News
The University of Texas Health Science Center at Dallas
5323 Harry Hines Boulevard Dallas, Texas 75235 (214)688-3404

July 25, 1983

CONTACT: Ann Harrell
Office: 214/688-3404
Home: 214/369-2695

There was a crooked man, and he
went a crooked mile,
He found a crooked sixpence beside a
crooked stile;
He bought a crooked cat, which
caught a crooked mouse,
And they all lived together in a
little crooked house.

DALLAS--Sometimes the whole world appears warped to people who are having emotional problems--depression, anxiety, panic, hysterical outbursts. This "crooked world" that they perceive may be a terrifying place, and their own terror often brings them to seek help for the distortions of their own minds. Fortunately, most are adults who can say to themselves, "I'm hurting. I need help."

Unfortunately, many are children who are not able to realize that something is wrong in their world. They may be frightened by their own out-of-control feelings or confused by their warped perceptions. In most cases, they cannot verbalize the things that are going wrong.

"Children are not likely to come asking for help," says Dr. Kenneth Wiggins, Dallas child psychiatrist and clinical assistant professor at The University of Texas Health Science Center. "A child is almost always brought in by somebody else. He or she is almost always doing something an adult doesn't want him to do or not doing something the adult wants him to do."

But that doesn't mean that the child is not hurting. In cases like these, children simply do not have the vocabulary, maturity or self-understanding to know that something is wrong—or that they can be helped.

Nor can it be supposed that treatment for emotional disorders in children can, or even should, be just like that for adults, says Wiggins. It is generally more difficult to treat a child. With an adult, the psychotherapist generally aims at restoring the adult to a previous level of control or satisfaction in his or her life. Children may never have learned or developed life skills to help them master the day-to-day environment. These skills may include relating to others, the ability to test reality, impulse control, learning to trust and a confident sense of self. In cases of certain neurological disabilities, children may have had difficulty even in learning to read, spell or deal with numbers.

A child or young person with a major physical disease, such as acute diabetes mellitus or a severe seizure disorder, may be overwhelmed by depression, even to the point of becoming suicidal. In addition, there may be problems due to the patient's medication. Also, behaviors that help people cope with life have never been learned by the invalid, who has spent a great deal of time away from other children during the growing-up years. Other young people may develop physical illnesses as a reaction to the emotional disorders they are suffering from or as a way of defending themselves from the world by becoming invalid.

The problems of some children that result in their "crooked" views of the world or "crooked" ways of relating to it are complicated by the fact that they live in "crooked" homes where the parents need help, too.

(over)

Besides the regular outpatient psychotherapy program in the Child and Adolescent Clinic, the Department of Psychiatry has developed a special short-term inpatient psychiatric program at Children's Medical Center for cases where in-depth diagnosis and treatment are called for. Children's is a hospital for acute care for children and is the major pediatric teaching hospital for UTHSCD. The hospital is physically linked to the medical school through Parkland Memorial Hospital.

The inpatient hospital program at Children's, says director Dr. Graham Emslie, a pediatric psychiatrist, is one of the few in the country that provides care for children whose psychiatric disorders are due to or closely associated with acute diseases. Patients with behavior disorders, other psychosomatic illnesses (such as some cases of asthma) and emotional disorders like schizophrenia are also cared for here. (The term "schizophrenia" refers to a large group of disorders characterized by disturbances of thought, mood and behavior sometimes marked by misinterpretations of reality, delusions and hallucinations.)

"Fortunately, the need for hospitalization doesn't come up very often," says Wiggins. "By far most children are normal--and even those with problems rarely need to be in a hospital. But sometimes it needs to be done."

Out of every 100 pediatric patients seen in the hospital for physical illness, about 75 can be handled without any special therapeutic help; others need only a little special attention, say from an understanding nurse, says Emslie. Maybe 20 percent need to consult a therapist, perhaps just for one visit. And a small number--between one and five percent of the children in the pediatric hospital—have severe and complex enough problems that an inpatient evalution is needed.

Some of these patients include young people like Wade, a 12-year-old boy who had polio early in life. Although he overcame the disease, Wade was left with agammaglobulinemia, an immunological deficiency that leaves him extremely vulnerable to infectious diseases and a poor prognosis for a long life.

Because of his medical condition, Wade has experienced a very limited childhood with much loss of school attendance and limited social contact with children of his own age. He has to take large, painful shots of gammaglobulin every two weeks and cannot participate in sports or other rough-and-rowdy games. He was admitted to Children's when his parents became alarmed that their son was suicidal. Wade had "accidentally" shot holes in the living room floor while playing with his father's gun collection.

"My sister must have put the bullets back in when I wasn't looking," he said.

After several weeks Wade was getting along well with the other children and teen-agers doing well with his school work and had become very involved in taking care of himself so he will have a better chance at a longer life. Although he couldn't play football with the other boys, he could go on nature walks, exercise in gym class in the unit, swim and participate in all the group excursions. The staff, especially child-care worker Eugene Kennedy, kept a watchful eye on Wade to keep him from overtiring. Kennedy, whom the kids call "Mr. Goo," would drop back to walk with Wade so he wouldn't seem so far behind. And since Mr. Goo is an ex-TCU and -professional basketball player, the kids think it's all right to slow down every now and then.

Patients come to the unit from all kinds of backgrounds. Many are transferred from medical areas in the hospital as soon as their acute disease problems are stabilized; others are referred by local pediatricians or psychiatrists. Some are sent from local emergency rooms following drug overdoses or suicide attempts. About 50 percent of the patients have psychiatric problems closely related to diseases. The other half have behavior and other psychiatric problems not connected to physical illness.

(more)

Dr. David Waller, chief of Child and Adolescent Psychiatry at UTHSCD, is a psychiatric specialist in psychosomatic disorders in children and young people. Waller, who is an associate professor of both Psychiatry and Pediatrics, is present at all medical intake rounds with attending physicians. In this way he is able to help the other specialists spot children with acute medical problems who might be helped with their emotional problems through a stay in the psychiatric unit. In his role as consultant, he is able to get acquainted with the patient and the family and talk with them about the possibility of a psychiatric referral to the unit in a non-threatening way.

"People must be comfortable with the subject of access to psychiatric help," Waller says. "You can't just refer to the psychiatric unit like a medical area in the hospital or you may get reactions from family members like 'Are you saying I'm a bad parent?' or 'Are you saying my child is crazy?' These parents may be feeling a lot of guilt about their child. You have to get to know them first in order to help."

Emslie agrees.

"The family," he says, "is a very important part of our program, and we can't help the child without their cooperation.

"We are a goal-oriented program, and that goal is to enable the child to function at home and in his community. We like to involve the families as much as possible. After all, the kids return to their families. In fact, twice-weekly family therapy groups are a part of the program, and patients are allowed weekend visits home whenever possible."

Depression is a common problem seen in the psychiatric unit at Children's. Johnny, a slender 14-year-old with high cheek bones had to be readmitted to the unit. Besides suffering from symptoms of depression, Johnny has anorexia nervosa--a condition that is somewhat unusual in a male. (Anorexia nervosa is a syndrome marked by severe and prolonged inability to eat, weight loss, loss of normal menstrual flow in females or impotence in males and other symptoms resulting from emotional conflicts and biological changes.) The staff was able to work with this young man successfully enough during this recent stay so that he did not have to be fed intravenously because of further weight loss.

However, he still has a long way to go. Johnny has a great deal of difficulty expressing himself to his family.

"They never know I'm mad," he says. "I don't tell them--I just don't eat!"

Besides gaining weight, Johnny's therapeutic goals include being honest with himself and his peers, opening up with the staff and expressing his opinions, trying to please himself more than others and practicing these new accomplishments in the home."

Emslie says that the short-term stays--usually from a few weeks to two months--are part of the new trend toward short-term hospitalizations in general. This trend includes a short time of stay for patients, serving more teen-agers than would be possible with long-term care units and furnishing care for a higher incidence of patients with severe physical illnesses. It is also in tune with the general trends in health care, including dealing with more complicated life-threatening conditions as quickly as possible and shortened stays in psychiatric hospitals. Psychiatric stays have been cut because of the increase in ability to treat people with drugs and referrals to outpatient care that is more available than in the past. In addition, the high cost of medical care, discrimination against psychiatric care by many insurance companies and the 30-day limit on psychiatric hospitalizations under Medicare have been big factors in limiting hospital stays.

Emslie says he believes the ideal approach is to spend a month diagnosing the problem or multiple problems, since this is usually the case--and working out an individual treatment program for each child and observing his or her progress.

(over)

"At the end of that month, I like to decide if I could keep the patient for three months, could I get him or her to change or would long-term residential treatment still be needed? The best kind of kids to work with are those about whom you get a sense a movement, a sense of change going on in them."

What happens to the child or teen-ager when he or she enters the unit?

Eleven-and-a-half-year-old Carla was brought in by her family for evaluation recently. Looking at least 15, the girl entered the unit sporting a bleached blonde punk-rock haircut, tight jeans and a full makeup job.

Carla had been running away from home, "hitching" to the Texas coast with older friends and staying gone for a couple of weeks at a time. She is sexually active, and, her parents say, has been involved in physical fights with older girls over her boyfriend. Once there was blood all over the room after one of these fights, her mother reported.

As soon as one of the staff members replaced a missing button on Carla's low-cut blouse with a safety-pin, she and her parents were interviewed together by Janet Devaney, the clinical nurse supervisor. Then Dr. Art Mirzatuny, psychiatric fellow on the unit, talked with Carla and checked for any signs of neurological disturbances.

The next step was a meeting of social worker Margery Steindler and Devaney with the parents to acquaint them with the program that includes individual, group and family therapy in the special environment of the unit. In addition, individual staff meetings are held around each case, and the children and teen-agers attend regular school classes weekday mornings and afternoons. They also have physical activities, arts and crafts classes, field trips and fun activities, like going to the movies or bowling, all part of the total therapeutic approach to emotional disorders.

After meeting with the head nurse and the social worker, the parents and child sit down with the whole therapeutic team to decide whether or not the parents want the inpatient program for the child. The therapists also discuss whether they think the program would be helpful in that particular case.

The importance of family involvement in the whole treatment program is stressed again at this time.

The family is then encouraged to think about its decision and call back in a day or so. If the decision is for admission, an appointment is made.

On the day of admission staff members meet with the parents and introduce the child to unit personnel, his or her roommates, teachers and classmates.

It is the morning of Carla's first full day in the unit. She is already totally involved in the therapeutic program and is becoming a part of the group. The kids are up at 7:30, straighten their rooms and dress before breakfast. She has already discussed what her problems are and why she is here with her peers. They, in turn, have told Carla about themselves and why they are in the hospital program.

Twice a week she will meet with staff members and patients in a community meeting to talk about problems in getting along together and how to solve them, in addition to participating in daily small group meetings. She will also have psychotherapy with her psychiatrist, group therapy with the other kids and therapy sessions with her family.

A complete physical examination by one of the physicians is given to all patients in addition to the preliminary nurse's exam. Entering patients are also given a barrage of IQ and other psychological tests by Dr. Bettie Hardy, UTHSCD psychologist, who also functions as psychotherapist. In addition, any suspicion of physical abnormalities are checked out by EEGs, EKGs and other laboratory tests, and medical consultants may be called onto the case.

"One of the outstanding features of the Children's unit," says Waller, "is the fact that some of the finest consultants in the country are available right here in the hospital and through the medical school. I know of nowhere else in the country where this kind of expertise is so instantly available for pediatric psychiatric patients. This, along with the fact that complicated medical care can continue for patients in the psychiatric unit, is our greatest strength."

Dr. Kenneth Altshuler, chairman of the Department of Psychiatry, agrees that this is, indeed, a model program.

"Nowhere else in the state and at very few hospitals in the country are there psychiatric units capable of treating patients with severe disease-related emotional problems in a unit with other young patients.

"And we are fortunate to have staff like Graham Emslie from Stanford and Dave Waller from Johns Hopkins and Harvard."

Waller is board certified in pediatrics as well as psychiatry, and Emslie did some of his training in England under the National Health Services.

Another valuable staff member is Pattie Westerlage, educational coordinator for the Dallas Independent School District curriculum and supervisor of the support child-care workers. "Mrs. West," as she is called by the children, holds a degree in special education and has been working in the unit for 12 years. Besides acting as "school principal," Westerlage is an important part of the therapy team, working with the young people in setting their own personal goals and fulfilling them.

This working toward individual goals is an important part of the program. The patients are evaluated by staff toward this end, and privileges are granted on a point system. In order to reach Level IV, the level at which a patient is allowed field trips and fun outings, behavior has to be cooperative and attitude show that the patient is striving in areas of behavior that need improvement. Because five-year-old Laura is too young to deal with points and charts needed to reach Level IV, she has a special chart with stars and stickers where she can see her accomplishments.

Besides restriction of privileges, the "sit out" room is used for punishment. Patients who are "acting out", upsetting themselves and distrubing others, are sent to the "sit out" room, a place where they can go calm down without hurting themselves.

Eight-year-old Don, who has trouble with impulse control, is a frequent visitor. Don's family sent him to the Children's unit for evaluation because they had lost control of him. He was stealing, running away and setting fires. Testing showed that he had a low level of intelligence and possible neurological difficulties. Don also had a great deal of difficulty getting along with the other children and was always fighting. At the end of his stay, it was determined that he needed full-time residential care, and he was transferred to Terrell.

Restrictions are used frequently with 13-year-old Rod, who has been in and out of special psychiatric programs and seen a dozen psychiatrists over about that number of years. Although Rod does not test out with as high an IQ as his upper-middle class family expects of him, in some ways, such as mechanical aptitude, he is almost brilliant. In fact, psychiatric nurse Devaney says that there is no way the lock on the unit door could keep Rod in; he can pick any kind of lock in a minute. It is thought that the patient's hyperactivity could haveinterfered with his concentration, and thus his learning in his early school years, so that he got behind. Because of his hyperactivity and poor impulse control, Rod needs a lot of structure and discipline. Going home is not an option for this patient because of the conflict between the young man and his parents. Perhaps a highly structured boarding school and later life in the military will help Rod function better.

(over)

Since treatment plans are individual, each patient works with his/her therapists in pursuing individual goals and working to alleviate his or her emotional problems. Learning some basic trust in people was a goal of Shelly's. This patient says openly, "I don't trust my parents, and they don't trust me." Running away from home was one of Shelly's behavior problems, as it is with many of the patients referred for evaluation and treatment.

Staff therapists say Shelly has trouble perceiving reality in the behavior of people around her, and thus believes that her family is "always blaming me, picking on me." Also, the teen-ager refuses to believe she is depressed. She seeks control and direction in her life by being domineering and overbearing with her peers. Her goals include minding her own business, working on her own problems rather than those of others, not intimidating her peers and talking about her feelings with her family.

It's not always easy to know, or even find out, exactly what the basis of an emotional problem is. And many times the problem is so complicated that all the answers are never sorted out.

"Too often we don't know the cause--although we certainly try our best to find out--but we can diminish the disability," says Emslie.

This was the case with Janet, a young girl with cyclic vomiting to the point of dehydration. Janet had an hiatal hernia but whether the hernia was causing the vomiting or just making it easier couldn't be determined. However, life in the therapeutic environment was a major factor in teaching the girl to control the vomiting so she could live a more normal life.

Neurological and metabolic problems are often among the most elusive. Warren, for example, had an extensive metabolic work up. And with Laura, the only kindergartener in the unit during her stay, neurological testing, as well as metabolic, was given to determine if there were physical complications involved. The child had experienced early abuse and had not had a mother during her formative years.

Laura and her brother were brought to a local child guidance clinic by their new stepmother. The clinic referred Laura to the Children's psychiatric unit.

"When the stepmother first moved in, the children were just like little animals, scurrying from the room and hiding whenever they saw her. They were really lucky that the woman cared enough to want to help.

An engaging child with big blue eyes, Laura has learned how to get attention from adults now. But she has no sense of bonding to one special person, a goal the therapists are working toward with her. Since each patient has a "primary person" on both the day and evening shifts, personnel are working toward seeing that Laura, who charms one and all, goes to her special person to satisfy her physical and attention needs. In this way they are trying to teach her to establish the kind of relationship most children learn as infants or toddlers.

Other types of cases seen on the unit include hysterical paralysis and drug-induced schizophrenia. The latter involved 13-year-old Mike, a leukemia patient transferred from intensive care in the hospital. The strong steroids involved in Mike's chemotherapy caused the young man to think he heard voices telling him to curse at and spit upon people. As soon as his condition was stabilized, Mike was transferred to the psychiatric unit, taken off the leukemia drugs, given anti-psychotics and encouraged to participate in the therapeutic program with the other patients. The change was remarkable, and soon Mike was allowed to return home with his parents.

Emslie, however, does not consider the child "cured" or treatment over at the end of the hospital stay. He believes that the staff is responsible for working out and recommending a continuing program of therapy for each patient or patient and family. Referrals may be made to the UTHSCD Child and Adolescent outpatient program or a private therapist. A staff member may continue seeing the child and/or family on a continuing outpatient basis, or recommendation for special schools, therapeutic programs, such as the one sponsored by the Salesmanship

(MORE)

Club, or long-term care at either a state or private hospital may be made.

Sometimes the victories won in the unit are small. Sometimes they're large. And sometimes the battle is lost.

How do team members keep from getting discouraged when so often their efforts are tilting at windmills?

"I've worked in this field 11 years now," says nurse Devaney, "and over the years I've gotten such pleasure seeing kids gaining in their self-esteem. We also get rewards when we see parents bringingkids back to visit and hear that they're having girlfriends, now have friends to call on the phone. Some have grown up and come back to their home-away-from-home on their own. One former patient is an evangelist who's building a church, another's a construction worker, one's a naval officer stationed abroad. Their experiences here played a big part in making them what they are today. I think about these successes."

##

DISTRIBUTION: AA,AB,AF,AG,AH,AI,AK,SL