and community planning and services. All proposed programs must directly or indirectly serve children under 6 or their families, pregnant women or teenage potential parents.

Proposed programs should be for 12 to 20 months duration and for a maximum of $50,000. Proposals must be submitted by Oct. 19.

For further information or to receive a request for a proposal packet, contact: Children and Youth Services Division, Texas Department of Community Affairs, P.O. Box 13166, Austin, TX 78711 or call 512-475-5833 or toll-free 1-800-252-9642.

Outreach

★Three outreach centers operated jointly by their local boards and the **Austin State School** have received two-year accreditations from the Joint Commission on Accreditation of Hospitals. The accreditation was achieved under Standards for Services for Developmentally Disabled Individuals.

The three boards of directors---Comal County MHMR Center Inc., New Braunfels; Guadalupe County MHMR Agency Inc., Seguin; and Schieb Special Opportunity Center Inc., San Marcos---had requested the surveys in order to have an outside independent review of the programs they were providing. These programs were surveyed in May 1979 and received accreditation in June.

★For the first time in Texas, an outreach mental health clinic has been built with funds totally provided by citizens of a community.

The recently dedicated Guadalupe County Mental Health Clinic in Seguin is one of 14 operated under the **San Antonio State Hospital and State School.**

Elie Selig, chairman of the clinic's board, led the drive for funds. She also is a member of the Texas Board of MHMR.

The new clinic provides a place for service to the mentally ill, including individual group counseling areas. Funds raised also made possible expansion of the Developmental Training Center for the mentally retarded, which is accredited by the Joint Commission on Accreditation of Hospitals.

★★★ Notice ★★★

The current Appropriations Act (Art. V, Sec. 66(c), H.B. 558, Acts 66th Leg., R.S., 1979) requires written verification that you wish to continue receiving IMPACT. Your name will be removed from the mailing list if you do not respond.

To remain on the mailing list, return this entire page signed and dated to:

Arts, Graphics and Educational Services
TDMHMR
P.O. Box 12668
Austin, TX 78711

( ) I wish to continue receiving IMPACT (and the TDMHMR annual report) at the address/corrected address shown on my mailing label below:

Signature Date

TDMHMR and community MHMR center employees are exempt from this response because the information directors receive a verified number of IMPACT copies and will continue distribution to those employees.

IMPACT

Published by the Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, TX 78711. An Equal Opportunity/Affirmative Action Employer. John J. Kavanagh, M.D., Commissioner.

Arts, Graphics and Educational Services:
Harley Pershing, Director
Hazel Casler, Coordinator
Judy Osborn, Editor, IMPACT
Sarah Bird, Journalist/Photographer
Nancy Collins, Graphics Coordinator
Helen Koinm, Graphics
Phyllis Haydon, Production
Linda Larson, Circulation

IMPACT will be sent to persons requesting it. Enclose full address label when submitting change of address.

Share this copy of IMPACT