

PROGRESS

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Validation not
Victimization**
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Dear Friends:

It's summertime and, just as our cover reminds us, the time of year when most of us take a break for some R&R or vacation. Certainly, it's part of a good mental health regimen to take a break, relax, get a change of scenery, and just get away from the everyday world we inhabit.

That said, I also want to assure you that the work and services of the Harris County Psychiatric Center continue all year long. Like all of our fellow healthcare facilities in the Texas Medical Center, we're on duty 24 hours a day, seven days a week to meet the acute mental healthcare needs of this region. Our University of Texas-Houston physicians and clinicians continue throughout the summer taking care of patients, researching for the causes and treatments of mental illness, and teaching the next generation of mental health caregivers.

Our membership in these institutions—the University of Texas-Houston Health Science Center and the Texas Medical Center—are very important to us, because they place us among the very elite in national healthcare communities, but mostly because they ensure you that when you or a loved one require any of our services, you will have the best care available.

Recent studies have demonstrated that patients of hospitals which are affiliated with teaching institutions often receive better quality care than those at other healthcare facilities.

*I think this issue of **Progress** will give you some idea of the caliber of people who are associated with HCPC and UT-Houston and of their commitment to this community. One primary example is Daniel Creson, MD, PhD, a community psychiatrist who continues to travel to the most volatile places on earth, not just to study the issues related to human violence and aggression, but to serve his fellow man. As you are reading this, Dr. Creson is planning another trip to the Balkans to support that region's mental health professionals as they work to bring some normalcy to the lives of their countrymen.*

Another is Ray Hays, PhD, JD, a forensic psychologist who is sought out as an expert witness in courtrooms across the nation. Hays, and HCPC child and adolescent psychologist, Sharon Morgan, PhD, were part of a collaborative research and education project under the direction of Mary Alice Conroy, PhD, associate professor of psychology and director of clinical training for the Forensic Clinical Psychology Program at Sam Houston State University. This project again points up the value of HCPC's connection to academia, because it provided a unique learning experience for both SHSU and UT-H students while it extended the knowledge base in the field of criminal justice and psychology.

Alan Swann, MD, is another academic and clinical star. Much of his career has been focused on bipolar disorder, but because he is a teacher and a clinician, as well as a researcher, his work is focused not solely on scientific breakthroughs but on improving the day-to-day lives of individuals who suffer from this chronic illness.

*Finally, this issue of **Progress** is proud to salute the work of our psychiatric hospital aides. It isn't luck that HCPC has been able to attract such loyal and gifted "techs," but our affiliations with world-class patient care, world-class health education and world-class scientific research in an atmosphere that brings out the best in each individual.*

So, relax, enjoy your vacation and remember that the formidable partnership—HCPC/UT-H/TMC—is here when you need us.

David R. Small, MBA, FACHE
Administrator



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On the cover: "Jolie de Mer" by Doris Dahlgren. Used with the permission of NARSAD Artworks, a nonprofit organization under the auspices of the National Alliance for Research on Schizophrenia and Depression (NARSAD). NARSAD's mission is to raise and distribute funds for research on causes and treatments of severe mental illness.

NARSAD Artworks showcase the museum-quality talent of artists who share the common bond of mental illness. "Jolie de Mer" is one of many works featured as a NARSAD Artworks project, and cards with this design can be ordered by writing NARSAD Artworks, P. O. Box 941, La Habra, CA 90633-0941 or by calling 1-800-607-2599.

PROGRESS is grateful to NARSAD for allowing the use of Dahlgren's work, as well as the works of Aranda Michaels and Chris Humphrey on pages 8 and 18 respectively.

Harris County Psychiatric Center
An Operating Unit of The University of
Texas-Houston Health Science Center

Robert W. Guynn, MD
Executive Director

David R. Small, MBA, FACHE
Administrator

Roy V. Varner, MD
Medical Director and
Chief of Staff

Geri Konigsberg
Director
Public Information and Education

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Fran Dressman, Editor

Alycia Matthews, Graphic Design

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*Mixed media artwork by an anonymous HCPC adult patient.
Courtesy Debbie Iglesias, HCPC Patient Clinical Programming.*





Wounds of War

During his work with trauma victims around the world, a UT-Houston psychiatrist has found that certain diagnoses can hinder rather than help the healing process. He has also learned that humanitarian aid is most effective when it leaves a strong infrastructure based firmly in the culture of the people it serves.

Dan Creson seems to have an affinity for the world's trouble spots—the warring nations of the Balkans, Northern Ireland, Angola, and prisons and crime-infested ghettos in the U.S. But Creson, physician and anthropologist, doesn't go there as savior or rescuer with the definitive solution. He's there to help, and especially, to learn.

Creson is director of continuing education in the Department of Psychiatry and Behavioral Sciences in the UT-Houston Medical School and a clinical professor who consults at HCPC.

He had no grand plan when he went to Sarajevo for the first time in December 1992, as the war between the former Yugoslav states of Serbia and Bosnia Herzegovina raged around him. "I just went to check it out and see if there was a mission there for the Health Science Center," says Creson, a family and community psychiatrist whose experience includes working with substance abusers and prison inmates. Upon his return, he began a small nonprofit group to provide medications and supplies for mentally ill or traumatized patients in Sarajevo.

But the next year, Creson returned to Sarajevo—then under siege and daily shelling—at the request of Catholic Relief Services (CRS). He was asked by CRS to help them create psychological and social services programs to serve a population facing daily and ongoing trauma. Now, five years later, Creson continues his work in Bosnia-Herzegovina and other areas in the former Yugoslav republic, helping to build a psychosocial infrastructure for the region.

This past April and May, Creson traveled to Albania, where the refugees from the scene of the lat-

est fighting, Kosovo, are huddled by the thousands in refugee camps. Creson worked with the Christian Children's Fund (CCF) helping train mental health workers to assist the thousands of dispossessed in these camps who had been forced to leave homes and families behind.

Although life in a refugee camp is a different experience from living in a besieged city like Sarajevo, Creson found similarities among the traumas experienced by the people caught up in the middle of this war: Loss of all kinds: life, loved ones and home; and having to just try to stay alive day to day, with no idea what the future will bring. Creson went to advise and help caregivers, but also to observe and learn.

Unlike other humanitarians who trek to such trouble spots to help the population, Creson had no intention of imposing his kind of psychiatry or psychological mores on the people of this region. Creson's hope was not to be the "great white father from the West," but someone who might help the native peoples discover how best to help themselves and to assist them in constructing an infrastructure to do that.

"Providing direct counseling and mental health services to individuals is very commendable," he says, "but what do they have when you leave? I believe that investing in a strong mental health infrastructure has a greater, long-term positive effect." Creson's work was primarily in training the local mental health professionals to provide services to their fellow countrymen and to train others like themselves.

Barging into the situation, no matter how desperate it may seem, and imposing one's own kind of diagnosis and treatment on a population often leads to programs that

really don't help a specific group of trauma victims, Creson says.

Rather, he says, one must look at the cultural mores, biases, prejudices and class hierarchy of a society before one can determine a course of intervention that will make a difference. His interest in the ways of man and society compelled him to return to school 10 years after receiving his MD from The University of Texas Medical Branch in Galveston to earn a PhD in anthropology from Rice University.

For the past six years Creson has helped CRS organize a series of programs to train indigenous social workers and health professionals to help their fellow citizens. He trained psychologists and social workers working in Sarajevo's social service centers and leaders in refugee and displaced person camps in how to deal with psychological and social consequences of war-related trauma. During the second phase, which began shortly after the Dayton Peace Accords in 1995, small groups of the trained professionals from Sarajevo traveled around the country training their peers. The third phase, which is still going on, is to help local mental health professionals organize an independent professional society, something unknown in this region of the world.

From his experiences and those of mental health professionals, both from the region and expatriates working in the Balkans, Creson has also compiled a field manual, *Psychosocial Interventions Under War Conditions* to be published by CRS.

The manual is a "how-to" for planning and implementing a psychosocial intervention project for populations subjected to the trauma of ongoing military conflict.

Continued

Wounds

Continued

Camp Memories: Dan Creson took dozens of photos during his work in Kosovar and Albanian refugee camps in early 1999 (clockwise from right)

Creson (center) with a group of refugees, a Kosovar child, Albanian doctors with representatives of the Christian Children's Fund, Northern Albanian refugees relocated south from earlier fighting, young Albanian mental health professionals.



See "Wounds" on page 3





Wounds

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In the planning phase of any such intervention, Creson says it is imperative to assess the specific psychosocial needs of groups to be served, what needs the project proposes to meet, the goals for the project and an evaluation process to determine if the program has met those goals. In the implementation of any program, Creson says, the plan must be strong but versatile. "Infinite contingencies must be built in because of the flexibility that a war situation imposes on a program such as this."

Throughout the manual, Creson stresses understanding these particular people, their history, and the specific situation they are part of, rather than imposing solutions from other situations.

To this end, Creson challenges the ongoing fascination of some mental health practitioners, the media, and even the general citizenry with the victims of trauma and the rush to diagnose people who have undergone psychological trauma as suffering from Post Traumatic Stress Disorder (PTSD).

PTSD came to prominence in the 1980s as a group of symptoms exhibited primarily by returning Vietnam War Veterans, men who had been subjected to trauma related to their war experiences. When the media began reporting on the various atrocities inflicted on the citizens of the former Yugoslavia by their former countrymen, there was a rush to assume that these people would become victims of PTSD and to use models developed in another context, and in another culture, to help this population. But many of these efforts failed, and Creson believes they did so because a Western, textbook diagnosis of PTSD was imposed upon a population where it did not fit.

"We may have stretched PTSD beyond its useful limits," he says, acknowledging that there is much debate in the mental health



Shy Curiosity: Creson photographed this Kosovar child and mother living in a tent in a camp near Tirana, Albania. Many of the refugees were children for whom living in the camps was seen as an adventure.

community over its legitimacy as a diagnosis and disorder. "We're really only beginning to understand what happens to people who experience ongoing psychological trauma. Our diagnosis for PTSD is still very subjective," he says. Implicit in the concept of PTSD is the danger of it being used as a "label," a simplistic way to understand the population caretakers are dealing with instead of getting to the real issues and the kinds of interventions that will be effective.

"For example, just because someone has 'startle responses' and nightmares from living in a war zone, and meets some criteria of

PTSD, it does not automatically mean they are unable to function," he says. "In fact, people in Bosnia do have these psychological traumas, continually, but they are actually functioning quite well, still able to do their jobs or take care of their families effectively. So, then, what these people need are support in their functioning and reassurance that their responses are normal, rather than to be saddled with a disease which has to be treated."

Creson points out that the needs of any traumatized population must be carefully assessed before any kind

Continued

Wounds

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of intervention is attempted. In Bosnia, mental health workers found that there was more concern over the consequences of social disruption on certain populations, than there was over PTSD. Specifically, these affected groups involved the delinquent behavior of children and adolescents, the depression and despair of the elderly population who had been left behind, the loss of support from extended families who had been split apart and separated by both the fighting and death, the issues of multiple families formed when a father or mother was separated from their original family and had formed another, the problems of refugees from various socioeconomic backgrounds having to live all together, and the conflicts between the rural refugees and the urban population of the cities to which they fled.

“The main pitfall in automatically diagnosing such populations with PTSD,” Creson says, “is that you saddle them with the burden of a disease or abnormality. They then become people with a disorder that needs to be fixed. Sometimes you make the trauma of their lives worse by this diagnosis.

“We must be very careful,” he adds, “how we ‘frame’ our understanding of what they are experiencing and dealing with by going through this trauma; it is very significant in how they will deal with their lives in the future. It is possible to create a certain amount of learned helplessness, where people who once were coping and surviving actually give up all control or hope for their lives.”

Instead, Creson stresses “normalizing” these people’s responses and validating their emotions and feelings. His manual presents a “response model” to deal with PTSD-type symptoms, based upon experiences in rehabilitating burned children and victims of torture.

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Waiting and Surviving: (top) Mothers and children in a Kosovar camp, (center) typical tent “homes” in the Tirana, Albania camp, and (bottom) relocated Albanian refugees living in converted cattle barns.





Some Personal Thoughts

Flying out of Albania on my way home, a colleague sitting near me said, "Whenever I hear 'Albania' again on the news or read it in the newspapers, it will mean something very different." That sums up my feelings. The Albanians will never be the same in my imagination now that I have met them and visited their country.

Working with the refugees from Kosovo, from Bosnia and from other areas, changes one's perspective. You can't put it into words; it's a different way of looking at the whole area.

Why I Go

I grew up in west Texas, in Lubbock; Buddy Holly was a year behind me in high school. I daydreamed a lot and I guess I spent a lot of time thinking there must be more exotic places to be and more entertaining things to do.

I think of new experiences as learning opportunities. I have curiosity about people; that's why I went back to college and got a degree in anthropology.

I can't always tell you where I learned something, but I can't think of any experience in my life that hasn't broadened my knowledge base. I don't consciously know how I'll use what I've experienced from my time in Albania. I will work no differently than I did before.

Therapists are curious about people. They should be observers, watchers, "nosey," if you want; it's what makes them effective. It allows them to put themselves in another person's place. As a therapist, you are looking through a window into another's life and the better you can fit yourself through that window, the better you will understand that person and his or her story.

It's fascinating to step out of your own culture and into another in which the social and physical fabric has been ripped apart. I think it's easier to see yourself and your world more objectively from such a setting. You realize how vulnerable to social disruption, war and devastation any culture is, even our own.

What It's Like

It's very hard for any one of us to understand what people are experiencing in the Balkans unless we have, at sometime or another in our lives, shared at least some part of their experience.

I guess I had a rather naïve reaction in Sarajevo, I never felt personal danger, but at times I felt some anxiety. A besieged city is hours and hours of boredom: anesthesiology punctuated by moments of sheer terror. I thought it was a pretty hopeless situation. I was in and out and glad I could leave.

The refugee camps are a huge amalgam of people, representing all social and economic states: city dwellers and rural peasants and professionals and working-class people, and partial and extended families. They're all thrown together. Some have terrible stories about their experiences in escaping; others don't seem so bad, except that they've had to leave their homes and all their belongings behind.

One can't help being struck by the children because there were so many. They play and carry on for the most part as if everything was a great adventure, but maybe they have only been in camp for a short time. It will be a long hard stay for them.

There's no way to measure which are the worst things for these people. You cannot compare people's traumas; everyone's experiences are different.



It is important if you want to work with people to be able to listen to, care about and hear their stories. That's different than interrogating them to get information.

Life on a battleground, in a besieged city like Sarajevo or in a refugee camp surrounded by the devastation of a military conflict becomes reduced to the psychically numbing purpose of just getting through the next day.

It is inadequate to say that boredom is the greatest enemy of refugees, because there are all kinds of basic things about survival that are crucial, but if there is one overwhelming invariable that reduces the hope and aspirations it is the endless boredom.

When something happens to normalize this process, like a return to home or emigration to a safe area, people at first are at a loss, because they are not faced with just the immediate present anymore, but with the job of refashioning their lives and looking to the future.

Friendships

This was my first visit with refugees and my first time interacting with Albanians and Kosovars and I found them delightful, interesting people. The young Albanian social workers were bright, sophisticated, well educated and eager, just like Americans in similar roles here.

It's impossible for anyone



Continued

Personal Thoughts

Continued

who sits down with friendly and bright people, not to feel for the terrible kinds of experiences they've been through and describe. It's inevitable, you can't divide your feelings up and put them in little boxes.

I shared meals with people in Sarajevo that they had to cook over burning books. They had to burn their books in order to eat. It's hard not to become emotionally involved with and concerned about people when you share an experience like that.

On People Who Come to Help

There is a tendency on the part of caring people to keep trying to fix things; they want to fix it all. They want to get a child glasses, to heal the little girl's arm, to get everyone food. But the reality is that you can't fix it all—and you need to deal with this early on or you're in trouble.



One of the terrible things that happens to well-meaning people is that they start programs and make promises they can't deliver on. And when they can't deliver they disappear with great embarrassment to themselves and a lot of damage to the people they were trying to help. They raise the hopes of people in a very vulnerable situation, and then pull the rug out from under them.

This is a cardinal rule: Narrow your focus and develop a program that you can accomplish. I tend to feel about it the same way that I feel about old age: I can't do much about it, but I do what I can.

On the Danger of Labels

We have to be very careful about how we "label" people. For example, we think of the people of Bosnia as either "Croats," "Serbs" or "Muslims." But the reality is that all these labels, these groups, overlap.

Before the war there was a very large population of people who lived in the cities, like Sarajevo, who really were none of those. They were not necessarily affiliated with one ethnic group or religion. They were intellectuals and thinkers, secular humanists. For the most part they were the educated professionals. Because they could never be defined as a "group," they were forced to join one of the factions, often based upon their ancestry. Now this group has basically disappeared as a voice within the society; the policy makers and the news media just negated them. And with their demise, I fear that the hope for any kind of liberal, democratic government for Bosnia has also died.

On Violence

What did I learn about the nature of violence from being in these places? I learned that a sharpshooter would rather hit an old lady in her hip and cripple—but not kill her—so that he could wait and kill the ambulance

people who arrived to aid her. I learned that there's never been a crime that human beings couldn't have committed. And I learned that, to various degrees and ways, the potential to commit violence lies in all of us.

People aren't inevitably violent; people are inevitably limited. They are limited by the extent of their capacity within their phenotype and by the context in which they are behaving. Context changes everything. I met a Croatia farmer whose family had lived in peace in Kosovo for generations and had never taken part in any

ethnic or religious wars. But he was now seeking revenge against the Serbs. That's his context, so he becomes a violent man.

On Human Nature

The inhumane atrocities in Kosovo, Bosnia or Angola, raise concerns about the nature of man. You begin to wonder if the religious stories attribute too much to mankind and if the religious expectations exceed man's consistent ability to achieve them.

I don't believe man is flawed. Within the human genotype there's a great deal of latitude for everything from sainthood to the maker of horrors. A rose isn't flawed, yet it has thorns. There are no reasons why the rose has thorns or why mankind is the way it is. We live in complex, highly organized technological societies that call for adaptation. We're geared to the society which we've created, but we are also adapted to those earlier, more basic instincts from which we evolved.

There was another certainty that I took away from my time in Albania: the awareness of the tremendous resiliency of humanity. I saw a tree growing in an alley where it should never have been. A big tree. I told my colleagues I wanted a picture of that tree in that alley because it was my symbol for this whole situation. ★

Dan Creson





The Pretenders

HCPC psychologists and patients collaborate with a local university's criminal justice program to help the judicial system identify teens who feign mental impairment in order to escape criminal punishment.

Juvenile crime in the U.S. has risen markedly in proportion to the overall crime rate since the mid-1980s; the number of juveniles arrested for violent crimes increased 60 percent as compared with 24 percent of the adult population.

While this still remains a small fraction of the criminal activity in the U.S., and recent years have seen decreases in juvenile crime statistics, it is indeed sobering to note that the greatest increases in juvenile crime have been among the youngest offenders.

This increase in violence and crime has brought more and more children into the juvenile and adult justice systems, into police stations and courtrooms where they face serious charges and life-altering punishments. Whether they are tried and sentenced as adults or incarcerated in youth facilities, their destinies have been radically altered.

No one wants to be punished, even if they know they have done something wrong. It is not unusual for anyone involved in illegal activity to deny involvement, proclaim innocence and seek to place the blame elsewhere. Certainly this is true as much for children as adults. In fact, an unwillingness to accept responsibility for one's actions is common among youth who act impulsively and who cannot foresee the severe consequences of their actions. In this part of the population this unwillingness or inability to accept responsibility can take the form of malingering.

Malingering is a rather old-fashioned word; one you might equate with that high school English teacher who lectured you on the perils of not working up to your potential; of denying your own abilities to be "popular." And most of us are guilty: Remember "playing sick" in order to stay home from school?



Sharon Morgan, PhD, and J. Ray Hays, PhD, JD, of the Department of Psychiatry and Behavioral Sciences, UT-Houston Medical School and HCPC staff psychologists.

"Malingering is defined as the intentional manipulation of symptoms to accomplish a specific goal, such as some kind of special consideration or escape from some form of responsibility," says J. Ray Hays, PhD, JD, an HCPC forensic psychologist and professor in the Department of Psychiatry and Behavioral Sciences at the UT-Houston Medical School. "So even if that stomach ache feels real, it's still malingering if you use it as a reason to get out of taking the test," he says.

Most often, however, malingering is used in a legal context involving the attempt to avoid criminal punishment. The forensic sciences—the branches of psychiatry and psychology that deal with the application of scientific and medical facts to legal problems—are flourishing, says Hays, and one-sixth of all cases involve the

court system. "Courts want scientists to offer their expertise to assist juries in the decisions that have to be made. Forensic psychology and psychiatry cover issues of competency and sanity as well as damages in personal injury cases. When used in this medical-legal context, malingering refers to someone trying to claim a disability or escape criminal punishment."

Malingering even has its own official designation in the Diagnostic and Statistical manual of Mental Disorders, or DSM-IV, under "Codes for Conditions Not Attributable to a Mental Disorder."

Hays says malingering is not a psychiatric illness but a behavior. According to DSM-IV, malingering in the legal/medical sense should be suspected when any combination of the following is present:

- 1) the voluntary production of physical or psychological symptoms as mentioned above;
- 2) a discrepancy between the claim of stress or illness and the objective findings;
- 3) a lack of cooperation by the subject with diagnostic and treatment procedures; and
- 4) the presence of antisocial personality disorder.

Malingers, then, are people who feign a psychological or physical impairment to avoid a consequence of their actions or gain some kind of benefit. Malingering is an old concept, but malingering in the adolescent population has not gotten much research attention.

How do you know when somebody's malingering? There are very few objective measures to determine if a person is pretending to be slow intellectually, says Hays. Forensic psychologists, like Hays, specializing in such matters estimate that 15 percent of us malingering, and that

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The Pretenders

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includes adolescents who are in some kind of treatment setting. And, Hays says, with the increasing number of juveniles in the court system, being able to identify malingering in this population has become crucial.

The dearth of information about juvenile offenders led Hays and colleague Sharon Morgan, PhD, to participate in a project with Mary Alice Conroy, PhD, of Sam Houston State University (SHSU). The project was designed to determine if a certain kind of test used to uncover malingering in adults could also be used with adolescents. In addition to inpatient subjects from HCPC, youth from the Harris County MHMRA, the Harris County Juvenile Probation Department and the Texas Youth Commission participated in the study. Master's level students in the SHSU clinical psychology program were involved in administering and evaluating the test results, under the direction of Conroy, an associate professor of psychology. She is also the director of clinical training for SHSU's new Forensic Clinical Psychology Program, the first such program in Texas. It is affiliated with SHSU's College of Criminal Justice, one of the nation's leading academic programs in criminal justice.

"This kind of collaboration fits all HCPC's missions," Hays says. "It offers an opportunity to further our knowledge about the adolescent population and this, coupled with our mandate to educate the next generation of mental health practitioners, compelled us to participate." Morgan, a developmental and child and adolescent clinical psychologist, was eager to become better acquainted with the field of forensic psychology. She coordinated the SHSU students' involvement and education in psychological testing procedures.

"There is a significant number of teens admitted as hospital patients," Morgan says, "who are also being



"Mind Flight" by Aranda Michaels. Courtesy of NARSAD Artworks.

adjudicated in the court system, and we need accurate measures to determine if they're truly impaired psychologically or using strategies to fake impairment and avoid the consequences of their behaviors. Many of them have conduct problems, have been in and out of various institutions and are developing anti-social behaviors. They may experience crisis, such as becoming suicidal, because they are incarcerated. But they don't want to acknowledge any of their own culpability; they see themselves as victims and they have very little remorse for any crime

they've committed."

The Conroy project involved the validation of a test known as the VIP (Validity Indicator Profile) with adolescents. Originally developed by psychologist Richard Frederick for the federal prison system, the VIP had been previously used and validated for accurate detection of malingering in adults, but not with an under-18 population.

The VIP is designed to discover whether a person is attempting to malingering some kind of cognitive deficits, in other words, appear to be

See "The Pretenders" on page 23



Beyond Make Believe

Looking Deeper at the Causes of Malingering in Adolescents

We already know from developmental psychologists that children are capable of lying and cheating, but malingering seems to require more complex skills that are not developed until adolescence.

But Dr. Mary Alice Conroy, a forensic psychologist at Sam Houston State University cites the work of psychologist J.T. McCann who believes that adolescents malingering differently than adults because of their level of maturity.

McCann posits four reasons why teens may malingering differently:

- 1) they have less experience with "the system" (judicial and mental health) than adults;
- 2) adolescents tend to be uncooperative with diagnostic tests;
- 3) teens are more influenced by their environment and want to share the symptoms of their more disturbed peers; and
- 4) adolescents have a different relationship with adults (including parents and clinicians) than do adults.

Those who are just there because they have to be, have a very different motive from those who are actually trying to 'dumb down' on the test to seem cognitively impaired," says HCPC adolescent and child psychologist Sharon Morgan, PhD. "It's secondary gain; they think that malingering will allow them to stay in the hospital longer, or get sent to a different care facility with better services, or they think they won't have to be responsible."

Morgan and her HCPC colleague, J. Ray Hays, PhD, JD, recently collaborated with Conroy on a study of a test to detect malingering in teens (see related story, *The Pretenders*).

Is malingering itself a sign that someone is mentally ill? No, say Morgan and Hays, because true malingering is a behavior and a forensic psychology issue. Malingering is a specific behavior designed to fake a major psychiatric illness for some kind of gain (such as being able to use an insanity defense for a crime they have committed). "Children may try to



'fake bad' or exaggerate reports of problems because they are in some sort of crisis, say an abusive home, situation and they need attention," says Morgan, "but that is different from malingering to escape punishment."

"The difference with the adolescent population, and what makes our ability to identify teen malingerers so important, is that we don't know what their goals are all the time," says Hays. "Are they trying to be different, or to rebel, or to act grown-up, or to escape the responsibilities of adulthood?"

Can malingering itself be a sign that something is "wrong" with a person, a symptomatic behavior of a disorder? Many adolescents who malingering have been diagnosed with conduct disorder (CD), and later as adults, with antisocial personality characteristics. "This is not psychiatric illness," Morgan says, "but the way a person's personality is organized. Some of these people lack the skills to cope with significant stresses in their lives and they may use antisocial behaviors, such as malingering.

"This may be their approach to the world in getting their needs

Continued





met," says Morgan, "just like they feel entitled to steal food from a store because they're hungry. They have no conscience about it; they don't want to take responsibility. Often, if you look at their infancies and childhoods, you will find they never developed a sense of trust or became attached to a significant caregiver. When children do not bond with a significant caregiving adult, they may not develop empathy for other people or a sense of respect for the welfare of others because they, themselves, never felt cared for and nurtured .

"These children, even with some support and nurturing, may never learn to take responsibility and be accountable for their own behavior," says Morgan. "They require an external control mechanism, in a highly structured environment where there are consistent consequences for antisocial behavior."

Morgan reports that some studies show a possible hereditary link: children with conduct disorder often had parents who experienced the same type of serious acting-out behaviors. Other findings reveal a relationship between the earlier diagnosis of ADHD (attention deficit hyperactivity disorder) in children and a later diagnosis of conduct disorder. And malingering is a behavior associated with adolescents having conduct disorder.

"ADHD kids are very impulsive," she says, "and they do not reflect on past mistakes or behaviors. This becomes serious, of course, as they grow into adolescence, become mobile and begin to act out in the community."

Mental health experts have also identified "attachment disorder," as relevant to the development of conduct disorder. This occurs, for instance, with refugee or orphaned children from war zones or with children who never get a chance to bond with their primary caretakers

because of crime, imprisonment or drug abuse. "Children with these kinds of antisocial tendencies are primary candidates for behaviors such as malingering. They'll do whatever is necessary to avoid taking responsibility and they have no remorse for anything they may do," Morgan says.

"Frankly," she adds, "the prognosis is not good for children with conduct disorders who do not get help early; they grow to become adults with antisocial personality disorder. There is not much hope for these young people if they have a



parent who has the same problem because they have no adult that is able to model or teach them to take responsibility or to demonstrate self-control. They are not socialized correctly and there is no proactive discipline. Instead, their parents punish them by venting their anger and acting out and the children learn to do the same.

"These children learn to live in the here-and-now and often have no understanding of the consequences or results of their behavior," she says. "They do what they can to survive in the moment with no internalization of the suffering

they may inflict on others or themselves. They have difficulty processing the consequences and the future based upon their actions."

Morgan admits that it is very difficult to change a person's intrapsychic dynamics without some kind of intensive, long-term therapy or corrective experience, such as actually "re-parenting." Sometimes there is hope that they will learn and be able to internalize enough from some kind of structured environment to function in society. But re-parenting doesn't often happen in the real world, especially the real world many of these children inhabit.

The number of juvenile offenders in the criminal justice system has increased dramatically over the last several years partly due to laws reflecting society's growing intolerance for all lawbreakers, especially those who commit violent crimes, no matter what the age. In addition, over the past decade, the issue of malingering itself has become a major concern in about one-sixth of all forensic work. More and more frequently, juvenile court proceedings involve mental health testimony because of their focus on treatment and rehabilitation, and the issue of malingering among juveniles becomes a key point.

With an increasing number of children living at-risk in our society, both Morgan and Hays are adamant that the research they did with Conroy is the kind of study needed to determine the extent of this problem. "Now that we have a good way to measure malingering," says Morgan (see *The Pretenders*), "it opens up all kinds of questions for us to explore. We can begin to look at epidemiological issues, such as how widespread cognitive malingering is among the adolescent population and in what kinds of settings it occurs." ★



First Aide

On the job with HCPC's Psychiatric Technicians

It is 7:15 a.m. and quiet on HCPC patient unit 2B; the day room is dimly lit. Patients are getting dressed, showered and ready for breakfast. As their day begins, Carolyn Presley is ending hers. A small, quietly friendly woman with a dimpled smile, she has an aura of calm nurturing. It's not surprising to discover that she's the mother of five and grandmother of 11. Presley has been at HCPC for 13 years, a psychiatric technician for 21 years, and a healthcare worker for 35 years.



Carolyn Presley

She gives a gentle laugh and says she may be the oldest tech at the Center; she'll be retirement age in a few years. She remembers the old days at Jeff Davis hospital before HCPC was opened. When asked to describe what she does, she talks about a quiet voice, a hug, and a kind word.

If any one person could get rid of the stereotypes the public has about aides in psychiatric hospitals, Carolyn Presley could. She is not a football halfback, she has no menacing grimace and doesn't raise her voice, she doesn't threaten with a straightjacket, and she doesn't wear a white coat.

But Presley is recognized as one of the Center's most competent and conscientious aides and she has that reputation precisely because she is not like the stereotype. She is a real "people person" who ensures a safe and therapeutic environment by watching, listening and getting to know her patients. She knows that the work she performs is central to the treatment process. And she is proud of what she does and the people she serves.

Their official job title is Hospital Aide III; the profession calls them Psychiatric Technicians; but to the HCPC staff they are a special breed of multi-talented folks known as "psych techs."

HCPC's 120 psych techs are part of the Center's Nursing Services. Each patient unit, with a capacity for up to 24 patients, is required to have at least two techs on duty during the day, three during the evening shift, and two overnight. Other techs do one-to-one patient care or observation, provide transportation and accompany

patients to court hearings and conduct peer training.

The official job description is deceptively simple: to practice effective clinical and technical duties in the area of direct patient care, under the supervision of a registered nurse. What they really do is a combination of everything, including the kinds of clinical care most folks think of when they think of a hospital aide.

Victor Holman and Rosie Nzei also began their careers as psychiatric technicians well before HCPC was built and both have been there over a decade. Stephanie Price, a young mother herself, also works as a chemical dependency counselor at another agency. Sergio Verduzco began working at HCPC while a student at the University of Houston.

"A confidant, the 'everything' for the patients" is how Holman describes who he is as a tech. "It's a big responsibility, being part of the patient treatment team," is Nzei's response. "A motivator who watches and listens," says Stephanie Price. Verduzco uses the analogy of an air traffic controller to describe what a psych tech does: someone who watches and manages the patients.



Robert Nearing

"Friend, confidant, parent, chaperone, and sounding board." Robert Nearing doesn't hesitate when asked what he does. "My primary job here is to be a motivator, to encourage and help the patients to find and create structure for their lives. If I do a good job as a motivator, my patients go home

and get on with their lives." One of Presley's co-workers from the Jeff Davis days, Nearing also works on Unit 2B, usually during the busy daytime shift.

He did civil rights work in Michigan as a teenager, has a college degree in psychology, and has worked in the automobile, chemical and aircraft industries.

He has been a psych tech for 26 years and he knows about stereotypes. "People think our patients have superhuman strength," he says.

Continued

First Aide

Continued

He acknowledges it can be a volatile environment and a psych tech has to be aware of the atmosphere (“milieu” is the clinical term) on the unit at all times. “But if you communicate with each person, help them understand what’s going on and why and not take words or actions personally, then the physical part of your job is just ten percent,” he says.

A psych tech’s shift usually begins with the nursing report from the previous shift and the assignment of patients. It is the tech’s duty to interact meaningfully with each patient, assess what a patient’s situation and needs are, and appropriately report or act upon those findings. Admission and discharge, basic medical procedures, patient hygiene, observation of behaviors and moods, therapeutic interpersonal contact, motivational groups and activities, safety and prevention of injury and patient escort are all within the purview of this position.

They know that what they do for a living is often misunderstood or misjudged. They are often looked down upon for working “in a place like that,” or with “those kind of people.” There is stress and anxiety, not because of the work but because of the stigma attached to mental illness. They do what they do, and for the most part get satisfaction from it, because they have found a place where they can make a positive difference in someone else’s life.

“We are the backbone,” Holman says, “because we are the ones who are able to spend the most quality time with the patients. Verduzco puts it another way: “We can be as critical to a patient’s outcome as the doctors and nurses of the treatment team.” Tech De Wayne Tennison seconds that: “We are the hands-on folks whose job it is to interact, assess and observe the patients as soon as they arrive.”

You are immediately at ease with Victor Holman; he’s friendly and gregarious. Holman has been a psych tech for 15 years; he has worked the 3-11 p.m. shift on Unit 3E at HCPC for several years. You are also immediately aware that this job is his career. He likes what he does and the people he works for and with.

“Folks think we have the easiest job at the Center,” he says. “What they don’t realize is that while there may not be a lot of physical procedures to perform, there’s much more thinking involved. We have to talk to the patients and accurately assess them all the while carrying a



Victor Holman

pencil and pad in our heads.”

But it’s that people contact that Holman likes best about his job. “Sometimes you interact with 23 people in a minute and you have to know each of them and know what’s the most effective way of dealing with each. You have to be with each person in that moment.

“Our job is to create a rapport with the patients so that if they become agitated or angry we can calm them down and reassure them; it’s not to control them.”

There is no single personality type that makes a good psych tech. For example, Nzei is as quiet as Holman is outgoing, Price as bubbly as Verduzco is intense. But they have definite ideas about the personal qualities one needs to be a tech: open-minded, empathetic, non-judgmental, diligent and self-aware. The same words—interact, talk, listen, take care—relating to communication and people, are what you hear from each of them.

“Patience and empathy,” says Price immediately when asked what are the key attributes for her job. They are words and feelings echoed by many other techs about their work.

“We must keep in mind that each of our patients has a story and we need to listen to that story and try to empathize and relate that story to something in our own experiences so we can get insight into their attitude and behaviors,” says Price. “Our job is to see, hear and give insight; the treatment team of physicians and nurses depends upon us for that.”



Stephanie Price

The energy field around Stephanie Price is palpable. She works weekends at HCPC, juggling two jobs with being the mother of two young sons. But her enthusiasm and spirit seem unquenchable and serve her well working with the teenage patients on Unit 2D.

See “First Aide” on page 14





What Our Patients Think . . . Findings from the HCPC Patient Satisfaction Survey

(January - March 1999*) (In %)

CARE BY STAFF

A. Did the staff treat you with respect?

	Last	Current	Norm
Always	61	56	66
Often	19	21	20
Sometimes	12	13	11
Rarely/Never	8	10	3

B. Were you comfortable sharing your personal concerns with the staff?

	Last	Current	Norm
Always	43	45	48
Often	25	24	23
Sometimes	20	18	22
Rarely/Never	11	13	7

CARE BY THE PHYSICIAN

Was talking with your psychiatrist helpful?

	Last	Current	Norm
Always	40	41	50
Often	24	26	22
Sometimes	22	20	20
Rarely/Never	13	13	8

MEDICAL OUTCOMES

Did the medicine help you get better?

	Last	Current	Norm
Yes	73	77	74
To Some Extent	21	17	20
No	6	6	6

PATIENT CLINICAL PROGRAMMING

Were the activities a helpful part of your treatment?

	Last	Current	Norm
Yes	70	73	66
To Some Extent	18	19	21
No	13	8	13

PATIENT EDUCATION

Did the staff explain your treatment in a way you could understand?

	Last	Current	Norm
Yes	75	69	80
To Some Extent	19	23	14
No	6	8	6

NON-CLINICAL SERVICES

Overall opinion of the housekeeping services.

	Last	Current	Norm
Excellent	38	40	32
Very Good	21	20	28
Good	25	19	28
Poor	16	21	12

*As compared with last HCPC Patient Survey results and national norms.

Statistical data provided by Office of Quality Programs, Decision Support Systems

The above data are just part of the findings from HCPC's ongoing program to assess patient satisfaction with the treatment they receive at HCPC. This information allows HCPC to continuously monitor its care and illuminates the Center's strengths and weaknesses as a publicly-funded healthcare institution.

The Patient Satisfaction Survey monitors eight areas, including overall satisfaction, care by staff, care by physicians, non-clinical services, clinical programming, patient education, medical outcomes (effectiveness of treatment), and other services.

Since its inception in 1996, survey findings have been the impetus for many major changes in administration, procedures, and direct patient care.

Progress will continue to publish selected findings from these quarterly reports.

First Aide

Continued from page 12

"I enjoy the children and teenagers because they are such a challenge and I learn so much. I enjoy youngsters because they are more verbally engaging, less reticent than adults to open up with you. I know that they can be manipulative because that may be the only way they've learned to get taken care of. I know I'm not here to be their friend and I expect their behavior to be a problem sometimes because that's why they are here."



Fred Thompson

Fred Thompson knows whereof these psych techs speak. An HCPC RN working on the adolescent unit, he respects the work that Price and the other techs do because he was a tech himself, working full-time while finishing nursing school at Prairie View A&M University.

"They're on the front lines," he says, "and their job is to maintain a safe and therapeutic environment so healing can take

place. They have to know about the diseases and behaviors associated with them. It's also crucial for them to know about the various medications and their side effects.

"Being a tech was really motivational for me because I got to do the real, hands-on work. I'd done my required psychiatric rotation but never really thought I'd like it. I learned that no matter what area you are in, you are dealing with human behavior."

What Thompson liked most about being a tech, and thrives on as a nurse, is being able to watch his patients improve. "It's very rewarding to see a patient who came into the hospital hostile and hurting, and probably very angry at you, make that transition to someone much healthier who appreciates what's been done here and can say 'thanks.'"

"Yes, sometimes it takes my geriatric patients longer to get better, but the biggest reward I get from this job is seeing them improve," says Nzei. "Mental illness is a horrible disease, and when you take care of a person from day one and you are able to see such dramatic changes you're glad to be part of it"

Rosie Nzei came to Houston from East Texas to work as a secretary at Houston International



Rosie Nzei

Hospital on Main Street. You can imagine her quietly watching and listening to all that went on. She soon knew that she wanted to work directly with the patients. She became a tech and came to HCPC one month after the Center opened. Currently, she is pursuing a nursing degree and works weekends with the geriatric patients on Unit 3D.

With her calm, easy-going manner, you have no doubt that she means it when she says, "I love to sit down and talk with them, they are so full of wisdom. Working with them has taught me how to be patient. I actually am looking forward to getting older because these folks are so full of energy."

Nzei, like many HCPC techs, helps facilitate a goal-setting session with her patients. Each day, patients are encouraged to set a goal of what they would like to accomplish for the day and talk about how they are feeling. In the evening, the techs gather the patients together again to discuss what goals they've achieved.

"We deal with solutions," says Verduzco, "and we not only must be open minded about our patients and their behaviors but be positive minded about their outcomes. We want the patients to become proactive about their lives, to maximize their self-reliance and self-accomplishment as much as we can within a safe environment"



Sergio Verduzco

Sergio Verduzco has been an HCPC tech almost five years. With experience in physical therapy he was looking for a new challenge in the healthcare field when he came to HCPC. A serious young man who speaks often about professionalism and opportunity, Verduzco is not sure what his future holds.

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First Aide

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He may return to college or pursue a nursing career.

He is committed to doing his best and bettering himself as a person. "I have learned a lot about humanity. I have seen the best and the worst in people. I have learned that the same fundamental things, both good and bad, are part of all of us. I have learned how to interact with people and how they will interact. I have learned not to be judgmental and to let people have their say. And I hope I have become a better person."

How do techs work with their patients?

"I like working with my mind better than my body," is how Holman explains his facility with people.

"Often," he says, "when a patient gets out of control, it's usually because no one has taken the time to have some rapport with that person."

"I have come in contact with some patients who were very angry," says Bobbie Wyatt, a psych tech in HCPC's Partial Hospitalization Program (PHP). "I say to them 'I have listened to you, would you please listen to me? I understand you are angry and I'd be angry if I didn't know why I was here and felt someone was doing something wrong to me.' Usually I have been able to get patients, both male and female, to calm down and listen, including adolescents. I think talking with people and giving them options is the most effective way to deal with a volatile situation," she says.



Bobbie Wyatt

Bobbie Wyatt can tell you the exact day she began working at HCPC: September 8, 1986, a month before the first patient arrived. She is very proud that she was personally asked by the Center's founding physician to join the staff. She has been a tech for 20 years working in substance abuse

and geriatrics, as well as general psychiatric care. Before that she'd been an aide on an oncology unit at Hermann Hospital.

For several years, she was in charge of transporting patients from their rooms to the Probate Courts housed at HCPC. She enjoyed that because she was able to calm them and help them understand what was going to happen in court. "I once had a patient I was taking to court ask, 'What would you do if I ran'? I just said, 'Well, I don't run track, so we're not going to do any running today,' and that stopped him."

PHP is a transitional program that provides day treatment, allowing patients to go home at nights and on weekends. Many stay in PHP for several weeks and Wyatt enjoys getting to know them. "When I talk to them, I use the word client rather than patient," she explains, "to reduce some of the stigma they may feel because of their illness."

Techs are also often called upon to interact with family members, especially those of patients in the day program. It is key that families understand and accept the illness of their loved ones, because if they don't the patients are likely to get no support or reinforcement for taking medications or continuing their treatment, and that means they'll eventually be re-hospitalized.

"By working with the families you can help assure a good environment for the patients," says Tennison, who works with Wyatt in PHP. Price, who works with young people, knows that family understanding and interaction is vital. "But sometimes," she says "it is hard because they are in denial, or the child may be manipulating them, or sometimes the child is the real caretaker in the family, not the parent."

"I guess one of the reasons I do this job," says Price, "beyond the fact that I love it, is because I understand personal struggle. We had trauma in our lives, but my mother always told us we could do it and to keep trying."

"I think one of the hardest parts of my job is knowing that there are just some problems in our patients' lives we can't solve," adds Tennison. "Sometimes, when patients become rehospitalized because they didn't take their medications, it's because they don't have the resources or transportation to get their medicine. When they return, we try to ask them not only what we can do, but what can they do, to make changes. We try to get them to take more responsibility, but also to call the PHP program when they need help."

"I always make a point of calling patients by their names because it makes them feel good," says De Wayne Tennison. In 1988, as a senior at Texas Southern University majoring in health education, Tennison came to work at HCPC; his future plans include more education.

Continued

First Aide

Continued



De Wayne Tennison

“I didn’t expect to be here long when I first started. But I received so much appreciation from the geriatric patients I worked with. And the enjoyment of working with them—and my co-workers—kept me here even though I had other job offers.”

All these HCPC techs have in common their enjoyment of being able to work with people, and knowing that they are needed because not everyone would feel comfortable or competent in doing their job.

They are well aware of the stigma surrounding mental illness that pervades most of society, both inside and outside the medical profession. And, each has felt the sting of that stigma personally, facing questions and stares from family members and friends who do not understand their choice of profession.

Many will even admit that before they took the job they had misgivings and misunderstandings, but that they have realized the truth in the old adage, “there but for the grace . . .” And there are many techs whose families have been personally touched by mental illness.

“I often shied away from my relative,” says Nzei, “and we never really talked about her ‘problem’ much in the family. Now that I work with people like him, I understand and can help him.” She, like most psych techs, has turned this particular stereotype on its head, using the Golden Rule as a motivation. “You put yourself in their place,” says Holman, “and try to imagine how you would like to be treated or how you would want a family member to be treated.”

“I try to get people to understand that just as you go to a hospital for a physical illness or injury, this hospital treats mental illnesses,” says Tennison. “And you never know when something like this could happen to you or one of your family. People don’t know and you have to tell them that everyone handles pain and trauma and disappointment differently and that these people are not bad, that they cannot help themselves, and that they are ill. I tell them to put themselves in that person’s place.”

And, psych techs often face a second layer of incredulity and stigma because of the socioeconomic

status of many HCPC patients. “It doesn’t make any difference whether they are a doctor or a ditch digger or a homeless person,” says Holman, “and I have cared for them all. When they are here as patients they all receive and are deserving of the same kind of treatment.”

Verduzco believes that ignorance and superstition about mental illness is still prevalent, and that people still believe what they see in the media about what goes on in psychiatric facilities and what kind of people work there.

“It’s a combination of ignorance and fear,” Price agrees. “People still shy away from the mentally ill, but I’ve noticed it is getting a little better because people have been touched by mental illness in their own families, and they can relate.”

While Holman sees an improvement in public awareness and understanding about his job and about mental illness in general, Nearing believes that most people still don’t understand. But he does agree that there have been changes, mostly improvements, especially regarding patient care and human rights. “Back in the Jeff Davis Hospital days,” says, “we didn’t have a lot to work with.”

All agree that knowledge is the key to reducing fear, rejection and shame among the general public, and that education is also a big part of their work.

“In years past they called it an ‘institution,’” Wyatt says, “and they thought patients were treated harshly like they see in the media. But I have explained that’s not what happens here. When I’m in the community people will say, ‘There’s been a lot of changes, I understand. I hear THAT psychiatric hospital is very nice’. And I ask them, ‘WHICH hospital?’ and when they acknowledge it’s HCPC I tell them I work there and that, ‘Yes, it is a very nice mental health facility’. And I stress that we take care of our patients and protect them.”

But Wyatt, like her co-workers, doesn’t let the stigma mar her feelings about her work. “I feel good about the clients. When a patient is admitted in serious condition, and I can watch that patient improve and be discharged with the ability to function with very little assistance, I feel I have been allowed to reach out and help someone.”

When you ask Carolyn Presley about the stigma of mental illness, she tells you about a friend of hers who once asked her how she could work with persons with mental illness. “She was just full of questions. Then she asked me if I ever sat next to any of them or touched them. I just looked at her and said, ‘PLEASE!’”





Lessons Learned

Tracking their life histories can help patients with bipolar disorder predict manic or depressive episodes, help them to lead more normal lives, and maybe even allow them to argue with that old saw about “history repeating itself.”

When Alan Swann examines his career as a physician and scientist he can see how certain unplanned circumstances intersected with his life and led him to focus much of his career on the study of bipolar disorder (manic depression).

“Most of my medical school research training had been in biochemistry, particularly the biochemistry of how excitable cells maintain their electrical properties by transporting sodium and potassium. I had done work in this area in medical school and for two years at the National Institute of Mental Health (NIMH).

“When I started my psychiatry residency at Yale in the mid-1970s, the research focus was on lithium, which remains to this day the most common drug used to treat manic depression. Lithium was new to the U.S. then and we were trying to understand how it worked. Because my research work had been in chemical elements similar to lithium, it was logical I would become involved. And, since most of this research was geared toward understanding and treating bipolar disorder, it became and has remained my focus.”

So, Swann, who is now a professor and vice chairman of research in psychiatry in the UT-Houston Medical School, understands how reflecting on one’s life’s events can help a person understand why or how certain other things occurred in his life, and yield certain important facts about their nature.

He also understands that the focus of his life’s work, bipolar disorder, is itself a life-long illness with the capacity to keep its victims from ever having the attributes of a normal life, such as a home, a family or a job. “Lithium was a breakthrough for many of these people



Alan Swann, MD, Professor and Vice Chairman of Research, Department of Psychiatry and Behavioral Sciences, UT-Houston Medical School, Mental Sciences Institute and HCPC.

and I could see the tremendous effect it had, allowing them some measure of stability for the first time in their lives.”

In the years since his residency training, Swann has continued to study the significance of bipolar disorder’s lifelong nature, along with its biochemical and behavioral attributes, and has become convinced that one way through its insidious labyrinth is life charting.

Simply understood, a life chart is a time line, a systematic record of key events or occurrences in one’s life. “For persons with bipolar disorder,” Swann explains, “we ask them to make note of the major events in their lives, when and what occurred, and also the episodes of their illness and treatment. The idea is to look at the disease over time and in relation to the events of life to see if there is a correlation and what that correlation might be.”

So, patients are asked to do both retrospective (history) and prospective (present) life charts.

Usually, the information is translated to data that can be analyzed by a computer to create a sort of “graph” of a person’s life.

The primary areas for charting include the dates and circumstances of important life events or changes (good and bad) including life changes that disrupt daily rhythms, mood symptoms (depression, mania, anxiety or irritability), when they have an actual manic and/or depressive episode, what treatments are given and changes that occur, when hospitalized and the hours of sleep. Currently, Swann and his associates at the Mental Sciences Institute, the research arm of the UT-Houston Medical School’s Department of Psychiatry and Behavioral Sciences, are involved in a study to test the usefulness of life charting in determining the efficacy of a new drug treatment for rapid cycling (several episodes of mania or depression a year) bipolar disorder. This study, being conducted at numerous sites around the country, is the first of its kind to use life charting in drug treatment research.

Life charting originated with the early Viennese school of psychoanalysis, but was reintroduced into the study of bipolar disorder in the 1980s by Robert Post, MD, chief of Biological Psychiatry at NIMH and director of the Stanley Foundation Bipolar Treatment Research Network. Post is also a consultant for the medication-life charting study in which Swann and his colleagues are currently involved.

Making an inventory of one’s life events, constructing a personal “time line” and “journaling” or writing about the events in one’s life, have been widely used and encouraged by psychotherapists for understanding and overcoming certain behaviors or moods. Now

Continued

Lessons Learned

Continued

life charting has moved into another realm, becoming an important source of clinical research about the disease itself.

“Research is about finding out everything you can,” says Swann, “which makes life charting very beneficial in itself for us. But there’s also a real practical purpose, because it often uncovers certain longitudinal patterns that can be related to when events, behaviors or illnesses occur. It also tracks the relationship of certain treatments to these events and behaviors.

“If we can find those patterns, an individual’s own life markers, we can anticipate changes that may be coming. We can see whether a person’s response to treatment stays the same or changes over a lifetime and whether or not treatment given earlier in a person’s life makes the course of the illness any easier. And we might even be able to predict much earlier when or if bipolar illness will occur in an individual.”

Knowing That We Don’t Know

Life charting should be a crucial part of research and treatment, Swann believes, because there is still so much that is unknown about bipolar disorder. “There are some things we know for certain about bipolar disorder and others we speculate are true, but need more evidence of,” he says. “But we have known for a long time that bipolar disorder is a life-long illness, and that, itself, makes life charting very important.”

“Bipolar disorder usually becomes a recognizable condition when a person is in their teens or early twenties,” Swann explains. “That’s when they begin having

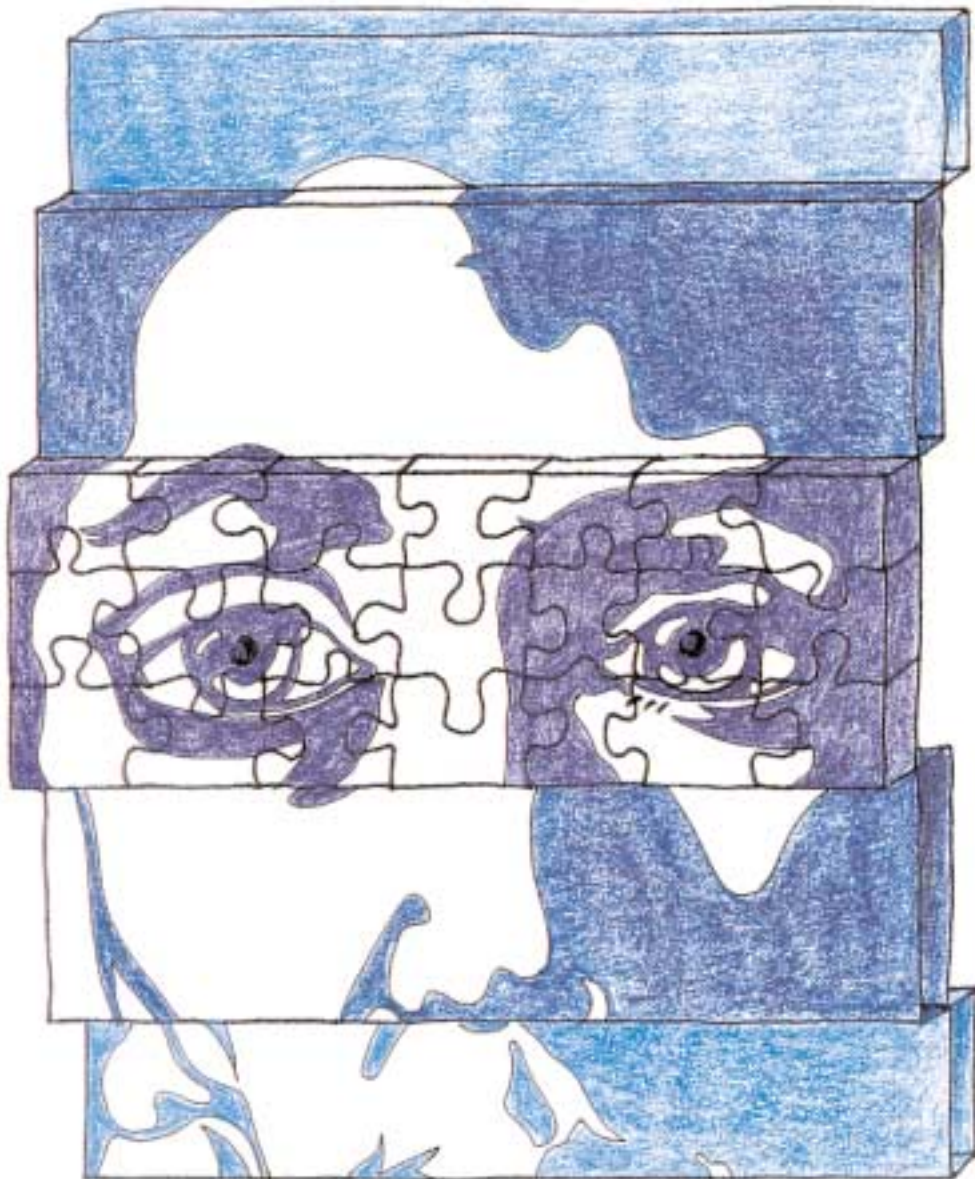
identifiable episodes of mania and/or depression. But there’s a strong association with problems earlier in that person’s life that may be forerunners of these episodes.

“However, children’s brains are different than ours and we only have adult diagnostic criteria to go by. Many childhood manifestations of bipolar disorder can be problems not specific to bipolar disorder. For example, a child with bipolar disorder may exhibit attention deficit disorder behaviors; or hostile and defiant behaviors, such as oppositional defiant disorder; or chronic depression or irritability (dysthymia); or have a substance abuse problem which began before the age of 12.”

Life charting of an individual’s life can be crucial in treating bipolar disorder precisely because the disorder is so stubbornly individual in nature. Scientists believe each person’s disorder is specific to him or her, but life charting could help discover if there are aspects of bipolar disorder that appear in many individuals.

“We also know that, in general, bipolar disorder runs in families,” Swann says, “and the earlier the illness begins in a person, the stronger the family history seems to be. So if you see one of these problems in a child and there is a positive family history of bipolar disorder, it’s

See “Lessons Learned” on page 19



Untitled drawing by Chris Humphrey. Courtesy of NARSAD Artworks.





Lessons Learned

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likely that the child will grow up with bipolar disorder and these are early manifestations. But if you don't see an early history of bipolar disorder, it's anybody's guess if these children have the disease.

"If we can trace, through life charting, the course of a person's illness or track manifestations of the illness in family members, we may be able to predict or detect possible signs of the disease and begin treatment early enough so that person has some hope of a normal life."

What Changes, What Stays the Same

Then, Swann says, there are some manifestations/components of the disease that seem to change over the course of the illness, and others that seem to remain constant. Researchers are still looking at these areas, and, they, too, are important to follow over time. Life charting can prove essential in finding out about these attributes and relating them to one another and to other traits of the disease.

One changing element is the effect that stressful life events have on triggering bipolar episodes of mania or depression. Researchers understand that bipolar episodes early in the illness are strongly associated with such events, but these stressors do not have to be extraordinary.

"A bipolar episode can be triggered by an event many of us would take in stride as just one of the 'slings and arrows of outrageous fortune,' that are part of life," says Swann. These might include such everyday disappointments as not making the basketball team, being jilted by a boyfriend, or moving to a new home. Of course, the disease can also be triggered by a more catastrophic event, such as the loss of a parent or sibling.

"The threshold of severity is different for each person, and even the same person having the same

experience can have a different kind of mood change (mania or depression) each time the experience occurs.

Therefore, many of the illness' early episodes can't even be identified, because the importance of the triggering event to that person may not be understood, or it cannot be readily connected to a period of sadness or hyperactivity which came after it. "But eventually," Swann says, "you begin to see clear patterns of disturbances of mood or behavior, manias or depressions, in response to stressful events of a widely varying severity. Life charting may allow us to get a handle on what these triggering stressful events may be, especially in the early episodes where they seem to have more influence in bringing on a manic or depressive mood," he says.

How often the episodes of mania or depression occur is another variable component of bipolar disorder. "Each episode," Swann says, "tends to come a little sooner than the last episode. For example, the first two episodes may have been a year apart and the next episodes may be six or eight months apart, and the next four or five months apart. Therefore, if the illness begins early in one's life, the chances are greater that he or she will experience progressively more frequent episodes." Swann says researchers believe that this may be caused by changes the brain goes through during each episode.

There are, physicians believe, other attributes of bipolar disorder which appear to stay the same from individual to individual.

One of the more crucial of these is circumstance: Although the specific triggering event which causes bipolar episodes can be different each time, the context in which the episodes occur tends to remain the same from early to later episodes.

For example, if a person's early manic or depressive incidents happened in the spring, there is a likelihood that later episodes will continue to occur in the spring.

"It could be that a person becomes conditioned to having mood disorders under certain circumstances and they become the important factor, rather than the stressful event," Swann says.

"How manic episodes unfold is another unchanging factor," Swann says. "It can happen gradually. You may not become wildly manic or severely depressed abruptly. Certain subtle changes in behavior and emotion usually occur over a one to three week period, getting progressively more serious. These subtle changes are different for every person, but in the same person these changes are consistent.

"So, if manic episodes begin with a person starting to stay up all night, or joining organizations, or arguing with co-workers, these things will usually happen each time an episode occurs."

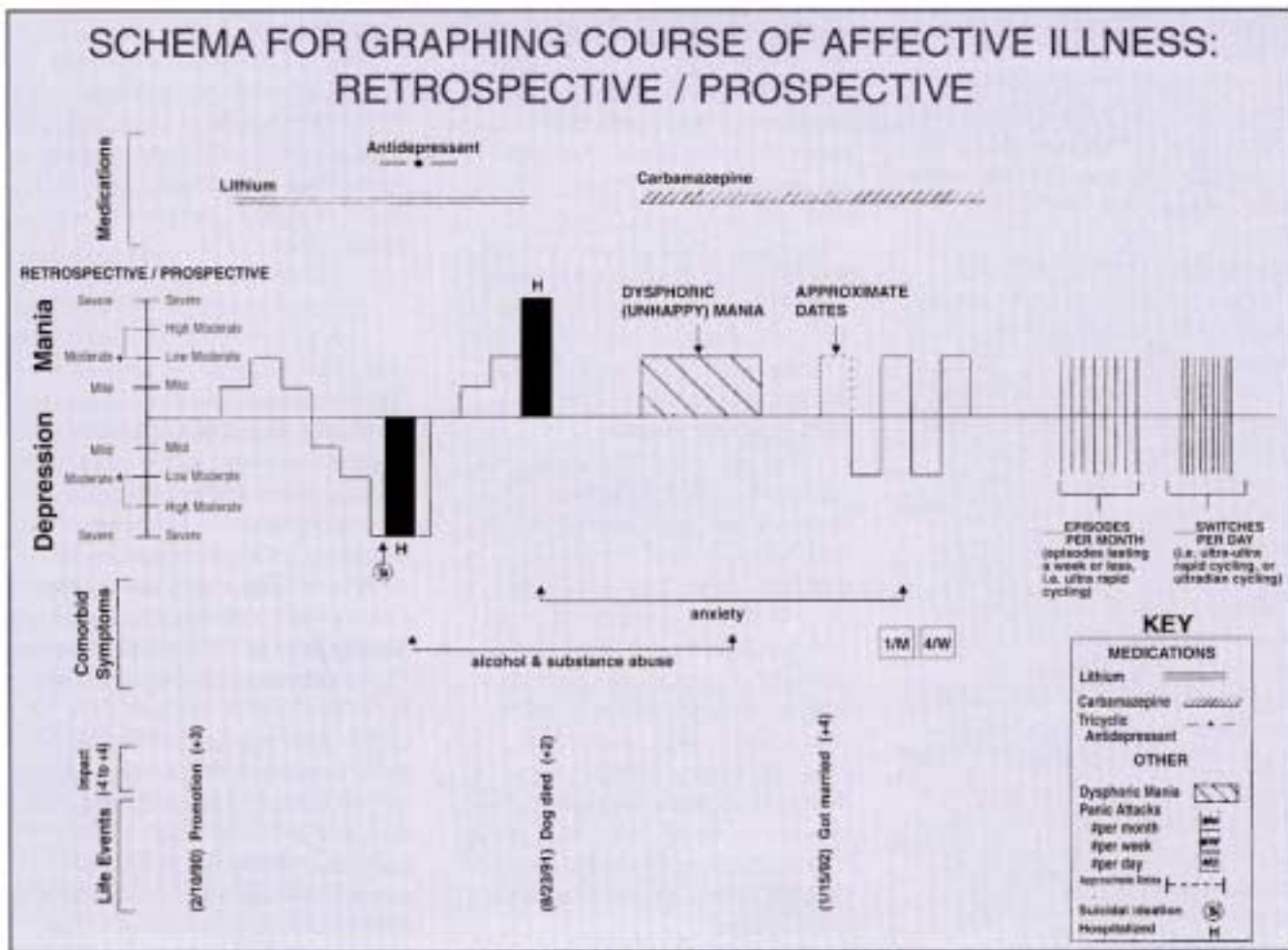
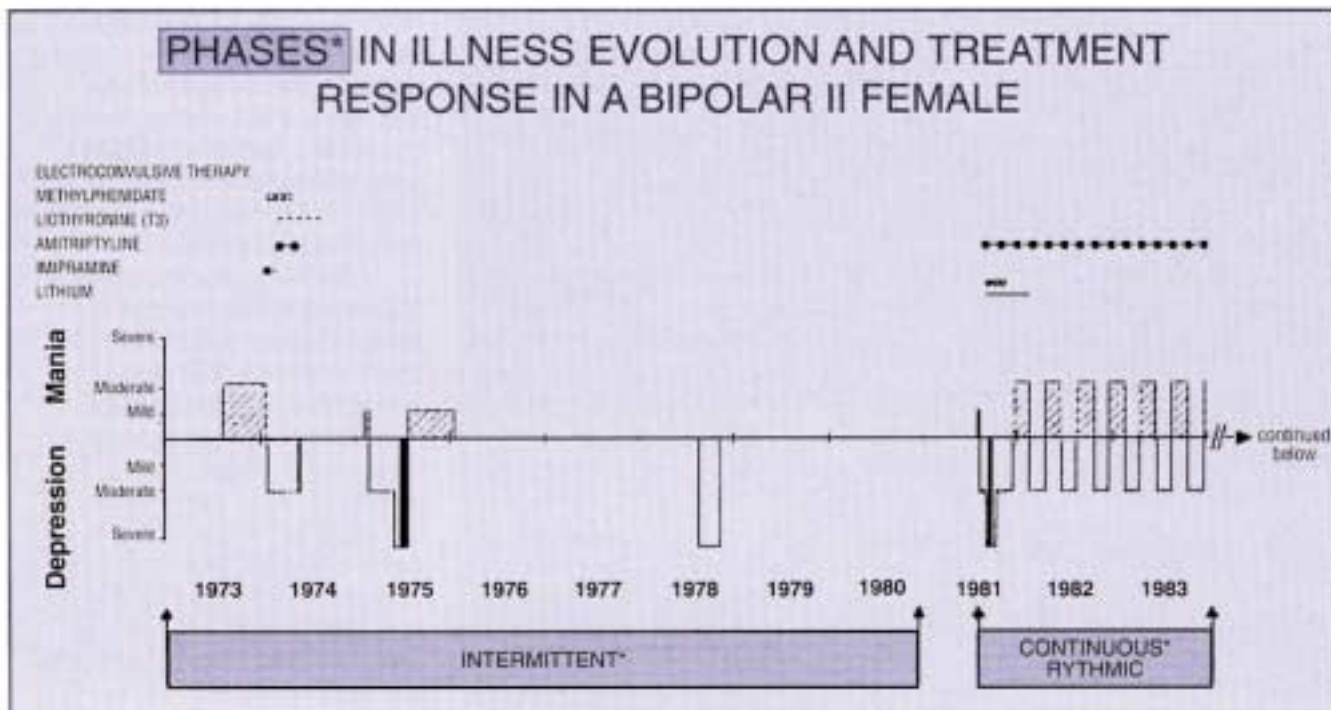
These subtle changes, then, become a warning sign, which could mean that the episode could be allayed with changes in medication, behavior or environment early on, before the illness becomes full blown and causes its victims problems for themselves or others. Not only is this ability to predict through certain changes useful in stopping episodes from escalating, but it also has a wonderful psychological benefit by giving the patient control over his life.

One Disease or Two?

Swann also believes that the response to treatment for bipolar disorder is something that is different, depending upon how often a person has episodes. "Lithium seems to work better for those who have only a few episodes than for those with many episodes or rapid cycling of episodes. People who have many episodes of illness may have manic episodes that respond differently to treatment than the manic episodes of people with only a few episodes of illness.

"It may be that there are two kinds of people," he says. "One kind is the person who has few

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Examples of life chart/time line graphs of (top) phases in the illness evolution and treatment response of a woman with bipolar disorder, and (bottom) schema for graphing course of affective illness outlining retrospective and prospective life-chart tools and methods for recording episodes. (Reprinted from "Charting the Course of Bipolar Illness and Its Response to Treatment," by Gabriele S. Leverich, MSW and Robert M. Post, MD in *MedScape Mental Health* 3 (3), 1998. © 1998, Medscape, Inc.)

See "Lessons Learned" on page 21



Lessons Learned

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episodes during his or her lifetime. They may be severe but, because they do not occur often, the person can maintain some kind of stable life inbetween. These are the people who seem to respond better to lithium.

"Then there are the people whose bipolar disorder has many episodes; they may not be as severe as the first person's but they happen so often that the person can never really be stable between episodes. And they respond poorly to lithium."

The "two different kinds of people" is one possible theory about different responses to treatment, Swann explains. The other theory is that the manic/depressive episodes themselves cause changes in the brain and as the result of those changes, the episodes are made resistant to the lithium treatment. "The changes caused by the untreated early episodes may render later episodes resistant to lithium," he says. "So one reason to systematically chart one's life and the course of illness is to systematically track those changes and be able to anticipate them."

Responses to different kinds of pharmaceutical treatment—which are sometimes consistent and sometimes not—also need to be tracked Swann says. "We know that anti-manic responses can change with regard to lithium," he says, "but no one really knows about manic responses to mood stabilizers besides lithium, although the response to the drug valproate does not seem to get worse as people have more manic episodes."* "And, we know very little," he says, "about how depression responds to pharmaceutical treatment. With most treatments no one really knows whether the person has a worsened response or not."

Other problems related to treatment that need to be tracked over time, Swann says, are the mood changes that various drug treat-

ments cause. "Anti-depressants can make your mood less stable, which is a very serious concern with bipolar disorder; rapid withdrawal from antidepressants can cause manic states. On the other hand, mood stabilizers can dampen someone's mood too severely."

Life charting is certainly more time-consuming and difficult than other ways of monitoring responses to the disease and treatment, but it is also a lot more useful, Swann believes. "You can do it every day, or every week, it can be as complicated as you want, but when you compare it with the 'big picture' in which everything may look chaotic, you can see a certain order emerge when you look at incidents and events in detail."

Usually, Swann says, the physician will ask patients to do a little "homework" and make some kind of chart or table of the past year, perhaps showing when they may have had "trouble with their nerves." Or the doctor may draw the patient out in a lengthy interview and record the information. Separately, the doctor will also ask the patient to construct a timeline of the significant events in his or her life: start of school, birth of a sibling, a move, when they got in trouble, the first job, marriage, birth of a child, death of a parent.

"But you want them to do this separately," Swann stresses, "because you don't want them to unconsciously 'edit' the two lists together. After the patient has done both lists, you look at them with the patient and see if things converge. For example, you may discover that every time a certain change was made or an event occurred, someone had a manic or depressive episode two weeks later; or you may begin to see that certain combinations of treatments seemed to work better and kept someone stable longer."

A number of studies and reports have appeared in recent years validating the usefulness of life charting in treating bipolar disorder. Various mental health advocacy groups such

as the National Alliance for the Mentally Ill and the Depressive and Manic Depressive Association endorse it, and there are now life chart forms for patients to use, some even published on-line, and software that can analyze such data from a large population.

"Life charting can be useful in discovering so much about this illness," Swann says, "how to know early who does and who doesn't have it, whether response to treatment changes or stays the same over a lifetime, or whether treatments given early in one's life can make the course of the illness better over time. Also it can show, with those attributes that change, how they change, how various attributes are related to each other, and which attributes may be inherited . . . I could go on listing things all day.

"Bipolar illness is a long-term lifetime disease," he reiterates. "What better way to know that disease and hopefully devise treatments that work than to look at how it manifests itself over a real person's lifetime?" ★

**(Valproate or valproic acid, an older medication first used for epileptic seizures, was first used for bipolar disorder in the 1980s; lithium since the 1940s. Depakote, a form of valproate, is the only medication, other than lithium, approved by the Federal Drug Administration in treating persons with bipolar disorder. Carbamazepine has been used since the 1980s but does not have FDA approval for bipolar disorder; neither do the newest possible mood stabilizers such as lomictil, gabapentin and topamax. Anti-psychotic drugs, usually associated with schizophrenia, are also used to treat bipolar disorder, as are anti-depressants, with very little information available about their risks or benefits.)*

Wounds

Continued from page 4

The model suggests that the caregiver begin with the basic assumption that a person is a normal individual experiencing the normal consequences of living through traumatic events and that he or she will survive this trauma and return to a normal life that has not been wholly impaired by the trauma.

1 • The first job of the mental health caregiver is to “normalize” people’s response to the trauma. In other words, to reassure them that they are having the expected response to such trauma, and allay their fears that there is something “wrong” with them.

2 • At the same time, the caregiver must validate the emotions of the traumatized, and help them understand that fears and phobias they may experience, or feelings of depression, guilt, anger, and hopelessness are perfectly natural for anyone who is going through what they are.

3 • The trauma victims should be encouraged to “experience the sense of control they have over their own lives.” This involves educating them about the trauma and its consequences so they can learn to cope and predict future behaviors. It also may involve re-experiencing the trauma in order to desensitize the individual from it (a method most Western professionals feel is necessary), but ONLY if the person himself or herself CHOOSES to do so.

4 • Finally, persons suffering trauma should be encouraged to look to the future, perhaps focusing on how well they have already been able to cope and deal with their lives, despite the trauma. The desired outcome is a person who has a self-concept of him- or herself as a normal human being who has been shaped by a multitude of experiences, one of which was the trauma.



From Olympic Triumph to Moral Tragedy: Dan Creson took this photo of the Sarajevo Olympic stadium turned cemetery in 1992. Sarajevo was the site of the 1984 Winter Olympics, but most of the Olympic sites were destroyed during the Bosnian War, 1992-1995.

Creson’s manual stresses that the service program must be able to handle the contingencies presented by the volatile situation. He also says that a good assessment of the population’s real psychosocial needs at the beginning of the program, rather than just the imposition of a program along with a diagnosis, must be coupled with a real plan of evaluation so that caregivers can know if they are really successfully helping people.

Another key concern must be for the caretakers themselves. “After all, Creson says, “they are also victims of the trauma and in many situations ‘burnout’ is too mild a term for these folks who must deal with facing the overwhelming needs of others, while coping with their own.

“These professionals are well trained, they just lack the exposure to outside ideas and interaction with others in their field that might have better prepared them for this crisis,” says Creson. “But I’m not there to tell them what to do but to help them discover effective treatments.

Anyone who has the least hint of a patronizing attitude is a disaster.”

Of course, there are lots of things Creson has learned during his experiences that he can bring back to his work at UT-Houston and HCPC. Chief among them is his belief that one must often go outside his or her own culture to become sensitized to how diverse society really is.

“In a society as heterogeneous as ours, it is highly dangerous to develop mental health professionals who understand and address human mental health issues in absolute terms without taking into consideration all the rich tapestry that provides the context in which they live.”

And Creson has again been brought face to face with a reality he already knew: “The human animal is very resilient, and we should never forget the tenacity of the human spirit, nor should we incapacitate its ability to transcend or deny the hope and self control that keeps it alive.” ★





The Pretenders

Continued from page 8

lacking in intelligence or reasoning ability; in the vernacular: to seem to be too stupid to be responsible for a bad behavior they may be accused of exhibiting.

"Malingering cognitive deficits is different from malingering a functional mental disorder or illness, such as bipolar disorder (manic-depression), schizophrenia or major depression," explains Morgan.

"When a person simulates the symptoms of an actual disorder, there are a variety of ways to determine if the symptoms the person exhibits are real. These include observing their behavior, having a psychiatrist evaluate them, psychological testing, or even a blood test. Their reports of false symptoms are usually quite vague, and when you observe the patient in the hospital, they never consistently demonstrate the kind of symptoms or behaviors as those persons actually suffering with the disorder. The 'fakers' aren't sufficiently familiar with the behaviors and symptoms that go with a specific diagnosis, so they can't really fake them very well.

"Cognitive malingering is not more difficult to discover," she adds, "It's just harder to document, especially when you need to gather concrete and unbiased data that will hold up in a court of law. We haven't had a systematic way or a testing instrument for evaluating cognitive malingering in adolescents as we have for measuring symptoms and severity associated with other psychiatric problems (e.g., Personality Inventory for Youth or MMPI-A)."

The VIP offers such a test, an objective assessment of cognitive malingering that can be admitted as evidence in judicial proceedings. "The VIP," explains Hays, "uses 'per-

formance curve analysis' to detect the malingering, based on the premise that when people are trying to fail a test on purpose they usually don't think about whether they should make errors on the hard questions or the easy questions.

"A performance curve is the predicted performance of an individual on any task. When the curve does not appear the way the prediction describes it, the person is either being careless or malingering."

Remember your teachers who graded "on the curve"? Well, they were talking about the standard "bell curve," so called because when the grades of all students were plotted on a graph, they would form the

answers to the questions and it will form a certain kind of curve, the form of which often correctly predicts whether the person is malingering.

The VIP test takes 50 minutes and consists of 178 randomly organized, forced-choice questions (only two possible answers), at various levels of ability, from simple questions that most people would be easily able to answer, such as, "What is two plus two?" to questions of greater and greater difficulty, such as, "What is the square root of ten divided by the square root of seven?" up to a level of difficulty no one is expected to answer correctly.

In theory, then, almost everyone taking the test should get the easy



"The Sunset of the Dragon" by Josh Hays, age 9

shape of a bell. Translated, that means that in a class of 50 random students it is predicted that most students will get Cs (the top of the bell) and that about the same amount of students who get As will get Fs, and the same number who get Bs will get Ds. Your teacher was going to make sure that the distribution of grades in his class formed such a curve (even if it meant you got the D and not the C you were so close to).

With the VIP test, researchers can look at the geometric curve formed by plotting an individual's series of

questions right and miss the more difficult questions. However, those who are attempting to malingeringly miss more of the easier questions in addition to missing the harder questions.

On such a test, Conroy explains, the expected performance curve of a person's answers would start off at 100 percent and go down to about 50 percent. If a test-taker's performance curve does not hit near 100 percent, they may be missing

Continued

The Pretenders

Continued

questions they should not be.

To determine why the person missed these questions, the VIP further divides the curves into four categories, based on the test-taker's intentions: **compliant**, or persons who are trying to do their best on the test, whose curve goes from 100 to 50; **careless**, or persons who intend to respond honestly, but don't try very hard, with a curve starting out slightly lower than 100; **irrelevant**, or persons who don't try hard and intentionally perform poorly, but who are not consciously malingering, with a curve remaining around the 50 percent level; and **malingering**, or those who are actually trying to miss questions to feign incompetence and beat the test, whose curves would start out below 50 percent and then rise to and remain at 50 percent.

The distinctions between motivation and effort and between careless, irrelevant, and actual malingering are very important in determining malingering in adolescents, say Conroy and others, because of a teenager's tendency to challenge authority and adults' efforts to make them conform to certain criteria or guidelines. "Many who may seem to be malingering," says Morgan, "really just don't care; they're filling in the dots or taking the test with the attitude that it's just 'something to do.'"

The VIP test was administered to 65 adolescents, of which four were girls, between the ages of 14 and 18. The nine HCPC patients who participated were between the ages of 14 and 17 years old and chosen at random with their parents' permission. None were currently involved in the criminal justice system, and none of the people involved in administering the tests, including Morgan, were aware of any of the adolescents' diagnoses.

Before the VIP was given to the participants they each took the TONI-2 (Test of Nonverbal Intelligence), a standard measure of

their non-verbal intelligence. The average test score for the group was 90.6 with a range of 63 to 144; four students scored in the mentally retarded range.

Some of the teens at each of the sites, other than HCPC, were told that they should try to beat the test; in other words, feign malingering. They were to pretend that they were trying to escape punishment for a crime by fooling the psychologist and convincing him that they were limited intellectually.

The rest of the test-takers, including the HCPC patients, were told that the test was being given to see how it measured abilities in juveniles and that they were to do their best in answering all questions.

The VIP actually consists of two parts, verbal and nonverbal. In the verbal test, which was given to the teenagers first, they were read a brief description and then asked to select from two choices the word that matched that definition: for example, "Does equine mean horse or pig?" The questions ranged from very easy to very difficult, as the words defined became more abstract, such as, "Does valor mean bravery or integrity?"

What Conroy hoped to show was that the VIP could distinguish the group responding honestly from those who were deliberately trying to seem impaired, and further distinguish between those juveniles who were not trying to deceive or hide anything, but who were just careless or uncaring with their answers from those who were malingering.

"Someone who is 'faking dumb' or malingering," Morgan explains, "won't know where to start feigning in a realistic manner; when they get to the harder items they really don't know the answers. There is a difference in the pattern of how they are responding, right to wrong," she says. "They're getting too many of the easy answers wrong, and when they have to answer the harder questions they don't know the answer so they start guessing and the pattern of their responses becomes more random, some right and some wrong; they can't fake it

totally anymore."

For the nonverbal, multiple-choice VIP, participants viewed several series of abstract figures and then had to choose which might be the next figure in that series, a very common type of testing of nonverbal problem-solving abilities. For example, they were shown a square with dots in it, like a domino, and were required to select the one square which would be next in the sequence.

The results of this "test of a test" demonstrated to Conroy the effectiveness of using the VIP to determine malingering in an adolescent population. Not only did it correctly identify the malingerers (those told to try to beat the test to escape punishment) from those who were trying to give honest responses; it also differentiated between malingerers and those adolescents who were just careless or not putting forth adequate effort and responding irrelevantly, but not consciously dissembling or trying to fake dumb.

"We also found," says Conroy, "that with participants under 16, the nonverbal subtest of the VIP (sequence of patterns) was more effective in distinguishing malingering from non-malingering, than the verbal (word definitions), probably because of underdeveloped language skills in the population being tested."

The work of Conroy, with the assistance of Morgan and Hays and their peers at the other facilities, is truly groundbreaking because it provides a new tool that can be used to accurately detect the feigning of cognitive impairment in adolescents. This means the VIP test results can be admitted in a court of law as valid evidence of malingering.

"This is something we needed 30 years ago when a significant number of adolescents began appearing in the juvenile justice system," says Hays. "It will assure that a child who is a malingerer does not receive treatment for a psychiatric illness, but does receive the kind of behavioral modification he or she really needs. You don't treat the malingering, you treat their whole behavior." ★





HCPC Heads On International Circuit

Two of Houston's leading psychiatrists are now known internationally for their presentations on AIDS epidemiology and prevention. Robert Guynn, MD, HCPC Executive Director and Chairman of the UT-Houston Department of Psychiatry and Behavioral Sciences, and Professor Pedro Ruiz, MD, Vice Chair for Clinical Affairs and Medical Director at the UT-Houston Mental Sciences Institute, took their expertise on the road again this spring with presentations in the Middle East and South America.

Guynn and Ruiz were invited to speak on AIDS and on student and postgraduate psychiatric education at the 8th International Pan Arab Congress of Psychiatry in Bahrain in February. In March, they led presentations on AIDS epidemiology and prevention and organized a course on depression for family practitioners as part of the VII Simposio Internacional De Actualizaciones en Psiquiatria (Advances in Psychiatry) in Bogota, Colombia.

"We've given AIDS talks for several years, beginning in Ecuador, in response to the need for information about the current trends and prevention needs," says Guynn. "There is little accessible information available in South America and the Middle East. Dr. Ruiz's expertise in cross-cultural delivery of services is key to the subject."

Ruiz, who currently is serving as president-elect of both the American

College of Psychiatrists and the American Association for Social Psychiatry, as well as being president of the Houston Psychiatric Society, is well known for his work in cross-cultural psychiatry and health services research. "The AIDS epidemic is international and knows no cultural or ethnic boundaries," he says. "It has badly affected minority groups in this country and populations around the world. I am very concerned not only



HCPC in Bahrain: Delegates at the Pan Arab Congress of Psychiatry where Drs. Robert Guynn and Pedro Ruiz presented a program on AIDS.

with the education and delivery of services regarding AIDS and HIV to a variety of populations, but also with the way in which the disease and its victims are perceived and treated under various cultures and ethnicities."

"The epidemiology of HIV/AIDS," says Guynn, "is understudied and I believe underemphasized. I have tried to take available statistics from a variety of sources, identify and make a judgement on important trends the disease is taking, and then report these to my fellow clinicians. This is specialized information that the average practitioner would have a hard time trying to research alone."

Despite a certain lull in the U.S. in

the visibility of the AIDS topic, Guynn and Ruiz have found that AIDS is advancing at a significant pace around the world. Guynn reports that in some African countries below the Saharan Desert region, 20 to 25 percent of the adult population are infected with the disease and the rate of infected children is frightening. "And with the fall of communism in Eastern Europe and the increase in drug abuse there, the rate of new HIV infections has skyrocketed," he says

But Southeast Asia is the new 'hot spot' where infection is spreading out of control. "Within the past few years India has become the country with the largest absolute numbers of infected persons," Guynn says.

How is the epidemic doing in the areas of their most recent visits? "In the Middle East, by and large," says Guynn, "the infection rate is low because of strong cultural sanctions against

certain 'risk' behaviors. Most of the cases in this region are from intravenous substance abuse. However, in Argentina, Brazil, Mexico and certain other areas of Latin America the epidemic has picked up steam and the rate of infection in the adult population is about to overtake that of North America. The population's youth, poverty, poor education and drug abuse, along with unstable social situations, are the key risk factors there.

Because the number of cases of HIV/AIDS in the U.S. has declined in recent years, mostly due to the new anti-viral medications, Ruiz believes there is a false perception that the dis-

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ease has been conquered. “This is definitely not the case, and we could get into big trouble with that kind of thinking,” he says.

Increasingly, the disease here has targeted minorities, and Ruiz has been active in developing prevention programs and approaches to educate certain ethnic and cultural groups and encourage them to modify their behaviors to avoid infection.

AIDS has a serious psychiatric component says Ruiz. “The virus attacks the central nervous system, and in later stages you frequently find dementia and delirium.

“Also, we must not overlook the depression and anxiety that can occur when someone is diagnosed with HIV or AIDS. Even if they are not infected with the virus, many of those in high risk populations suffer from great fear and stress.”

Ruiz also says that persons who already suffer from mental illness are at greater risk for contracting the AIDS virus. “Persons with schizophrenia are especially vulnerable,” he says, “because they suffer from disordered thinking and their judgement capacity is greatly altered. Therefore they are prone to become involved in more risk-taking behaviors.”

Guynn concurs, citing the chronically mentally ill as a little-talked about, high-risk group. “In the U.S., the HIV infection rate among adults is approximately 0.6 percent (about one out of every 170 people), whereas a half dozen studies have shown that the rate among the chronically mentally ill is at least ten times that: 6 to 7 percent (or about one out of 14 to 17 people),” Guynn says.

“I am hoping we can study our own population, ultimately with an idea towards prevention programming,” he concludes. ★

Research-Revealing Results

The Brief Psychiatric Rating Scale (BPRS) provides a reliable source of measurable data in assessing the effectiveness of patient treatment at HCPC, reports David Lachar, PhD. Lachar, a UT-Houston professor and HCPC clinical psychologist, recently presented his findings at the Department of Psychiatry’s lecture series.

Since 1997, Lachar and a team of colleagues from HCPC and the Mental Sciences Institute (MSI) have been involved in a project to identify and collect data about patient outcomes now mandated by TXMHMR and managed care companies. Identifying and assessing the usefulness of the BPRS in such research was the first step in the group’s ongoing work.

The findings and Lachar’s proposal for the way the BPRS can be used most effectively to measure change will now be submitted for publication.

The BPRS, an 18-item assessment of an adult patient’s mental state, is required to be completed on all patients within 48 hours of admission as well as at discharge. It was developed over 30 years ago by UT-H professor John Overall, PhD, head of the MSI Psychometric Laboratory.

Lachar and his team, including post-doctoral fellow Steven Bailley, PhD; psychology resident Gretchen Diefenbach, MA; and Alex Espandas, MSW, reviewed 750 influential or contemporary journal publications that apply the BPRS to describe patient status or document change in clinical symptoms. In 1997, they gathered data about almost 3,800 separate HCPC patients at admission and at

discharge using an anchored version of the BPRS. They also collected basic demographic information and information on the individual’s diagnosis, medications, length of stay, repeat admissions and discharge status.

The BPRS has been further divided into four factor-derived scales: Resistance, Positive Symptoms, Negative Symptoms and Psychological Discomfort. These scales identified diagnostic groupings of patients at admission.

Lachar’s team found, based on comparison to independent ratings of patient improvement for diagnostic groups and individual cases, that changes in BPRS standard scores presented in profile form for admission and discharge ratings were a reliable summary of symptom change and improvement over a patient’s HCPC hospitalization. ★

NAMI “Journeys” to HCPC

The nation’s largest grassroots advocacy organizations for persons with mental illness, NAMI (National Alliance for the Mentally Ill), now has a regular presence at HCPC.

Each Thursday, Linda Zweifel, Regional Education Coordinator for the National Alliance for the Mentally Ill of Texas, spends the day at HCPC, working with the Probate Court, MHMRA, and HCPC Patient Services personnel to help patients and families understand the workings of the mental health system and their rights, and to advocate on behalf of families and caregivers.

In addition, Zweifel has helped HCPC organize and facilitate an

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BRIEFS

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NAMI at HCPC: Linda Zweifel (second from left), Regional Education Coordinator of NAMI-Texas, works closely with HCPC Patient Clinical Programming staff Peter Simone, PhD; Vicki Sherman, LMSW-ACP, and Priscilla Cleaveland, MS-LPC

ongoing education program for patients and families, "The Journey of Hope." Each weekly session is be a combination of education and support designed to provide families and caregivers with the facts about mental illnesses, treatments and medications; teach coping skills for living with persons with mental illness; and give participants the opportunity to share with others like themselves.

"I am the parent of an adult child with severe mental disabilities," says Zweifel, "so I know how sad, angry, confused and alone these people feel. The stigma against brain disorders is so great and the mental healthcare system so complicated that there is often no one to turn to, even just for a kind word of encouragement.

"Mental illnesses are chronic conditions and the strain on the caregivers is almost as great as on those

with the disorders. Support for them is paramount if their loved ones are going to get better and go on to lead as normal lives as possible."

Zweifel's program is just part of a larger effort to provide education and support groups every evening on each patient care unit, under the direction of HCPC's Patient Clinical Programming staff. ★

Investigating the Roots of Violence

by Pamela Lewis, UT-Houston Office of Public Affairs

Too often we think of violence in its many forms as something that is an aberration, a deviation in the normal life of human beings. But if we look back through history, certainly if we

look at the morning newspaper, we have to stop and think that there is something in this creature we call human that carries not only the capacity for violence, but the propensity for it. Understanding that propensity may be one of the most important ways of determining some method for seeing less violence in the world, in this society.

- Daniel Creson, MD, PhD

A certain confluence of events during the week of April 18-24 pointed up the apparent truth of that statement as well as the need for the April 24 continuing medical education conference "Juveniles & Violence: Current Perspectives," at the UT Medical School. Continued strife in the Balkans, school violence in Littleton, Colo., questions from the general public, media and politicians about problems and solutions all were addressed by one expert or another during the conference and at the press conference on the topic on April 23 at the UT-Houston Mental Sciences Institute.

The program director for the conference was Dr. Daniel Creson, professor of psychiatry and behavioral sciences at the MSI and HCPC, who had returned from two weeks in Albania, where he worked as a consultant for the Christian Children's Fund, analyzing the need for and logistics of setting up psychosocial services for refugees arriving from Kosovo (see Wounds of War, page 1).

Creson warns that those non-governmental organizations (NGOs) providing refugee assistance have to take a very careful look at the real needs of the refugees before rushing in with a preconceived notion of what they may

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need. "These camps are not communities. They are groups of people thrown together by terrible chance."

Given those provisos, Creson said that one of the ways NGOs can provide assistance is to help the people within the camp set up psychosocial services. There are a lot of resource people living within these camps-- teachers, social workers, physicians, nurses who, he said, can be trained to work with those in need.

"It is essential to try and normalize the very abnormal circumstances in which these children, adolescents and adults are living," said Dean Ajdukovic, PhD, of the Society for Psychological Assistance in Zagreb, Croatia, who spoke at the conference.

Ann Saunders, MD, chief of child and adolescent psychiatry for the UT-H Medical School, said the differing perceptions of children and adults can produce differing outcomes when exposed to trauma, whether in the Balkans or in the United States.

"As adults we kind of have a good sense of what the order of things is and how the world should be. Children don't have such a permanent and definite sense of the world as this. When circumstances change and they are traumatized, they begin thinking that this is the way the world is and they begin rebuilding their personalities and their reactions during the time of the upheaval." In addition, she said, research suggests that early trauma seems to change the brain and the way the brain works. "Later experiences can shift the brain again, the way experiences are integrated, the way emotions are felt."

She believes for those in Littleton, Colo., the trauma to that community could be felt as deeply, if not more deeply, than by the refugees in the

Balkans. "In the Balkans, tensions and general disorders predated the current upheaval, so the children there may be more acculturated to it. But in the US, we tend to pretend that violence and aggression aren't so intrinsic to what we do. I think we are in much greater denial, so the shock might be greater; a real sense of disillusionment."

Associate professor F. Gerald Moeller, MD, an associate professor at MSI and HCPC, is one of the researchers looking at the way early aggression and violence can affect an individual's biology. He is studying the effects of serotonin, the main chemical through which Prozac works (see *Progress*, April 1999).

"We are just very early into the study of this type of behavior—how the brain is affected by trauma and what we can do to ameliorate this change. It looks like early trauma does lower

the levels of serotonin in the brain at least in lab animals. Severe stress can lower those levels in lab animals. This is a very complex subject, so this one chemical is not going to be the only answer to why someone commits violence, but it looks like serotonin plays a part."

Since early childhood trauma can affect the biology of individuals and can affect their later life, Moeller says it's important to focus on these traumatized children early so they do not go out and develop antisocial behavior. ★

(This article reprinted from *Monday Morning*, a publication of the UT-Houston Health Science Center).



To Learn, To Prevent: Held shortly after the school shootings in Colorado, Creson's (above) conference attracted widespread attention.





The Leota Fountain in HCPC's courtyard provides an emotionally soothing and aesthetic focal point for staff, patients and visitors. Dedicated in 1994, the sculpture is the work of Nancy Pfeifer and Joe Broussard and dedicated to Leota Glimpse Macon (1890-1935), mother of the late Don Macon, historian of the Texas Medical Center and a guiding force of UT-Houston television.

P R O G R E S S • J U L Y 1 9 9 9



Public Information and Education
Harris County Psychiatric Center
W. Leland Anderson Campus
Texas Medical Center
2800 South MacGregor Way (77021)
P.O. Box 20249
Houston, Texas 77225-0249

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