

## POINT OF VIEW

### Individuals or Systems ? Some Implications for Mental Handicap

The profusion of unfilled vacancies for Clinical Psychologists in the area of Mental Handicap suggests it does not appeal to this group of professionals as a whole. This paper hopes to make some suggestions to account for the current situation and presents an alternative and hopefully, more appealing approach.

Historically, mentally handicapped persons have been the poor relations in the mental health field in terms of attracting professional expertise and commitment. Two factors immediately present themselves to help explain this. Firstly, mentally handicapped people do not get "cured" and this, I feel, poses problems for us as professionals. How do we get adequately and appropriately reinforced, assuming this is one of the prime motives for working as mental health professionals ? Secondly, Clinical Psychology is a relatively new discipline still seeking acceptance among the more established mental health specialisms. Other areas, such as child and adult psychiatry, present themselves more forcibly in assisting clinical psychology fulfil its *raison d'être*.

Historically, (and to a large extent, currently) psychology has approached mental handicap from an individualistic standpoint. By this I mean the "identified problem" (I.P.) is seen as the mentally handicapped individual, rather than implicating the I.P. and his/her social context, as for example, systemic family therapy does, by definition. The individualistic standpoint is evidenced by the behavioural approach to the problems, which clearly, if implicitly, places one person (the therapist) in a position of health and the other (the mentally handicapped person) in the position of ill-health. The same position is also taken by Psychoanalytic and cognitive approaches. Behaviour programmes including toileting, dressing, undressing and social skills are all designed to move the patient as near as possible towards some norms of socially accepted behaviour. The I.P. concept is also implicitly recognised by enlisting parents to carry out behavioural programmes, which by the role definitions of the participants excludes them from implication in the problem. A third piece of supporting evidence for the I.P. concept is the lack and often total absence of counselling for families after the birth of the mentally handicapped member.

Although research is needed regarding reasons for the unattractiveness of the field of Mental Handicap, I feel the immediate association clinical psychologists might make between 'mental handicap' and 'behavioural programme' would be enough to dampen many appetites. There is a need to examine two related points here. Firstly, why is the behavioural approach so dominant in this area ? and secondly, can it be replaced by anything else.

Over the years there has been a move away from the radical Skinnerian behaviourism towards what can be broadly termed a cognitive-behavioural approach. The intricacies and confusions of human cognitions have set us apart from other animals and through this mechanism we have created the "wonderful" world in which we live today. So it is not surprising that radical behaviourism, which lacked this essential ingredient, was not destined for a long reign. If radical and cognitive-behaviourism are loosely seen as two ends of a continuum, I think it would be fair to say that the programmes devised for mentally handicapped persons lie more towards the former end than to the latter. The mentally handicapped person with

his/her limited cognitive ability consequently trails in the wake of developments in psychological theory and practice and presumably becomes a less attractive client. The move away from radical behaviourism seems, admittedly in retrospect, a natural one, but it raises the question why similar moves have not been made in the area of mental handicap. After all, although a mentally handicapped person's cognitive development is not as complete as persons of normal intelligence, they do have cognitions, which are denied, or at best bypassed by radical behaviourism. Instead of facilitating optimum use of cognitions we impose our values through the use of behaviour programmes. This developmental lag regarding the behavioural approach to mental handicap might be understood by looking at the function more radical behaviourism has for the families of handicapped persons and the professionals, rather than for handicapped persons themselves.

Families of newly born handicapped children enter a process something akin to bereavement. Their grief is for the loss of the normal child who was never born. In the early stages of child development, many mothers I have worked with describe how they strove hard with their handicapped child; how they pushed the child more than their other children. One interpretation of this struggle to make the handicapped children as normal and acceptable as possible is the denial stage of the bereavement process, which is facilitated by the unrealistically high expectations mothers have of their handicapped children. Interestingly, in later years mother's expectations often become unrealistically low, and result in over protection of their "children" (who are now adults). The "leaving home" process for the young adult consequently becomes very difficult and often impossible. One of the functions of over-protection is to protect the recipient from life events; it also protects the protector from observing this and facilitates denial. Consequently, the over-zealous use of behaviour programmes in the child's formative years could be seen as collusion with the family's denial process, the programmes facilitating the hopeful struggle towards normality. The function of over-protection in later years prevents exposure of the mental handicap through the same behaviour programmes.

What are the functions of radical behaviourism for the therapist? Firstly, it's clinical application offers the psychologist the security of an empirical paradigm. Secondly, it secures a job and a *raison d'être* but more fundamentally I feel, it is also a denial mechanism which attempts to obscure the fact that the psychologist has been unable to facilitate the optimum use of the handicapped person's cognitions. The role relationships within a behavioural programme draw a clear and rigid boundary between the participants the therapist being in a position of superiority.

One of the major problems of the behavioural approach is, I feel, the uni-directional emphasis, which precludes a more comprehensive understanding of the social and interpersonal context of a problem. Systemic family therapy by definition takes as its focus of attention the "handicapped family" rather than a mentally handicapped individual. A major premise of the systemic approach is that all the elements comprising a system interact with, and affect, each other. Consequently, there is an implicit equality between the component parts. This seems a far more appropriate standpoint as it presents professionals, families, caring agencies and other elements in the handicapped person's system with the challenge of looking at the contribution they make to the problem. A systemic approach abandons the I.P. concept or to be more precise, examines the function it has for the system and I have earlier examined some of the functions it might have for professionals and families.

If the systemic approach is accepted as a reasonable alternative, what are the implications for psychologists working in the field of Mental Handicap? Elsewhere I have given an account of some implications for myself and some of my colleagues from other specialisms in South Devon. (see p. 101 of this issue) Firstly, the focus of attention lies with the "handicap system". The size of the system will vary from case to case but includes some of the following: the family; the mentally handicapped person; the N.H.S.; Social Services; voluntary agencies; private sector agencies; etc. Each of these elements are sub-systems and it is the intra- and inter-sub-system relationships which I seek to work with and understand

There are two aspects to my work with family systems. Firstly, systemic family therapy, which results from case referrals. The mechanics of this approach (or to be more accurate, these approaches) are described in a variety of sources and further discussion is not the brief of this note. Secondly, owing to the individualistic approach, the social and interpersonal context of the 'handicap system' has received less attention. Mention was made earlier of the bereavement process which the family enters following the birth of the handicapped member. Further research is needed on how different families, and within each family how each member, are affected. Also, with the birth of the handicapped child, a re-alignment of the relationships within the family often occurs. Commonly, the mother-handicapped child relationship replaces the husband-wife relationship as the dominant one in the family. Research is needed as to whether the re-alignments are enforced or just facilitated by the arrival of the handicapped child. In family therapy terminology, does the handicapped child act as a probe whose arrival serves to highlight an existing problematic system, or as an intervention which changes it? The birth of a handicapped child adds to family size and thereby changes it. The "change" mentioned above however relates to the manner in which the family organises itself around the I.P.

In South Devon several colleagues and myself set up an interest group to look into some of these questions. Over the past several months we have been running two groups comprising parents of handicapped persons; one group of married couples, the other all females. (The method, procedure and discussion of these two groups will hopefully be published in a future paper). The groups serve a number of functions. Firstly, meeting on a regular basis facilitates improved parent-professional relationships, and secondly, enquiring about parents' needs and feelings implicitly acknowledges the systemic nature of the problem. Thirdly, the information-gathering function of the groups places parents rather than professionals in the executive position. This, combined with acknowledgement of the importance of the parents' needs, I feel, enhances trust and facilitates expression of difficult, painful emotions. Finally, information gathered will hopefully give us a better understanding of the 'handicapped family system' and the bereavement process, which in turn facilitates more comprehensive and effective family therapy.

The other sub-system we have been working with is the "professional" sub-system, starting from the premise that systemically, professionals are part of the handicap system, rather than intruders who intervene and make things better. A number of colleagues and myself have set up a closed group which has been running for three months. The function of the group is to look at and share our values, attitudes and beliefs and to become clearer about how they affect our professional and client relationships. We feel this is a healthy move, away from the conventional "professional role", towards a more personalised view of professionals as value-laden human beings first, and professionals a poor second.

In concluding, I acknowledge there are many elements in my particular working system (i.e., N.H.S.) which I have not mentioned here (e.g., administration, managements, etc) and at a practitioner level, have not tackled. I would welcome fellow colleagues both considering approaches to other parts of the system, and re-thinking the traditional approach to Mental Handicap.

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This article has also been published by the DCP Newsletter.