TRIMS • THERAPY • NOTES

The TRIMS program for nonresponding schizophrenic patients

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About a year and a half ago, the TRIMS inpatient service and biological psychiatry section began an evaluation and treatment program for schizophrenic patients who were responding poorly to neuroleptic medication. This report is an update on the program and a clarification of our referral standards.

So far 19 nonresponding schizophrenic patients have been admitted to our research inpatient service. Five patients were referred but not accepted because our review of their clinical records and conversations with their physicians suggested that the patients were not diagnostically or behaviorally appropriate for our study.

The referring facilities have been Big Spring State Hospital (6 patients), Austin State Hospital (8), North Central Texas MHMR Services (1), San Antonio State Hospital (1), Rio Grande State Center (2), Wichita Falls State Hospital (1). A patient from Oklahoma will be admitted to the unit if the referral is approved by TDMHMR.

The patients admitted to TRIMS have received an extensive diagnostic workup including multiple rating scales, nuclear magnetic resonance or computed tomography brain scans, neuropsychological tests, and controlled trials of one or more standard neuroleptic medications, with weekly monitoring of drug blood levels.

Eleven of the 19 patients improved sufficiently during the research and treatment program to be discharged back to their facilities with a recommendation for home or community placement, if possible, and no current need for hospitalization. Four of these patients were not placed in the community, however, either because appropriate community treatment was not available or because they had no relatives to care for and house them.

Four patients achieved some clinical improvement but were not considered ready for hospital discharge or community placement. Four patients were returned to their hospitals after no or minimal improvement, and with our recommendation for low- or moderate-dosage neuroleptic maintenance and avoidance of high-dosage neuroleptic treatment. Although these four patients did not improve substantially during the treatment trials, we documented their minor improvement during treatment with standard neuroleptic drugs and suggested a drug treatment program that is likely to reduce the patients' risk of developing tardive dyskinesia.

Two case examples demonstrate the types of treatment outcomes that might be expected from our program.

Patient 1, a 27-year-old man who had been hospitalized many times for schizophrenia, improved substantially. His CT scan showed very mild cortical atrophy. He was treated with thioridazine for about six weeks, with dosage adjustment based on his drug blood levels. At therapeutic drug levels he achieved a 20-percent reduction of psychotic symptoms. During subsequent treatment with 40 mg/day of thiothixene, and drug plasma levels of 6.5 ng/ml, his psychotic symptoms improved 55 percent. His family believed he was better for the first time in several years. He was discharged to his family and is being followed up at a community mental health and mental retardation center.

Patient 2, a 42-year-old woman who also had had multiple hospitalizations, responded slightly to the controlled treatment trial. Her CT scan revealed moderate cortical atrophy. She was treated with haloperidol, with the dosage adjusted every few weeks according to her blood-level test results. Although the patient achieved therapeutic blood levels of 9.2 ng/ml at 12.5 mg/day of haloperidol, her psychosis, evaluated by multiple rating scales, did not improve. When her medication was changed for several weeks to thiothixene, 40 mg/day, her psychopathology scores improved slightly, about 15 percent. The staff's evaluation was that the patient had probably reached the best possible improvement with standard neuroleptic medications and would not benefit from additional treatment in our program. She returned to her referring state hospital with a recommendation for maintenance on low to moderate dosages of neuroleptic drugs (e.g., 20 to 30 mg/day of thiothixene or 10 to 15 mg/day of haloperidol). Our recommendation was that high-dosage neuroleptic treatment would not be likely to improve her clinical condition but might increase her risk of tardive dyskinesia.

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Research Reports

Three times a year *TRIMS Therapy Notes* will publish brief notices regarding some of the research carried out at TRIMS and other TDMHMR facilities. These are to inform TDMHMR staff members about who is doing what research for what purpose, and how the studies apply to treatment of the department's clients and patients.

These notifications will seek to provide the essential elements of the research protocols: name of the principal investigator (PI), facility, title of protocol, a brief description of the project, its purpose, and applicability.

All research done by TDMHMR staff members or involving patients and clients of the department must first be reviewed and, as appropriate, approved by the Central Office Research Review Committee (CORRC).

Research Reports will include three types of CORRC-reviewed protocols: those newly approved, those in progress, and final reports of completed ones.

More detailed information about a protocol may be obtained from its principal investigator.

Albert S. Moraczewski, O.P., Ph.D.
Executive Secretary, Central Office Research Review Committee, and TRIMS Liaison Officer for Research and Consultation

Final Reports

***Attitudes of institutional staff toward the sexuality of the mentally retarded (82-0047)*-completed.**

PI: Lisa Schultz Mann, Richmond State School (713) 342-4681 (STS 853-9011).

A multidimensional questionnaire designed to assess attitudes toward the sexuality of the mentally retarded was administered to staff members at a large residential facility for the retarded. Questions dealt with heterosexual behavior and masturbation, as well as respondents' demographic characteristics. Sexual behaviors were arranged in order of increasing intimacy, and respondents were to indicate the acceptability of these behaviors in public and in private, for three types of people: the retarded in institutions, the retarded in the community, and normal persons. Significant prejudices against sexual expression by the retarded were evident. Of the three groups, the institutionalized retarded were afforded the least sexual freedom, followed by the retarded in the community, followed by normals. Both higher education and male gender correlated positively with sexual liberality. Religious belief correlated negatively with sexual liberality.

Applicability. The findings will help in designing sex education programs for clients in state schools and in formulating institutional policies concerning the allowable expression of sexuality.

***Family therapy dropout and therapist-patient family environments (79-0019)*-completed.**

PI: Carlo C. DiClemente, Ph.D., Texas Research Institute of Mental Sciences (713) 797-1976, ext. 6405 (STS 874-6405).

Premature termination from family therapy is estimated to be quite high. This study used the Family Environment Scale (FES) to examine 103 patients and their therapists for differences between dropouts and continuers. Dropouts (N=64) did not differ from continuers (N=39) on any demographic characteristics. A discriminant function analysis yielded one significant discriminant function ($p<.005$), which produced a highly accurate prediction rate (80%) for the dropouts and continuers. Continuers tended to be higher in independence and moral-religious emphasis and lower in intellectual-cultural orientation, to have greater discrepancy on conflict and less on control with therapists' families of origin, and higher discrepancy scores on intellectual-cultural orientation with therapists' ideal families. Personal growth dimensions of the patients' family environments and differences with the therapists' families of origin on a relationship dimension (conflict) and a system maintenance dimension (control) may subtly influence the patient-therapist interaction and continuation of family therapy.

Applicability. The training of family therapists may benefit from a consideration of these findings. In choosing therapists for particular patients, a better match of their respective families may reduce the likelihood of premature termination of therapy.

***Moderating the relocation effect in geriatric alternate care placement (80-0024)*-completed.**

PI: Mark S. Mosty, M.A., Kerrville State Hospital (512) 869-2211.

This study was designed to investigate the nature of stress associated with involuntary relocation of chronic geropsychiatric patients to nursing homes and to develop strategies for alleviating untoward effects. A secondary issue dealt with the effects of relocation on mortality rates among this group.

In spite of modest efforts at relocation counseling, there was no significant difference in mortality rates between those who had received traditional counseling and those who had not. The study tends to confirm previous findings of an upward shift in mortality rates following relocation as well as the observation that mortality is highest in the first three months after relocation. Further study is required to identify the important factors that contribute to higher mortality.

Applicability. Increased awareness of problems related to the relocation of elderly patients and factors that either lessen or increase morbidity and mortality in such patients will enable staff members to select and care for patients who need to be moved.

***Obesity levels in 553 institutionalized mentally retarded adults (81-0075)*-completed.**

PI: Richard A. Ness, Ed.D., Denton State School (817) 387-3831, ext. 4501 (STS 893-3011).

This study was the first attempt to calculate percentages of body fat in an institutionalized mentally retarded population that included mildly to profoundly retarded adults.

The data revealed that the level of total body fat was higher in those less retarded. It is believed that the supplemental caloric intake (available upon request) and the lack of regular gross-motor activity by higher-level residents are major and direct contributors to the steady increase in percentage of body fat found in clients at each decreasing level of retardation (profound to mild) in this study.

Applicability. The findings may contribute to improving the physical health of mentally retarded adults. Greater attention both to dietary intake by less retarded adults and to the quality and amount of physical activity will help to decrease the body-fat percentages of residents.

***The development of an MMPI-based scale to measure personal responsibility (82-0034)*-completed.**

PI: Robert William Federman, Ed.D., Wichita Falls State Hospital (817) 692-1220 (STS 836-9222)

The purpose of this study was to develop and provisionally validate a self-report psychological test to measure personal responsibility (which includes the elements of personal accountability, capability, and unselfishness). The results were encouraging, but substantially more research will be necessary to validate such a personal responsibility scale.

Applicability. When validated, this personal responsibility scale will provide potentially another way of measuring and tracing an individual's mental health.

Approved Studies

***Joint attention and communication in autism (83-0064)*-approved Jan. 25, 1984.**

PI: Katherine A. Loveland, Ph.D., Texas Research Institute of Mental Sciences (713) 797-1976, ext. 6694 (STS 874-6694).

This research concerns the role of nonverbal attention-directing behaviors, such as looking and pointing, in the language and social development of autistic and other developmentally disabled children. The following groups will be included: 30 autistic children previously seen (follow-up), 15 autistic adolescents, 15 Down's syndrome adolescents, 15 younger Down's syndrome children, 15 children with early-onset pervasive developmental disorders. Children are observed in videotaped, unstructured play sessions with a parent, and in structured play sessions with investigators. Tasks assess language and gestures, awareness of differences in points of view, speech acts of and patterns of interaction. Specific aims are to investigate developmental aspects of the autistic child's communication skills and those of other developmentally disabled groups. Factors such as IQ, acquisition of words and grammar, and level of joint attention skills are hypothesized to interact over time to produce different levels of communication effectiveness in autistic children.

Applicability. The study will contribute to improved understanding of the development of the autistic syndrome, assist in the differential diagnosis of developmental disabilities, and provide improved methods of assessing the autistic child's functional deficits and strengths in communication.

***Family relationships in affective disorders of the aged (83-0048)*-approved Jan. 25, 1984.**

PI: George Niederehe, Ph.D., Texas Research Institute of Mental Sciences (713) 797-1976, ext. 6715 (STS 874-6715).

This research is directed at defining the interpersonal behaviors and perceptions that typify the family relationships of elderly depressed patients. Families with elderly depressed, normal control, or other psychiatric control members will be evaluated and followed over time to discover family characteristics that may be associated with positive or negative clinical outcomes. Both the elderly patient and a close family member will receive comprehensive clinical evaluations, complete standardized psychological tests and questionnaires, and be videotaped in interaction with each other. The role played by other family members in late-life depressions will be analyzed, as will the impact of depression on the physical, mental, and social well-being of collateral relatives.

Applicability. Depressive episodes are prevalent in the elderly population, and they seem to become more chronic or recurrent in many patients with increasing age. This project will enhance the department's ability to deal with the family issues involved by identifying interactional patterns and other critical factors to aid clinical understanding of, and intervention in, late-life depressive disorders.

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Call the TRIMS consultation service for diagnostic or treatment advice, or for a literature search on a specific topic.

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We are actively seeking more referrals to our schizophrenic nonresponder program. Patients should be between the ages of 18 and 52 and be diagnosed as schizophrenic by strict *DSM-III* criteria. The patients should be able and willing to give written consent to participate in a research treatment study, should not be mentally retarded, not show violent or disruptive aggressive behavior, and should not have a major physical illness or alcoholism.

The referral process for transfer to TRIMS usually takes three to eight weeks. A detailed clinical history and chart review, as well as telephone consultation with the treating physician and the chief of our inpatient research team, Dr. Ravichandran, is required before a patient can be evaluated for acceptance in the program. The referring hospital must agree to allow the patient to return after our evaluation and treatment program has been completed, or at any time that the TRIMS staff believes that the patient's further participation in the program is inappropriate.

Several kinds of problems have arisen in the referral of patients.

1. Patients with inappropriate diagnoses have been referred—for example, patients diagnosed as having schizotypal or borderline personality problems, alcoholism, or mental retardation. If we believe that a patient does not fit into our program, our physicians will not accept the patient but will try to give diagnostic or treatment advice in a phone consultation.

2. Our research treatment program usually lasts two to four months. Patients transferred to our program while they are on brief civil commitment often cannot complete their treatment before the commitment period is over. They will, therefore, have to be transferred back to their referring hospital with an incomplete diagnosis and treatment evaluation, and they may not fully benefit from the program.

If you have a poorly responding schizophrenic patient who meets the outlined criteria and whom you would like to refer to our program, please call one of these persons at TRIMS: G.K. Ravichandran, M.D. (713) 791-6706; Rhonda Johnson (713) 797-1976, ext. 6380; or Robert C. Smith, M.D., Ph.D. (713) 791-6609. Our STS prefix is 874.

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