Develop. Med. Child Neurol. 1967, 9, 506–510

The Psychiatrist and the Handicapped Child

*A Report from a Study Group**

A SMALL international study group met at Alfriston from March 9th to 12th, 1967 to discuss neuropsychiatric disorders of childhood and the role of the psychiatrist in the care of neurologically handicapped children. The group, deliberately a small one, included paediatricians, paediatric neurologists, child psychiatrists and psychologists, but did not include a number of other disciplines which are regularly involved with the care of chronically handicapped children. Inevitably the role of other members of the team was from time to time discussed and in drawing up a report the group were exercised by the problem of making pronouncements on aspects of the care of handicapped children on which they were not fully qualified to speak. Moreover, as an international group, we did not consider in any detail local service arrangements as these are bound to be very varied. We have tried, therefore, to concentrate on the actual working role of the psychiatrist and psychologist and not to involve ourselves in the intricacies of service problems. As we emphasised above, these children must be cared for by multidisciplinary teams and the close co-operation of members of the team is the first desideratum.

1. The Organisation: Need for Psychiatry

Children with chronic neurological handicaps can no longer be the concern of a single specialist. They are more appropriately seen in clinics, especially organised for the study and care of such children. We have not been concerned here to discuss where such clinics are most appropriately placed—*i.e.*, in association with hospital outpatients, or with a special school. Different communities will experiment with different solutions to this problem, but whatever the setting and the personnel, the clinic must have close relationships with other local community services and with local community administrative departments. It must be in close touch with the schools to which the children are likely to be sent, and where appropriate, with the medical officers of the schools concerned. Normally the major medical role in such a clinic will be played by the paediatrician, or the paediatric neurologist. He will be responsible for integrating the contributions of the many medical and other specialists who are concerned with the different aspects of the child's problems and it will be his particular concern to see that the care and therapy suggested are fitted into an overall pattern which is acceptable to the child and his family. He will be concerned to see that the parents and the handicapped child do not receive conflicting advice from different experts. The organisation of such clinics has recently

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been discussed in an annotation by Dr. K. S. Holt (*D.M. & C.N.* 1966, **8**, 770) and it was our task to consider how the child psychiatrist could be incorporated into the work of these units and consider what his role was in the care of these children.

In the past the child psychiatrist has frequently been involved at a late stage when a 'psychiatric crisis' has occurred. This has involved detailed psychiatric study of the child at a stage when effective treatment has often been difficult. On the other hand, were the child psychiatrist to attempt to assess all neurologically handicapped children, the already over-stretched psychiatric services would be unable to cope with the large numbers of children involved. At least for the time being, such intervention is impossible. Moreover, we doubt if it is the most economic way to employ psychiatric manpower.

Nevertheless, there is good evidence now that these children are at risk of psychiatric disorder. Rutter (to be published) demonstrated in the Isle of Wight that children with neurological handicaps have several times as much psychiatric disorder as 'unhandicapped' children. It is difficult to say whether this is a primary phenomenon due to basic brain injury, or whether it is a secondary effect or due to a combination of both. In any event, the types of disorder seen are not dissimilar to those seen in children without physical handicap. But, whatever the cause, the child psychiatrist should be an integral member of the team treating these children but he should normally be playing a consultative role. Clearly in some cases where the psychiatric disorder is severe the psychiatrist will play a more central role, but the group were concerned with the additional problems the child might face if this involved transferring him. The psychiatrist must be easily available, not only to see particular children presenting particular problems, but for discussion with other clinicians about the prevention and management of psychiatric disorders in childhood. At each age range he has specific interests and these are outlined below.

In a clinic for handicapped children skilled psychological assessment and skilled social work are essential. Both psychologists and social workers are members of the team and the information they obtain will often be crucial, and must, therefore, be freely available to all members of the team. The integration of the work of the members of the team is discussed later. While the concept of the multidisciplinary clinic with a number of experts jointly discussing cases is an acceptable one, the amount of professional time, and hence money, involved, is extravagant. Many cases may, in fact, be studied by two or three members of the team who will use the knowledge and experience they have gained from other colleagues during case conferences on particularly difficult problems.

2. The Contribution of Psychiatry

The Infant

The psychiatrist has traditionally an investment in the importance of the psychodynamics of early mother-infant family relationships. Where these are disturbed his advice may be sought at an early stage. Careful social work with the family may be important. With the increasing complexity of obstetrical care, it is as well to be aware that the mother may be severely disturbed before the birth of the child. Kolvin outlined for us a case where a mother whose infant had been transfused in utero had become convinced that her child was handicapped and where hospital admission was necessary. It was important to be able to identify the children and families who were likely to be at risk of this sort of disorder, and this would involve close relations with obstetric units.

The Pre-School Child

In this group of children the importance of so-called minor disorders, such as late speech development or clumsiness, was discussed. It was hoped (although there is no evidence one way or another) that early treatment will improve the prognosis of these conditions. In some instances, either as a direct phenomenon or as a secondary effect, behavioural (*e.g.*, hyperkinetic syndrome) sometimes with emotional problems will arise. In these instances again, the psychiatrist's advice will be important in management.

The School Child

The age at which a child goes to any particular school will vary with the individual, but information is required not only about the educational side of such schools but the 'care' side. The combined assessment of the child should lead to advice being available about the placement in a specific school. The existence of multiple handicaps in many of these children makes the use of particular labels like 'maladjusted' inappropriate, and we in the study group were interested to hear from Melchior of an experiment in the Danish schools to get around this 'labelling' of the child.

For many children *residential* placement is a consequence of psychosocial problems (*e.g.*, epileptics rarely require placement for their epilepsy alone) and in these instances the psychiatrist will be involved in assessing the total family situation and dynamics. A move to a residential school is sometimes suggested, or becomes necessary, when the child is 9, 10, or 11, and we were made well aware of the dire effects of incorrect assessment and misplacement. (We were concerned with the ill-organised special school service in the U.K. and, as above, with the relevance of labels such as 'maladjusted' but discussion of these problems was beyond our remit.) As in the pre-school child, early consultation with the psychiatrist about problems which may arise in the school may be preventative and obviate the need for lengthy psychiatric study. The psychiatrist, we were reminded, is concerned with optimal development.

Adolescence

The problems of normal adolescence may well be accentuated in handicapped adolescents, who will in addition present particular problems which relate to their late maturation and/or development. These people are, therefore, more properly the concern of the paediatricians and the child psychiatrist than of the adult specialist. Special facilities are required for their management and they are inappropriately seen in the same setting as the child. Handicapped adolescents will frequently require help in obtaining employment. The work of the Spastics Society employment department in this connection was discussed, and the fact that comparable specialised services are not available for other handicapped children was much regretted.

The Family

As the presence of a handicapped child in a family is a great strain, the advice of the psychiatrist will often be needed to assist in coping with the family's problems. The demands on the mother and other members of the family by individual therapists may be excessive, unless the family situation has been assessed in the home. A completely unreal picture of the situation may be built up in the minds of those people working in the clinics. The parents will become angry that the child is not 'cured' and the team discouraged by

the failure to improve. Crisis periods in the family may be helped by the provision of temporary care for the child. Further discussion of the family and the child was conducted under the following sub-headings:

(*a*) The care of the child in hospital includes simple physical services, such as laundry, which are not available at home, and their provision presents practical problems which must be considered in relation to the family situation.

(*b*) The care of the child may be complicated by psychiatric disturbances in the family.

(*c*) The implications of the handicapped child in terms of the reactions of the sibs and parents.

3. The Staff of Handicapped Children's Units

The psychiatrist has an important role in interpreting difficulties of management to all the staff of units, hospitals and schools concerned with the handicapped child—*e.g.*, nurses often feel that parents resent them, and indeed they may, and this parental behaviour should be explained to the nurses. The staff have important roles as observers, and the observations made should be interpreted in discussion.

Psychiatrists and paediatricians must understand what each does and what their roles are. In discussing the problems of communication between the different specialities we were particularly aware of the problems of language. The dissemination of information must be made in the simplest language. All medical specialities are guilty of failure in this respect. Perhaps the psychiatrist has a particular load to bear as many physicians are very unfamiliar with the language he uses.

The Psychologist

We also discussed the role of the psychologist as a member of the team. It was agreed that he had two roles, one in assessment and the other in recommendations about educational management of particular learning difficulties. Assessment does not simply consist of the traditional psychometry (or, as most of us preferred, 'Binet bashing'). The psychologist assesses assets and deficits and tries to detect patterns of developmental imbalance which are likely to lead to learning difficulties. From his assessment he must then process information which will prove useful to the teacher. It is not only the teacher that he may be able to help but also the physician. He may have an important part to play in the quantification of such items as movement abilities and language. The assessment should enable the psychologist to recommend to the teacher a pattern of remedial procedures which will help the child. The procedures are still exploratory, and the psychologist must evaluate his results within the classroom.* The psychologist (be he classified as educational or clinical) may well be the best 'linkman' between the teacher, the classroom and the team at the handicapped children's clinic. We have not discussed the teacher's major role in management which clearly goes beyond the mere academic education of these children and which is again clearly beyond our capacity, but we were convinced that psychologists should work very closely with the teacher.

Diagnosis of These Disorders

We have tried to discourage the labelling of these children with such titles as 'maladjusted' or, again, 'minimal cerebral dysfunction'. From a service point of view these labels are perhaps useful to alert some people to the type of disability. Such labels may have their value but they do not imply specific therapeutic programmes for

individual children. We do not wish to imply—and indeed do not feel—that accurate diagnosis is undesirable, but we are aware of a lack of advice on management, which is often what those directly concerned with the child look for from the doctor, and which they often fail to obtain.

* Even if they were not, he must still spend much time observing the children's learning capacity in the classroom setting.