MEMBERS OF THE CORE TEAM

Dr Israel Kolvin advocates that a flexible multidisciplinary approach to psychiatric disorders is still of value in diagnosis and treatment

THE traditional philosophy of assessment and management of psychiatric disorders in children was one of shared responsibility by a tripartite interdisciplinary team. This philosophy was based on the belief that a single member of the team would be unable to provide the diagnostic formulation and the therapeutic intervention needed for the total family.

In its original form this team consisted of a child psychiatrist, a child psychologist and a psychiatric social worker. Each of these had his own circumscribing role and function. In brief, it was considered that the main expertise of the child psychiatrist lay in the area of medical and psychiatric diagnosis and psychotherapy. That of the psychologist lay not only in the multiple areas of personality assessment, intelligence and educational functioning, but also in psychotherapy. If the psychologist were educationally qualified his expertise principally consisted in educational assessment, management and placement of certain categories of handicapped pupils. The expertise of the psychiatric social worker was considered to be threefold: proficiency in eliciting relevant social history, in undertaking therapy, and in understanding the available community resources and their use.

The work of the team had two phases — the psychodiagnostic formulation phase, followed by the phase of planned treatment. In clinical child psychiatry the exercise of diagnostic labelling is considered far less useful than the wider exercise of advancing a psychological diagnostic formulation. This consists of an individualised theory to explain the child's behaviour on the basis of intrinsic factors such as personality and intellectual and physical development, and extrinsic factors which consist of current and previous experiences in the home, school and community.

The second level formulation is based on two sources of information, social history and psychiatric interview, and hence is likely to constitute a more sensitive and valid representation of the problem. The third level is based on the previous information together with that available from psychological assessment and this is generally considered the most sophisticated level attained at the end of the investigative stage. However, a definitive formulation may be achieved only later, after the onset of treatment, when information crucial to an understanding of the problem has emerged.

On the basis of the above diagnostic information the core team, in joint consultation, decided on treatment. This generally consisted of regular sessions over a long period of time. In this way psychotherapy was clinically evaluated and if unsuccessful alternative treatment attempted.

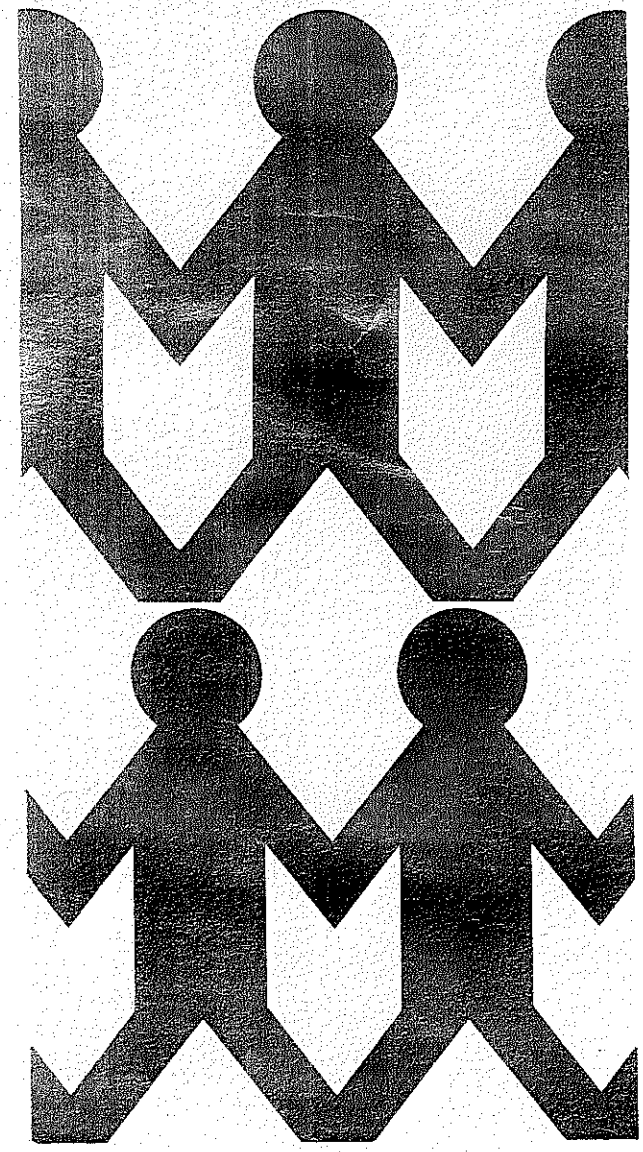
Some mention needs to be made of the components of therapy. Individual psychotherapy with the child starts within the framework of a therapeutic relationship. The method of therapy will vary with the age of the child and the therapeutic philosophy of the therapist. Basic to the process is a focusing on the relationship with the child.

Casework, as undertaken by the social worker, similarly utilises psychodynamic principles and focuses on parental personalities and pathological interpersonal interactions within the family. Some caseworkers confine themselves exclusively to such factors, whereas others are prepared to manipulate the sociocultural environment or may guide families in need towards making relevant use of appropriate community resources. Central to casework is the development of a warm empathetic relationship.

Defects of the approach

The traditional multidisciplinary approach has in the past been the subject of some destructive critical attacks. Among these is the charge that it is a time-consuming exercise which is expensive of clinical staff with many trained professionals frequently seeing relatively few children and their families; it is insensitive to the needs of the community which it is intended to serve and is of unproven effectiveness. Most critics have concluded that in its original form it was a crude and insensitive tool used in too doctrinaire a fashion.

Many clinics now use the multidisciplinary approach in a more flexible manner as one



model permits an abandonment of the fixed role structure described above. According to the needs of the situation a child or a family may be seen by a representative of a single discipline or, on the other hand, help may on occasion be provided not only by the core team but additionally by other specialists such as a remedial teacher or occupational therapists.

The decision about who is to take the leading role in treatment is determined not so much by the background discipline of a staff member as by his recognised skills and interest in a particular clinical problem. Further, he may decide it necessary to liaise with another discipline within his team or an appropriate outside agency such as the probation service. However, teamwork experience is still of value.

Further, though there has been a narrowing in one sense, in another sense there has been a move towards flexible expansion of horizons by the proposal that the modernised multidisciplinary team be incorporated into the network of comprehensive social, educational and health services which are slowly being developed to cater for a wide variety of acute and chronic conditions, many of which are psychiatric in character or have psychiatric components

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