

UT HARRIS COUNTY PSYCHIATRIC CENTER • THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON

PROGRESS

A U T U M N 2 0 0 2



IN THIS ISSUE

SPECIAL PULL-OUT SECTION
Children's Mental Health
Problems

The Reality for Kids
in Foster Care

The "Write" Stuff

Local Researcher
NARSAD Artist



Dear Friends of Progress:

Mental illness is an "equal opportunity" disease, striking people of all ages, cultures and professions. Due to an increasing openness by certain individuals in the public eye, we know that mental illness afflicts many of our creative artists: poets, painters and performers. In fact, many of those we deem our finest artists—often those whose work touches us most deeply—suffer from a major mental illness, such as schizophrenia, bipolar disorder or major depression.

As clinicians looking for effective treatments, we also understand the great rehabilitative power that participation in the various creative arts can have for those with mental illnesses.

In this issue, we are proud to highlight two aspects of the arts in which members of our community—both consumers and caregivers—have active roles. Contributing writer Sylvia S. Villarreal delves into the writer's mind, or more correctly, the minds of writers, to discover the many ways in which the written word reveals and heals.

***Progress** is pleased, too, to feature the contribution of the plastic arts to mental health, in the form of paintings by Houston-area neurobiologist David Sweatt, PhD. Sweatt is one of only a few clinicians selected as a NARSAD Artworks contributor. NARSAD Artworks, the organization which has provided **Progress** with so many wonderful works of art, it is a program of the National Alliance for Research of Schizophrenia and Depression (NARSAD), the unified research program of the National Alliance for the Mentally Ill, the National Mental Health Association and the National Depressive and Manic Depressive Association. Each year, NARSAD gives significant grants to researchers working in the various fields of mental health, of which Sweatt has also been a recipient for his research. We are proud that a Houstonian and a member of the UTHCPC Community Advisory Board, Carolyn Hamilton (who was featured in the Spring 2002 **Progress**) is a member of the NARSAD's national board.*

The stories which lead off this issue address one of our community's most vulnerable—and often overlooked—populations: foster children. We hope you will read these pieces to understand what really happens to children who become part of "the system," and what is being done to improve their mental healthcare.

As you may know, this is a story close to my heart. One of my mandates, as a community mental health administrator, is to see that increased and quality services are provided for our children and youth. This includes prevention, assessment and early intervention, as well as treatment. There is no doubt that when a mental health problem in a child is found and treated in a timely fashion, there is every hope for that child to be able to go on to lead a productive life. There is also no doubt that these kinds of program mean a significant financial commitment from our community.

But when there is no such intervention and no timely treatment . . . well, you all know what happens then . . . and you know how high a price we all eventually will pay.

*As always, we hope this issue of **Progress** will provide enjoyment and enlightenment.*

Sincerely,

Lois J. Moore, BSN, MEd, LHD, FACHE
Chief Administrator



Contents

Addressing Stigma

An editorial by Robert W. Guynn 1

In the Arms of Destiny

Foster Children, Foster Care 2

Fostering Hope

Trying to make "The System" Work 3

Wednesday's Children:

Recognizing and treating the special needs of foster children 5

In Our Own Words:

Enlisting writing in the service of healing 7
A local writer explores the power of words on paper

Exposed Nerve

Neuroscientist David Sweatt paints what he knows yet cannot see 11

Setting the Precept for Care 27

SPECIAL PULL-OUT AND SAVE SECTION:



"Elephant Baby and Papa," painted clay, Luisa, age 6 and Bryan, age 7. Courtesy of ALDEA Children's Art Therapy Program.

ALDEA (the Spanish word for village) Children and Family Services serves the mental health needs of children and families in Napa and Solano counties in California. To support the program, ALDEA features its children's artwork on engagement and wall calendars which are available by contacting ALDEA Children's Art Therapy, P.O. Box 390, Napa, CA 94559, (707) 224-8299. Progress thanks ALDEA, Inc. for allowing the use of its artwork throughout this issue: pages 15, 18, 19, 28 and the back cover.



On the cover: "Flying Free" by Susan Miyamoto. Used with the permission of NARSAD Artworks, a non-profit organization under the auspices of the 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 showcases the museum-quality talent of artists who share the common bond of mental illness. For more information, write NARSAD Artworks, P.O. Box 941, La Habra, CA 90633-0941 or call 1-800-607-2599.

Progress is grateful to NARSAD for allowing the use of Miyamoto's work.

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

Robert W. Guynn, MD
Executive Director

Lois J. Moore, BSN, MEd, LHD, FACHE
Chief Administrator

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

Geri Konigsberg, Director
Public Information and Education

Progress is published by the Public Information and Education Department of the Harris County Psychiatric Center (UTHCPC), which is operated and staff by the University of Texas Health Science Center at Houston

Fran Dressman, Editor
Alycia Matthews, Graphic Design
Sylvia Sullivan Villarreal, Contributing Writer
Nandita Sahni, Intern

For reprint rights and permissions, call 713-741-7878

UTHCPC Volunteer Services is dedicated to the support and encouragement of HCPC patients through volunteer activities, financial gifts and community contributions. To volunteer or make a financial contribution, contact Carol Rone at 713-741-8692.





EDITORIAL

Addressing Stigma

by Robert W. Guynn, MD, Executive Director

A senior legislator visited UTHCPC; statistics were presented as well as an explanation of our therapeutic interventions and goals. There was a tour of the hospital, and we offered an opportunity for questions. At the end of the tour, as we were moving towards the door, the legislator turned and said, "Y'know, I don't know what to make of all this mental illness business. Sometimes I think it is just laziness!"

Stigma against the mentally ill is commonly decried—but only by the sufferers, their family and friends and the treatment community. If behavior is any indication, no one else really cares.

Typically, "education" is touted as the way to address stigma. The theory is that the newly "educated" will somehow now be compelled to behave differently. In this case they will develop a new-found empathy for the suffering that mental illness brings and will "do the right thing." Although there is a certain logic to that approach, it really doesn't seem to be all that effective.

Smoking is arguably our greatest controllable health hazard. The scientific evidence is compelling—even overwhelming—to the reasonable person. Yet, some very bright people, including some physicians, continue to smoke. Admittedly, the rate of smoking has declined, but consider the

sheer volume and magnitude of the educational activities that has had to be mounted, not to mention the media coverage, to make even a modest impact on behavior.

Consider, also, the multi-leveled educational campaign that has been mounted about the transmission of HIV in the United States. Yet, over the last twenty years the rate of infection with the virus has not shown a dramatic change in the United States and is accelerating in other parts of the world.

Education, therefore, would seem to be a rather weak tool for changing behavior of the public at large. It is too easy to dismiss data presented by interest groups as either very biased and self-serving or irrelevant to oneself.

To have an impact, one needs to do more than educate: one has to make the plight of the mentally ill relevant to

the self interests of the community at large. The cancer field has been successful in this tactic. It wasn't that long ago that cancer also carried a significant stigma for both the individual and the family. Cancer wasn't discussed in polite circles. One didn't admit that either a family member or oneself was a victim.

As long as cancer victims were one of "them," the stigma persisted. When cancer began being seen as a universal vulnerability, changes of attitude were possible. It is all about enlightened self interest, after all, not about "doing the right thing."

For a legislator to be re-elected he/she has to be sensitive to the important issues of his/her (contributing and voting) constituents. If the public at large saw mental health as a major, compelling issue and donated to the legislative candidates who could embrace that cause, we would be much further along in stamping out stigma and obtaining appropriate funding for treatment. As long as the public at large doesn't care, there will be no changes. Don't preach to the choir, disturb the public—shake it from its complacency. Don't just educate.

Support the legislators who do care. Go after the constituents of the rest. Unless the public at large can be converted to the cause, there will be little progress. ★



Dr. Guynn is Executive Director of UTHCPC, Chairman of the Department of Psychiatry and Behavioral Sciences in the UT Health Science Center at Houston (UTHSCH) Medical School and Director of the UTHSCH Mental Sciences Institute.

Destiny's Wards

Foster children. Wards of the state. In protective custody. Their numbers are growing. The family problems they face are more serious. Their futures—without intervention—are very uncertain.

“All of us, including caregivers, idealize and want the best for these children,” says UT Houston child psychiatrist Sonja Randle, MD. She’s talking about the estimated 520,000 children in the U.S. who are in foster care; for Texas, the total is over 13,000. In Region 6 of the Texas Department of Human Services (TDHS), which includes Harris and 12 surrounding counties, over 4,700 children are in foster care. In Harris County alone, there were about 3,400 children in custody each month for 2000, as of the end of May 2002, that number was 3,978.

According to the Texas Department of Protective and Regulatory Services (PRS), there has been a steady, if relatively small increase in the number of children in foster care during the past decade; the 2001 total for Harris County represented an 11 percent increase over 2000.

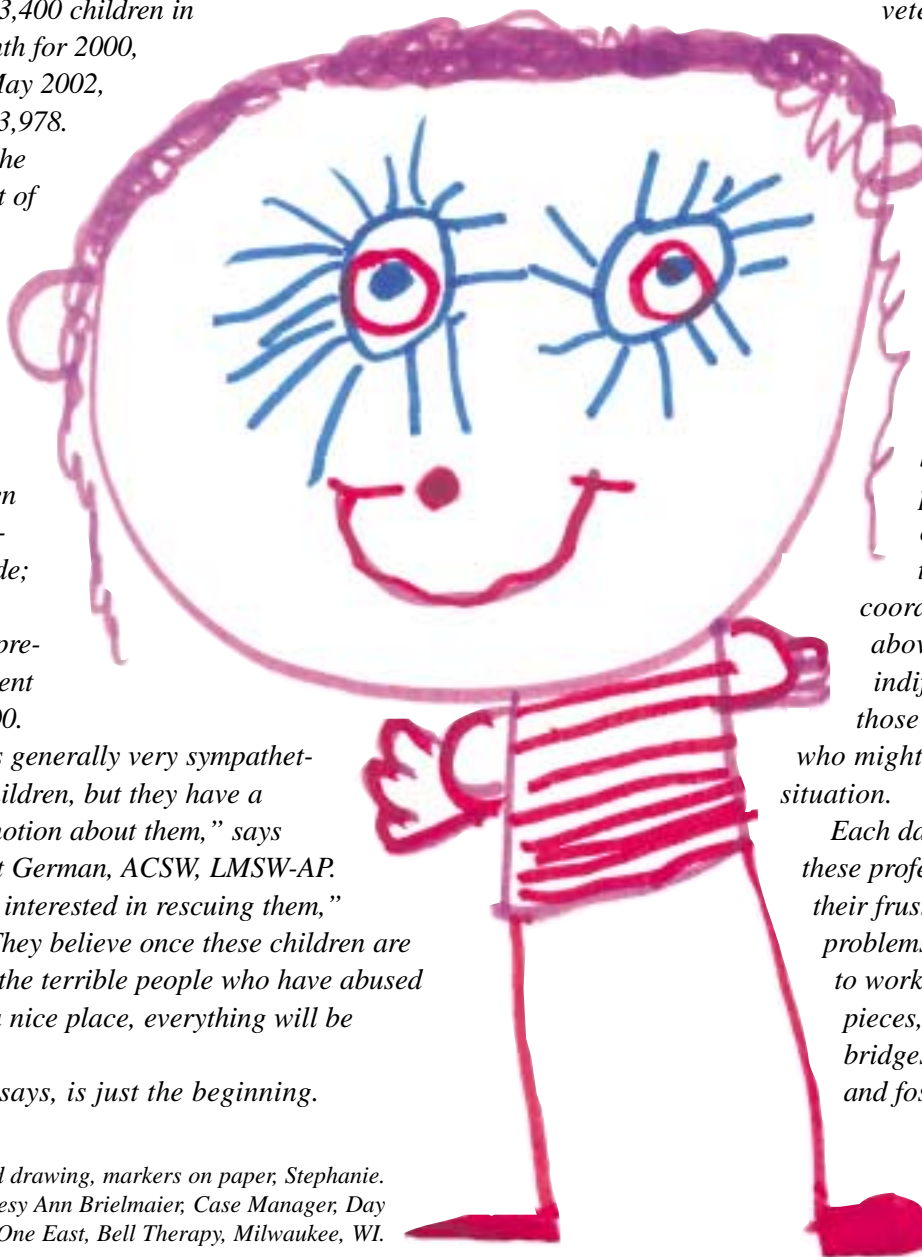
“The public is generally very sympathetic towards our children, but they have a rather romantic notion about them,” says social worker Pat German, ACSW, LMSW-AP. “People are very interested in rescuing them,” German adds. “They believe once these children are taken away from the terrible people who have abused them and put in a nice place, everything will be okay.”

But that, she says, is just the beginning.

“The hope,” Randle says, “is that the child will be removed from the home temporarily and placed in foster care only as long as it takes the family of origin to resolve matters. We don’t want to think about the worst case scenarios, when the state has to terminate parental rights, the child becomes a ward of the state and remains in foster care until he or she is 18 or finishes school.”

Randall and German are veterans of working with this most vulnerable of populations. They are always aware of the serious impediments placed in the way of putting lives back on track: poor funding, complex systems, lack of coordination and, above all, the indifference of those in society who might change the situation.

Each day, however, these professionals ignore their frustrations and problems, and get back to work picking up pieces, building bridges, taking care and fostering hope. ★



Untitled drawing, markers on paper, Stephanie.
Courtesy Ann Brielmaier, Case Manager, Day
One East, Bell Therapy, Milwaukee, WI.





Fostering Hope

Trying to make "The System" Work

In 1997, the American Academy of Child and Adolescent Psychiatry (AACAP) concluded that "[overall] the systems affecting children (child welfare, education, health, mental health and juvenile justice) often do not work together. Five years later, this is still the case. Now, as then, our society's leadership institutions, set "a low priority on children's well-being."

Child psychiatrist Sonja Randle, MD, is all too aware that mental health services for all children are woefully lacking. She is especially concerned, however, for one extremely vulnerable population—children in foster care. For them, she says there must be quality, consistent mental healthcare. Randle is an assistant professor in the Department of Psychiatry and Behavioral Sciences at UT Houston and Director of the Child/Adolescent Outpatient Services at UT Mental Sciences Institute.

If nurture, protection, trust and security are the requirements for psychologically healthy development, the inconsistencies that abused or neglected children have already experienced puts them at great risk for a Pandora's box of psychiatric problems.

Youth in foster care have been identified with serious mental illnesses, developmental delays and learning disabilities, psychological maladjustments and behavioral disorders. (See related story.)

Foster children may have excessive guilt or fear and low self esteem. They may be unable to develop friendships or build any kind of meaningful relationships. They often exhibit high rates of aggressive, delinquent and withdrawn behavior and substance abuse.

These illnesses, disorders and



Nicole Dorsey, PhD, and Pat German, ACSW, LMSW-AP, of Harris County Children's Protective Services Children's Crisis Care Center.

unhealthy behaviors can stem from the abuse and neglect itself, poor relationships with their parents, the family or community environment or from predispositions inherited from parents who may also suffer from mental illness.

"We forget," Randle says, "that mental illness can be a chronic disease. These are not conditions children can 'grow out of'. If not properly treated, children will continue to suffer from these or related illnesses and disturbances into adulthood and, as a consequence, society will pay a high price."

Unfortunately, many psychological problems are either manifested or made worse by a child's being placed in the foster care system. "Children come into foster care traumatized twice," says social worker Pat German, ACSW, LMSW-ACP, of Harris County Children's Protective Services (HCCPS). She acknowledges that

"the cost of separation is often high."

According to the American Pediatric Association, there is a significant association between the rates of mental health problems in foster children and the ages at which they enter care, the number of placements and whether or not they are placed with non-relatives or relatives. There is also a strong genetic connection: in one study of out-of-home care, 75 percent of the children had family histories of mental illness or drug/alcohol abuse.

Randle worries, too, that child abuse and neglect are underreported, and that many children remain victims—most often from neglect—because allegations of abuse are poorly investigated by overworked caseworkers. "If abuse or neglect are not proven by physical evidence, a dangerous environment or an irresponsible parent, these children don't get

Continued

Fostering Hope

Continued

taken out of the home," she says.

The AACAP study noted that "[m]ost foster children carry a permanent emotional scar from their separations" and asserted that "[f]oster children are a huge reservoir of unmet pediatric and psychiatric needs."

In its latest policy statement on the mental healthcare of foster children, the AACAP recommends an initial mental health and substance abuse screening within 24 hours of placement in foster care, which assesses the "internalized and externalized levels of distress in the child regarding the separation," and, once stabilized, a comprehensive mental health and substance use assessment for both children and parents.

PRS/HCCPS

There are no good answers to the dilemma of foster children. There is no "perfect" way to handle the removal of a child from his home and family; to ameliorate the various bio-psycho-social problems that he faces. It is no surprise then, that given the nature of its work, the foster care system faces some incredible difficulties.

For 28 years, German has dedicated her career to helping children and families navigate this system, working at different times for both the Texas Department of Protective and Regulatory Services (PRS) and Harris County Children's Protective Services (HCCPS).

She now heads a one-of-a-kind program for HCCPS, the Children's Crisis Care Center (4Cs), designed to improve the process of foster care placement, provide mental health and other services more quickly and both improve and expedite the decisions about a child's final, permanent placement. PRS is the Texas state agency charged with the protection of

vulnerable populations: children and adults with special needs. It licenses day care centers, and other facilities where such persons may be cared for and also investigates any reports of abuse or neglect and takes appropriate action.

In 2000, PRS in Harris County completed 15,544 family investigations involving 24,961 alleged victims; nearly 30 percent of these were confirmed cases of abuse or neglect.

PRS can remove children from their home if its investigation finds that they have suffered physical abuse or neglect or they would be in danger if they remained in the home. PRS takes children into the protective custody of the State of Texas until they can be safely reunited with their family or adopted. If the PRS investigation is inconclusive or finds the family in crisis, they may allow the children to remain in the home while they provide direct services to both the children and the parents, allowing the family unit to remain intact.

Children taken into PRS protective custody are often placed in a licensed foster care setting while PRS investigates the abuse/neglect situation. Foster, or substitute care, includes a variety of settings: emergency shelters, relatives' homes, single family foster homes, group foster family homes, therapeutic foster care (for children with serious emotional or behavioral problems), habilitative homes (for children with mental retardation or delayed development) and primary medical needs homes.

All children in protective custody are assigned to a PRS caseworker who is responsible for determining foster care placement and reviewing the child's status throughout his or her foster care.

The average number of cases assigned to each caseworker by PRS throughout Region 6 (Harris and 12 surrounding counties) is 30, a number that, despite getting smaller, is still well over the number recommended by the Child

Welfare League of America.

Children's Protective Services (HCCPS) is a separate agency and not part of PRS. HCCPS was created by Harris County Commissioner's Court to work in concert with, and provide ancillary and support services to, PRS activities in Harris County. HCCPS has no legal jurisdiction over children in foster care.*

The ability of agencies like PRS and CPS to keep up with an increasing number of foster children has been seriously compromised, not just in Texas, but around the country.

A 1980 Public Law required states to make reasonable efforts to keep children from out-of-home care, and mandated timely permanent placement for children in the foster care system or return to their families. While the average length of time for a child in Harris County to remain in protective custody until permanent placement has declined from 24.4 months in 1998 to 18.5 months for 2001, many children remain in the system for long periods, moving from home to home.

The 4Cs

Like most states, Texas adopted a law requiring PRS to find a permanent placement for any child within 12 months after his removal from home and placement in protective custody, allowing one six-month extension.

See "Fostering Hope" on page 15

* *Children suffering sexual abuse are served by PRS and, in Harris County, by the Children's Assessment Center, a privately managed social service agency funded by Harris County, which provides specialized assessments, investigations and treatment services to children and families. See **Progress**, Spring 2001.*





Monday's Child Tuesday's Child Wednesday's Children: Thursday's Child Friday's Child Saturday's Child Sunday's Child



Recognizing and treating the special needs of foster children

(Editor's Note: Please see the special, pull-out section, "Children's Mental Health Problems," for more on specific disorders.)

Scars, bruises, burns, sores. These are the signs of child abuse. Usually, they are ample evidence for the state's protective services agency to remove a child from the environment where such things have occurred.

But what about the scars that can't be seen? How are they treated? These are the scars that concern child and adolescent psychiatrist, Sonja Randle, MD, Director of the Child and Adolescent Outpatient Services at UT Houston's Mental Sciences Institute, where she works with several foster care agencies.

As a veteran of 12 years in the public mental healthcare system—including work with foster children—Randle knows that the psychological scars of trauma are not as easy to mend as the physical scars. Not only are they unseen but they are more complex, involving a child's biological, psychological and social status. "Too often," she says, "the physical disability gets immediate attention, but the psychological traumas may or may not get treated."

Five years ago, the American Academy of Child and Adolescent

Psychiatry (AACAP) observed that children entering the foster care system were different from previous foster child populations.

Unlike foster children of earlier eras, many of whom were placed in foster care by their families because the parents were unable to provide or care for them, most of today's foster children have been taken from their homes involuntarily.

Today's foster children, the AACAP says, have been "severely traumatized, often witnessing or experiencing homelessness, substance use, prostitution, domestic violence and homicide."

In addition, the U.S. Children's Bureau reports that there has been a 33 percent increase in the number of children placed in foster care because their parents are in prison or jail.

TRENDS

In a recently released policy statement, the AACAP along with the Child Welfare League of America reported that an estimated 85 percent of foster children in the U.S. have an emotional disorder and/or a substance abuse problem. Earlier studies have reported developmental and emotional problems in 80

percent (and cognitive) problems affecting about one-third) of foster children aged one to five and 52 percent of school-age children.

Nationally, the maltreatments cited most often—over 60 percent—as the reasons for removal of a child from his/her home were neglect, medical neglect or deprivation. Physical abuse accounted for 30 percent of removals and sexual abuse for 16 percent. Almost two-thirds of the perpetrators of the abuse were the children's parents.

In Harris County, neglectful supervision and physical abuse each account for about one-third of the maltreatment found in completed investigations, with physical neglect accounting for 11 percent and sexual abuse for 14 percent.

Another disturbing trend is that children are entering the foster care system at younger and younger ages. A University of Iowa study found that the number of children under five years old in foster care was double the number of children ages five through 17 in foster care, and that young children remain in foster care longer than older children, with infants remaining significantly longer than other ages.

The majority of foster children—over 60 percent—are now from

Continued

Wednesday's Children

Continued

minority populations. These same minority populations make up only 19 percent of the general population. Minority adolescents who might be in foster care are more likely to be in jails or psychiatric facilities.

FEELING REJECTED, BAD AND ALONE

Abused children often believe that they are 'throwaways' about whom no one cares says the AACAP. Many times, unfortunately, these children are right about their situation and entering foster care only compounds this. They must contend with why they were given away by, or taken from, their biological parents. This is a severe blow to self-esteem and can lead to depression and/or suicide.

"Kids perceive the situation as if they did something wrong," says Randle. "They have a lot of guilt and believe that if they had been 'good enough' or behaved better, the situation wouldn't exist. And because so many of them are placed at a young age, they internalize the guilt."

Sometimes, experts like Randle say, children will even say that their biological parents were right to abuse or neglect them—they are so anxious to return to their families and will claim they are bad while their parents are good.

Older children, usually between ages of 10 to 12, have the reasoning capacity to understand that they didn't cause the problem. But that depends upon the amount of information and psychological treatment they have had and their cognitive development. "It's not enough just to do play therapy with these children; there needs to be a relationship between therapist and child where they can talk about healing," she says. Randle believes all children placed in foster care need psycho-

logical and psychiatric evaluations and an ongoing relationship with a mental healthcare provider. (See related story.)



Sonja Randle, MD, UTHCPC attending physician and Director, Child/Adolescent Outpatient Service, UT Houston School of Medicine Department of Psychiatry and Behavioral Sciences.

MENTAL DISORDERS

Many foster children exhibit developmental delays, meaning they do not function at the intellectual or psychological level appropriate for children their age. According to social worker Pat German, ACSW, LMSW-AP, 50 to 60 percent of the young children five and under assessed in her program are developmentally delayed in some way: social skills, language, motor ability. German heads the Children's Crisis Care Center (4Cs) of Harris County Children's Protective Services (HCCPS).

Neglect has a major negative impact on attachment and cognitive and physical development and fosters antisocial behavior. For example, when a child has no regular supportive communication with an

adult, his language and vocabulary skills are stunted.

As more children are entering the foster care system at younger ages, a time when brain development is most active, the need for psychiatric intervention becomes even more crucial says the AACAP. The parts of the brain that regulate personality traits, learning processes, emotions and coping are in place by the age of four. Damage to nerve connections and neurotransmitters caused by the effects of a negative environment (fighting, abuse, neglect) are responsible for delays in a child's cognitive or learning ability and emotional stability.

And because children's brains do not complete development until the late teen years, the behavioral and psychological damage may not be immediately evident, but may show up in later problems that can seriously hinder them.

Randle offers some hope, however. "Because they are more malleable, it can be somewhat easier for younger children to adapt to life in a foster care situation. If you have a consistent parental figure who can get a structured system in place," she says, "the child will respond to that and be able progress in his emotional development."

ADJUSTMENT DISORDER

"The largest percentage of the children that I see have an adjustment disorder," says Randle, "with mixed emotional features and disturbance of conduct. That basically means that there are going to be different circumstances in their environment that may trigger them to act out."

An adjustment disorder, as defined by the psychiatric diagnostic system, is developed in response to a major life event or change. Usually occurring within three months of the event, its symptoms include extreme stress and anxiety and significant impairment in a child's social and academic life.

A child's age and developmental

See "Wednesday's Children" on page 21





In Our Own Words

Enlisting writing in the service of healing.

By Sylvia S. Villarreal

*I was angry with my friend:
I told my wrath, my wrath did end.
I was angry with my foe:
I told it not, my wrath did grow.*

From "A Poison Tree" by William Blake



Chants and songs, storytelling and poetry have always had a role in healing humans.

Prophets and medicine men, shamans and curanderas have all intuitively recognized and harnessed the rhythm, texture and power of words in moving us from one mental state to another.

The Greeks, striving for balance in life, honored the constant interplay of reason and emotion. Ancient Greek

mythology positions Apollo, god of light, reason, and poetry as father to Asclepius, the god of healing, binding the two together. Aristotle (384-322 BC) espoused the concepts of "Psychogogia—the leading out of the soul through the thrust and power of art" as well as "Katharsis—a purgation of the emotions," inviting the exploration of the arts as a source of hope and healing.

Traditions in literature uphold the continuing power of the narrative. While the Greeks had Odysseus making his mythic journey, the twenty-first century finds storytellers like Garrison Keillor spinning his tales of Lake Wobegone. And Saint Augustine's *Confessions* have given way to more modern tales of personal struggle. *An Unquiet Mind* by Dr. Kay Redfield Jamison offers us a compelling, unflinching account of a person who has been both provider and consumer in the healing relationship.

The power of our words to convey our deepest griefs, our confusion and anger, our surprising insights, and our undiluted joys, lives most vividly in personal journals and diaries, some written for public consumption, and others discovered and published after the writer's death. The poignancy of Ann Frank's *Diary of a Young Girl* resonates with adolescents and adults to this day, and writer May Sarton offers us an up close look at one woman's deliberate journey into her deepest self in her, *Journal of Solitude*.

Bibliotherapy

Employing written materials, both established literature and original writing, in a therapeutic context is a discipline known as bibliotherapy. In reading bibliotherapy, patients are assigned specific readings chosen by a therapist to serve as a catalyst and guide in the discussion and treatment of particular issues.

In interactive bibliotherapy however, the emphasis shifts to the original compositions of the client. In this process, it is critical for the client's writings to be unencumbered by issues of literary or technical merit:

Continued

In Our Own Words

Continued

the value and significance of the activity lies in the meaning of its author. They are to be accepted, reviewed and discussed based on their validity for the writer, rather than any aesthetic concerns. Simply stated, in creative writing in a therapeutic setting, patients must be free to express any and all feelings in words of their own choosing. Grammar, spelling, handwriting and composition all take a backseat to the free flow of thoughts and emotions.

Interactive bibliotherapy may take a number of forms. Journaling, poetry, songs, personal essays and storytelling are all time-honored vehicles for self-expression. In fact, one of the original poetry therapy programs in this country has been in operation at Pennsylvania Hospital for over 150 years, where in 1843 it began to publish a newsletter, *Illuminator*. The entire publication, including all the poetry, was written, edited and hand copied by patients who were all diagnosed with mental illnesses.

Since that time, the use of creative writing in mental health settings continues to evolve. In 1974, Arleen Hayes, O.S.B., established a formal bibliotherapy program at St. Elizabeth's Hospital in Washington, D.C., and her book, *Bibliotherapy: The Interactive Process*, offers guidance and techniques for mental health workers using writing exercises with patients. From one word poems—writing one word to describe a reaction to whatever material has been presented—to a group poem—where participants may have to exercise respect and patience that help build social skills—the exercises challenge patients to distill and express their inner experiences. Hayes points out that a group poem can also help patients who have difficulty expressing feeling responses in written form, those with limited writing skills or

even those who might be daunted by trying to construct a whole poem on their own.

For patients who find that structure constricts the process of self-reflection, unstructured writing might be the technique chosen by a therapist. This can range from free verse to any simple expression of feeling. Storytelling, using one's own written material to generate an oral presentation, autobiographical sketches and journaling are all rich with possibility in the therapeutic situation.

The American Psychological Association (APA) endorses creative writing as a technique for gaining personal insight and achieving therapeutic change. In fact, the use of writing as a therapeutic tool was the focus of an APA symposium in 1965, and it continues to be of interest to psychological researchers.

Historically, studies have found that daily writing aided patients in decreasing obsessive thinking, increasing their self-expression and encouraging orientation to reality. Studies also observed that clients released anger, identified problems and formed better relationships through writing.

In addition to the psychological improvements generated by writing therapy, intriguing new evidence is emerging that writing about psychological and physical traumas may have profound effects on physiology as well. Studies conducted in 1992 by UT Austin social psychologist James Pennebaker, PhD, examined the effect of the disclosure of traumatic events through writing on the functioning of the immune system. These studies produced a number of articles explaining how patients engaging in journaling and other writing exercises, which allowed them to process previously undisclosed traumatic events, had improved scores on measures of health status after completing the writing therapy. Even more recent studies by these same researchers have compared specific laboratory measures of

immune system functioning, such as levels of viral antibodies, and found significant positive differences in those who engaged in therapeutic writing about traumatic events versus those who had not done the writing.

One Clinician's Perspective

Dr. J. Ray Hays, PhD, JD, UTHCPC staff psychologist and professor of Psychiatry and Behavioral Sciences at UT-Houston Medical School, is well versed in the discipline and value of the written word. A forensic psychologist, Hays has written extensively on both mental health and legal issues involving psychiatric patients, as well as published in the creative writing arena. He confesses to being a “sporadic journaler” in his own life but has a real appreciation for what the process of writing can bring to the therapeutic relationship.

Citing the long history of patient narratives and diaries written in the context of mental health, Hays explains the advantages of using the patient's own reflections in the therapy situation. “Sharing their journals allows opportunities for patients to see and understand patterns, to develop awareness about the sequence in which events happen, and the chance to begin to label their own experiences,” he says.

Although not widely used by therapists, Hays feels that writing things out is good practice, particularly for those patients who are not self-aware. “If in writing things down, patients become aware that their lives contain more bad things than good, then the question becomes ‘How can I change this?’ Some people don't understand that they have choices, that they can behave in a variety of ways rather than just having the same reaction. This inability to be flexible is the essence of neurosis. The distance

See “In Our Own Words” on page 9





In Our Own Words

Continued from page 8

someone achieves by writing about these issues can lend a new perspective—as patterns emerge people can work on changing them.”

For journals and diaries to work in therapeutic ways, Hays stresses, they need the process of reflection. “Just chronicling events in the absence of feedback would be like an archer shooting at his target while wearing a blindfold. His capacity for improvement is nil without some knowledge of how well or poorly he is hitting the target.”

Similarly, reinforcing positive behaviors and outcomes that are documented in patient journals and diaries is vital. Hays illustrates with a story of some friends who raised a large family. The father was a successful businessman, while the mother, who was highly educated, elected to be a full time homemaker. Each day as the husband returned from work, he would greet his wife with the same request, “Tell me something good that happened today.” This simple practice gave both the opportunity to rise above the challenges of the day and reflect on deepening their awareness of the richness of their family life. Hays feels sure their now-adult children continue to benefit from this simple but highly significant activity. “The process of reflection allows one to not just experience the world, but to step back from it and develop new perspectives.”

When asked if journaling is appropriate for people who may be experiencing a psychotic state, Hays is thoughtful. “If people do journal in this state, it may be helpful for them to see it later when they are no longer psychotic. In a sense they have a document of their own journey through psychosis—both the evidence of their distorted thoughts and emotions and the proof that they are now functioning more effectively.”

He finds a patient narrative published in 1976 particularly compelling and a “fascinating read”: *Insanity Inside and Out* by Kenneth Donaldson. Diagnosed as a paranoid schizophrenic, Donaldson was committed by his family to a Florida state psychiatric facility where he remained for seventeen years. Professing to being a Christian Scientist, he refused any psychotropic medications on religious grounds. He was treated with “milieu therapy” and the book is his chronicle of daily life at the institution.

Keeping journals and diaries also supports another principle dear to behavior therapists.

“One of the best way to change behaviors is to start counting them,” says Hays. “For example a recovering substance abuser may have 20 cravings for heroin that he writes down. Using this as a baseline, he can keep track of events that trigger cravings and how to handle them. He can then note and chart his progress in reducing the cravings and engaging in more desirable behaviors.”

Cognitive behavior therapy (CBT) also employs written exercises to help patients formulate rational responses to their own irrational thoughts. For example, a patient may be asked to keep a record of inaccurate and damaging internal self-talk, then must answer each negative statement with a rational and positive response. Counting and recording and then answering these thoughts through writing becomes the vehicle for moving from a constant stream of tense, critical thinking to a more relaxed, self-affirming way of viewing the world.

Hays also feels journaling can be of real value in helping people handle powerful emotions like anger and grief. “Anger management programs are geared to help you track down what triggers your anger. Writing down those triggers and reflecting on them in therapy can help you understand the roots of that anger, and then you can develop new more appropri-

ate ways of responding.”

In a similar fashion, grief is also an emotion that can overwhelm in its intensity. “Part of grief is reflecting on what you had with that person and cherishing those memories until you can move to a different level,” Hays says. While he cautions against “wallowing” in grief, journaling about these feelings can be quite therapeutic.

As an example, Hays tells of a diary his late father kept while a patient at a tuberculosis sanitarium during the 1950s. Describing his dad as a man who absolutely thrived on hard work—“he could outwork me up until the last few years of his life”—Hays says his father chronicled his daily life at the facility as a way of coping with his confinement. In particular, he remembers a passage his dad wrote about a fellow patient he befriended who died. His father was not one to display emotions, says Hays, but he did write about his feelings upon the death of this man. This small window into his father’s emotional life is still deeply cherished by family members.

When it comes to how the journaling is done—using a computer versus a bound book—Hays says that it is the prerogative of the journaler and should be something that suits him or her. “I personally enjoy the feeling of pen flowing across the page, but people need to be comfortable with their own materials.” Children, he points out, may not be as verbal as adults so giving them materials with which to draw or paint or somehow get those feelings out on paper can give therapists a medium to get at issues, and then they can then help the children label and interpret their experiences.

Whether journaling in therapy or on one’s own, Hays feels that the “meditative aspect” of writing about and then reflecting on our experiences confers a benefit. “We are all living in a very competitive world. Just keeping track of your successes and failures can be very helpful.”

Continued



UTHCPC
psychologist
J. Ray Hays,
PhD, JD.

written, as are stories about personal experiences. Letters to family members and loved ones are popular; and they contain a variety of emotions. Some people are struggling with anger issues, while others may be asking for forgiveness or for help. At times people can become emotional; overall it seems to be quite productive,” Miller observes. “It seems to help create a more open atmosphere within the group, and helps participants build social skills in both sharing and listening to others.”

For those who may have difficulty getting started, Miller provides “journal cards” as an incentive. These cards might contain a phrase or picture that might stimulate a thought or memory, which in turn leads to a flow of ideas.

Miller herself has used a journal “off and on” in her life to help deal with certain events. She cites the time of her father’s illness and death as one of those times. Journaling about this passage helped her reconcile the physical loss of her father, while reaffirming that his spirit would remain with her always. She has also found solace in inspirational writings and art.

Though she has only been at it a few months, Miller would love to see the program include more art therapy as well. “Not everybody has strong verbal skills,” she points out, “some people are much more comfortable with drawing and using color. These can also become part of the larger context of keeping a journal.”

Journaling and Therapy

“I have no more made my book than my book made me”
Montaigne

Psychologist Alfred Adler, who created the concept of the “inferiority complex,” believed that uncovering, inspecting and relating core beliefs to both feelings and actions in our lives

See “In Our Own Words” on page 25

In Our Own Words

Continued

Reading the journals of others like Susanna Kaysen’s *Girl Interrupted*, Hays believes, can also be enlightening for a number of reasons. “These accounts can offer hope to people, they can help people understand that they are not as alone as they may feel, that others have survived some very difficult times and come through them intact.”

Writing It Out

Lillian Miller has been nursing a good idea in her work with patients at UTHCPC. A Level II staff nurse, Miller works weekends on a general adult unit. A few months ago, she began noticing that on weekends patients had more time outside formal process groups, and she decided to try something a little different. Miller assembled a variety of materials including different colors and textures of paper, colored markers, crayons,

metallic markers, stickers and the like. She then invited patients to choose from these materials and create whatever they wished, something written, a drawing or any combination of the two.

Miller adheres to the principles underlying interactive bibliotherapy. “The things people create are absolutely private,” she says. “They have the option to express exactly what they want and decide themselves whether or not they wish to share it with the group. They can share anything they create with their doctors or therapists, in fact these things can go into their patient chart if they so desire.

“Nobody,” reiterates Miller, “is forced to share with anybody else; it is totally up to the discretion of the patient. Some people choose to write, some draw, some may use stickers and other ways to convey the feelings they wish to communicate.”

She says the general themes that emerge in such an exercise cover a broad spectrum. “Often we see religious themes. Prayers are frequently



Exposed Nerve

As a neuroscientist, David Sweatt, PhD, works every-day with real things he cannot see. As an artist, Sweatt uses abstract forms to convey the complexity of their reality.

Through his painting, Sweatt tries to “describe” the functioning of the molecules and neural circuits in the human brain. “Modern science is really an almost purely abstract endeavor,” he says. “Things we can see with our naked eye have already been revealed. My colleagues and I work with phenomena of the nervous system that are intrinsically abstract. But they are very real, reproducible phenomena and I try to express those phenomena through art.

“All our creativity, emotions, perceptions, memories and beliefs arise from the coordinated action of the nerve cells that make up our central nervous system,” Sweatt says. “My artwork is a way to communicate the complexities of the molecules and neural circuits that underlie our behavior.”

Sweatt has gotten attention for both his scientific and his artistic expertise. In addition to post-doctoral work with Nobel Laureate Eric Kandel, his research has been recognized with a number of awards, including an Independent Investigator Award from NARSAD (National Alliance for Research on Schizophrenia and Depression), which he received four years ago—just about the time he began to paint.

In January 2002, Sweatt’s artwork was featured in an NARSAD Artworks exhibition held in New York City. Sweatt may be the only neuroscientist whose works are represented by NARSAD.

The fundamental work of Sweatt’s lab at Baylor College of Medicine, where he has joint appointments in both the Division of Neuroscience and the Department of Molecular Physiology and Biophysics, is to study the molecular mechanisms for learning and memory. “We are interested in how molecules are involved in the process of learning and memory; how information is stored in the nervous system,” he says. “We use a variety of techniques to understand the enzymes and proteins involved in memory formation.”

Sweatt’s NARSAD grant supported some work related to this, specifically the regulation of gene transcription factors, molecules involved in learning and memory. “We are studying gene expression (the process by which a gene’s coded information is converted into the structures present and operating in the cell) in order to understand how the long-lasting changes in the central nervous system are made, and the implication of these for schizophrenia and depression,” he says. Recently, an Assistant Professor in his laboratory, Laura Schrader, PhD, also received a NARSAD Young Investigator Award.

Sweatt began painting as something he and his wife, Kim Strifert, could do together for fun. “I had been taking classes at the Glassell School of the Museum of Fine Arts, Houston.

About a year and a half after I began,” he said, “I took a class called ‘Focus on Realism’ from Patrick Palmer. Things began to click. I was interested in painting real things; I wanted to portray the intricate complexity of the nervous system, but I wanted to express them in a way that captures their abstract attributes. I took Patrick’s technical approach to portrait painting and applied it to my paintings of real objects that were abstracted.”

Sweatt contacted NARSAD Artworks’ director Hal Hollister after finding out about it by accident on the NARSAD website; at the exhibition in January, Hollister purchased one of Sweatt’s paintings. Both and Strifert have also exhibited their work locally.

Despite his artistic talent, scientific research is Sweatt’s passion. “On my way to finishing my doctorate in pharmacology, I realized that I was going to spend my life as a research scientist. So, I decided that I should choose the most interesting thing in the whole world to make my life’s work. For me it was learning and memory.”

Because his research is so narrowly focused and basic, Sweatt had never really been involved with the larger issues of mental illness and brain disorders, and never personally. Then five years ago, his mother was diagnosed with Alzheimer’s Disease. “It is very ironic,” he says, “because my specialty is memory. Because of her, I added an Alzheimer’s project to my research. Now I see my work as not just an intellectual pursuit, but as an opportunity to improve the human condition.” ★

“Artists and scientists have in common the goal of presenting a valid and novel interpretation of their observations in nature. My paintings deal with the contemporary scientific study of nervous system function from the anatomical parts we can see to the submolecular space we cannot see.”

“These paintings are from a series I did of nervous system-related objects and functions, ranging from the most visual all the way down to the atomic level, from the molecular to the neuronal and synaptic structures to parts of the atoms themselves.”

David Sweatt



Fear Conditioning

“Like the Schaffer painting (on page 13), this is a representation of a structure of the brain we can see, the amygdala, part of the limbic system involved with fear. Actually, this symbolizes the role of the amygdala: neurons with long projections, hellish colors to symbolize its involvement in our fear response.”



Water-Atomic Resolution

“This is the last piece in my series, a water molecule. This is the base; everything we work with is in an aqueous environment. And even when you get down to the individual molecules in water, they are in constant motion. There is a lot of empty space and they shoot around continuously.”



Exposed Nerve

Continued from page 12



pkccat

“This stands for protein kinase c catalytic site, part of a single molecule. This site is involved in signal transduction: the change in its chemical structure changes the activities of molecules downstream from it. This molecule is involved in learning and memory and regulating the long-term changes in the nervous system. This painting is an attempt to capture the activity when the target fits into a cleft in the molecule, and is transformed by it. It is really a landscape; you can see the cave-like part of the molecule.”



Kv4.2 Potassium Channel

“Like the pkccat, this is a molecule that I’ve worked on for about five years. A potassium channel makes a hole in the cell membrane that an ion can go through. This is the potassium ion and the protein structure that creates the channel. Hundreds of amino acids go into making this. Even at the molecular level, there is great complexity and constant activity. Through my colors, I try to capture the dynamic activity of these molecules and how quickly things happen.”



Schaffer Collateral Synapses

(This painting is used as a background for this article)

“This is a painting 13 years in the making, because it is about what I have been researching during that time. It portrays the activity in the part of the brain called the hippocampus (the seahorse-shaped part of the brain’s limbic system, crucial in learning, memory and emotion), and the actual nerve cell interconnections I study: the Schaffer Collateral synapses of the hippocampus. With a high-powered microscope, you can see the cells and the synapses, and this represents the connections between the neurons and how the axons and dendrites (the sending and receiving parts of the nerve cells) connect in a very regular crosshatch fashion.”

See “Exposed Nerve” continued on page 14



Neuropil

“We are descending further into molecular brain matter. If you have a group of nerve cell bodies that are making connections with each other, the place where the synaptic connections take place is called a neuropil. This work conveys the motion and sense of fluidity within the neuropil, where all the information is being exchanged from one cell to the other.”



Fostering Hope

Continued from page 4

Even before the passage of this law in 1997, Harris County CPS had created a pilot program to address the effects of the trauma from such events on foster children. With implementation of the law, the pilot became the 4Cs, the only early assessment program of its kind in the state.

Every physically abused or neglected child taken into protective custody in Harris County is now required to have thorough psychological evaluations and assessments conducted by the 4Cs when they enter the foster care system. The 4Cs professionals assist the PRS caseworker by finding out as much as possible about the child and his family. They also assist in developing a permanency plan for each child, including suggesting appropriate foster care placements.

"Our promise is to get to know every child in foster care individually," says German, "to make sure he gets any special help—like mental healthcare—as early as possible, to make sure he doesn't get lost in the system and to determine in a timely fashion the most beneficial outcome for the individual."

One 4Cs team gathers all the information it can on the child or children involved. Child psychologists and clinical social workers conduct the psychological assessments. Children under five are given developmental assessments and developmental assessments for babies are conducted by the staff of the Department of Developmental Pediatrics of the UT Houston Medical School.

A second 4Cs group, the family program team, finds and meets with the birth parents. Through assessment measures, clinical interviews and a thorough family history they provide the PRS caseworker with a clear picture of how that family functions. German says

about 50 percent of the parents under investigation participate in the 4Cs program.

"Our social workers are adept at listening to and encouraging parents who are often angry and fearful to tell their story," says German. "Not only do they find out what makes this family dangerous to their child, they also try to find what strengths this family may have to build upon."

Armed with the findings of the child and family reports, the most innovative element of the 4Cs program occurs: the convening of the Permanency Planning Team (PPT). Because it takes an all-inclusive as well as expedient approach to finding and planning the best possible outcome—future—for that child, the 4Cs PPT has caused a vast improvement in the way foster children are initially handled when they come into foster care.

The first of many Team meetings occurs about 30 to 45 days after the child has been placed in protective custody. It brings together everyone and anyone who is important in the life of this child—PRS caseworkers, teachers, relatives, attorneys, foster and birth parents—and the child himself—to assess the impact of the separation on him, find out how he is doing in placement and determine if his special needs are being met. This group then develops a plan for services for the child and his parents.

In subsequent PPT meetings, the team uncovers what kind of progress is being made toward a permanent settlement for the child. They evaluate how well the parents are complying with the plan of services (drug rehabilitation, parenting classes, etc.) that PRS has mandated for them in order to regain custody. They discuss the various alternatives available for the child's permanent placement: whether or not he will return home, live with relatives or become available for

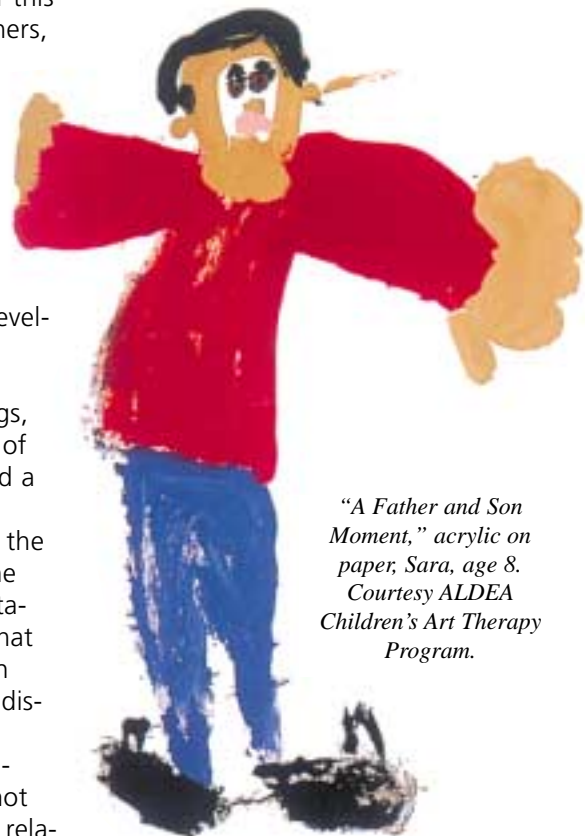
adoption.

"In most cases, we start with a plan that will return the child to his/her family," says German, "but not always. Sometimes, especially when there is a chronic problem, we begin with adoption. In earlier times, reunification was always the best solution, but now we are more careful and, while we hope that it can occur, if it doesn't work and the child's best interests are not served by returning to his family, we will advise termination of parental rights."

In addition to reuniting the child with his parents, permanent placement can be living with family members, referral to a special permanent substitute care facility (residential care), or adoption (after parental rights are terminated, either by the parents or protective services.)

"Reunification is the ideal," adds Randle, "but that depends upon the parents' willingness and ability to seek treatment. It may be better for the child not to return

Continued



*"A Father and Son Moment," acrylic on paper, Sara, age 8.
Courtesy ALDEA Children's Art Therapy Program.*

Fostering Hope

Continued

to a toxic environment with a parent who has exhibited such antisocial behavior and cannot provide love and consistency.”

Stability

Not only does the 4Cs help PRS evaluate a permanent placement for the child within the deadline established, it also keeps children from getting lost in the system.

A national study reported that about 23 percent of children in foster care have two different placements during their time in foster care, 20 percent have three to five placements and seven percent have seven or more placements.

While there has been a decrease in the average length of stay in foster care in Harris County, of the 3,497 children in protective

custody in 2001, 31 percent had been in foster care for more than two years, 34 percent had been in foster care for two years or less, 19 percent were living with relatives, four percent were in adoptive homes and seven percent were with their own families.

According to a study of foster care in five states, including Texas, by the Chapin Hall Center for Children in Chicago, African American children could expect to stay in foster care 32 percent longer than white children.

“These are more reasons why it’s so important for foster children to have a consistent therapist or counselor, who they can talk to,” says Randle, “someone who can help them work through all these things.

“It is difficult for foster parents to do this,” she continues, “because they haven’t been the primary, consistent persons in that child’s life. In addition, they are often overwhelmed by the traumatic experiences that their foster children talk about.”

“Part of our goal with this 4Cs model,” German says, “is to prevent frequent changes in foster care. If we can better understand who this child is, we can make a better match and better predict what kind of setting the child needs.

Also, we can better prepare the foster caregiver.

“We strive to put children in the most appropriate placement and get services initiated as quickly as possible. The PPT continues to meet, assess and evaluate placements at five, nine and 13 months and longer, until that child is permanently settled,” she says

“The accelerated process of permanent placement has given us needed structure and boundaries,” adds German, “however, it depends upon the energy and commitment of all involved up front, within the first six months.”

While there have been concerns that with shorter foster care stays, children are returned too soon to their families and end up coming back into the system, research conducted in 1999 showed that recidivism had not increased.

“If there are not sufficient legal grounds to terminate parental rights and free the child for adoption within the one-year or 18-month timeframe,” German says, “he may be taken into ‘permanent managing conservatorship,’ a sort of in-between status.

Unfortunately, we have too many children in this situation who have no permanent home.” But, she says, the PP Teams continue to meet regularly about these children, many of whom are adolescents, to make sure “they still have a voice and visibility.”

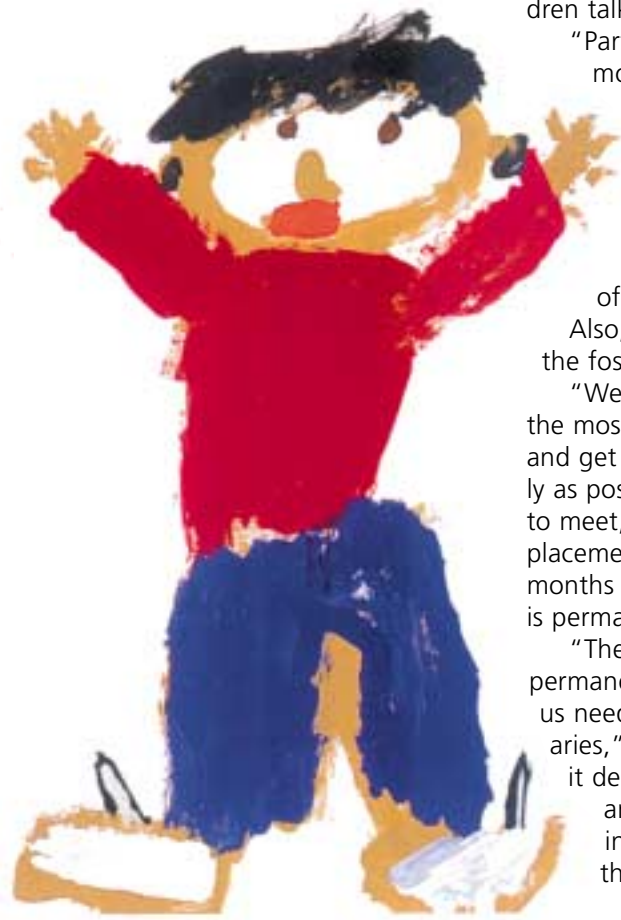
The new permanency regulation also does not take into account that it sometimes takes longer for parents who are conscientiously working to regain custody, but cannot get their act together in this timeframe. “It’s something all agencies like ours struggle with,” German says.

“Most children want to go home; it’s where they want and need to grow up, but it’s a hard call deciding if that is going to be possible or if it should be cut off and another solution proposed.

“A family struggles with a chaotic lifestyle, then stabilizes, but stressors occur which cause it to go back to the abuse,” she explains. “This is especially prevalent when the parents are substance abusers, which is a factor in about 80 percent of the cases of children in foster care.

“The nature of addiction is relapse, and it often takes more than one try at rehab, longer than a year or 18 months, for parents to get on their feet and be able to provide for their child. But those parents may still be salvageable. The struggle for us is determining when is the recovery stable enough

See “Fostering Hope” on page 17





Fostering Hope

Continued from page 16

for permanent reunification.

"I cannot overstate the serious impact of substance abuse," German says. "And it has absolutely increased and continues to grow. Before, we had a substantial percentage of families with various life stressors and family crises that precipitated the abuse, and there was a small problem with mental illness issues.

"Now, it is very different; substance abuse is the problem in the majority of abuse and neglect problems. We're even beginning to see generations of it. Even if there are other problems in the family, the parents have to become clean and sober before you can solve any of those. Serious mental health issues, too, have also significantly increased."

Levels

Texas PRS contracts with Youth for Tomorrow, a private agency, to determine what kind of foster care placement is best for each foster child in the state, based upon findings from the PRS caseworker and others, including the child's psychological evaluation or assessment. These levels do not apply to children placed in kinship or relatives' homes.

Youth for Tomorrow has defined six Levels of Care (LOC), dependent on the various bio-psycho-social needs of the child, with Level 1 being for children with no specific disorders or illnesses who require parenting in a normal environment,

Levels 2 through 6 provide increasingly higher levels of care and services, ranging from "additional structure and guidance" at Level 2 to "highly structured, residential treatment facilities," which includes a variety of medical and psychological services for children with severe impairments requiring

constant supervision.

Currently, according to HCCPS reports, there are 4,700 children in Region 6 who are in protective custody. Of that number who have an LOC designation, about 1,500 are in Level 1 foster homes. Of the total, 4,700 live in a basic foster home settings, 1,400 live in therapeutic foster care and 1,100 live with relatives.

Mental health services are mandated for children placed in the higher LOC facilities, and most of those are provided by psychologists or psychiatrists, some of whom come to the facility and others who are employees of the foster care institution. Some group homes at the higher LOCs have clinical mental health staff; therapeutic and residential placements usually have clinicians on staff as well as psychiatric consultants. Foster parents with professional training can also be licensed to provide the necessary mental health services at higher levels.

Children at the lower LOCs who are assessed as needing mental health treatment are referred to public agencies, such as the Mental Retardation Mental Health Authority of Harris County (MHMRA), or they can seek help with agencies or private practitioners who have contracts with PRS or accept Medicaid.

The cost of providing such mental health services, depending upon the amount required, are included in the stipends received by foster parents.

Consistency

Randle would like to see the inclusion of a thorough "continuum of psychiatric care" as needed. And, despite LOC, German and her colleague Nicole Dorsey, PhD, manager of the 4C's program, also realize that almost ALL children in foster care need, do need or are going to need psychological some kind of appropriate clinical mental health care.

"They have all been wounded by the abuse or neglect and by separation and loss," says German, "so it stands to reason that many—even at Level 1—will experience one or a combination of psychological problems."

"These children," says Randle, "are at risk for disruption in their new environments. It is critical that psychological help be consistent throughout their stay in foster care—and even after. While everything else in their lives may change, if they can continue to see one mental health counselor on an ongoing basis, there is great hope for them coming out of the foster care situation more well-adjusted."

A child at Level 1, German explains, might be defined as a child who enters foster care with no specific behavioral problems beyond those of his normal developmental level and who exhibits no overt symptoms of mental illness or other disorders—beyond what any normal child who has been through the trauma of abuse and neglect would experience.

The catch is what is a "normal" experience of abuse? What is normal about being ripped away from the only family they may have ever known?

"I would have to say that almost all the children we see and assess here," says Dorsey, "receive some sort of official DSM-IV diagnosis, even if it's just an adjustment disorder, because they all have emotions related to their situation."

"There is not one child who comes through the 4Cs," says German, "who has been physically abused or neglected to the extent that he or she must be to be brought into conservatorship, who has not paid a price mentally. What kind of a price and how much and even their ability to let us know that may vary, but every single one will pay a price."

Randle couldn't agree more. "The reality is that most of them

Continued

Fostering Hope

Continued

will require some form of therapeutic intervention." Even if a child is assessed and found to be functioning normally, she still believes it is good for that child to have regular access to a mental health counselor. "Foster children," Randle says, "should get psychiatric care that is just as comprehensive or even better than any other kind of medical care."

Foster Care

Foster or substitute care is any type of care provided a child out of his own family. Usually when first removed, the child is placed in an emergency shelter, such as the Chimney Rock Center run by HCCPS. From the shelter, depending on the child's needs, he may be placed in a traditional foster situation, in a foster home with several other children or in a residential or therapeutic program if

he has special psychological or medical needs. A child may also go to a foster-to-adopt home, where he is carefully matched with foster parents who are hoping to adopt, or to a "kinship" placement, in which he lives with a relative, usually grandparents, aunts and uncles or with a close family friend.

There are 703 foster homes to serve the over 4,700 children in foster care in Region 6; Harris County, as of June 2002, has 374 of these homes.

While PRS manages some foster facilities of its own, most of the facilities used by PRS are managed through local social service agencies, health care organizations or churches, which PRS contracts with to provide foster care.

Prospective foster parents are assigned a caseworker and take part in the 10-week PRIDE assessment and training program. Designed to help boost the prospective parents' abilities and confidence, PRIDE also uncovers their particular parenting strengths or weaknesses. A series of home

studies follows to make sure the environment is appropriate and safe and to discuss the potential foster parents' motivations, relationships, health status and their understanding of, and approach to, parenting.

Foster care for an emotionally battered child is difficult for professionals, Randle says, and many of their problems are too much for any foster parents, no matter how loving or well-meaning, to handle.

"Each one of these children brings with them such a bundle of needs and experiences that they would be a challenge for any family, no matter how well prepared," German says.

Background checks are conducted for each prospective foster parent, but they are not given psychological assessments. "I believe that most of the people who become foster parents have good motives," Randle says, "and they truly want to be helpful. But there are some foster parents, who because of their own personal life experiences, probably should not be."

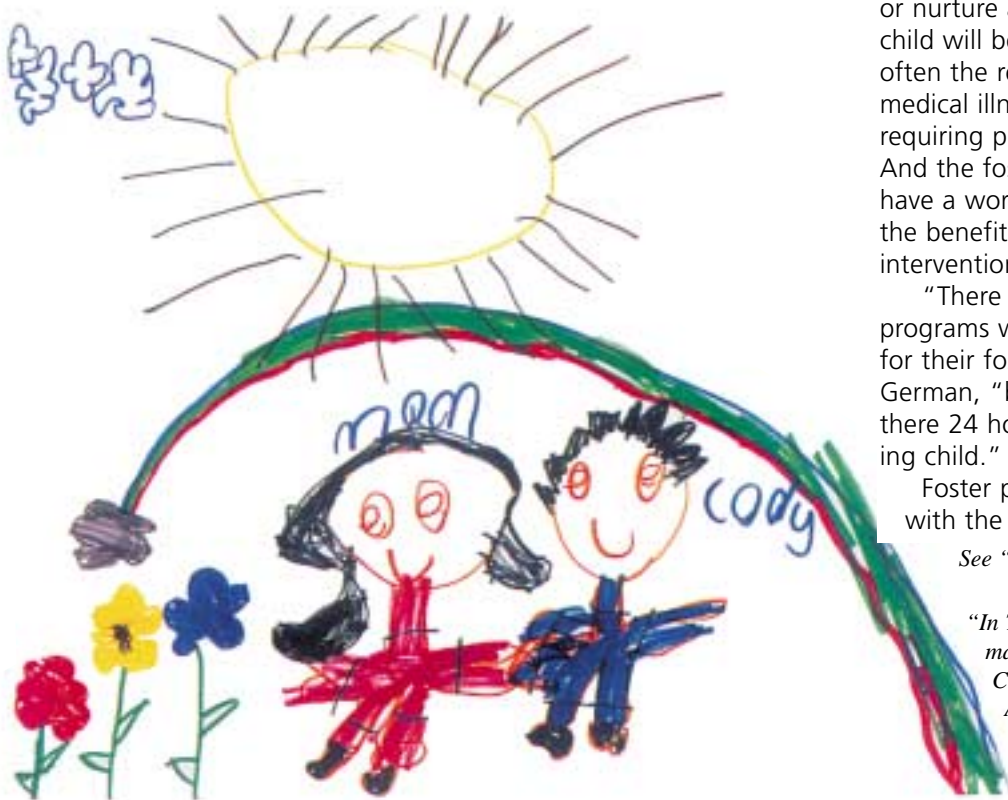
"Foster parents," Randle continues, "think that if they just love or nurture a child enough, the child will be okay. But that's not often the reality. These are serious medical illnesses and disorders requiring professional intervention. And the foster parents need to have a working understanding of the benefits of mental health intervention."

"There are some supportive programs which agencies provide for their foster parents," says German, "but no one else can be there 24 hours with that challenging child."

Foster parents also must deal with the basic dichotomy of the

See "Fostering Hope" on page 19

"In The Garden With Mom," markers on paper, Cody, age 7. Courtesy ALDEA Children's Art Therapy Program.





Fostering Hope

Continued from page 18

foster care system, which can also cause more emotional turmoil for children because of the tension between foster and birth parents. Foster parents are encouraged to bond with their foster child and provide a stable and loving environment, but at the same time they also must prepare him for return to his family of origin.

The active participation of the foster parents in fostering a connection between the child and his or her biological parents is very important in the reunification process, but foster parents need training and support in these efforts. Researchers found that with infants in foster care, the attitude of the foster parents towards visits by the biological parent is a key factor in psychological trauma.

Randle says children who enter the foster care system often get very spotty psychological attention, provided in direct relation to the instability of a child's placements. The group home may have one mental health provider for several children, foster parents may want the child to see someone they know, or adoptive parents may feel on-going psychological services are unnecessary.

"Again," Randle reiterates, "it's the foster parents' responsibility to see that the child is getting appropriate treatment, and that means that these parents must be educated and learn how to pay attention to the mental health needs of their foster children."

Indeed, a recent national study found that the more educated the foster parents were, the more likely they were to seek mental health services for their foster children.

Kinship

While nationally, the number of foster homes has decreased over the past decade, there has been



*"My Family," markers on paper, Maria, age 9.
Courtesy ALDEA Children's Art Therapy Program.*

an increase in kinship home care, in which foster children are placed with family relatives or close friends. It is the first avenue a PRS caseworker will look for help when a child must be taken into custody.

Kinship care helps solve the dilemma of more children/fewer foster parents, and has become a sizable portion of the foster care system—almost 50 percent of foster homes in some locations. Stability and continuity of care are believed to be the benefits of placing foster children with family members or relatives.

"This is a good solution," Randle says, "if PRS stays involved and monitors the situation. A grandparent can be a very stabilizing influence, especially for a child whose parents have substance abuse problems. They are familiar and offer continuity.

"But sometimes relatives are not the best caregivers," she adds. "They may be on rigid, fixed incomes that will not allow them to get the child the kind of care or services he or she might need. They may have difficulty setting limits, just as they may have had with their own children. We must be careful to make sure we aren't placing the child in a potentially worse situation, such as with a grandparent who abused the child's parent."

Some national studies have reported that, while foster children in kinship care remain connected to their biological families and cultural environment, they are less likely to receive needed health services.

Continued

Fostering Hope

Continued

Going Home?

In 2001, PRS in Harris County placed 1,400 children in permanent living arrangements: 33 percent returned to their families, 26 percent were placed with relatives, 24.5 percent were adopted, and 11 percent were placed in long-term substitute care.

The Adoption Support Alliance Project, funded through PRS and HCCPS, estimates there are more than 800 children in Harris County are ready to be adopted and 78 percent of them are minorities.

Parents whose children are taken into protective custody are served by the same PRS caseworker who is working with their child, and a plan is established for their rehabilitation. While they are required to attend a variety of treatment or educational programs, they must also want, and be able, to participate; many do not have what it takes to persevere, especially if addiction is involved.

Randle worries about children in therapeutic foster care who go back to their parents. "Do the parents continue with mental health care? Do they follow up? Probably not, because they think their child needed psychiatric treatment only because he was taken away. Even when the intervention has uncovered developmental delays or ADHD while the child was in custody, these needs may not get attention, because there is no one to explain the need to the parents."

For her part, she would like to see more effort made to make rehabilitation services for these parents more accessible. She also advocates testing all parents for mental health disorders and for providing them appropriate treatment. "One of things I think is lacking is appropriate mental health intervention for the offend-

ing parents. In the attempt to get parent's back on track, parenting classes are just a small piece of what is needed," she says.

"The Adoption Assistance and Child Welfare Act of 1980 required 'reasonable efforts' to keep children from out-of-home placement," Randle adds, "and in 1993, a new provision of the Social Security Act, the Family Preservation and Support Services was enacted to strengthen it. States receive added funding to encourage broad-based consensus building, collaboration and systems reform through providing family support and family preservation services.

"We need collaborative consortiums that really look at the options," she says. "We talk a lot about treating children in the context of the family, but when the family is disrupted how do you coordinate service? We need to make treatment accessible for them, not just give them a list and tell them to get help; this is the same for those with substance abuse problems. When these things are not treated properly, the cycle of abuse and neglect continues."

"Once Children's Protective Services identifies the problem, they do the best that they can with limited resources," Randle says, but she is frustrated that more attention is not given to providing families with multiple problems resources before HCCPS' involvement. "The system needs to provide parents who warrant intervention the resources they will need to help them break some of their negative parenting habits."

HCCPS does provide family-based safety services to reduce the risk of future neglect or abuse. In cooperation with Harris County Juvenile Probation and the Mental Health and MHMRA, HCCPS has formed TRIAD—three county agencies working together to intervene and serve children and families who are at risk. One part of TRIAD is Family Preservation, in which MHMRA senior caseworkers

provide short term, intensive, home based counseling and case management services to youth identified with serious mental health issues and their families. This TRIAD Prevention Program activity has allowed children at risk for residential placement to remain in their homes.

Success

"There will be children who are more resilient and don't require intensive therapy; they're survivors and they'll make it," says Randle. "There are also those children who are able to overcome their situations and respond well to the sustained continuity of support the foster care environment provides. I have seen adolescents who have been in the system for a while, but are doing well and functioning appropriately.

"They have basically 'recovered,' and probably that's because they had some good foster parenting along the way." The AACAP reports the key attributes of children who have successfully navigated the foster care system: they are of at least average intelligence and have good dispositions; they experienced foster parenting that elicited trust, autonomy and initiative; and they had a good external support system.

"One teen whose case I consulted on and who needed psychiatric intervention was able to be tapered off his medications and did well in school," Randle says, "so I told the foster parents and the agency that he no longer required psychiatric care per se, but I did stress the importance of him having access to his therapist.

"Kids can recover from trauma," she says, "but those who do best have stable foster home environments and continuity in mental healthcare. Yes, they will have long lasting memories of hurts and losses, but they are able to cope and function well." ★





Wednesday's Children

Continued from page 6

status at the time of separation can determine his reaction to life in foster care. For example, because their relationship to time is much different than adults', children often don't fully understand the concepts of "temporary" and "permanent" custody.

Typically, Randle says, foster children who have become used to fending for themselves have learned adaptive behaviors necessary for their survival in an abusive situation. These behaviors aren't healthy for them and do not serve them well in their new environments. This results in serious conduct and management problems with their foster caregivers. Such maladaptive coping styles can also result in relationship difficulties and school conduct problems.

Because they have been abused and have not established strong attachments to loving caregivers, foster children can have trouble adjusting to life in a family. Depending upon the environment they came from, children will rebel against the routine structures of the typical home environment, or they'll be exceptionally regressive in their behaviors for their age, because they didn't get the guidance they needed to develop normally.

Adjustment disorder can be accompanied by depression—feelings of sadness or hopelessness about one's situation—or with disturbed conduct—acting out behaviors such as fighting or truancy.

Randle says one of the most difficult situations for a foster child is being left behind. "It is especially hard for older children whose younger siblings have been permanently placed while they remain in the system. The reason might be something as trivial as a sister or brother being more physically attractive, even though this child is just as loving and responsive.

"Or, she says, "there are the children who believe that they will

get permanently placed, but then at the last minute, it doesn't happen. It's devastating for them. I hear these things from foster children; you can't imagine their anguish.

Feelings of rejection and an inability to form intimate relationships or maintain friendships often also occur if a child in foster care has been moved several times. "An older child who has already been in and out of foster care can be very skeptical when placed in a new stable situation. They are often reluctant to feel hopeful, even though they want this placement to be better," says Randle.



ANXIETY AND POST TRAUMATIC STRESS DISORDER

Anxiety disorders, fears and phobias are among the most commonly diagnosed psychiatric problems of foster children. Many clinicians, including Randle, believe that children who are exposed to ongoing abuse and neglect are at risk for developing Post Traumatic Stress Disorder (PTSD). This anxiety disorder usually occurs after experiencing a major traumatic event—war, rape, natural disaster—when the victim develops anxiety symptoms related

to that event.

Physical or emotional abuse during the early years causes chemical and electrical changes in a child's brain that "fixes" the brain in an acute stress response mode, making the child fearful and hypervigilant. This repeated trauma also affects the child's anxiety control and results in behavior like hyperactivity, mood swings, impulsiveness and sleep problems.

A child suffering from PTSD often manifests his great fear and helplessness through agitated and disorganized behavior. Such a child may also reconstitute the event through repetitive play, have frightening dreams or actually re-experience the trauma.

At the other extreme, are those children who have learned to detach, avoiding anything suggesting the trauma. Such children may become numb and unable to feel or express their emotions, withdraw from others and be unable to recall certain things about the trauma. Increased arousal may cause the child to be overly alert and watchful, as well as experience problems sleeping and concentrating.

GRIEF

Entering the system traumatized by abuse and neglect, foster children often suffer further emotional difficulties by being separated from parents and familiar surroundings.

"This is a major loss," Randle says. "It can be more painful if the abusive parent continues to have visitation rights, but it can be positive if the parents are actively working to get their act together."

Losses and lack of permanence undermine a child's ability to form secure attachments. Obviously, children who are maltreated or ignored or older children who are shunted from caregiver to caregiver are unable to build such a bond and are likely to "shut down" because they don't have an object of trust.

Continued

Wednesday's Children

Continued

ATTACHMENT DISORDER

Younger children in foster care, especially those who have not bonded with a parent or who are transferred from foster home to foster home, are at risk for attachment disorder, although a California study found no evidence that it is more prevalent among foster children than children in the general population.

"The development of attachment disorder," says Randle, "is dependent on how the parents—both the parents and the foster caretakers—nurture a child. When there is persistent disregard of the child's basic emotional needs for comfort, stimulation and affection; parental disregard for the child's basic physical needs; and repeated changes of the primary caregiver, an attachment disorder can be a likely result.

ODD and CD, ADHD

Abuse, says the AACAP, "creates a milieu of violence that affects socialization with peers."

Oppositional defiant disorder (ODD) and/or a more serious related condition, conduct disorder (CD) can occur in foster children because of the abuse or neglect received from their family of origin, or because of frequent changes in caregivers.

If there has been or continues to be fighting and arguments among caregivers, inconsistency in expectations, lack of supervision or harsh punishment, the child is at significant risk for ODD and CD. While some experts report a link between CD and foster care, it may not be a simple cause/effect relationship, many older children are in foster care due to their problem behavior.

Attention-deficit with or without hyperactivity disorder (ADD/ADHD) is another common problem often found with such children. Although

most researchers believe ADHD has a genetic connection and is related to a chemical imbalance in the brain affecting the neurotransmitter dopamine, they do not discount the influence of environmental factors on the growing brain, such as chronic exposure to a highly charged, unpredictable and fearful environment.

German also notes that a small, but consistent percentage of children in foster care suffer from a serious mental illness or serious behavior disorder and their parents can no longer care for them. "Often these parents have no recourse: they can't find or afford treatment, or they've



exhausted all their emotional and financial resources," she says.

"While these are not abuse or neglect problems, these children come under PRS jurisdiction and are usually they are in the higher Level of Care (see previous story) facilities."

OUTCOMES

"Older children who come from a chronic situation of family abuse where they have taken on the parental role, often have serious attachment problems," says HCCPS

child psychologist Nicole Dorsey, PhD, "especially if separated from their siblings. They haven't been able to focus on themselves in a long time."

"These children have had to divert their energy to this anxiety or anger at their parents," German adds, "or maybe there's been a role-reversal and they're worried if their parents will 'make it.' Because of this, these children have not been able to manage their own development, and their socialization skills and academic development suffer greatly."

The "outcomes" for these children are not good, she says, and often they find no permanent placement and "age out" of the system at age 18. The Center for Adoption Research at the University of Massachusetts reported in 1999 that these children totaled about 25,000 nationally.

Of this group, 66 percent do not graduate from high school, 61 percent are unemployed, 34 percent end up on welfare and 25 percent end up homeless. Another study found that 27 percent of the males and 10 percent of females were incarcerated 12 to 18 months after leaving the system. A 1998 study at the University of Wisconsin of children who "aged out," reported that nearly half received counseling or medication for mental health problems before they left, but only 21 percent received this help after they left.

TREATMENTS

Any kind of psychiatric treatment must be tailored to the needs and experiences of the individual child. "The bio-psycho-social perspective is very important in treating any child, especially a foster child," says Randle. "We as providers can't deal with just the psychiatric illness, we must look and treat the total child, which includes culture, environment and education."

See "Wednesday's Children" on page 23





Wednesday's Children

Continued from page 22

Whatever the approach, it must be based in nurturance, support and consistency in order for the child to feel comfortable, safe and loved.

"Society's stigma surrounding mental illness is still very great," says Randle, "and it impacts children, who are terrified about having to see a mental health professional. The foster parents need a lot of education and support in helping their children understand and accept help for mental health problems. At UT MSI, our services are family centered and individually tailored to meet a child's needs."

In 1998, *Child Welfare* magazine outlined a three-phase preferred model for the delivery of mental health services for children in out-of-home care.

Phase One, Prevention-Evaluation, closely resembles much of what of German, Dorsey, and their colleagues at HCCPS' Children's Crisis Care Center do: comprehensive screening and assessments to identify problems as soon as possible and to lessen the trauma of separation and negative impact of placement.

Phase Two or Treatment, recommends short term, intermittent intensive treatment for the child and family members, which might include theme-oriented group therapy, family therapy, substance abuse counseling, individual psychotherapy, play therapy, creative arts therapy and behavior modification.

Phase Three, Relapse Prevention, or aftercare and maintenance of relationships is "crucial" in preventing a child's relapse in emotional and behavioral functioning. It also acts as a "buffer" if there are delays in the system. Like Randle, the authors believe "continuity of the therapeutic relationship is often vital for children in care whose behavior may be stabilized but who still require a consistent, durable object relationship" while permanent arrangements are made.

WRAPAROUND AND PARENT MANAGEMENT

California professionals found two psychosocial treatment interventions that demonstrated clinical effectiveness in working with two groups of foster children—those with externalizing disorders and those who are aggressive, defiant and disruptive—whose emotional and behavior problems might lead to unstable foster placement situations or prevent them from returning to their families or of being adopted.

The "Wraparound" approach, developed by Hewitt Clark and associates at the University of South Florida, includes the integration of social, mental health and health services into the treatment program for children and their families—either biological or foster.

Family specialists function as case managers and in-home counselors. Specific services provided include family systems therapy, tutors, behavior specialists, vocational training for parents and child abuse and grief counseling. The program emphasizes the family's strengths and provides encouraging and reinforcing natural family supports, and provides follow-up services after permanent placement as long as needed to prevent problems from recurring.

In the Oregon Social Learning Center's treatment foster care intervention, developed by Patricia Chamberlain and colleagues, the foster parents, instead of professionals, are the main mental healthcare providers. This model is targeted especially for children and adolescents with chronic delinquency, severe emotionally disturbed adolescents and preschool and elementary school-aged children with behavior problems. Parents are given parent management training, consultation and clinical support and are trained to use new strategies in working with their children, such as setting consistent and rational limits, nonviolent punishment and daily encouragement.

(Parent management training is

based on the theory of Gerald Patterson, who studied aggression in children. Parents and children, Patterson says, can get in a negative reinforcement cycle in which the children's deviant behaviors are reinforced by the parents' critical or coercive behaviors. By teaching parents to use problem-solving and positive reinforcement skill, their children's social interactions will improve.)

For some specific mental disorders in foster children, there are types of therapy that have shown positive results. Cognitive behavior therapy, self-control therapy and a group treatment program using self-control and problem-solving therapy were all found to be helpful for depression. For ADHD, behavioral parent and teacher training and classroom consistency management, along with the use of medications, have proven helpful. Anxiety disorders, such as phobias and fears, are best treated with desensitization therapies or with cognitive behavior therapy. For disruptive behavior in foster children, parents are trained to affect change by utilizing operant principles of behavior change. Positive results for children with conduct problems have also occurred with anger control training and anger coping therapy, assertiveness training, delinquency prevention, multisystemic therapy and rational emotive therapy.

However, professionals are quick to point out that a stable and good foster environment must come first. Mental health intervention is designed to help children take advantage of a good situation. For a child to improve his psychiatric situations, he must first have stability, safety and predictable caretakers.

PRIORITIES V. NEEDS

HCCPS' German and Dorsey are well aware that, despite all they try to do, there is a shortage of mental health services for seriously ill children; indeed for all children.

"We're not naive," German

Continued

Wednesday's Children

Continued

says. "We know there's no solution out there that we are avoiding. The problem is that mental health services for ALL people, especially children, are still in the developmental stages. We don't know everything about helping these children."

Like Randle, they are most concerned about the damage that is being done by not having uniform, consistent mental healthcare for children in Harris County. "Parents and their caseworkers are left on their own to find services," German says.

"The caseworkers and their supervisors make the decisions about what kind of care children need; they determine what's supposed to happen. But we really have no idea if it does happen," she says

The volume of children entering foster care is certainly one culprit: an average of 200 were taken into protective custody in March and again in April of this year—25 percent more than the usual number. The fact that caseworkers oversee double the number of cases recommended by experts is another.

But perhaps the biggest problem remains the lack of mental health services for children, all children, and the fragmentation of those that do exist.

"I would like to see a direct link from our assessment at our HCCPS 4Cs Crisis program to a specific service provider," says Dorsey.

"We worry that the recommendations we make based on what we see and hear during our 4Cs processes are not happening, or not happening the way they should be. If any vulnerable population deserved a uniformly consistent and available continuum of care, surely it's this one," she says.

"People in our professions—child protection, mental health social services—need to act together," German adds. "These big systems could build bridges that would guarantee certain things—a model in which there would be integration

of agencies and services all participating in a consistent manner. Right now, everyone has something to bring, but they're just throwing it at the problem."

"Information is not shared among all the providers," says Dorsey, "and people end up providing the same service or no service. For example, siblings may all see a different mental health counselor and there's no coordination among them, let alone between them and us."

IS THERE A BETTER WAY?

Does another society have a system that is more effective?

"Even if another country has a better system," Dorsey says, "they still don't have the volume that we have here.

"Abuse and neglect do not happen in a vacuum; they occur in a context of deprivation. Anytime that you have a culture with a large number of children living in poverty—like Texas—you will have a lot of abuse and neglect."

So, finally it comes down to—as it always must—more attention and money from the public and the policy makers they elect.

But German believes the fault goes even deeper: "Do you think our society really supports families? Look at our priorities." ★



Artist rendition of the artwork in the lobby of the central offices of HCCPS.

IMPORTANT PHONE NUMBERS AND WEB SITES

Texas Department of Protective and Regulatory Services (PRS)/ Harris County Children's Protective Services (HCCPS)

HCCPS	713-394-4000	www.hccps.org
PRS		www.tdprs.state.tx.us
BEAR...Be a Resource for CPS Kids	713-940-5296	www.BEARResource.org
Foster and Adoption Inquiry Line	1-800-637-3528	
Texas Adoption Resource Exchange		www.adoptchildren.org
Texas Abuse Hotline	1-800-252-5400	
Child Abuse Prevention	713-394-4000	www.itsuptoyou.org
Community Youth Services	713-664-5701	
Services to At Risk Youth (STAR)	713-664-3459	
TRIAD Prevention Program	713-664-5701	
To become a Volunteer	1-888-892-3777	





In Our Own Words

Continued from page 10

was one of the major functions of therapy. Adlerians strongly encourage the use of the journal as an excellent tool in "...concretizing, revising, anchoring and celebrating beliefs."

Adlerian psychologist Mark Stone, in writing about the use of journaling, makes observations similar to Hays' comments. "Journaling moves clients away from the artificial dichotomies they bring to life's decisions." Adler called these dichotomies the haven of the primitive mind and the neurotic, seeing only two alternatives instead of the array of possibilities that exist. Further, Stone says, "Journaling provides clients with a tool...a quiet time where thought can prevail over expedient action so that people can find sense and meaning in the issues of life. We need to foster in our clients greater respect for inner thoughts and encourage them to work out solutions to the major tasks of life by using journaling to aid reflection and contemplation."

And Stone doesn't restrict journaling to those who are literate. For limited or disabled clients, he suggests audio taping the client, then having the tapes transcribed into book form. Producing such a document is a truly empowering experience he says. "To observe a client receiving a book written in his/her own words is something that must be seen to be appreciated."

Stone notes the contribution that writers in general make to our ability to gain insights about ourselves and our world. "Our speech can be glib and transparent," he says, "whereas words on paper are far more explicit. But the task of journaling is not to produce a work of art for the world at large but to mirror our own inner world. Therefore, whatever we write is 'good enough' from the vantage point of recording our thoughts, and



UTHCPC staff nurse Lillian Miller.

we gain skill in journaling as we continue to write."

A Passion for Patient Narratives

One academic who feels passionately about the value of patient narratives and descriptions of struggles with mental illnesses is psychology professor Gail Hornstein of Mount Holyoke College. In her article, "Narratives of Madness, As Told from Within" in the January 2002 issue of *The Chronicle of Higher Education*, Hornstein asserts that memoirs by psychiatric patients have not received the attention and respect they warrant from the medical profession. Fascinated since her early life with reading these books, she says "years of poring over these books—as both a child and an adult—have left me with a view of psychology completely different than what I learned in graduate school."

Determined to expose her psychology students to this rich resource, Hornstein teamed with an English professor to teach a seminar for psychology majors using these works as the sole text. Her students were fascinated, she says, because "...nothing

in their prior coursework even hinted at the idea that mental patients could be authorities on human psychology."

Hornstein relates patient stories like that of Charlotte Perkins Gilman, a nineteenth century economist and feminist theorist whose physician warned her to "...never touch pen, brush, or pencil for as long as you live." Assuming that mental activity was upsetting to those who were already psychologically distressed was standard medical practice for the time. Gilman became increasingly ill and withdrawn and eventually healed herself by taking up writing again.

Particularly ironic is a quote cited by Hornstein from the 1946 book *The Snake Pit* by Mary Jane Ward. In talking about the psychiatrist who treated her while hospitalized, Ward says, "He was always talking about hearing voices and never hearing mine."

Hornstein, while very strongly supportive of patient accounts in general, worries a little about public perceptions that may be generated by more recent narratives like *Prozac Diary* by Lauren Slater and Susanna Kaysen's *Girl Interrupted*. "While these works are definitely honest and valuable and represent the true sufferings of their authors," she says, "they are hardly representative of the majority of people hospitalized in this country for serious mental illness." She points out there are enormous experiential and socioeconomic differences between these two young women and the average psychiatric hospital patient, particularly patients in publicly funded facilities.

Hornstein, encouraged by the enormous interest her article about these writings has aroused, is currently writing a book on the subject of patient narratives. She is also planning to link some of her psychology theory classes with specific patient accounts: for example, in a personality theory course she will assign Freud's famous case study of Daniel

Continued

In Our Own Words

Continued

Paul Schreber with Schreber's own *Memoirs of My Nervous Illness*. Hornstein says she eagerly awaits the day when literature by patients with mental illness is seen by physicians as insightful as patients' accounts of struggles with cancer or heart disease.

Of Poetry and Patients

The deeply affecting nature of poetry provoked by its use of rhythm, as well as simile and metaphor, make it a potent tool in the hands of a competent therapist. In the **Handbook of Innovative Therapy**, therapist Arthur Lerner suggests that using poetry can act as a "softening up" process which can allow patients to get at deeper questions of personal behavior.

Poetry has been around much longer than therapy, Lerner emphasizes, and the rationale for the two fields is based on very different experiences and assumptions. He reminds us that when one is using any kind of poetry in therapy, the emphasis must always be on the person and their reactions and not on the poem, as it would be in a poetry workshop.

Poetry therapy can be used one-on-one or in a group situation, and is most effective when geared to the level of understanding of the participants. The poem can function in a number of ways Lerner points out: as a catalyst through which emotions are filtered, a vehicle for interpreting certain feelings, or to facilitate understanding of a person's feelings, lifestyle or preferences.

When asked about using poetry or creative writing of any type in a therapeutic setting, Houston poet and writer Cathy Stern, who teaches creative writing at the university level, sees potential benefits but also the

need to be very clear. "My first impulse is that creative writing—fiction, creative non-fiction, or poetry—shouldn't be done solely for therapy if one has any expectation of its also being art. It always has to be 'transformed.' When I teach poetry workshops, I try very hard to make clear to my students that there is an enormous difference between spilling it all out and making that spillage into a finished poem.

"Having said all this from the view of the poet," she continues, "I strongly believe that creative writing of all kinds can and should be used as a form of therapy for emotionally disturbed persons, much the same way that music and dance are used in this way.

"The differences here come down, in part, to the goals of the teaching process—the creation of art or the creation of an emotional outlet that may provide the writer with a degree of relief and insight." Stern wisely points out that this does not mean that therapeutic writing never turns into art.

Buttressing Stern's observation is this excerpt from a poem entitled "Having It Out With Melancholy" by the widely respected late poet, Jane Kenyon.

*...With the wonder
And bitterness of
someone pardoned
For a crime she
did not commit
I come back to marriage
and friends,
To pink fringed
hollyhocks; come back
To my desk, books, and chair."*

Kenyon suffered from severe depression for much of her life, and both the skill of the poet and the suffering of the person shine out from these lines.

As for creative writing in general, Stern offers the perspective that "for those of us who write, when we do write the poem or story we had hoped to write, that experience is tremendously significant to us, a kind of therapeutic experience in a different sense. It reaffirms that we are in touch with something both fundamental and marvelous"

The Last Word

Each of us has a story to tell and creating and relating that story in prose, pictures and poems can be a revitalizing experience. In a recent article in *Smith College Studies in Social Work*, researcher Rebecca Leavitt of Bridgewater State College asserts that within the therapeutic community the value and power of expressive writing needs to be recognized and promoted. "When clients write for themselves, they express their innermost thoughts and feelings, often in disguised metaphoric forms. If they choose to share these writings with a clinician, therapy can move more spontaneously and rapidly around core conflicts." This applies to people of varying age and writing ability, Leavitt says.

The unique power of self-reflection, captured in words can have a potent effect for readers as well as for the writer. Consider this excerpt written by Toni, a 25-year-old patient attending a poetry workshop while hospitalized for mental illness. She imbues her simple verse with an elegant truth.

*"When my mind, body
and heart feel right
I'm at my best
with all my might.
When all three are
out of whack,
I feel that I'm going*





Setting the Precept for Care

By Nadita Sahni

In the world of a psychiatric patient care unit—filled with constant activity, variation and demand—the nurse preceptor is the glue binding it all together. While the duties of any nurse are demanding enough, a preceptor is required to be nurse, teacher, nurturer and role model all in one.

Since its inception in June of 2001, the UTHCPC nurse preceptor program has promised to build a more stable, more educated, more confident generation of nurses. And so far, it has delivered.

“The program began as a department initiative to retain new nurses and to recognize existing nurses—giving them both reasons to stay at UTHCPC,” says Arslee Mackey, RN, MEd, UTHCPC’s Nursing Operations Manager. “Not only does it reward nurses for their competency and expertise, but it also provides a subsequent step on the career ladder.”

The program also hopes to develop an infrastructure that recognizes and rewards the clinical role of the psychiatric technician, the nursing aides who are front-line patient care staff.

To be a successful preceptor takes an exceptional and capable person, Mackey says. In addition to the job’s background requirements—current license as a registered nurse in the state of Texas and a bachelor’s degree in nursing with three years of psychiatric experience at UTHCPC or its equivalent—preceptors must possess a wide variety of qualities. Being flexible, committed, articulate, humorous and involved in the community are just a few on the list.

“Preceptors at UTHCPC undergo an extensive training workshop to study their role, special educa-



UTHCPC Nurse Preceptors James Green, RN, and Laarni DeGuzman, RN.

tion issues, adult learning techniques and interpersonal skills,” explains Susan Grice, RN, DNSc, UTHCPC Director of Clinical Care.

After perfecting their own skills, the preceptors go on to spread their knowledge to those around them, playing a decisive role in the education, training and socialization of staff and nursing students. Currently, UTHCPC has 20 nurse preceptors who move among the 12 patient care units, depending on needs.

Nurse preceptors are responsible for orienting new employees and students, coordinating hospital in-services and providing ongoing education and training staff to improve staff competencies and help update skills.

First and foremost, preceptors are teachers. They must be personally interested in education and realize its vital importance for the hospital, the individual patient

and, indeed, the community as a whole.

Because a new nurse’s first few months on the job have the greatest influence on his or her perception of the institution, the preceptor—who represents the entire organization—eases the transition and helps acclimate the nurse slowly—but realistically.

Laarni de Guzman, RN, a preceptor since June of 2001, says her number one responsibility is to be a resource person for the unit.

“Whether answering questions about policy, procedure or theory, we preceptors do all we can to make ourselves and information accessible to the students. This requires absolute confidence in one’s own capabilities in order to hone those of your students,” she says.

Even when not actively searching, preceptors are always on the

Continued

Nandita's Story

Continued

lookout for new techniques and skills. Another preceptor, James Green, RN, relies on Internet sites, periodicals and online programs to keep himself updated. Because of its fulfillment of UTHCPC's educational mission, as well as the Center's role as a teaching hospital affiliated with the University of Texas Health Science Center at Houston, the preceptor program is that much more significant, and the nurse preceptors themselves become an extension of this objective.

Starting at orientation and continuing through graduation, the preceptors provide a consistent and continuous communication link with new staff and nursing students. This method allows preceptors to assess the needs and direction of students on an individual level, and therefore know when their teaching is over. De Guzman compares it to having that maternal instinct:

"Preceptors must know when to step back and let their nurses 'walk' on their own." The moment they step onto a unit, preceptors become role models for those watching and listening—what they do and say is just as important as what they do not do or say. How they tackle the stress and realities of the job directly influences how their students (and their fellow staff members) will learn to handle those things themselves. "We make sure to focus the students' attention on the most enjoyable and interesting duties of the job," says Green, "always reminding them of why they are here in the first place."

The preceptor program meets patient needs while simultaneously meeting student needs. Not only are nurses and staff better equipped to care for patients, the preceptors continued presence in the units raises the standard of

quality as a whole. "Too often," Mackey says, "hospitals lose employees with the most expertise to positions away from the patients."

"But here, maintains Grice," preceptors are able to stay close to the bedside while being recognized for their clinical skill development."

While the program is still young, the results are already apparent. On an individual level, the support and morale from preceptors is creating more confident, more informed and more independent nurses. The infrastructure also gives the new nurses the opportunity to grow professionally within UTHCPC.

"The best part of my job," says Green, "is having countless students personally thank me and let me know what a difference I've made in their training."

"This is an accomplishment for the hospital," adds de Guzman,

"and, at the same time, it feels like a personal achievement for us."

On an institutional level, the preceptors have facilitated superior communication among staff through in-service training and the general improvement in accessibility.

Although exact numbers are yet unknown, members of the staff agree that retention rates are higher and turnover rates lower. "In essence, UT-HCPC has front line staff with expertise," declares Mackey, "a benefit to everyone involved."

Such changes within the hospital, in turn, affect the community, as well. Through outreach and education, Green says, the staff does its part to reduce the stigma surrounding mental illness.

Thus, through the small—but very momentous—steps of the nurse preceptor program, UTHCPC continues to strengthen itself from the inside out. ★



"Alone in My Room," watercolor, Rebekah, age 8. Courtesy ALDEA Children's Art Therapy Program.





"Together at Home"
(Exterior)



"Together at Home"
(Interior)

*"Together at Home" (Exterior) (Interior), mixed media, Amanda, age 6.
Courtesy ALDEA Children's Art Therapy Program. To order calendars featuring children's art,
contact ALDEA, P.O. Box 390, Napa, CA 94559, (707) 224-8299.*

P R O G R E S S • A U T U M N 2 0 0 2



UT HARRIS COUNTY
PSYCHIATRIC CENTER

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

Non-Profit Org.
U.S. Postage
PAID
Houston, TX
Permit No. 209



THE UNIVERSITY of TEXAS
HEALTH SCIENCE CENTER AT HOUSTON

Address Service Requested
 Please change name or address as marked
 Please remove my name from mailing list
 More than one copy received
Check the appropriate box and return to the above address.