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DEPARTMENT OF PUBLIC WELFARE

TO: All Medical Services Division Institutions  
Attention: Medical Directors  
Administrators  
Social Services Directors  
Nursing Services Directors  
Task Force

May 2, 1966

FROM: David J. Vail, M. D.  
Medical Director

SUBJECT: Articles from Roche report regarding mental retardation

I bring to your attention these interesting articles from the April 15, 1966, issue of the Roche report, Frontiers of Hospital Psychiatry. They are about projects concerning treatment of the mentally retarded.

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Ending the hopelessness surrounding "headbangers"

One of the most difficult problems faced in institutions for the mentally retarded is the management of a group of children who are persistently and violently self-destructive, striking their heads and faces against solid objects and with their fists and knees. Commonly called "headbangers," these children generally have exhausted parents and patient staff members and often are restrained and isolated in the "back wards" to prevent further self-destruction. Frequently, an attitude of hopelessness towards these children prevails. However, recent studies at Sonoma State Hospital at Eldridge, Calif., indicate that these children are not as resistant to help as was once believed.

Isolation increases a sense of alienation and bewilderment and thus further ingrains the pathologic behavior pattern, Larry H. Dizmag, M.D., who carried out these pioneering studies of these children, told ROCHE REPORT in an interview. Dr. Dizmag said that institutional attitudes may contribute to this self-destructive behavior and can make it "just as irreverable as if it were due to irreparable neurological changes."

The institutional label, "headbanger," often implies complete rejection. "Yet, headbanging," Dr. Dizmag said, "may indicate positive therapeutic potential if viewed as a complex and effective, yet pathologic, maneuver to communicate. It suggests these children have more ability than . . . usually given credit for."

Dr. Dizmag began an intensive therapeutic study of 5 headbangers in January, 1965, at Sonoma State Hospital, while in the Napa-Sonoma State Hospital

#2 - May 2, 1966

psychiatric residency program. He is presently with the National Institute of Mental Health, Bethesda, Md.

By June, the children "made very significant and often dramatic improvement in their behavior," Dr. Dizuang said. "They needed less restraint, developed new and constructive ways to communicate their needs, and most significant, began to reach out and explore the world." The progress of one girl, Jeanne, was recorded in a film, The Headbangers. When Dr. Dizuang first saw Jeanne she needed constant restraint, had permanently blinded herself, and had been recommended for lobotomy. After a few months, she was functioning at a level never before envisioned. In May, she began talking.

Although headbanging is often attributed to "severe mental retardation" it can occur in almost all diagnostic categories, Dr. Dizuang said. "Severe mental retardation" is a very poor etiologic diagnosis for headbanging or any behavioral problem, and is often a means of avoiding a closer look at the symptom and its meaning." Dr. Dizuang considers headbanging "one manifestation of a defective ego development." He defines ego function as the way a person perceives and deals with reality, communicates, and relates to himself and to the world. "To sort defective children on the basis of intellectual measurement is a gross oversimplification," he said. Many ego functions must be examined "in the context of a dynamic and meaningful human relationship.

"The project's success," Dr. Dizuang said, "resulted from recognition that self-destructiveness arises not only from psychic disruptions within the patient, but also from interactions with the environment. Any therapeutic efforts limited to the children would be ultimately doomed to failure, as had been true in the past with this kind of patient."

Dr. Dizuang first convinced hospital administrators that a special program was needed for these children, and that much of the therapeutic effort would involve the nursing staff. The staff included a registered nurse, Mrs. Doornal Nichols, and 7 psychiatric aides. They were exempt from relieving in other wards, and were not to be transferred from the unit unless they so requested. This gave the children "a unique chance to experience consistency in their environment." The only previous consistency was custodial routine. This prevented the children from forming meaningful relationships with any person, Dr. Dizuang said. In the project, schedules were sacrificed so that the same 2 or 3 people could always work with a child.

Dr. Dizuang selected 5 of the most severely disturbed children with untestable I.Q.'s. Ranging in age from 9 to 14 years, they were unresponsive to tranquilizers and required almost constant restraint to prevent headbanging. They were moved to "the intensive study unit for the emotionally disturbed," a small ward physically and administratively isolated from the rest of the hospital, because "the institution, like the family, often tries to unconsciously block further therapeutic efforts when the child begins to improve," Dr. Dizuang said.

"The most important part of initiating the program," Dr. Dizuang told ROCHE REPORT, "was a 2-day seminar held exclusively for the new staff to help them shed

#3 - May 2, 1966

custodial roles and become a significant part of the research unit. By the second day, enthusiasm was high and goals seemed attainable. Our objective was not to cure the children but to better understand their behavior. Since almost nothing was understood about these children, this seemed a relatively easy goal to attain."

#### Finding the answers

Early in the project, Dr. Dismang spent considerable time exploring ways of relating to the children, dealing with staff frustration and anxiety, and helping the staff relate to one another. "When Jeanne began hitting herself," he said, "I would stop and ask the staff, 'Why now?' Soon they not only 'listened' to behavior they never heard before, but also asked, 'Why?' and began finding answers. They discovered that understanding the children's 'language' seemed to reduce their self-destructiveness."

One day, someone noticed that loud noises often caused Jeanne to hit herself. The staff felt guilty because recognizing this earlier might have prevented Jeanne's blindness. To deal with their guilt and resentment of the hospital, Dr. Dismang said, "I helped them realize that while we couldn't change the past, we might learn enough to prevent other 'Jeannes'."

"As anxiety developed with the staff's increasing involvement," Dr. Dismang said, "I became less a model of how to listen to the patients, and more a mental health consultant. Using mental health consultation, it was possible to help the staff cope with the normal anxieties that resulted when they could no longer use the psychological defense of dehumanization, and treat the children as objects or wind-up toys. It was important to help the staff deal with 'defenses against closeness' and ego insults from the children who were defending against the devastating threat of another meaningful but -- from past experience -- temporary relationship."

Mental health consultation, according to Dr. Dismang, is a basic clinical technique requiring a "combination of psychiatric skills." It involves model setting, suggesting courses of action, and drawing parallels in a teaching -- rather than insight-giving -- sense.

Consultation often dealt with euphoria and anxiety the staff intermittently felt as the children backslid after progressing. Dr. Dismang explained this as part of the process of normal ego growth and development, and helped the staff express both positive and negative feelings toward the children. He told of his initial angry feelings when Jeanne threw grape juice at him one time, using this episode to show it was not "bad" to feel angry or frustrated. He showed how such an incident could be used to communicate with Jeanne who, in this case, was clearly testing whether he would reject her.

Consultation dealt mainly with staff relationships to the children and to a lesser extent with intra-staff relationships. Dr. Dismang believes "many other behavioral disturbances in hospitals for the mentally ill or retarded will

#4 - May 2, 1966

respond to a carefully planned program where the primary therapeutic tool is mental health education and consultation. This would go beyond "milieu therapy" as practiced in most hospitals today." He emphasizes that long-term follow-up and evaluation are needed to understand why these particular children used "headbanging" as their major method of interacting with themselves and their environments. He concludes, "There is little question that appropriate alterations in the environment can reduce or eliminate the use of pathologic headbanging by the child in a fairly short period of time."

#### Residents benefit

The intensive study unit continues at Sonoma State Hospital, and a sixth patient has recently been accepted. One facet of the residency program in which Dr. Dismang participated is based on the premises that the mentally retarded, as a teaching resource, have as much to offer the psychiatric resident as the resident has to offer the retarded. James C. Dawson, M.D., director of the residency program at Sonoma, believes that in the case of the headbanger project, this premise was well borne out.

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#### Disturbed retarded children present "unique" problems

Of 616 children referred to the Nebraska Psychiatric Institute, Omaha, as suspected retardates, 151 displayed both mental retardation and emotional disturbance, thus presenting unique clinical problems that are not generally appreciated, according to Frank J. Menolascino, M.D. Diagnoses combined mental retardation with chronic brain syndrome and behavioral reactions (24), or psychotic reactions (27), with adjustment reactions of childhood (39) with unspecified psychiatric disturbance (11) and with functional psychoses (5).

Treatment approaches to disturbed retarded children must "address themselves first to the global nature of the child's interactional problems, and only secondarily focus on specific handicaps such as a seizure disorder, motor dysfunction, or speech and language delay," the investigator said. "No treatment approach is successful unless a long-range working relationship with the family has been established. However, with the establishment of such a mutual contract of help with the family, these multidimensional treatment needs can be delineated, augmented and followed through. Here, the psychiatrist must open his vistas to the special contributions of the allied professions in his efforts to arrange a life-plan for the child which will be both therapeutically positive and eventuate in self-realization for the child. In such treatment planning, we have noted that it is helpful to focus not on what the child present is but on what he can be."

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#5 - May 2, 1966

Mental retardates' behavior altered by reward techniques

BERKELEY, CALIF. — The social behavior of 16- to 19-year old mental retardates in workshop setting can be modified by operant conditioning procedures, according to James R. Lant, Ed., D., University of Kansas, Bureau of Child Research, Parsons State Hospital and Training Center, Kan. In turn, productivity and the patient's chances of vocational placement outside the hospital are increased.

First, tokens were given as a reward for working and for abstaining from behavior detracting from work output. The terms of token delivery were made clear. The effectiveness of this type of reward was further established by exchanging the tokens for money and taking the patients on a shopping expedition in town.

The following behaviors during working hours were labeled "negative": talking, nonverbal play, nonproductive work, sexual contact, unmannerly conduct, grossly immature actions and defiance of authority.

A token was automatically dispensed to each of the 3 workers in this pilot study, every minute during the 4-hour working period; however, whenever the patient behaved negatively, no tokens were forthcoming for a 2-minute period. At each misbehavior, a light above the token dispenser would appear and would last throughout the tokenless period. This served to make the patient aware of the reason for withdrawal of reward.

In response to this conditioning, maladaptive conduct while working was reduced and continued abated after termination of the experiment. How long this will last is now being observed.

Operant techniques are also being employed to curtail antisocial behavior of patients 6 to 19 years old in different settings. Frustrations in dealing with these behaviors, such as stopping food-stealing from another's tray in the dining room, is leading to refinement of reward techniques, Dr. Lant told a joint meeting of the Association for the Advancement of Science and Western Psychological Association.

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Illinois converts VA hospital for use with retarded youth

DWIGHT, ILL. — The former Veterans Administration hospital here has been transferred to the Illinois State Department of Mental Health for use as the William W. Fox Children's Center for retarded youth.

The new facilities and staff have made it possible for 80 profoundly retarded, physically handicapped patients to receive an intensive course of physical therapy, according to Mr. Merlin Lagnor, mental health educator at

#6 - May 2, 1966

Fox Center. Prior to the transfer, only 2 of the 40 girls and 40 boys could walk and only one could feed himself, Mr. Legner told ROCHE REPORT. However, after only 2 months of physical therapy, 14 of the patients are walking and 5 are able to feed themselves. The patients, most of whom have I.Q.'s below 20, range in age from 6 to 14 years.

Fox Center has a capacity of approximately 250 and it is expected that additional patients will soon be admitted from other state institutions, Mr. Legner said.

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