News
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***Child psychiatry residents offered emphasis on problems that span medicine and psychiatry.

DALLAS--Sometimes the question of which comes first--physical illness or disease-related emotional problems--is just like the question about the chicken or the egg. It really doesn't matter which comes first: you'll just waste a lot of time sitting around thinking about it.

Instead of wasting time, pediatric specialists interested in psychomatic medicine at The University of Texas Health Science Center at Dallas use a team approach in working with disease-related problems and behaviors in children and adolescents. Now, says Dr. David Waller, chief of Child and Adolescent Psychiatry and a specialist in psychosomatic disorders, a new dimension has been added to the school's residency in child and adolescent psychiatry. A new $17,933 Child Psychiatry Training Grant from the National Institute of Mental Health will enable the six residents in the two-year program to have special training to work with patients with diabetes, eating disorders, such as anorexia and bulimia, and affective disorders. The term "affective disorders" includes depressive and manic-depressive illnesses.

The health science center program is one of a number being funded by N.I.M.H. grants that allow in-depth training in areas of institutional expertise. Directing the UTHSCD program is Dr. Lawrence Claman, associate professor of Psychiatry. In addition to attending lectures in these special areas, the residents will work with patients having psychological problems in both inpatient and outpatient clinics and in consultation situations. They will also have the opportunity to be involved in research.

"The receipt of this grant opens up an invaluable opportunity for the Department of Psychiatry to serve medical education by offering its special expertise, both in research and patient care, to child and adolescent psychiatrists in training. We believe that the contribution of faculty members interested in diabetes, eating disorders and depression will be very important to residents with special interests while strengthening our community outreach," says Dr. Kenneth Altshuler, chairman of the Department of Psychiatry.

Dr. Graham Emslie, chief of the inpatient psychiatric unit at Children's Medical Center, estimates that about half of the patients there, who range from pre-schoolers through 17-years of age, have disease-related mental illnesses. In addition, Waller, who is certified in both psychiatry and pediatrics, attends medical intake rounds at Children's as a consultant. He says that in this way he is able to help other specialists spot children with acute medical problems who might be helped with their related emotional problems. As a part of the hospital team, he is able to get acquainted with the patient and the family and talk with them about psychiatric referral in a non-threatening way since all patients who have repeated hospitalizations receive a psychiatric consultation. Also, many of the in-patients Waller and his associates see for psychotherapy have problems that "span medicine and psychiatry," he says.

Besides members of the psychiatry team, other UTHSCD faculty involved in the training program include the following: Dr. John Chipman, diabetes, assistant professor of Pediatrics; Dr. Dan Foster, eating disorders, professor of Internal Medicine; Dr. Kathleen Zeller, eating disorders, assistant professor of Clinical Internal Medicine; Dr. John Rush, affective disorders, professor of Psychiatry; Dr. Warren Weinberg, neurology, associate professor of Clinical Neurology and Pediatrics; Dr. Bettie Hardy, psychology, assistant professor of Psychiatry; and Kathy Sedlet, nutritionist, instructor in Nutrition and Dietetics. Also working with the team is Dr. George Bo-linn, Baylor Medical Center gastroenterologist, who is a specialist in laxative abuse.

DIABETES

Pediatric-diabetes specialist John Chipman says that the addition of the psychiatric expertise to the diabetes clinic at Children's Medical Center will be a tremendous asset to the hospital program. Physicians there are currently following around 200 patients.

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Diabetes, he says, is one of several diseases that may be especially difficult to manage in adolescence. This is when teens are working out issues such as a stable identity and independence from their families. They're looking for career paths and developing relationships with peers. At the same time their disease is imposing daily constraints on them: they have to take regular blood-sugar tests, give themselves insulin shots and stay on a "diabetic diet" rather than eat typical teen junk food like their friends. There may be pressure to drink alcoholic beverages, and pregnancy brings special hazards to the diabetic adolescent. The biologic changes during puberty further complicate the teenager's changing insulin and nutritional needs, thus requiring more frequent clinic visits in order to monitor the patient's progress.

Add to these considerations any home problems--such as alcoholism, poor parent/child relationships or psychiatric problems with any family member. In addition, says Chipman, if the patient and the family are using the disease to manipulate, then both the care of the disease and the process of growing up is interfered with. The psychiatry team will be an important asset in evaluating these particular families and in helping them develop new skills.

The goal is to help the young person to act responsibly in living with a disease in which non-compliance with treatment can be life-threatening.

While the majority of children and teenagers do just fine, sometimes outpatient psychotherapy sessions or even hospitalization in Children's inpatient psychiatric unit is necessary. "The care--or, rather, lack of care--of diabetes may be just a symptom of more complex problems such as depression or acting out. It can even lead to suicide, as in the case of one patient who tried to shoot herself" on a parking lot.

Chipman is involved with Waller in research on the diabetic patient's family-support system and its relationship to metabolic control. Waller recently presented a paper on this subject at the annual meeting of the American Academy of Child Psychiatry in Toronto, Canada. Preliminary results with 40 out of 80 patients being studied show a high correlation between warmth/caring and guidance/control with medical compliance.

EATING DISORDERS

Another disorder that can be life-threatening to the patient is anorexia nervosa. Waller believes that cultural ideals, such as the super-thin fashion model and the slim starlet are contributing to the rising number of female patients.

The typical patient with anorexia is a teenage girl who restricts her eating severely while maintaining to herself and others that there is nothing abnormal about her rapid weight loss of around 20-30 percent. It quickly becomes apparent to those around her that the image they see and the image she sees in her mirror are quite different: she "sees" herself as fat and in need of further dieting even when literally at the point of starvation.

A whole spectrum of symptoms should be examined when diagnosing anorexia, Waller explains. The sudden drastic weight loss is the overriding indication, but certain attitudes and behaviors concerning weight and food also constitute critical factors. Another indicator is the patient's false self-image. Anorexics tend to choose high protein diets with lean meats and fresh fruits and vegetables, often supplemented with large vitamin doses. The victim may also induce vomiting and/or take laxatives.

Another clue is an obsession with exercise. Emslie says that the compulsive behavior he sees in his anorexic patients is often exhibited in the perfectionistic performance of certain physical tasks, such as cleaning, mowing the lawn, dancing, swimming or diving. In fact, many anorexic patients are dancers or athletes.

Females with anorexia may cease regular menses with weight loss and lack of proper nutrition, says Waller. Immature patterns of luteinizing hormone (LH) secretion, which is necessary for ovulation, underly the disorder. Waller finds other evidence of hypothalmic dysfunction in anorexics, including impaired thermoregulation, leaving the patient chilled; partial diabetes insipidus, a metabolic disorder that can lead to kidney problems; and a reduction in pulse and blood pressure. In addition, there is an increase in soft, downy body hair that is light in color.

A related eating disorder is bulimia. Like anorexia bulimia is also treated in both outpatient and inpatient programs, as well as on-going research in these areas.

The patient with this disorder exhibits bizarre behavior, including the compulsive vomiting of food, usually coupled with regular use of diuretics and laxatives, says Waller. Although bulimia is also associated with teenage and young women, as in anorexia, victims may be of any age or sex. While the patients with anorexia may be described as "restrictors," the patients with bulimia more nearly fit the description of "gorgers." While bulimics

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would like to restrict their eating all the time, they tend to go on giant eating "binges," followed by self-induced vomiting. The bulimic may also take large and frequent doses of laxatives.

Besides being dangerous to the patient's health--as well as flirting with possible death--these disorders are psychologically devastating, says Waller, who has seen eating-disorder patients for 11 years. The patient with anorexia sees the reaction of friends and family to her weight loss and compulsive behavior as threatening. She then becomes deceitful and further isolates herself, drawing more and more into her rigid, compulsive inner-personal world. The home is thrown into game behavior with the family trying to force the victim to eat and the victim resisting with all her will.

Waller believes the bulimic patient to have special problems with sensitivity to certain kinds of pressures. The bulimic's "bingings" is a way of relieving anxiety. Also, they get a feeling of "being in charge" by controlling the "binge/purge" behavior. However, at a certain point this behavior may start controlling the patient.

DEPRESSION

The third area of training under the grant is in childhood and adolescent depression. While many people overlook the fact that depression is a pediatric problem, not so Emslie. The child and adolescent psychiatrist sees depressed patients both in the hospital and as outpatients.

"Unfortunately," he says, "depression is a common problem in young people. And it is often seen in the hospital setting. A child or teenager who has acute diabetes or a severe seizure disorder may be overwhelmed by depression. In addition, a child can be the victim of depressive illness without any accompanying physical problems.

"Also," says Emslie, "the same biological markers that we know are present in depressed adults may be present in children and adolescents. Diagnosis is difficult, however, because it's hard, especially for younger children, to talk about being depressed."

Some of the specific symptoms and signs of the depressive syndrome include increased feelings of guilt and suicidal thinking; difficulty in concentration coupled with decreased energy, weight, appetite, sleep and sexual desire; and a depressed, sad or anxious mood.

Waller is very excited about the relationship between the residency program and the Affective Disorders Unit, headed by Rush. The unit is involved in research, patient care and medical education in endogenous and non-endogenous depression, manic depression and other related illnesses.

Endogenous depression, Rush explains, may be thought of as "biological depression." "At least biological abnormalities are frequently found in that group. There may be external stressers, but when an endogenous depression gets started, it seems to have a life of its own." Patients with endogenous depression tend to exhibit such symptoms as diminished capacity for pleasure, sex drive and appetite, as well as sleep problems. Thus, it is suspected that the condition is connected with the limbric system of the brain, the system that controls emotion. Non-endogenous depression may be thought of as depression that follows unhappy or unfortunate life events. "Of course," the affective-disorders expert says, "it's not that easy to separate the two in real life."

In contrast to the depressed patient, the manic depressive often experiences wide mood swings that may range from a deeply depressed state to one of extreme elation. These patients sometimes get into tangles in their lives through their bizarre reactions in the manic stage.

Research in the Affective Disorders Unit includes developing diagnostic tests for specific illnesses, finding methods to determine the appropria treatment for the individual patient and mapping brain regions by blood flow as an indicator of specific mental conditions in collaboration with Dr. Frederick Bonte, director of the Nuclear Medicine Center, and Dr. Michael Devous, assistant professor of Radiology.

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