

## *Point of View*

### A CHAIR AT ST. GEORGE'S

Recently my Registrar failed his MRCPsych. examination. It seems that his examiners discovered that he had a rotational appointment to a m.d. hospital and he was quizzed on the neuro-chemistry of epiloia. I recollect a previous talented Senior Registrar being asked about Hallerman-Streif Syndrome. The Registrars now tell me there is a countrywide agreement not to betray any experience of mental handicap as it can result in silly questions at examinations.

The recent appointment of Dr. Joan Bicknell to the first Chair in the Psychiatry of Mental Handicap at St. George's Hospital, London and recent advertisement by the Chief Scientist in Scotland for research ideas. (with the declared purpose of furthering academic departments in mental handicap) makes it opportune to consider what an academic department can do to help recruitment and what kind of research and practice it might promote.

In Britain there are two views of how doctors should be designated in the field of mental handicap. In Scotland, mental handicap is no longer regarded by many as a viable speciality (Batchelor 1978). It is considered that experts from outside the field contribute to its progress and particularly that doctors with "a special interest", for example paediatricians and psychiatrists should have a sizeable number of sessions in this field. (The Peters Report 1979). It is not widely recognised that a large proportion of the problems of the mentally handicapped are emotional and that special experience is required in the psychiatry of mental handicap. In many parts of Britain the sub-speciality of mental deficiency, within the rubric of psychiatry, is considered to include an expert knowledge of genetics, paediatrics syndrome identification and epidemiology as well as the psychiatry of mental handicap.

Although undoubtedly a psychiatrist in the field of mental handicap ought to know more than the average doctor about the causes of mental handicap, his job should be sufficiently circumscribed for him to practice the study of emotional disorder in the mentally handicapped and their families. Conversely there is no reason why there should not be experts in mental handicap in the same way as there are experts in 'forensic psychiatry', but just as most 'forensic psychiatry' is practised by ordinary psychiatrists, so most of mental handicap might be practised by ordinary psychiatrists who regard mentally handicapped as a special interest extension of their ordinary practice. An urgent reason for such a special interest view of medical care of the mentally handicapped is that some 40% of whole-time consultant posts in mental handicap are currently going unfilled and in many parts of the country, with an ageing consultant psychiatrist population, joint appointments are likely to happen by necessity rather than design, and general psychiatrists pressed reluctantly by their vague contracts to fill gaps.

It is obviously undesirable that consultant psychiatrists without interest or training enter the field on a part-time basis. Rather some consultant psychiatrists, who have been encouraged to work in the field by a stimulating experience of the Psychiatry of mental handicap as an undergraduate and a postgraduate might give a significant proportion of their time, as a 'special interest'. This, a Chair in the Psychiatry of Mental Handicap will kindle.

#### WHAT PERHAPS NOT TO STUDY FURTHER

What areas of research might such a department undertake? In 1977 DHSS identified four priority areas for research in mental handicap namely -

- (1) prevention.
- (2) Neuropathological studies linked with clinical studies.
- (3) psychological research for programmes of intervention, and
- (4) sociological studies of the mentally handicapped in the community.

This paper is concerned with (3) and (4) confining comment on the other priority areas to noting shortage of neuropathologists.

It is important that a psychiatric department does not fall into the trap of thinking that all experimental psychology is its stamping ground. The Hester Adrian Unit and the M.R.C. Unit for Developmental Psychology have pursued educational problems and cognitive difficulties of the mentally handicapped with such expertise that academic psychiatry might prudently avoid a fresh entry into such areas. Moreover significant advances in the past ten years have resulted in fundamental research being less of a priority in education than studies of the delivery of results of research so far (Mittler 1978). In other words psychiatrists should study what they do best and what only they can do. It is no longer productive for psychiatrists to study the number of mentally handicapped persons in an area or the number of psychiatrically ill mentally handicapped people in an area or institution. We know enough already. Primrose (1971) studied reasons for hospital admissions and found that 8% were admitted for psychiatric illness and 50% were admitted for anti-social behaviour. In hospitals for the retarded a Department of Health and Social Security consensus (1972) showed that 16% had a severe behaviour difficulty and a further 16% a lesser behaviour problem. This agrees with Ballinger and Reid's (1977) prevalence rate for significant psychiatric disorder in hospitals, of 31%, and in an adult training centre the prevalence of significant emotional disorder was 13%. Reid (1976) estimated the frequency of psychosis among inpatients was 1.2% for affective psychoses and 3.2% for schizophrenic psychoses.

Nor is it the psychiatrist's job to review endlessly what is already known. The little that is worth reviewing has recently been set out in the book "Psychiatric Illness and Mental Handicap" (James and Snaith 1979) produced by the Royal College of Psychiatrists. If we raised the threshold of mental handicap by five IQ points we would increase the prevalence rate twofold and a different book would have been written. It is thus important that psychiatrists do not use too loosely the terms 'mental subnormality', 'psychosis', 'neurosis' etc. These are only hypothetical constructs which cannot be directly observed but are inferred. Psychiatric diagnosis is an imperfect business at the best of times. Agreement between psychiatrists is seldom higher than 60% (Kendell 1977). There is a case in theoretical research for abandoning diagnostic labels altogether and substituting comprehensive formulations of the predicament of each patient. Yet in practice clustering of clinical signs does occur. Reid, Ballinger and Heather (1978) in a cluster analysis of the behaviour problems of profoundly retarded people found 'ragbag' groups for which 'porridge' labels were needed: a 'manneristic autistic' group, an 'overactive' group, a 'multiple-problem' group, and a 'wilful-conduct' group.

## THE PSYCHOSES

Most psychiatrists would agree with Reid that affective psychosis can be diagnosed on existing classifications symptomatically and biochemically, but schizophrenic psychoses present much more difficulty. Assistance will be needed from research in other fields, for instance, psycho-linguistics. Topic drift is a common feature of the language of schizophrenia. Analysis of mentally disturbed (presumed schizophrenic) mental defectives' discourse might reveal this too. Ethological approaches may also be helpful (Richer 1979). The attribution of the stereotypes and mannerisms associated with profound handicap to a 'psychosis' would be best disregarded until ethological descriptions cataloguing discrete behavioural items have service utility.

## THE DEMENTIAS

Research into psychiatric aspects of mental deficiency is already being done by general psychiatrists. One example is the psychiatry of ageing, and the apparent proneness of mentally handicapped people to dement sooner (7.1% amongst patients in mental deficiency hospitals over 45 years, Reid and Aungle 1974). This susceptibility may be due to a previously damaged, precariously processing brain being tipped by a few senile plaques into dementia. The MRC Brain Metabolism Unit in Edinburgh is interested in whether Down's are particularly likely to develop Alzheimer's Disease. More work is needed in other centres wherever there is the facility to freeze brain quickly.

## THE NEUROSES

The topic of neurosis was recently reviewed by Forrest (1979) who had useful things to say about families (e.g. the high incidence of separation in parents of severely handicapped ambulant children) but less useful to say about the retarded person's neuroses. It does seem that the mentally handicapped make the 'functional shift' from 'neurotic' to 'endogenous' depression with more facility. The literature has little useful to say about the effects of life events on the mentally handicapped. For instance, how many have their friendship ties unceremoniously broken in hospital and community settings? A common problem for psychiatrists is the unresponsive retarded person, depriving the doctor of his customary raw material, yet often not prevent the latter from surmising 'neurotic' or 'hysterical' reactions.

A 50 year old previously peaceful severely handicapped man of IQ 40 suddenly starts to throw breakfast buns at holiday visitors in an unusually thick morning fog in a seaside resort. The state of excitement subsides rapidly and no further incidents occur. He can offer no explanation. Yet he has, in theory, the communicative competence to be explicit. Similarly, few backward fireraisers, who can talk, can describe their motives. It seems particularly important for the therapist, faced with unresponsiveness, to develop ways of relating to the patient. Further research should clarify what are the factors in social and therapeutic situations which cause the mentally handicapped person to withdraw from communication and for sociologists to determine what disproportionate weight or value might a handicapped person place on events, thus leading to misunderstanding.

It is now technically feasible to improve the communication skills of almost any child (Schiefelbusch 1979). Moreover, given identification of a risk subcultural defective children and 'total' intervention "The Milwaukee Project" (Heber and Garber 1977) has convincingly showed that language skills can be enhanced by two years compared with controls. The noteworthy point from a psychiatric view is that increased behaviour disturbance followed in later childhood. Such children had not the interpersonal competence to match their language skills.

## PERSONALITY DISORDERS

Cluster analysis (Tyrer and Alexander 1979) had revealed five discrete categories of personality disorder in people of normal intelligence (sociopathic; passive dependent; anankastic; schizoid; and non-personality disorder group). Most were 'passive dependants' or 'sociopaths'. There have been no comparable studies of personality disorders in the mentally handicapped. (Corbett (1979) has commented on the inadequacy of our ways of describing personality disorder in the retarded. Psychiatrists with a forensic interest might consider alternative ways of assessing, and rehabilitating the mentally handicapped offender in secure settings. (For example, stress interviews, role playing and miniaturised 'reversals' or life setbacks - vignettes); and also try to aid our

perception of the mentally handicapped offender, and his view of the world. This, the Semantic Differential test has shown to be distorted, but the Semantic Differential, although it has utility, lacks sufficient validity below IQ 50 (Dow, Fraser, Ledwaighte, Bhagat 1975). We require more sophisticated construct theory instruments to study the retarded individual.

## COMING TO TERMS WITH PEOPLE AND LIFE

Rather than start research with words like Neurosis and Personality disorder, it seems wise to discover first how the stable retardate maps his world, and to study the vulnerable points in his life. Some of these are fairly easily identifiable - at five years, fourteen and seventeen years, but not much secondary prevention is done. There is a common opinion that mentally handicapped persons suffer less from bereavement. A major study of what death means to mentally handicapped people is needed. I have seen many severe non-verbal reactions in all degrees of retardation to parents' or friends' mortality. It seems important for the psychiatrists to learn about non-verbal as well as verbal communication. In recent studies in our research programme (Leudar 1980) Down's Anomalies' emotional relationships were expressed mainly in non-verbal communication, detectable in body/head orientation, proxemics, arm position and mobility. We found that the manner in which retarded people chose to affect their audiences depended on their social relationship to the audience, particularly on the distribution of power and the relationship of reciprocity and negotiability. Covert communication, in which the sender attempts to affect his audience by covert means (avoidance of eye contact, closed seating, gesture and posture) and aggression were both functional ways of relating when the distribution of control was unequal and not negotiable e.g. between a patient and his therapist. The training of psychiatrists and therapists ought to make them more sensitive to this form of language. I expect that 'mental examinations' as catalogued by the next generation of psychiatrists will include a whole section on non-verbal behaviour, covert messages, emotional cover-ups and leakages.

Little fundamental research has been done by psychiatrists into the reproductive biology of mental handicap - masturbation, sexual aspirations or phantasies and needs of groups of mentally handicapped folk (nor do we know much about the effects of premenstrual tension). Mildly mentally handicapped people are likely to consult the general psychiatrist. Their mental handicap is often camouflaged. So general psychiatrists ought to benefit from studies of interactions between normal people and the mentally handicapped.

More should be known about the natural history of mental handicap in the community. There have been few objective studies of re-location problems of ageing and infirm and profoundly handicapped populations. There is also the nagging fear that economics will require the persistence of present conditions whatever the ideal to normalise and the ethic of equality of opportunity demands. The subsequent disappointment may result in increased psychiatric and psychosomatic illness among the mentally handicapped. More interest is needed into the effects of fatigue on the mentally handicapped person. The mentally handicapped adult does not seem to have stamina consistent with his physique. In the early days of open employment he is drained of energy. He may spend all week-end in bed and is too tired for leisure (as indeed is the physically handicapped person). When a mentally handicapped person becomes fatigued, like a child he may become excited; but often the retarded person becomes continuously excited, unlike the child who has a tantrum which settles after a good sleep. This non-specific state of arousal in the retarded may go on for days, like brief agitated depressive states. We need more knowledge about the precipitating and maintaining factors and treatment.

## TREATMENT

The effects of psychotropic drugs can now be measured by quantitative pharmacencephalography. There is no reason why we should not be able to measure antidepressant's effects on the mentally handicapped person's brains using such computer assisted EEG's. Corbett (1979) has commented that there are few adequate trials of drugs used with the handicapped; that the patients on trials are often heterogeneous, their characteristics ill-described and the rating scales invalid. The trend away from polypharmacy, and the now routine blood level monitoring of anticonvulsants, of folic acid and calcium have led to better control and fewer side effects. The treatment team also needs a greater rapprochement between radical behaviourism and medicine. Life endangering self mutilation needs more effective weapons than DRO (differential reinforcement of other behaviour) or Time Out; and more humané ones than aversion. We also need more trials of the service relevance of what seems a major behavioural technical advance - the utilisation of errorless learning with the severely and profoundly handicapped. We need urgently to clarify professional dynamics.

Recent reviews of research priorities (Lader 1979, Haywood 1977) have emphasised the need for research in the mental health of retarded patients - what behaviour problems are associated with low intellectual functioning; which ones occur in retarded persons in much the same manner as in non-retarded persons, and which behaviour problems are an interactive function of social/emotional pathology and mental retardation.

Congratulations and best wishes to Professor Bicknell.

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