Psychiatric Consultation in Mental Retardation

Formulated by the Committee on Mental Retardation

Group for the Advancement of Psychiatry

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This is the fifth in a series of publications comprising Volume X. For a list of other GAP publications on topics of current interest, please see last page of this publication.
STATEMENT OF PURPOSE

The Group for the Advancement of Psychiatry has a membership of approximately 300 psychiatrists, most of whom are organized in the form of a number of working committees. These committees direct their efforts toward the study of various aspects of psychiatry and the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisages a continuing program of work according to the following aims:

1. To collect and appraise significant data in the fields of psychiatry, mental health, and human relations
2. To reevaluate old concepts and to develop and test new ones
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations

GAP is an independent group, and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

Psychiatric Consultation in Mental Retardation was formulated by the Committee on Mental Retardation which acknowledges on page 598 the participation of others in the preparation of this report. The members of this committee are listed below. The following pages list the members of the other GAP committees as well as additional membership categories and current and past officers of GAP.
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Jean Lang, Los Angeles
William Hosfield, Minneapolis

Thomas G. Webster, Chairman

1

INTRODUCTION

The field of mental retardation provides significant opportunities for psychiatric consultation. Psychiatrists can find needs and opportunities for engaging in a wide variety of consultation activities, using their knowledge of the emotional, biological, psychological, social and learning aspects of mental retardation.

There are an estimated six million intellectually impaired persons in the United States, about three percent of the population, based on definitions and studies described in previous GAP Reports\(^1\),\(^2\),\(^3\) and more recent corroborations.\(^4\),\(^5\) At any given time, approximately two million of these persons are actively involved in care, treatment, habilitation and special education programs\(^6\) and could be diagnosed as having "mental retardation." Because of this high prevalence, plus the frequency of emotional problems, the field of mental retardation holds enormous potential for the psychiatrist as a consultant. The work is challenging and includes the whole gamut of emotional problems and therapies with which psychiatrists are familiar. Consultation is particularly concerned with developmental delay, encompassing several hundred syndromes with genetic, organic, psychological, family sociocultural, legal and economic factors.

The personal capabilities of many retarded persons, the resourcefulness of many parents and the effectiveness of workers in this field are often very impressive. This contrasts with common stereotypes and aversions held from a more distant perspective. The field provides opportunities for both direct clini-

* By APA/DSM III definition. See page 633 of this GAP Report.
cal services and indirect consultation, collaboration, and teaching by the clinician.

Most physicians, except for those who provide primary care to the families, have infrequent contact with mentally retarded persons and their families. Psychiatrists vary in their specific knowledge of and experience with patients who are mentally retarded. However, their medical and psychiatric training equip psychiatrists with useful knowledge and integrative skills for working with the multifaceted problems encountered in this field. The present GAP publication is aimed at psychiatrists and their colleagues, whether practitioners, trainees, faculty or consumers of psychiatric consultation services. The purpose is to enhance the contribution of psychiatrists as consultants in mental retardation and to foster the satisfactions available for all concerned in this underserved and yet fruitful area of work.

Beginnings

In seminars on mental retardation for residents in psychiatry and child psychiatry, the teachers are apt to discover that trainees have obtained more personal knowledge and familiarity with mental retardation through acquaintance with mentally retarded persons among family and friends than through clinical exposure in medical school or residency. These personal experiences serve as a useful baseline. They may provide dramatic illustration of the contrast between the low amount of instruction in mental retardation received in medical and psychiatric training compared to the high prevalence in the community. Social and family adjustment problems as well as biases encountered by retarded persons are highlighted when trainees talk about situations they have known among family and friends. Such reviews of personal experiences provide a basis for discussing the effects of stigmata on observers of retarded individuals, and often on their families, and the aversion to mental retardation which is so common among professionals.

The combination of college, medical school, and specialty training gives the psychiatrist a broad range of biopsychosocial knowledge. Comprehension and clinical assessment of the interplay between behavioral, biological, cognitive, and neurological factors in abnormal personality development, and in clinical syndromes, combined with understanding of the role a retarded person may play in the dynamics of family life, school, work and social settings provide a valuable background for consultation work. Knowledge of psychological and biological aspects of sexual development and genetics, combined with increasing awareness of legal and bioethical issues, prepares the psychiatric consultant to discuss problems of sexuality, including contraception, abortion and sterilization, and homosexuality.

In order to be useful, consultants must know something more about the special area in which they are consulting than the persons requesting help. Thus, psychiatrists as consultants need to understand: (1) the consultation process; (2) the technical aspects of diagnosis and management; and (3) how to evaluate affect and to separate data from opinions when listening to the subjective reports of consultees.* Consultants should also be aware of the limitations of their knowledge and skills and should have the good judgment to refer patients and consultees elsewhere for help in areas that are beyond their scope. For example, psychiatrists usually are not prepared to suggest methods of special education, in spite of their knowledge of psychodynamics and awareness of the meaning of classroom behavior.

In the clinic or hospital, patients of any kind may often be referred to the psychiatrist-consultant by physicians or other caretakers with a minimum of communication. The consultant

* Several members of our GAP Committee were not taught "consultation." This report reflects our varied experiences and our emphasis that consultation skills are best acquired by specific training as well as experience. However, the integration of basic substantive psychiatric knowledge and clinical skills into our consultation experiences has often been crucial.
may thus work in relative isolation. He may prepare extensive notes and report in the best medical tradition, emphasizing diagnosis, evaluating psychopathology, and providing advice, treatment or suggestions for disposition. In order to achieve effective results for either the consultant or consultee with this approach it is important that consultations provide at the outset a focus and forum for communication. The consultant may need to participate with the consultee in formulating the questions and issues at stake: “Why is this consultation being requested? What is it you need or want to know? How can I help?” Such initial exploratory discussions make the task of the consultant easier. They often will clarify the difference between conscious, rational bases for requests and the more complex, often unconscious, needs of professionals to “get rid of” bothersome patients.

In order to respond appropriately to the request for consultation, the psychiatrist should obtain information in the beginning from all the people who have contact with the patient, including physicians, nurses, teachers, hospital personnel and the family. These contacts will usually provide background information that is quite different from that obtained in patient interviews. Similarly, at the close of the consultation, verbal communication between the consultant and consultee is vital. While this does not obviate the need for a formal written consultation report, the consultant’s verbal information and suggestions are particularly helpful to the consultee in the management of the presenting problems.

Beyond addressing the immediate situation, the consultation discussion should include an exchange of information, views and generalizations regarding related clinical issues, thus increasing the knowledge and skills of both the consultant and consultee. This consultation-education approach is familiar to psychiatrists from consultation-liaison work. Although in private practice the informal educational time usually cannot be financed by the customary patient service fee alone, the cultivation of an ongoing working relationship between consultant and consultee is usually worth the investment. In training settings, imaginative administrative solutions are sometimes necessary. From a health economics viewpoint, the determination of cost-effectiveness is basic. Give a man a fish and you give him a meal; teach a man to fish and you feed him for life. Demonstrating the value of the psychiatric consultation-education approach for efficient and effective patient care is the best avenue to getting appropriate funding.

* “He” is used in this report as a literary expedient. Actually, psychiatrists and child psychiatrists include a higher proportion of women than occurs among physicians in general. Examples are given in which the consultant was a woman.
SPECIAL NEEDS AND SPECIAL SKILLS

Mentally retarded persons and their caretakers have needs that call for special knowledge and skills from psychiatrists. Teachers and other workers with retarded persons are familiar with cognitive development, learning-conditioning and physical handicaps, but they are less well trained in psychodynamic knowledge and its integration into clinical applications. The psychiatrist is one of several experts. No longer can any consultant take exclusive authority, even as the medical expert in a complex specialized area. There are many complementary specialists, medical and nonmedical, and many contending authorities. The psychiatrist can remain within the realm of his knowledge and expertise and still be very useful in meeting the needs for special skills in this field.

The psychiatrist is called upon as a medical specialist to contribute his special knowledge of emotional development and its aberrations. It is important, therefore, that the psychiatrist understands the ego development of retarded persons, their psychopathology, mental mechanisms and prognosis, as well as the social system in which retarded persons function. He needs an awareness of the "culture of poverty," the legal disadvantages and the deviant social roles which many retarded individuals suffer. The psychiatrist need not be a social scientist but he should know the cultural realities and resources within the patient's community and be aware of the personal resources of the patient and his family. The psychiatrist should also be familiar with: (a) the broad principles of education of the mentally retarded, including behavior modification; (b) the socioeconomic, medical and neurological status of the patient, and (c) the use of psychopharmacological agents. The development of his consultant role requires the psychiatrist to be informed about basic conditioning techniques and ways of collaborating with educators, caretakers, and parents in the care and upbringing of retarded children and adults.

Beyond these aspects of mental retardation, the psychiatrist should be aware of the interplay between organic and functional illness— the patient's response to illness and immobilization, removal from family, and lack of stimulation. He should be aware of possible underlying organic pathology. He should also consider the manner in which specific somatic complaints may reflect emotional problems even when there is structural change. He should recognize the clinical manifestations of psychiatric disorders, regardless of other factors also present.

Psychiatric trainees need to use their medical knowledge along with their intensive training in interpersonal skills. The role of the psychiatrist differs when working with an adult, child, family, agency, colleague or teacher. He should assess the human problem in psychiatric and psychodynamic terms and translate the assessment into a clearly communicated action-oriented plan for everyone concerned.

People working with retarded persons often turn to the psychiatrist to figure out what is going on inside their patients or clients. Disturbing behavior by a retarded child is sometimes dismissed as incomprehensible and is viewed as part of the intrinsic nature of retardation. The realities with which parents and caretakers must contend need to be appreciated; at the same time their own individual reactions may need to be understood. Even experienced professionals sometimes need explanations of inconsistent or irrational family complaints about physicians, teachers and social workers, including the sometimes sudden parental withdrawal from professional help.

The consultant may find that a physician who tolerates well some occasional irascible behavior from a retarded patient may become frustrated and impatient with particular parents. This
Psychiatric consultation in mental retardation

occurs most often when parents are going through the process of grieving, initially with shock and denial, then often with guilt or resentment. Primary care physicians or other professionals who have worked closely with the families of retarded children during pregnancies, deliveries, illnesses and childrearing become invested and identified with them and may also experience grief and mourning. Denial, anger, magical thinking, bargaining, or withdrawal and depression appear as defenses against working through the narcissistic injury (the parents' wish for a perfect child, or the professional's empathy for the parents and the wish to be omnipotent and curative). In this process, parents can become stymied or can regress at times of crisis, and professionals can transitorily lose their usual patience and composure. On the other hand, maintaining interest and perspective over the long haul of "chronic sorrow" may be more difficult than the crises.

The presence of such problems in consultation work should not lead the psychiatrist to underestimate the serious stresses and frequent frustration encountered by parents of retarded children—particularly with doctors and professionals—or the tremendous strengths, patience, and constructive attitudes of most parents. As a matter of fact, the amazing adaptive strengths and maturity of many parents and other caretakers become an important source of professional interest and pleasure for psychiatrists in this field. A timely expert insight, gained by the parents from the psychiatrist, can yield significant progress. Kanner classified parents' reactions to mental retardation in their children as variations of three response types:

(a) Mature acknowledgment of the realities of the situation with concomitant acceptance of the child.
(b) Disguises and distortions of part of the reality with a search for scapegoats upon which to blame the retardation, or a quest for magical cures.
(c) Complete denial of the existence of retardation.

The latter two responses can be further distorted by mistaken impressions. Deeper acceptance of the retardation and other facts, with consequent gain in more realistic expectations of the child, is a gradual process involving grief. The following is an example of a psychiatric consultation in such a process.

Vignette #1 (Consultation Types I C & II A & B)*

The teachers in a pre-school retarded children's nursery told the psychiatric consultant that Jeff had become more tearful lately. Jeff was a six-year-old child with Hurler's disease (gargoylism) without prominent stigmata and an IQ of about 45. In the nursery he had participated on the sidelines but had been tractable and had required considerable direct help and encouragement to engage in independent activities. He seldom reached out to other children or to the teacher unless approached. Earlier he had had a relatively pleasant or neutral disposition but recently had seemed depressed and apathetic, and had cried frequently.

According to a previous routine psychiatric diagnostic assessment, Jeff's emotional development was roughly comparable to his intellectual level, which was a mental age of 2 to 3 at the chronological age of 6. At that time the psychiatrist had noted Jeff's well integrated ego functions plus immaturities of personality development, mild isolation in relationships and a fair range of appropriate affect—all within normal limits consistent with his age

* Types of psychiatric consultation and related functions are outlined in the Appendix, p. 670, for easy reference. Vignettes in the Report will be referenced accordingly, such as "Type I C and II A and B" above. The Type most relevant to each vignette is underlined, such as "I C" above. For example: Direct clinical consultation (I C) including diagnostic assessment of the child plus consultation and brief psychotherapy with the parents is most relevant in this example, but indirect client centered case consultation (II B) with the teachers is also involved. This first vignette is elaborated in detail in order to provide specific illustrations of several points about psychiatrists' functions that are emphasized elsewhere in this publication.
and degree of retardation. Jeff did not manifest the typical phallic interests and anxieties of a 4 or 5 year old child, but had achieved a mild degree of the negativism and independence of a 2 or 3 year old. He was initially timid but responsive to personal overtures.

Earlier pediatric and neurological assessment confirmed the stigmata and diagnosis of Hurler’s disease, showed the maintenance of a consistent physical growth channel, and demonstrated neurological immaturities but no significant handicaps in neurological and motor development—all consistent with his rate of intellectual and emotional development. No psychoactive medications were used.

In a routine visit to the nursery, the psychiatric consultant conferred with the teachers and observed Jeff to be indeed changed in affect and behavior compared to earlier observations. He phoned the pediatrician and learned that no physical changes had been found at Jeff’s most recent visit. He then arranged to interview the parents. The consultant also noted an earlier psychiatric assessment reported that Jeff’s quality of (personal) object relations was sufficiently developed so that he was capable of a clearly identifiable loss reaction on separation from his mother—a reaction which is not always very clear in preschool age children who have a greater degree of retardation or those with a greater disturbance in ego development.

The psychiatric consultant’s interview with Jeff’s parents revealed that they were fully informed about Hurler’s disease. They were well aware of the cycles of progress and deterioration to be expected with the condition. Although they had noted no particular deterioration in Jeff a month earlier, the parents, like the teachers, worried whether his withdrawal and apathy represented a progression of his disease. He seemed less interested in activities at home and was more withdrawn and more easily tearful at home. The parents also said they found him more obstinate on occasion. Several times during the interview his mother wondered if Jeff needed more discipline and punishment, yet this was interspersed with many comments of loving concern and affection for him as a seriously handicapped child.

During the course of the interview, the parents revealed that they had recently learned of another family with an older child, about age 13, with Hurler’s disease, and within the past month had visited that family. They saw the child, who was in a more advanced stage of the disease, confined to a crib and manifesting advanced stigmata. This was an extremely shocking experience for the parents, despite their extensive reading and knowledge of the subject. They were even more crushed when the mother of the older child stated that Jeff appeared very much as their child had at age six.

Both parents expressed sadness and hopelessness following the shock of realizing that Jeff might end up like the older child they had seen. The mother’s tears alternated with questions about institutionalization and whether he should be punished more often. They were obviously undergoing a serious crisis and were manifesting some withdrawal of their attachment and investment in Jeff as a child who did have, but didn’t yet “really” have, Hurler’s disease as an inevitably deteriorating condition.

Work with the parents and the teachers helped them understand and accept the fact that there was really no great change in Jeff’s basic condition but that there had, in fact, been a significant change in the family’s attitude and reaction to him in recent weeks. His reaction, in turn, had reinforced those of teachers and parents in a vicious cycle of withdrawal, isolation, and grief. Recognizing the nature of the problem enabled the teacher and parents to help Jeff adapt more successfully, and also helped the parents with their very painful feelings.

Note in this example that a continuing relationship existed among the nursery school teachers, the pediatrician and the
psychiatric consultant. The consultant was able to follow the work of the teachers and pediatrician with individual children over a period of time and so could intervene in timely preventive fashion before more costly complications developed. This process was facilitated, and the psychiatrist's consulting task made more effective, by routine individual psychiatric assessments when children entered the nursery, along with routine psychological, pediatric and neurological reports or examinations. One institutionalized child would have cost far more than this psychiatric consultation service for 50 retarded children and their families and caretakers.

THE PSYCHIATRIC CONTRIBUTION

The following section describes the basic attributes of psychiatrists and their training which prepare them for useful consultation in the field of mental retardation. Naturally, individual psychiatrists vary in their particular talents, training and skills. However, for purposes of consumers of psychiatric consultation, this section is a guide to relevant knowledge and skills provided in all or most of the basic education and training of psychiatrists. The section also serves as a relevant reminder and guide for psychiatric training programs.

Psychiatric consultants concerned with retarded and developmentally disabled individuals bring to a consultation unique clinical knowledge, attitudes and skills. They are conversant with the psychobiology of human disease, with basic theories of personality development, and with the vital concepts of fixation and regression, both in individuals and their families. They are trained in crisis intervention, pharmacotherapy and psychotherapy. They can deal with the maladaptations and psychoses of physical illness, organic brain syndromes, congenital defects, and dementia. The range of neurotic disorders, psychoses and psychosomatic conditions that psychiatrists see in the general population also exist in retarded people.

The psychiatrist is a physician who bridges medical and non-medical areas in individual development and family life problems. His general education in physical and mental growth and development, ego psychology, and psychodynamics of individuals and groups form a solid knowledge and experience base for useful consultation. This base is significantly enriched by self-understanding and by the psychiatrist's intensive individualized
supervision by experienced clinical teachers during at least three or four years of training.

Psychiatrists' knowledge of general hospitals, state institutions, and medical bureaucracy is also important. The acute crisis experiences of hospitalization, dread, despair, and loss, are all part of the medical background which psychiatrists bring to their consultation work.

Psychiatrists' training and experience prepare them to comprehend affection, sex, attachment, strivings, gratifications, self-esteem, emotional pain, disappointment, helplessness, rage, bitterness, and despair in retarded persons, in their families, and to some degree in their teachers and doctors, and finally, within themselves as consultants. The psychiatric consultant should understand family dynamics, the reactions of parents to children, and especially the reactions of parents to having a handicapped child. The consultant understands social dynamics regarding the handicapped and deviant behavior in general. With such understandings he is better able to make judgments about the forces to be considered when making plans for treatment, special education, habilitation and rehabilitation.

Consultation is rapidly becoming a major function of general psychiatric practice, particularly in view of the current emphasis on psychiatry in primary care. Though always a part of child psychiatry and medical consultation services, consultation work will probably increase in both general and child psychiatry practice during coming years. Examination of patients specifically for consultation purposes is taught as part of basic clinical training.

The psychiatrist's background is not likely to prepare him to understand all of the complex problems of consultees in agencies and in the community. The basic skills, however, of listening, learning, and then diagnosing are much the same in consultation as they are in psychotherapy. As a consultant, the psychiatrist identifies problems and finds solutions using the biopsychosocial conceptual integration that is a strong mark of his training. The neophyte psychiatric consultant should, however, remain aware of differences compared to his training and avoid making a "patient" out of the consultee. He should, as in psychotherapy, also be aware of his limitations; the pitfall of omniscience is constantly present in consultation situations. Assisting the trainee to avoid such tendencies should be an integral part of his education, particularly in the intensive supervision of his early consultation experiences. Supervised consultation experience should begin with direct clinical consultation and continue through community agency consultation during residency, then to administrative consultation (generally at a post-residency level).
THE CONSULTATION PROCESS

In the old mode of operating, the senior medical consultant entered a room omniscient and effulgent, dropped his pearls of wisdom and left, never to return. This mode has a function in classical medical consultation, but it has serious limitations in psychiatric consultation where strong emotions of other people in the situation are crucial and information may need to be assimilated gradually. What is most helpful is a developing relationship between the consultant and the consultee. The two must work as respectful colleagues, not as competitors or antagonists.

The psychiatric consultant may become concerned that his role is not accorded proper status when working in mental retardation. A gradual mutually educative process is often involved. He needs to be clear about the limits of his authority and tolerant when his advice is not taken. The consultant must be able to determine an appropriate management plan that involves support staff and is translated into terms which others who work with the patient can understand. To accomplish the intended purpose for the patient and the referral source, collaboration and coordination must take place. The consultant’s status depends largely on his capacity to be “on target” with consultee concerns.

Individual consultation involves complex decision making and management. A typical example is found in the case of Cynthia.

Vignette #2 (Type IA & II A)
Cynthia, age 22, was moderately retarded. Her parents, who had had psychotherapy at various times in their lives, consulted the hospital psychiatric clinic because of an increasing antagonism among members of the family. The father had never fully accepted the conclusion that Cynthia was behaving as she did because of a true disability. Instead, he thought of her as “lazy.” When she sat at home watching television news programs, which she could not understand, he railed at her because she was not reading the newspaper. The mother was concerned about Cynthia’s lack of response to intellectual stimuli at home. When Cynthia failed to stick with a job, both parents criticized her. The contrast with a younger sister, who was doing extremely well as a dental technician, aggravated the whole problem.

The family was assigned to a psychiatric resident for clinical evaluation and intervention. Although Cynthia had had remedial schooling, psychotherapy, and other special care throughout her life, she had had little job training. An important part of the ongoing clinical consultative process, therefore, involved placing Cynthia and her family in touch with a sheltered workshop, with careful follow-through of the referral process.

This consultation evolved into ongoing family therapy. Although the consultant was concerned with the details of the sheltered workshop referral, the principal consultation task was to increase understanding on the part of all family members regarding Cynthia, her problem, and her needs.

The following vignette illustrates the complexity of a mental health consultation service to a community agency for retarded children. The vignette also identifies serious obstacles to consultation success, despite relatively intensive efforts.

Vignette #3 (Types II A, B, C, D, III C & I C)
The consultant psychiatrist spent five hours weekly in a pre-school therapeutic nursery for retarded children funded by a local government. This was a new program which opened after many delays necessitated by prob-
lems of funding and of recruitment of staff, in a very marginal setting (one large, unpartitioned room in an inpatient children's mental health center). The director, a mental health professional, had previously worked in a program for mildly to moderately retarded adolescents capable of considerable independent functioning. In the adolescent program, emphasis had been on independence and vocational planning, with large amounts of group and milieu therapy. The director's knowledge of pre-school development was limited, as was her knowledge of strategies of treatment or education for pre-schoolers.

Two teachers, recruited two days before the school began, were elementary school teachers who had taught learning disability classes. One was a black, middle-class, upwardly striving woman who was warmhearted, but who firmly believed that "these kids need to shape up. It's a hard world out there and they have to compete." The other, a white male, seemed to feel that all the ills of childhood could be cured by large doses of affection and freedom from limits. The contrast between the restrictive and overindulgent teachers permeated every team meeting.

In this setting the staffs' fantasies of radical improvement and rescue predominated. Their expectations were continually frustrated, practically every day. The progress of the children was extremely slow, especially in academic skills, and the seemingly capricious administrative establishment made promises and stated deadlines which were never met. In one week $4,500 was added, subtracted, then added again to the budget. Racial overtones added fuel to problems of authority and status. Anger and frustration changed the suspiciousness of the director to reactions that at times resembled frank paranoia.

In the beginning, the consultant was regarded as something of a magician who would provide the methods for "cure"—and rapid cure at that. Covertly the consultant was given the task of settling the fight between staff members, most of whom were black, a task which the director could not undertake because the staff did not respect the director or other white social workers. The consultant was also seen by black staff members as part of the white establishment and was held partly responsible for the many frustrations in the program.

The consultant tried to work with these problems by initiating the following activities:

1. a series of case-oriented staff seminars on child development and mental retardation, teaching principles of positive behavior modification, psychopathology, and the use of drugs in treatment. These were combined with diagnostic evaluations and therapeutic planning for each child in the center;
2. the involvement of appropriate professionals (speech and hearing, neurology, psychology, outside educators, pediatricians, etc.) in staff team meetings;
3. the recommendation and subsequent hiring of a specialist in early child development and education to provide specific help in educational methods and materials;
4. a recommendation for remodeling the area to provide more closed, structured spaces.

The last recommendation, remodeling, was initially ignored. Later, without warning, the director began the remodeling without consultation with the staff or consultant. The remodeling was interrupted when staff noted that two of the children were eating the plaster dust from debris. (There was no substitute area to use during the remodeling.)

The results of the consultant's suggestions were not satisfactory either to the consultant or to the staff. Failure, however, hinged on errors of omission. Of these, the most important was the lack of sufficient attention to the frustration of staff expectations and rescue fantasies.
They had hoped to have a tremendous impact on the development of these children and were disappointed in the extremely slow rate of progress. While the children's socialization and verbalization improved, staff expectations regarding intellectual development and reading skills were not met. Like parents, they attempted to defend themselves from their grief by denial, anger, and projection. As a result, they were more vulnerable to the capriciousness of the system and to the lack of consistent, constructive institutional support.

Also significantly absent from this program was an insistence that parents should be involved in the affairs of the school, as well as in regular individual counseling sessions. This omission contributed to the development of an adversary relationship between the parents and the school, each projecting their grief, guilt, and anger onto the other.

Frustrations and failures in consultation are the most difficult and unfortunate, yet often the most instructive, aspects of consultation. The importance of timing and early intervention is obvious, but that is easier said than done as a complicated situation unfolds. Post hoc analysis and clarification of problems is always easier than when the consultant is caught up in the midst of complaints and demands of the consultees, clients, or patients.

In the above situation, the consultant found in retrospect that a greater proportion of effort should have been devoted to the two problems mentioned. In a case where such measures proved still insufficient, the consultant could tactfully point out the problems and the eroding effect on all concerned, and that they were beyond the ability of the consultation to modify sufficiently in the time allowed. The latter approach can sometimes mobilize additional concerted attention from the consultees and/or open doors to new solutions. If still faced with an “impossible” predicament, the consultant can consult a more experienced colleague if available and/or renegotiate the goals and conditions of the contract.

Failing the above, in extreme cases the only alternative is to withdraw from the consultation and state the reasons. The latter statement should be tactful but candid, directed to the appropriate primary consultee, emphasizing reality limitations from the consultant’s point of view, preferably based on factors that are self-evident to the consultee. The consultant’s own external circumstances, if relevant, should also be mentioned among the limitations.

Training in psychiatric consultation should prepare trainees for such complex consultation experiences, preferably on a graduated basis that provides initially for a greater assurance of success. In the event of failure, post hoc review should be provided with a constructive learning emphasis.

Generic interdisciplinary “mental health consultation” has not stressed the clinical expertise, or particular knowledge or experiences, that the consultant needs in order to work with such agencies as schools, courts, day care centers, recreation programs, and nursing homes. Instead the emphasis in mental health consultation has tended to be on the common knowledge and skills possessed by consultants from a number of disciplines.

In mental retardation settings, as well as in other similar settings, however, the mental health consultant needs to understand group dynamics, social systems, and crisis intervention theory and methods. The unique training and experiences which each discipline and each individual from that discipline can bring to the consultation process has recently received more emphasis. Psychiatrists as physicians have a unique background which is derived from their medical education. In the psychiatric version of mental health consultation the knowledge base that comes from medicine is often important, as evident in the following vignette.
Vignette #4 (Type III A, B & C, II A)

At a state school for retarded children, with an active training program, the psychiatrist on the teaching staff used seminar discussions in a brief intensive course to provide trainees an opportunity to integrate a variety of factual material being taught in other courses. Much of this material had to do with basic sciences, such as genetics, that are relevant to mental retardation, plus a variety of clinical subjects, such as medical and psychiatric syndromes and treatment methods. Other subjects included epidemiology, home services and organization of services for the mentally retarded. Case-oriented instruction by the psychiatrist proved to be a valuable means for integrating the biomedical, psychological, and social aspects of mental retardation. It also served to engage the students actively in experiential learning instead of passively absorbing lecture information.

The psychiatrist practitioner should be aware of a trend that is bringing direct clinical and case-oriented consultation into genuine collaborative efforts with public health and community mental health consultation. Public health focuses on large populations and a host of agencies with concepts of breadth and scope. Clinical psychiatry focuses on the individual, with special techniques, knowledge and unique skills. Clinical psychiatrists are often called upon as consultants in clinical work with individuals from many agencies. Examples of such agencies include school systems, public health departments, community mental health clinics, social agencies concerned with the placement of dependent children, and pediatric clinics concerned with the health and appropriate parenting of handicapped children.

Initial Consultation Arrangements

Before embarking on a new consultative assignment, arrange-
NEW ALLIANCES

It is extremely important that the consultant try early in the consultation process to grasp the full context of the problems presented to him by the consultee, such as the consultee’s position, constraints, and resources within the social system of the school or hospital involved. The consultant also needs to assess the chances for implementing his suggestions and the difficulty of obtaining particular services. How can the constraints be faced realistically and strategies developed for dealing with them? Consultants need to respect consultees as persons with their own knowledge and skill and explicitly to acknowledge the consultant’s own limits in the consultation functions. This mutual education and acquaintanceship is a vital part of the evolving consultation process.

The core consultation relationship may expand to include other relationships of the consultee and relations of the consultee agency with the community at large. These might involve the attitudes of the general public toward developmentally handicapped or mentally retarded individuals. The understanding and feelings of the psychiatrist-consultant about services can influence the development of adequate treatment, special education, habilitation and rehabilitation services for this group of individuals. The consultant may become interested in the political aspects of how local and state governments support programs for the handicapped. The development of political “clout” by parent groups nationwide has, over the past 30 years, generated substantial interest and support for programs for the mentally retarded and developmentally disabled persons. Recently, however, countervailing adverse reactions by communities to group homes or half-way houses for retarded persons in neighborhood settings have become more evident.

As the consultant develops interest and understanding in these broader issues, the consultees themselves may begin to gain a broader vision of the specific problems under consideration and their complexities. Side by side with this greater mutual understanding is the process of ventilation and clarification of feelings. One mark of the successful consultation process is that areas of agreement are firmly established and gradually expanded. In order for this process to advance satisfactorily, two further conditions must be met. First the consultant must create a confidential setting for the consultee. There is a truism in consultant work—namely, that the consultant can move up or down the hierarchy in a system only in accordance with his ability to develop and maintain confidentiality. Secondly, the consultant must earn the confidence of the organization and those working in it by demonstrating competence and being useful in a practical way. There is no denying that individuals vary in their ability to move about within an organizational system, each with different degrees of charm and facility. However, consultation to institutions and agencies is also to a great extent a trainable skill.

A further step in the consultation process consists of a plan of action based on the understanding of the problems as presented and careful consideration of the consequences of each of the alternatives. When it comes to consulting with colleagues on a clinical case, the alternatives will center about treatment and management. When working with other agencies, consultants also call upon their past experiences with community resources and often suggest collaboration and involvement of additional special persons in the work with the patient and family.

Consultants should become acquainted with all of those resources which may be mobilized and should be free to express expert opinions or points of view. However, decisions regarding next steps must clearly rest with the consultees and consultee agencies. It is extremely important to be clear about the
decision-making responsibilities for particular problems or for case management, even though the consultee is apt to want the consultant to take on these responsibilities. Often during the course of consultation the consultee will make an effort to involve the consultant more directly in case management. Decisions should be reached regarding steps in problem resolution. Specific management issues may be resolved in one consultation session or over a series of meetings.

Greenspan, Nover and Brunt have laid out some of the steps needed for working with staffs in day care programs. Their recommendations are applicable to day care for retarded persons and to residential schools. A variety of consultant roles are included. They stress the following:

1. Defining the group by establishing boundaries of activity.
2. Facilitating discussion of overt and covert themes in a natural pattern of emergence.
   - Focusing on understanding what group members were saying.
   - Facilitating discussion by rewording and clarifying.
   - Posing questions to highlight and develop themes raised by staff.
   - Encouraging the development of group members’ own thoughts and feelings and their expression.

Plans for follow up are an integral part of any consultation. The consultant must take some initiative to review previously discussed cases and to inquire about disposition, course of treatment, special education or rehabilitation efforts. These inquiries should be made judiciously so that the responsibility for implementation remains with the consultee.

The psychiatric consultant may develop continuing relationships with consultee organizations and individuals. These relationships usually evolve in terms of collaboration, shared commitments to common goals, mutual respect, and the development of a continuing deeper understanding of each person’s area of special competence and expertise. Professionals who develop such consultant relationships over the years will be called upon more and more to help in resolving difficult clinical and administrative problems with which the consultee agencies and individuals are struggling. An example of this type of collaboration can be found in the organization of inter-agency or community councils concerned with services for the developmentally disabled.* These councils enhance the ability of communities to maximize their use of resources which are often inadequate.

The consultant may work with parent groups and self-help groups. He may participate in the preparation of applications for public or philanthropic funds. The consultant hears many complaints and shares the frustrations of parents who may feel that several years of special education for their child and themselves have been to no avail. The consultant recognizes the need to orient parents and to involve them as partners in the development of strategies to design effective programs to maximizing growth of developmentally handicapped children. The consultant should help temper their hopes that quick, crash programs and simple solutions will be effective.

By being aware of parental and agency hopes and resistances, by being available for follow-up while being able to tolerate anxiety, ambiguity, and the inability to “cure,” the psychiatrist can clarify issues and ease tense situations to provide a basis for resolution of conflicts.

Vignette #5 (Type I A & II A)

A psychiatrist practicing in an urban center was asked to see Cindy, a sixteen year old retarded girl. She was reportedly having dramatic symptoms of a neurological type, although there was no detectable change on neurological examination and no other sign of acute organic disease. The parents were frantic and requested medications, hypnosis, psychological testing, or identification of some new neurological syndrome which would explain her change. Cindy’s father was a dean in a small university. Her mother was involved with serving as the official faculty hostess while also busy with the local association for retarded citizens and church social activities. Two older sisters were academically and socially successful and were similar in outlook to their parents.

Cindy had been born with a questionable neurological disability, following a long labor and considerable perinatal distress. She developed in a slow but consistent manner as a mildly to moderately retarded child. She walked at three and did not use phrases until four, though words had begun at two. She had no obvious cerebral palsy, but the persistence of “soft signs,” on neurological examinations, such as mild fine motor incoordination, continued to suggest brain damage and raised questions in the parents’ mind concerning Cindy. Her parents had tried to take her everywhere with them and had included her in both family and professional socialization. She had been in a special class during all of her years of school.

At fifteen, when Cindy began to menstruate, she was terrified, even though her parents went to considerable pains to explain it to her.

When the family had moved, following the father’s university promotion, the social life of the family expanded considerably. Cindy went to a new school and began to talk less. She seemed preoccupied and gradually stopped walking normally. She began to crawl on all fours, especially during faculty cocktail parties in the home, to the consternation of her parents. She began to walk in a scissors gait, to flail her arms around, and to use baby talk. Her school had also been surprised by the marked regression in her functioning. After neurological studies had revealed no change, she was brought in for psychiatric consultation.

In consultation with the family and with Cindy it became evident that she was not psychotic, and that her symptoms were not caused by any new neurological syndrome. On the other hand, her behavior could readily be understood from the consultant’s perspective as a regressive and manipulative response to her changed environment and a desperate need for support and attention. This understanding had to be carefully demonstrated to the parents, who observed the reactive nature of Cindy’s behavior with the consultant. Several sessions with the family helped them first to ventilate their anger and hurt about Cindy and then to enroll her in a school where she got more attention. They also implemented a program which clearly showed what they wanted her to do when guests came, rewarding her for good behavior. Her conduct gradually improved, with some embarrassing relapses, but the family was able to deal with her in a more effective manner.

In this direct clinical consultation (type I A) with the patient and parents, the psychiatric consultant integrated her technical psychiatric assessment of the patient’s and family’s symptoms with neurological, pediatric and school teacher’s assessments. Based
on her assessment, the consultant’s action included brief psycho­
therapy for Cindy (psychodynamically oriented) and guidance for
the parents (utilizing behavior modification principles) plus active
involvement in planning and case management. The modified
diagnostic view of Cindy and her problems was conveyed to the
parents and concerned professionals (Consultation types I A and
II A).

Assessment of Development,
Psychopathology and Assets

Mental retardation is a clinical developmental syndrome that can
best be understood in dynamic developmental terms, regardless
of involved etiologic factors or the various functions that are
affected. There is a tendency for professionals and parents to
create stereotypes, or jump to conclusions, on the basis of diag­
nostic labels. Clinicians should first assess separately and then
integrate the data on: (1) intellectual functions and degree of
retardation, (2) neurological status, (3) emotional development
and psychopathology, (4) etiology and any associated medical
diagnosis, (5) genetic factors, and (6) family and sociocultural
factors. Assessment should include an estimate of the degree of
severity of disturbance in all these sectors. Assets in each sector
should also be identified. Assessment should never be limited or
condensed into a numerical intelligence quotient. The mentally
retarded person and family should also be helped to gain a
realistic view of the assets and limitations in each sector. Find­
ings should be translated into behavior and terminology they can
comprehend, preferably using their own words and observa­
tions. The psychiatric consultant should use a similar approach in
providing consultees with a realistic perception of the retarded
person as a unique individual with his or her own unique assets
and limitations. Developmental phases and psychosocial aspects
of adaption should also be emphasized.

Primary intellectual limitation, a slow rate of development,
immaturity of evolving personality structure, limited differenti­
ation of ego functions, and immature psychosocial adaptation15,14
are inherent factors in the mental retardation syndromes. Com­
mon descriptive traits include repetitiveness, inflexibility, pas­
vivity, periodic withdrawal into a world of one’s own, and simplic­
ity of emotional life and expression. All these characteristics are
roughly proportional to the degree of retardation and should be
distinguished from other factors and complications that may also
exist in individual patients or subtypes.

Complications in emotional development are associated with
the intellectual handicap and slow rate of development, also
somewhat proportional to the degree of retardation. Limitations
in abstraction, language development, symbol formation, and
imaginary play affect emotional problem-solving capacity at ear­
ly crucial stages of development and also have cumulative effects
on adjustments to developmental tasks over the years. However,
the emotional complications and impact of these limitations can
be significantly modified or partially prevented by anticipatory
guidance from parents, caretakers, teachers, and therapists.

Secondary influences that commonly complicate emotional
development, with great individual variation, include: physical
illness, neurologic impairment and seizures, physical handicaps,
and emotional trauma. The latter may stem from sensory and
emotional deprivation, recurrent hospitalization, overstimula­
tion, confused or conflicting expectations on the part of parents and
caretakers, withdrawal of emotional investment by bereaved or
over-taxed parents and caretakers, tendencies of parents to fuse
their image of the child with an image of their own defectiv­
ness, and tendencies of parents and caretakers to reinforce
infantilization of the retarded individual.15 These secondary influ­
ences are directly related to the retarded person’s condition and
should be distinguished from preexisting psychopathology of
parents, individualized distress reactions of parents, disturbed
family systems, and sociocultural factors.

Retarded children are especially vulnerable to emotional dis­
orders. In psychiatric services for retarded children, high rates of moderate to severe emotional disturbances are reported. Webster,16 in a study of 159 preschool age retarded children, (3 through 6 years) applying for nursery schools in the Boston metropolitan area, found 48% moderate and 18% severe (mainly psychotic) disturbances in emotional development. All degrees of retardation were represented, with 36% of the children below IQ 50. More than half had definite evidence of organic brain disorder. However, organic brain disorder itself did not correlate with any higher rates of moderate and severe emotional disturbance. Rather, severe emotional disturbances were more prevalent among children without organic brain disorders. The families came from all socioeconomic strata. However, this preschool selection of children included a higher proportion of more serious or visible cases than one would find in a sample of older retarded children in the public school system.17

Philips18 reported on 170 retarded children (later 227 cases)19 seen in a clinic at the University of California at San Francisco, ages 9 months through adolescence, with all degrees of severity of retardation: "It was uncommon to see a retarded child who presented no emotional maladjustment of moderate to severe degree as part of his clinical picture."20

Chess20 reported on 40 retarded children seen in a New York University clinic, ages 5 to 11 years and IQ range 50-75, excluding children with "significant motoric disturbance": "70% were found to show significant behavior disorders on psychiatric evaluation. . ." of whom 45% had reactive behavior disorder, 5% "neurotic behavior disorder," 17.5% "behavioral dysfunction due to brain damage" and 2.5% "psychosis." Chess21 later reported on 52 cases: "30 (58%) were diagnosed as having a behavior disorder."

Menolascino22 reported on 616 children with “a suspicion of mental retardation” seen in a state clinic program at the University of Nebraska serving rural and urban patients. In these children, primarily outpatients, ages 7 days to 8 years: “31% (191 cases) displayed prominent psychiatric problems. . .” Of these, 40 out of 191 had “primary emotional disturbances without mental retardation” and the remaining 151 had both handicaps. Menolascino24,25,26 later reported on 1,025 children, ages 1.6 years to 14.2 years, of whom 25% (256 cases) were both "emotionally disturbed and mentally retarded . . .” Of these 256 cases, 117 had “chronic brain syndromes with behavioral and/or psychotic reaction,” 8 “functional psychosis,” 39 “adjustment reactions of childhood,” and 11 “psychiatric disturbance not otherwise specified.” Reports on institutionalized mentally retarded persons of all ages indicate a comparably high incidence of psychiatric disorders similar to the above clinic studies.*

Practically all of the classical psychiatric disorders seen in the general population also occur among mentally retarded children and adults. From a descriptive and psychodynamic perspective, moderate disturbances in retarded children include disorders of impulse and behavior, excessive fears and inhibitions, grief and loss reactions, exaggerated negativism and compulsive traits, exaggerated immaturities and regressions, and low self-esteem. Serious emotional disturbance, such as psychosis, occurs with greater frequency in mentally retarded persons than in the non-retarded population. In cases of severe and profound retardation, the different types and severity of psychosis can sometimes be quite difficult to assess. Just as emotional disturbance can lead to "pseudo-retardation," severe degrees of retardation can lead to psychotic-like symptoms with relatively

* A similar self-selective bias presumably operates in clinics as in preschool nursery programs. That is, more severe cases and more behavioral problems are apt to appear compared to the total population of mentally retarded persons. Also, there is a sharp peak in the reported incidence of mental retardation during school age, as compared to preschool and adult populations.22

* It should be emphasized that most mentally retarded persons rarely if ever see a psychiatrist during their lifetimes. Of those who do, a significant number are doing remarkably well, considering their handicaps. If, in a given year, each psychiatrist in the United States saw mentally retarded persons, and all intellectually impaired persons (below IQ 70) used psychiatric services, every psychiatrist would have an average of 240 such cases.
less serious ego disturbance than is found with comparable symptoms in non-retarded persons. Almost all varieties of emotional disturbance, and almost all degrees of retardation, can be associated with a particular neurological or etiological diagnosis. Therefore, we again emphasize the necessity for independent assessment of these factors.

As retarded children advance in age and social experiences, a great many "socially reinforced" patterns of behavior occur. Heber's review of experimental research on personality factors in mental retardation led him to emphasize "motivational" and "social reinforcement" variables as the most striking and consistent findings that distinguished retarded from nonretarded subjects. Reactions of peers and teachers, many experiences of failure or unfavorable comparisons, the tendency to be easily led, and limitations in social judgment are among these social influences. However, many desirable traits and adaptive skills can be socially reinforced as well. For example, retarded children and adults often generate a special, positive response and investment from parents, siblings, and caretakers that can foster self-esteem and healthier emotional development. Nevertheless, their vulnerability to negative reactions or overly rosy reaction formations from family, peers, school, work, and social environments should not be overlooked.

In addition to providing comprehensive diagnoses, the consultant should help formulate realistic treatment, education, and training programs for the patient which can be developed within the context of the patient's life situation. Uniformed pessimism about the prognosis, after the development of a diagnosis, should be replaced with more realistic optimism about what can be done. Caution should be taken, however, against inappropriate expectations which lead to disappointment. Overexpectations and disillusionment may lead to professional withdrawal or lack of interest on the part of the consultee, as well as obvious disadvantages for the patient and family.

A.P.A. DSM III

The proposed new Diagnostic and Statistical Manual of the American Psychiatric Association (DSM III) proposes five axes as follows for describing disorders: (I) psychiatric syndromes and other conditions; (II) personality disorders and, in children, specific developmental disorders; (III) physical disorders; (IV) psychosocial stressors; and (V) highest level of adaptive functioning in the year preceding the evaluation. This provides a comprehensive framework for defining the complex situations found in psychiatric consultations.

The essential features of mental retardation listed in DSM III are: (1) deficits in adaptive behavior, taking the individual's age into consideration, (2) significantly subaverage intellectual functioning, more than two standard deviations below the mean for the general population on the Wechsler or Stanford-Binet intelligence tests, and (3) onset before age 18. The four subtypes which reflect the degree of intellectual impairment designated are: mild ("educable," Wechsler IQ 55-69), moderate ("trainable," Wechsler IQ 40-54), severe (Wechsler IQ 25-39), and profound (Wechsler IQ 24 and below, extrapolated). Sociocultural factors (such as learning styles, languages used, and childrearing practices) and intrinsic factors (such as reading disorders, arithmetic disorders, and the dysphasias) are classified separately under axes IV and II in DSM III. The subcategory, "borderline," has been removed from the mental retardation diagnostic category, but some cases may be classified under a more "specific developmental disorder," such as a specific reading, mathematical or language disorder.

Newborn, Family Crisis

The family crisis arising from the birth of a handicapped child presents a series of dilemmas for the attending professionals. The consulting psychiatrist must be aware of the hazard of
attempts to tell the parents too much at one time, and the need to avoid contradictory information from several sources. There are immediate care issues as well as issues relating to long range care, and genetic counseling. The psychiatrist should be particularly sensitive to the involvement of all family members in the crisis, such as siblings, aunts, uncles, and grandparents. The different cultural and subcultural modes of handling grief, disappointment, blame, guilt, shame, and feelings of inadequacy must also be recognized. Friends and neighbors will frequently be significantly involved in such crises. Siblings of newborn handicapped babies often tell their parents later that secrecy and mystery made them think the situation was really much worse than it turned out to be. They also express anger at being left out. "If they would just tell it like it is" is a frequent comment in discussion groups for siblings of retarded children. Secrecy from neighbors and friends contributes to isolation, avoidance, and the buildup of fantasies which distort the reality of the situation. The consultant can be of specific help to parents when aware of such potential problems.

Another use of the consultant is to provide guidance to parents about how and when to tell close relatives, especially grandparents. Confused and grieving parents can be helped to see that they are not obliged immediately to share or "unload" their problem on relatives. Waiting until personal grief and shock is somewhat resolved and more is known about the dimensions of the problem will often allow communication to take place with less discomfort.

Not only can consultants help individual parents directly, but a consultant can also meet with self-help groups to which new parents of retarded children can be referred. These groups consider psychological issues, such as guilt about neglecting older or younger siblings in order to meet the needs of the handicapped child, as well as management issues regarding day care, hospital care and special education. Siblings can be of great support to parents, especially when they are involved with self-help peer groups. Open communication can help prevent many family and neighborhood problems. Many families mobilize their internal and external resources to meet such crises and come out better, rather than worse, as a functional family unit.

The consulting psychiatrist can be of specific help in family crises involving the extended family.

**Vignette #6 (Type I A)**

A maternal grandfather, still grieving over the recent death of his wife, was confronted with his daughter's delivery of a Down's syndrome baby. Very upset, confused and ill-informed, he told his daughter that it was all her fault. She had worn pants which were too tight, thus did not give the baby enough room to breathe! The upset mother was helped by the consultant to understand the tendency of this "old country" father, still mourning his loss, to react with great anger and to blame the daughter as a way of handling the new loss before he had worked through the old. Parental disapproval of modern dress for emancipated women was also discussed. Deeper psychological issues were avoided. The mother and father were eventually able to reestablish a comfortable and realistic relationship with the maternal grandfather.

As the clinician becomes involved with problems such as the above (direct clinical consultation, I A) he finds familiar dynamics at work, and comes to realize that when dealing with disappointment, loss, and grief one has to individualize. One cannot assume that every individual or family will work through stages of grief in the same fashion, or at the same pace.
ORCHESTRATING CASE MANAGEMENT

In many settings for retarded persons, caretaking staff who have had long, practical case experience with retarded children have had limited or no contact with psychiatrists. They are often confused about the role and functions of the psychiatrist and may feel threatened by a consultant. (On the other side, psychiatrists may be ignorant of the behavior of retarded people and may have negative feelings or an aversion toward them; they may stereotype them as impulsive, uninteresting, nonverbal, dull, rigid, and essentially untreatable.) Many professionals as well as nonprofessionals working with retarded persons are apt to know a lot of mental health jargon but don't truly absorb the concepts. "They know the lyrics, but they cannot carry the tune." Thus, they often have difficulty implementing suggestions for handling the painful feelings, bottomless sadness, hunger for affection, and ineffable rage of the person who is retarded.

Vignette #7 (Types I A, B, II A, B, C & III B & C)

Rose was a fifteen year old moderately retarded girl who was referred to psychiatry by the department of obstetrics/gynecology in a large teaching hospital. The gynecologist requested consultation prior to a parent-requested sterilization procedure.

Rose was an attractive girl with a six-month history of running away from home and disappearing for one or two days before being found by police or returning voluntarily. It was not always clear where she had been during these absences. Living in a warm climate, she slept on park benches, appeared unannounced at homes of friends and relatives, and once was found in the early morning sleeping in the school yard. Rose's independence in travel contrasted with her dependency and fearfulness. Her school performance was erratic and on the decline. School reports generally indicated she could function at about a third-grade level, but they too were inconsistent.

The parental response had alternated between avoidance of this "damaged" child (including absence from school conferences and parent meetings) and over-protection, stemming from anxiety about the adequacy of her functioning and her ability to take care of herself. Most of their attention and hope was invested in an older sister who was quite bright, and two younger children, the second of whom was conceived immediately after the diagnosis was made of Rose's mental retardation.

The parents' concern about Rose's sexuality seemed to be related to the pregnancy of her unmarried eighteen year old sister as well as to the recent commencement of her menses. Rose was seen by her parents as clinging and dependent, demanding physical contact with others. Her parents felt she had limited discrimination and judgment, especially when she made requests for physical affection, such as requesting cuddling with strangers.

The consultant was first contacted by the clinic staff who were angry at the parents' request for sterilization. The consultant agreed to sit in on the conference with the parents, and helped with the task of sorting out the heated feelings and responses. It became clear that the parents had never really come to terms with their grief and disappointment at the original diagnosis of mental retardation.

After helping to clear the air and defuse the situation, the consultant was able to work individually with the various parties involved. She consulted with the school regarding assessment of the child, considering both her present emotional state and her level of academic performance. Liaison work with the gynecology clinic team led to an interdepartmental hospital conference on adoles-
Psychiatric consultation in mental retardation

cent development. A grand rounds session on the rights of the retarded was jointly sponsored by the departments of psychiatry, gynecology, and pediatrics. The pediatrician, who had become so anxious and uncomfortable when confronted by the parents with the sterilization request that he made a quick referral to gynecology and avoided counseling them at that time (particularly in terms of adolescent development and sexual behavior in the retarded) subsequently became a member of the team. The mental health counselor working with the older sister also took part in the conference on adolescent development, and she provided valuable information about the anger and depression (and stimulus for sexual acting out) in the home.

The consultant also met for four sessions with the parents, helping them to work through their hurt and fury at Rose and her sister, as well as their guilt, thus making further team intervention more feasible and productive.

This vignette contained elements of direct (I A, B) and indirect consultation (II A, B, C) and collaborative team functioning and education (III B & C), as well as brief psychotherapy. In this case, the consultant functioned as a conductor of an orchestra who also performs and gives music lessons. Some performances are more difficult than others, especially where sexuality is concerned. The emotional issues were identified and worked on. The parents became able to tolerate Rose’s sexuality without sterilization. This vignette demonstrates the role of the psychiatrist in a medical center setting as a clinician involved not only in indirect clinical services but also in liaison psychiatry as a consultant and educator.

A prominent feature of the subject of sexuality in retarded persons is the special blend of fear, misinformation, and lack of information which both professionals and the public share. Criminality as such among retarded persons is also a subject filled with suspicion and misconceptions. Sex and crime get mixed into the fears and images of unbridled impulses. There is no scientific evidence that criminality is linearly related to a measured level of intelligence. In Federal prisons there are extremely few mentally retarded prisoners; it takes a minimum of intelligence to engage in major crimes. In state prisons the average intelligence of prisoners is considerably lower than in the general population. Statistics based mainly on low normal intelligence and news stories of dramatic incidents can foster an inappropriate stereotype of truly mentally retarded people.

Paradoxically, views of mentally retarded persons being easily led into minor legal offenses, partly valid for a few, can be combined with views of their bursting with sexual and aggressive impulses and thus further foster the fears and stereotypes. A few mentally retarded persons do commit crimes, and this should not be glossed over. Unfortunately, when they do commit offenses, the problems are too commonly handled within the criminal justice system without sufficient psychiatric consultation or other attention relevant to their special needs, particularly while incarcerated.

Sexual concerns exist for mentally retarded individuals as well as for their families and the general population. Community-wide worries are common about how to teach sexual education, how to deal with the epidemic of venereal disease, early pregnancy and
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illegitimacy, and the separate but related concerns for the rights of individuals. Sexuality is a particularly interesting and needed aspect of consultation because it is fraught with so many overt and covert conflicts of attitude, opinion, and action.

Every sexual issue now being argued in society has ramifications for the mentally handicapped. The sexual revolution is made known to retarded persons in the community through television and newspapers. Abortion laws and sterilization legislation\textsuperscript{34,35} impinge upon the lives of retarded people and their families. Their right to marriage,\textsuperscript{36} to enjoy sexual gratification and to bear children either in the community or in institutions is argued. Homosexuality can create tremendous concern among institutional staff members and training schools. Prostitution, contraception, and sex education information, all present different problems for retarded people. John Money\textsuperscript{37} has stated one of the issues well, emphasizing the need to face sexuality clearly: “Only if one can be completely nonjudgmental about sex can one think clearly about the wisdom and possibility of making proper arrangements for conjugal living where mentally retarded members of the two sexes become true partners.”

Sex in Institutions

Consultees ask a variety of questions about the sexual conduct of institutionalized persons.\textsuperscript{38} Some are more troubled by self-destructive acts such as head banging, or by cursing. The consultant needs to provide information to institutional staff to help them define policies. This information also needs to be shared with the families of the patients so that there is less anxiety about the significance of cursing and masturbating, so that both staff and relatives during home visits maintain a standard way of reacting to patients on these issues.

Schools sometimes hold social functions, such as dances, that encourage retarded youngsters to meet each other and to teach them social skills and conduct. There is often a covert level of anxiety about what to do when retarded children, adolescents, and adults engage in sex play and attempt to have intercourse.

Vignette #8 (Types II A, B, C, D)

In one training school after dances and other social affairs, the retarded adolescent boys began to have intensive homosexual wrestling matches leading to mutual masturbation and fellatio. The staff alternated between panic and fury, wanting to punish the boys. They did not note the influence of the social stimulation that the boys had experienced. A psychiatrist met with the training school staff and examined the situation with them in order to work out a plan for instructing patients about acceptable limits on their behavior, recognizing the ubiquitousness of homosexual play in institutions. This led to a greater tolerance, with decreased punitiveness toward these boys, as well as more appropriate social control. The old approach of trying to get children to exhaust themselves (and rumors about giving saltpeter to institutionalized people), but then denying the existence of sexuality, seemed to linger in the background until these matters were explicitly discussed.

This is an example of a mixed client centered and consultee centered case consultation (II A & B) and a program centered administrative consultation and consultee centered administrative consultation (II C & D).

The sexual enfranchisement of retarded people has been a nervously accepted attitude. It has been assumed that the mentally handicapped persons do not have the same rights of self-expression or cannot handle these rights, as other individuals. Sometimes the most benign situations cause protests.

Vignette #9 (Types II A, B, C, & IV C & D)

One state training school had a special rehabilitation
program for criminals who were nearing the end of their terms, in which male convicts engaged in maintenance work around the buildings and grounds. One of these, a man of 28, became acquainted with a retarded woman of 23. After completing his prison term, he asked to marry the young woman. This request produced an administrative furor in which he was reported to his parole officer without further administrative consideration. He and the woman were both forbidden to have further contact. There was no further examination of the situation by the administration, including consideration of the idea that these arbitrary administrative injunctions might be illegal, as well as destructive to both individuals. The consultant tried to intervene but was overruled by the superintendent of the training school.

This consultation presumably involved types II A, B, C, with the consultant also stepping out of the consultant role into the social action role of patient advocate, IV C & D.

Homosexual and heterosexual assaults upon inmates and patients have been a problem in institutions for the mentally ill and retarded patients, as well as in prisons.

Vignette #10 (Types I B, II A & C)

A psychiatrist was called to examine two adolescent retarded boys in a state school for the developmentally disabled. The boys had complained of physical and sexual assaults by several male attendants. The employees denied the charges and said that the boys' wounds and bruises were self-inflicted. Before the consultation there had been recurrent rumors about these employees, but no action had been brought to protect the residents due to a feeling that there was insufficient evidence. The psychiatrist and staff attorney worked together to pursue the action. Psychiatric examination of the boys confirmed their ability to give testimony* in court against the employees. The employees were found guilty and dismissed from the school.

The case of a forty-nine year old school bus driver who raped two retarded girls of ages 12 and 13 (reported in newspapers in 1977) is illustrative of the vulnerability of adolescent retarded girls to sexual abuse and exploitation. His 25 year history of sex offenses was withheld from his employers under his right of privacy. The girls' intellectual handicaps and social behavior tended to convey their defenselessness to people who saw them, and thus placed them at a disadvantage and made them extremely vulnerable to predatory males.

In institutions for retarded persons there appears to be relatively little assault by residents upon other residents, although (for both erotic and affectional reasons) an enormous amount of unsophisticated flirting, seduction, and sex-play occurs. Retarded persons who are sexually active are not necessarily less adept at interweaving physical and emotional needs than are individuals of normal or high intelligence. Preparing the retarded for discharge should involve sex education, with a focus on what will be expected of them by their families and communities. Psychiatrists and other mental health specialists should become involved in these training programs. Gordon* has pointed out that in spite of special knowledge, not all "experts" on sex are expert in the practical methods of sex education:

"Everybody has to be so well qualified these days to do anything that it is difficult to get anything going. Yet some of the best education is done by formally unqualified people. I have noticed that teachers, nurses, and doctors

* Competency to give testimony because of mental retardation is usually not questioned by a court. Competency to stand trial is more often questioned, but that was not an issue in this case where the retarded boys were not the defendants. However, credibility as a witness is apt to be challenged by opposing lawyers during the trial. Psychiatric consultants to the mentally retarded person and his/her lawyers may be helpful, as in Vignette #10, in preventing unnecessary trauma or useless testimony.
are, in general, not especially good sex educators. We have overstated the importance of expertise when what counts is attitude and good will..."

Psychiatric consultants are generally experienced in discussing sex with an awareness of the emotional reactions, defenses and attitudes of the other persons involved. Because of this experience and their special biomedical knowledge, psychiatrists can be particularly helpful in working with staff members who have the task of giving sex information to institutionalized retarded persons. Psychiatrists are often automatically assumed to be sex experts who will give The answer. However, in regard to sex and retarded persons, psychiatric skills can best be employed in bringing out the different emotionally laden attitudes and value systems of the staff and trying to reconcile them. As a consultant, the psychiatrist should function more as a “group therapist” than as a “transmitter of factual data.” However, the psychiatrist absolutely must be aware of the realities of the social matrix in which different groups of retarded persons live their sexual lives.

Retarded persons who have less access to heterosexual outlets generally have many more homosexual experiences. If retarded adolescent girls and women do not know about birth control measures, they are obviously more likely to become pregnant. It is also well known that sexually active adolescent girls of average or superior intelligence who do know about birth control measures frequently avoid contraception and become pregnant. Thus, sex counseling for teenage youth, retarded or not, is an extremely important and generally neglected area. The consultant psychiatrist has a potentially very important role to play in such counseling and counselor training. There is need for clarity and resolve about a plan in this area. The specific state abortion law regulations and procedures should also be known. Persons with mental retardation who marry may be quite able to rear children successfully. Birth control instruction with follow-up programs needs to be supported by guardians, parents, physi-

cians and others to make sure it is effectively carried out. Abortion laws and rights of consent need to be understood and considered in developing plans for patient management.

Vignette #11 (Type I A)

A moderately retarded eighteen year old woman, IQ 45, who had been living at home for most of her life, met a seventeen year old boy who seduced her with talk of living together and marrying. When found to be pregnant, she was delighted, saying “We’ll get married and go on welfare.” She had no plans for prenatal care and viewed the potential child as a toy with which to play. Her mother consulted a psychiatrist, who convinced the patient not only to have an abortion but also to be sterilized. Neither the mother nor the psychiatrist considered that there might be any legal constraints upon themselves. The patient had an abortion and sterilization. As it turned out, she was not strongly affected by the surgery. She soon wandered off from her attachment to the young man, who had never seriously intended marriage. However, the psychiatrist should not have overlooked the rights of the patient and their possible legal implications.

In this instance of direct clinical assessment, with recommendation and referral, the psychiatrist should have followed the very important rule of knowing the related laws in his state. State and local laws are often not consistent about the rights and protections of the mentally handicapped in making contracts. Consultants, therefore, need to know about the law and regulations in their particular jurisdictions.

Vignette #12 (Type I A)

A twenty-seven year old moderately retarded woman lived with her middle aged parents. She began to feel
their exhaustion, frustration, and irritation with her when no place to institutionalize her could be found. She began a series of adventures into a nearby town, seeking out men on the streets and going home with them. The parents were shocked and sought to hospitalize the patient. She enjoyed their discomfort. When a psychiatrist evaluated the situation, he saw the parents together and individually. By working in individual sessions to clarify the anger and embarrassment of the parents, the sexual desire and wish for attention of the patient became understood. In family conferences the psychiatrist helped the parents and patient to state what the home rules should be. They set up curfew times, and dishwashing and bed making chores. They told the patient that they wanted her to avoid sex with strangers. This reestablished the household equilibrium, stopped the patient's forays, and offered an alternative to a residential placement for the patient.

In the Community

The public tends to be limited in its understanding, and to think of retardation in terms of stereotypes which often have little relationship to actual social behavior or types of functioning of the retarded. As the consultant becomes involved with sexuality of the retarded, he comes to see that familiar human problems of poverty and unemployment, crowding and overpopulation, and an often inadequate system for delivery of care will shape the management of individual cases.

Morganstern\textsuperscript{41} wrote of three major attitudes held by the public toward retarded people: (1) they are subhuman and animalistic, or (2) they are childish, or (3) they are developing individuals. He stressed that the first view is the more general and popular feeling, namely, that retarded people have stronger, more uncontrollable erotic impulses and that violence and sexual aggression are more frequent in the retarded. This view leads to the wish to have mentally retarded people segregated, hidden away, or confined.

Some retarded individuals, as well as others with normal or superior intelligence, do approach children. Some people's reactions are, "I don't like the way they look. I don't think they are dangerous, but they are creepy and I don't understand them." For others, images of rapist, child molester and prostitute loom up, even though these roles are most frequently filled with people of normal intelligence who are often emotionally or mentally disordered.

Morganstern\textsuperscript{42} noted that the paternalistic attitude, people tending to see mentally retarded persons as childlike, is a less hostile attitude than the animalistic one. However, this attitude often results in a failure to recognize the realities of patients' sexual impulses and the limits to their expression. Those who hold the view that retarded persons are "slow developers" are for the most part enlightened parents, educators and others who are interested in retarded people in the community.

Consultants must be aware of these three contrasting popular views about retardation as they work with patients, parents, colleagues and community groups.\textsuperscript{43} It is most important, however, that they remember that the majority of retarded people are coping and have blended into the population. The latter are functionally beyond the purview of any professional advice. A general goal of professional workers should be to help more retarded people to function satisfactorily in the general community. This requires a sensitive awareness of the complexities and realities of sexuality for these people.
Knowledge about the genetic origins of many diseases and the genetic risks involved for individuals and families has resulted in a mushrooming of genetic counseling centers over the past 10 to 20 years. Such centers are, for the most part, located in tertiary care teaching hospital settings. The purposes of such centers are to impart information about genetic disorders and risks, and to help patients and families use the new information for decision making.

Families fear the risk of recurrence of a genetically-damaged fetus, the fate of siblings, and risks for collateral relatives with similar genetic pedigrees. Family concerns regarding carrier status and the consequences of marriage for particular partners are also commonplace in genetic counseling. Childbearing risks include the hazards for progeny of older parents, of persons exposed to drugs or radiation, and of families with histories of genetic illness. Adoption agencies also ask about risks, such as in children born of incestuous or other consanguinous unions.

Most conditions reviewed in genetic counseling are multiply-determined and are not classical, pure Mendelian dominant or recessive genetic disorders. When clear and specific etiologies are not present, genetic counselors must, when they meet individuals or families, review the variety of possibilities in only a general fashion. Information is provided, but decisions are up to the individual and families involved.

While the primary tasks of genetic counseling are imparting information and outlining risks, counselors have found their tasks to be very much complicated by the presenting psychological crises of the individuals involved. One study in a leading center demonstrated that over 40 percent of those receiving genetic counseling do not “get the message” regarding the nature of the disorder and the implications for them, their children, and relatives. Many people are confused and frightened rather than helped by insensitive advice when they are already upset.

Genetic counseling takes place at times of severe emotional stress. The first contact with an individual or couple may occur at the time of birth of a defective child. Serious questions arise for the counselor, such as how to inform parents or whether to tell the father first. Genetic counselors usually stress “bad luck,” and “no one’s fault,” and naturally try to avoid reinforcing the prominent tendencies toward guilt and blame. Most importantly, the counselor should structure the conference so that there can be an unhurried, private discussion, ending with arrangements for further follow up to see if the family has truly absorbed the information provided. Follow up is important for better working through of emotional issues as well as for further genetic study and reinforcing “the message” realistically.

Genetic counseling sessions are best scheduled early in pregnancy when possibilities of amniocentesis and termination of pregnancy are to be considered. Other genetic counseling sessions are scheduled for individuals and families at times of screening for genetic disorders such as Tay-Sach’s Disease. Family pedigrees are obtained, and siblings and other family members are often involved in the follow up. The advent of amniocentesis and the prediction of some defects with an opportunity to abort them adds both to the technical advance of science and to the ethical dilemmas of parents and practitioners.

All of these situations are potentially loaded with emotionally shattering complications. Denial and avoidance are widespread. This is, no doubt, part of the reason for the gross lack of retention of information about specific genetic disorders and their practical implications, as reported by genetic counselors. Depression, with feelings of inadequacy and a tendency to blame oneself
and/or others, is especially frequent after major disappointments such as the birth of a defective child. Genetic counseling, as commonly practiced, is often not attuned to helping distraught individuals deal with such strong and complex personal issues. The process of overcoming the damaged self-confidence of parents who have produced a retarded child requires sensitivity and awareness of the long time needed for the parents to deal with guilt and to find solutions for the sense of "defectiveness" in their marriage. Still more time must pass in order to help the couple make plans for any additional offspring. Expert help is needed. A goal-limited and time-limited psychiatric consultation or psychotherapy program may be in order.

The psychiatrist is apt to be particularly attuned to the irrational conflicts of families with a retarded member. He is prepared by training to comprehend that the terrible worries of mothers who have produced a "defective" child can come from non-logical sources that cannot be allayed by statistical information. The psychiatrist may provide individual therapy for the depression seen after the birth of a retarded child, and he can help translate the factual genetic data given into advice that the patient can assimilate. Separating out the objective worries from the tangled subjective ones can determine the adjustment of the whole family. The psychiatrist may provide both group and family therapy to help individuals support each other and clear the tensions in the air.

Psychiatric consultation and other mental health education can be used to help train genetic counselors in the emotional aspects of counseling and help them integrate more appropriate pacing of the information that is offered. The psychiatric consultation-education service can also be used to review with the counselors the many apparently illogical responses that parents manifest while they are thrashing about in the midst of their initial grief after producing a retarded infant. A psychiatric consultant can teach concepts and demonstrate interviewing that helps parents deal with grief, mourning, depression and the helpless rage that can afflict parents. Psychiatrists should teach counselors to blend their facts with sympathy, support, and advice which makes clear that genetic statistics are complex, that parents may have questions about the relevance of their own past illnesses and that human reactions are intricate and long-lived. Psychiatrists can also be useful to help ameliorate or repair the trauma of parents who have been bombarded too intensely by technical knowledge in lieu of understanding and emotional support.
DEVALUED PEOPLE

One of the underlying issues in consulting on problems of mental retardation is that retarded people are a group with devalued social status. Working with them frequently will present status problems for the consultant. Colleagues and friends wonder why he bothers with such efforts. Can’t he “make it” with persons of average or superior intelligence, or high social status? Retarded persons may be referred to by medical professionals as well as by the public as “wierdos,” “funny looking,” “gorks,” or “crocks.” Siblings may be ashamed of them.

Insight about such matters can augment the consultant’s empathy and tolerance for the frustrations of others. The psychiatrist as an independent practitioner can choose whom to see as a patient or a consultee. Disagreeable situations may thus be avoided. In contrast, public schools, social agencies, public health and mental health services are under more pressure to take what comes, to respond to situations when referred, and to deploy their meager resources as best as possible.

Psychiatric consultants in mental retardation should be especially aware of the problems of value-laden attitudes of both the patients’ families and clinical and special education staff working in this field. Currently prevailing philosophies involved in mental retardation, such as “normalization” and “mainstreaming,” differ from the philosophy of psychotherapy, which stresses self-realization, usually for the more intellectually competent emotionally disturbed or mentally ill person. Sometimes a devalued attitude on the part of non-retarded persons is thinly obscured by reaction formation in the form of an unconvincing overvaluation. Children are sometimes more sensitive than their parents to such attitudes.

Vignette #13 (Type IA)

Harry was a fourteen year old adolescent boy, a childhood schizophrenic who had been referred for psychotherapy because of severe depression which had developed as he entered puberty. He was of slightly below average intelligence and ordinarily quite verbal. His parents were highly motivated and sensitive to his need for understanding and help. It was, therefore, quite surprising when the therapy, which had been going well, suddenly bogged down. Harry would lapse into depressed, anxious silences, or would produce sudden anxious “bursts” of meaningless word streams. For the first time, it seemed he did not want to keep his appointments and showed relief when the session ended so that he could leave.

All attempts to find a precipitating cause for this block were unproductive until one day he abruptly asked his therapist, “What does MR mean?” It happened that he had observed signs in the hall outside the therapist’s office announcing an MR Conference, being held on the same floor, and he had then taken note of some books on the therapist’s bookshelves concerning mental retardation. He had privately concluded (or feared) that his parents had selected an “MR expert” because they believed Harry to be “MR” himself. From his limited viewpoint, “MR” carried connotations of failure and defectiveness. When he thought of himself as “MR,” this was a blow to his already fragile self-esteem and had worsened his depression and undermined his enthusiasm for the therapist and the therapy. Once the issue was confronted and the therapist had explained the therapeutic relationship to Harry and had alerted the parents to his need for reassurance of their pride in his accomplishments, the therapy resumed its satisfactory course.

Psychiatrists and other professionals may engage in negative value judgments either overtly or more subtly in their attitudes toward working in the field of mental retardation. This may be a
problem for the patient, their families and others working in the field, especially in the initial phases of contact and work with mental retardation.

11

IN COURT AND SCHOOLS

Work in the legal arena carries its own special problems, such as in the cases of sexual problems previously described, pages 641 to 645. Inker and Peretta⁴⁹ point out that a person is not responsible for criminal conduct if at the time of such conduct—as a result of mental disease or defect—he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of law. They go on to point out that in court situations a retarded individual is likely to waive his rights, thus leaving it to his attorney to handle the case.

Vignette #14 (Type II A & B, I C)

Maria, a 23 year old mildly retarded woman, had become pregnant in a casual sexual encounter. She denied the pregnancy as long as she could and did not tell her employer at the shop where she worked as a cleaning woman. She had been obese since childhood and her pregnancy was not noticed for four months. At this time she was pressed to go for prenatal care but did not go and became withdrawn and truculent. She was delivered of an apparently normal child. When the child was three weeks old, the patient visited her parents, leaving the baby alone for three days, by which time it had died of dehydration. She was charged with homicide and assigned a public defender.

The young attorney who took over Maria's case was determined to provide the best defense possible and sought psychiatric consultation. The psychiatrist obtained psy-
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chological testing, and these data were presented to the court. Because of Maria’s older appearance, her silence, and apparent indifference, there was concern that with an apparently adequate work history, and in the absence of obviously disturbed behavior, the defendant would be treated as a normal individual. However, the psychiatrist, the psychologist, and the defense attorney made clear to the court the nature of the patient’s handicaps and impairment. She was given a suspended sentence on a charge of manslaughter and ordered to have treatment and probationary care.

Consultation to schools constantly requires that the consultant tolerate his own anxiety and inability to cure, while providing help to consultees who are on “the firing line.”

Vignette #15 (Type I A, II A & C)

The principal of a school wished to expel John, a thirteen year old boy with neurological impairment of his arm and leg, against the strong wishes of the parents. John had significant intellectual impairment with learning difficulties since starting school. More recently he had also shown an increase in disruptive behavior at school. Both parents were highly intellectual and held rigidly to their own opinions. They refused to acknowledge that John’s academic failure might be based on a specific learning handicap. They had moved from one end of the state to another in order to escape the difficulties that plagued John and themselves.*

John’s mounting frustration and failure in school work was accompanied by his becoming more of a behavior problem. He annoyed other children and became the victim of his classmate’s anger. The parents were proud and independent people. Typically, in interviews the mother called the father, “Mr. Smith.” They felt they had conquered an earlier disability when they rejected the advice to institutionalize from doctors who said that the boy would be a cripple. By dint of self-learned physiotherapy, they had gotten John to use his right arm and leg better. However, he continued to be an awkward child and this aggravated his psychological difficulties.

Rather than merely utilizing school disciplinary procedures to dismiss John, and feeling that he could not break through the resistance of the parents, the principal requested consultation services from a nearby child guidance clinic. He asked that the clinic: first, retest John; second, assist in explaining the best procedures to the parents; and third, help in working out a new school placement. The parents were reluctant to place John in a special class because of the type of children in it and because of their resentment at the school system for not keeping their son, even though he was not learning. Since they were both “self-made,” they felt John could make it too.

The clinic process, involving intake interviews with both parents, review of the medical history, and psychological testing and assessment of the child, led to a gradual ventilation of the parents’ personal struggles with and responses to having a defective child. They never explicitly acknowledged John’s handicap, but they began to collaborate in planning with the clinic, and the clinic kept in regular contact with the school. This led to a different mode of working with the family.

The clinic consultant and principal were pleased when the parents agreed to consider other schools. Ultimately they placed John in a special school setting.

School consultations are sometimes concerned with handicapped children where the main problems are primarily emotional or psychodynamic in nature, even though physical handicaps and developmental learning disabilities also exist.

* A question of interest is what impact recent Federal legislation for learning disability services, Public Law 95-602, might have had on John and his family’s experience if they were available in his state in earlier years (see page 683).
Vignette #16 (Type I A, II A)

A sixteen year old, mildly retarded girl with epilepsy was referred by the school for therapy because of violently disruptive behavior which occurred only at home and contrasted with her truculent withdrawal when upset at school. In special classes at school and in her “job” as a playground aide to an understanding teacher, she generally functioned quite satisfactorily. After only a few sessions with the girl and with her parents, the major source of the problem became glaringly evident. She was, unfortunately, not an attractive girl, having an unfocused stare, a “silly” facial expression, and a speech impediment aggravated by the high doses of medication needed to control her associated seizure disorder. As puberty had advanced, however, she had developed quite large breasts, presenting a striking figure. Her figure was all the more noticeable by contrast to her childish manner.

Her father, with whom she had a close relationship, suddenly became unable to tolerate her presence. The more she tried to regain his attention, the more he repulsed her overtures. By pathetic and ultimately exasperating attempts, she tried to recreate remembered good times. She remembered the family singing together and would now provoke them by singing loudly at inappropriate times. It seemed clear that the conflicts experienced by many a father watching his little girl become a woman were involved in this rejection. Unfortunately, the first suggestion to this father that their fights not be seen as signs of “hatred” (his word) between himself and his daughter, but perhaps rather as an underlying affection which needed better understanding by both of them, was immediately followed by the father’s decision to return to the referring neurologist with a request for some “more tranquilizers” for the girl.

In the above example of a direct clinical consultation (I A), the consultant’s task was to understand common developmental phenomena, to have patience with the father’s defenses, and to continue his availability in the face of the father’s retreat from sessions. Work with the referring neurologist was initiated so that he might help the family to understand the dynamics of the girl’s behavior, and to respond to her needs more appropriately.
12

THE NEEDS OF CHILDREN

With increasing awareness of the need to involve parents actively in planning what is best for their child, the consultant becomes sensitive to the inadequacies of community resources to meet the needs of all children, not just those who are handicapped. The consultant also becomes more aware of the subtle (and sometimes not so subtle) indifferences or prejudices toward children in general and the handicapped child in particular. Such problems are manifest throughout our society and are encountered in a variety of ways in psychiatric consultation work.

Vignette #17 (Types II C, III D, IV C & D)

A child psychiatrist was asked to chair a series of community meetings to plan services for children and youth in a county mental health program, and to serve as a resource person. The participants were lay persons, non-professionals with special interests in the needs of mentally handicapped children. Many were parents of children with Down's syndrome, brain damage, schizophrenia, and autism. Inadequacies of the diagnostic process were a major concern of some parents. They shared experiences of going through several years of frustrating superficial clinical studies which often resulted in statements such as: "parents are over-anxious," and the "child will outgrow it."

In addition to unsuccessful efforts to involve professionals in more extensive studies of the problems and needs of the child and the rest of the family, they were particularly frustrated by losing two or three years as they shopped around while desperately looking for help. The participants at these meetings recommended that a special multidisciplinary diagnostic service be available on a regional basis for youngsters with severe developmental disabilities. They spoke of the time and effort involved in trying to coordinate services from two or more agencies. A comprehensive study center would obviate such difficulties considerably.

In addition to this outpouring of feelings concerning the inadequacies of the diagnostic process with fragmentation of clinical resources, the parents spoke of a desperate need for respite care resources. Parents, especially those of hyperactive children, become exhausted; they need relief, if but for a few hours a day or for a weekend. These parents stated that emergency respite care capabilities were needed in the community. Indeed, they noted that parents may be "abused" by their children, and that when reaching the "end of their tether" some parents may lash out in a state of anger and fatigue and hurt their children.

Confronted with these outpourings, the consultant felt a responsibility to continue with the dialogue, to gain more understanding, to share the information with others in the mental health organization, and to help the parent group become more effective in solving these problems. This could be done by developing a self-help group approach and helping them to mobilize their "parent power" to influence important decisions regarding allocation of mental health funds in the community. Thus, the consultant encouraged the parent group to continue to meet to share their feelings of frustration. He encouraged them to channel their energies into activities aimed at mobilizing professional help available for these children and their families, particularly interdisciplinary comprehensive services that include psychiatrists and can help parents integrate medical, neurological, psychiatric, psychological, educational, family and social assessments. Lastly, he helped them become effective in political action—both
in generating awareness of and interest in the needs of handicapped children and in generating more funds to support needed programs.

At community planning and educational meetings, where the psychiatrist is a resource person or speaker, one or more parents often “buttonhole” him or her for a “curbstone consultation.” This can occur in both a general question period and after the formal meeting has adjourned. This did not occur in the case described above, but when it does happen the parents frequently will ventilate their frustrations with the difficulties in obtaining adequate and appropriate service. They describe being overwhelmed with the need to carry their burdens alone. In order to be effective the consultant must not only know what resources are available, or lacking, for the particular problem under discussion, but also has to be aware of specific programs and problems within helping organizations (such as schools, churches, health and mental health agencies, social and recreational services), and aware of tensions between these organizations which may affect availability, appropriateness, and quality of services. Recognition of the need to obtain this type of information by both the consultees and consultant may be the major useful outcome of such impromptu consultations. This is no less true in the case of other more formal consultations in hospital, office, clinic or agency settings.

13

AUTHORITY AND HUMILITY

The most familiar form of psychiatric consultation outside of a clinical setting is the case consultation held in a school or social agency setting (see Appendix). There, psychiatrists often meet with a group of individuals and may use a group process type of teaching-learning to carry out their consultation role.

As outside clinical consultants “invade” institutions for the retarded, they have the double task of assessing staff, and helping staff to assess themselves and identify their problems related to the patient. This is in addition to the consultants’ case centered work. The consultants may clarify individual and group roles in education, treatment and management, and may propose new approaches for individuals, or for specific groups of retarded children or young people. They may help resolve interpersonal and intrapersonal stresses and strains in staff and staff functioning. They may become involved in policy decisions.

In any such consultation there are often two sets of information available to the consultant. The more familiar, manifest and readily available, data deal with the scientific facts about the problem(s) and the evidence of benefit from any new program to be recommended. The second set of information has to do with the politics of the issues at hand. This information may not be readily available and may come to the consultant only after a positive relationship has been established. Which people in authority are interested? Why are they interested? Consideration of both the clinical situation and political factors must be done as the consultation process moves toward decisions.

Consultants may adopt either a removed, distant stance or a close, involved one. Not too many years ago, use of the more
removed stance, with a model derived somewhat from analytic therapy, was the one advocated for use by mental health consultants. In more recent years, there has been pressure for consultants to become more “involved,” with a continuity of consultation advice from year to year. Such a level of involvement makes it even more important that the consultant provides support as well as technical professional judgment.

The authority aspect of the consultation process is often crucial. Part of the reason for the choice of a consultant is to have an authority in the field. Part of the consultant’s task is to explain and to convince. Psychiatrists should bring insight to the consultees, which implies more than mere information or knowledge. One of the criteria for success in consultation is that it be satisfying to both parties. Warmth and involvement can come from being a consultant, over and above other satisfactions. However, errors made in consultation may often stem from overuse of authority due to the consultant’s personal satisfaction in exercising power and influence. Intense consultation relationships with a dominant-submissive consultant-consultee relationship and the overuse and/or misuse of information are frequent sources of error.

In some settings, clinical consultants are so influential that individuals feel that they must follow their advice. Conversely, an overly authoritarian orientation may lead the consultant to feel that the consultees are not behaving properly if they do not follow his recommendations. This violates a fundamental principle, namely, that a consultant may give advice, but the consultees must be free to utilize it as they see fit. A consultant should not dictate, but rather should offer insight into new ways to organize and understand the data, and new ways to approach problems through actions and attitudes. Parents as consultees should be told they can seek other opinions. True as this may be for the whole field of medicine and psychiatric therapy, it is even more obvious when the psychiatrist is functioning as a consultant.

Humility in the consultant role is important. Early in their training, psychiatric residents sometimes feel that if only their insight were deep enough, their vision dynamic and clear enough, and their determination sufficient, they could perform miracles and eliminate problems. Tempering theoretical knowledge with clinical experience produces clinical judgment, including an optimism that comprehends realistic limits. Trainees are recurrently disillusioned in their conscious and unconscious fantasies of rescue and omnipotence while they learn to tolerate the vicissitudes of the field as a whole. For the field of mental retardation they must, in addition, integrate specialized information and data. Through this they will learn to understand and appreciate the biological, psychological, and social aspects of handicapped people and their families. The trainees’ own personal experiences with disillusioned expectations before and during medical school and residency can be the source of useful insight and empathy with parents and others concerned with the handicapped.
The opportunity for assistance to families through effective consultation is tremendous. The opportunity for failure is equally obvious. The following two vignettes suggest some of the difficulties that can occur, partly out of naivete and partly out of an inability to see the pitfalls of consultation.

**Vignette #18 (Type I B, II A)**

Dr. Smith, who was serving an obstetric portion of her internship, had just delivered a forty year old woman of her first child. The baby had definite but subtle evidence of Down's syndrome. Dr. Smith consulted a house staff colleague, Dr. Jones, who was a new psychiatric resident with pediatric experience, to present this problem to the baby's parents. The parents were curious but alarmed by the fact that Dr. Smith had told them they had a "different" child. They feared what the "difference" meant, being unable to see it for themselves. They waited anxiously to hear from the more expert Dr. Jones. He indeed presented the diagnostic criteria simply and emphatically. At his own level, he explained that the child would be retarded and would never be able to fend for itself; therefore, they should begin to think about institutional care for the child.

Because of his busy schedule, Dr. Jones spent little time with these two new and now very worried parents. Dr. Jones assumed that he had done an excellent job and had clarified the route for these parents for some years to come. He was pleased with his own consultation and somewhat annoyed that his peer, who had asked for it, was so worried about what might happen to these parents after they went home. Pleased with his own efficiency and his dissemination of knowledge, he went his own way, content with this "success."

This incident points out the importance of structure and supervision for consultations in a busy teaching hospital, in addition to issues intrinsic to the case. Failure to follow up on the effects of the consultation left an incomplete learning experience for Dr. Jones, as well as obvious problems for the parents.

**Vignette #19 (Type I B & II A)**

As a first year psychiatric resident, Dr. Brown was asked to assist in a diagnostic workup of a five year old borderline retarded child preparatory to a school placement. Psychological tests had been done suggesting that the child would have to be handled in a special education setting. The parents had had a variety of consultations over the years and had accumulated a host of diagnostic labels for their child. Most of the diagnosticians had been unable to specify a cause of the retardation. This left the parents feeling that there was considerable disagreement among the authorities as to what "nothing wrong" meant.

The tests seemed very clear to Dr. Brown. He pointed out that the parents had great expectations for their child, which could not be met. He explained the limits and capabilities of the child, which is an important part of the consultant's task, but he made no attempt to find out exactly what the worries and fears of the parents were. He saw their anxieties as being pathological, yet he did not explore them because he felt that the abundance of knowledge he offered was convincing.

A year later, in a totally different context, Dr. Brown received a request for information about this consultation. The parents were on their second consultation after that—still struggling for a better definition of their child's potential, as well as a better understanding of what their
own relationship should be with the child. They were still wrestling with anxieties associated with their sense of guilt for having produced the child and were unable to understand what any authority was saying to them.

In both of these illustrations, the consultants felt they had done a "good job." Their lack of comprehension of the impact of such devastating and overwhelming information on families was the basis for their lack of humility. This naive, but authoritarian, informative approach prevented the parents from working on their own anxiety and grief against which they were defending.

A trained consultant becomes more aware of the chronic nature of these problems and reactions, and that they cannot be alleviated simply by one consultation. The physician needs to develop an understanding of the long term nature of the relationship with the parents in order to help them work through their shock and ultimately achieve a more realistic view of the child's limitations and potential. The consultant should attempt to modify the physician's orientation through information and education. Physicians, like parents, are not just manifesting "psychopathology" in such situations.

Bruch\textsuperscript{36} says that, basically, psychotherapy is helping patients keep a hope of coping when they feel they are failing. In the field of mental retardation, consultants must have a sense of what can and cannot be accomplished. Results in retardation are more modest than in general psychotherapy, slower in coming, less dramatic, and do not return the subjects to "normality." The discreet maintenance of a realistic perspective with an accurate calibration of results is an intrinsic and sometimes invisible function of a consultant. Patients quickly sense hope in the staff, as studies in psychotherapy with retarded persons have indicated. The "Pygmalion effect" noted by Rosenthal,\textsuperscript{51} when teachers overestimate the competence of students, is another notable phenomenon in mental retardation. There may be danger when initial improvement leads to overly optimistic expectations and an ultimately greater disappointment.

Many authors, such as Dybwad\textsuperscript{52} and Tizard,\textsuperscript{53} have called for participation by psychiatrists in research on the personality development of retarded persons. Important opportunities exist for psychiatrists in these interdisciplinary fields. Psychiatric consultants can function as advisors to such studies. They can be useful to the staff and also further their own understanding of the ego development of the retarded person. Psychiatrists are particularly suited for investigations of psychotherapeutic approaches in the treatment and habilitation of mentally retarded persons. They can examine the emotional developmental impact of behavior modification, special education, and vocational rehabilitation methods and help determine in which type of patients, and in what developmental stages or life circumstances, the benefits and limitations of different approaches are apt to occur. Overall, they can help enhance the lives of the patients and the families they see in consultation and help foster the human values and humane care to which mentally retarded persons are entitled.

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In the appendix which follows, the nature and extent of psychiatric consultation and related activities are outlined and summarized for easy reference.

It will be obvious to readers of this report that the concepts expressed are not limited to mental retardation. They apply to a host of other handicapping conditions, particularly in children, and point to the needs of a variety of other disabled \textit{persons} and their \textit{families}. These personal adaptations to the handicaps are beset by special mixtures of physical, psychological, and social hazards.
APPENDIX

TYPES OF PSYCHIATRIC CONSULTATION AND RELATED ACTIVITIES

I. Direct medical consultation. Clinical service consultation to patient and/or family.
   A. In office, clinic, or home.
   B. In hospital or other residential care and treatment facility.
   C. In community settings, such as school or social agency.

II. Indirect consultation to professionals, administrators and/or staff.
    A. Client-centered case consultation.
    B. Consultee-centered case consultation.
    C. Program-centered administrative consultation.
    D. Consultee-centered administrative consultation.

III. Education.
    A. Elementary, secondary, and college level education.
    B. Graduate and post-graduate education.
    C. Inservice training and staff development.
    D. Public education.

IV. Administration and community organization activities.
    A. Administrator of mental health clinic, center, or other health or mental health program.
    B. Member of a board of directors, a professional advisory committee, etc.
    C. Participant in social action.
    D. Participant in political or legal action.

The outline above, and its elaboration below, lists types of professional functions, most of which are described and illustrated in this GAP Publication. The outline serves as a conceptual guide for understanding the different roles, settings, goals, processes, and content of consultation work and related activities. Each illustration, or Vignette, in the text includes a reference to the type of consultation, education and community organization activities involved, such as "I A, II A and B." Multiple functions and working relationships are particularly relevant in the field of mental retardation, in which such pervasive handicaps exist over long periods of time. Also, the nature of the handicap strongly impacts on and is influenced by the functioning of the family, the many different caretakers and organizations, and the support by the community. Still, the direct medical consultation, with which psychiatrists are most familiar, is extremely significant and often core for engaging in the other types of activities listed.

A broad spectrum of clinical consultation, mental health consultation, education, organizational development, and community organization activities has emerged over the past twenty-five years in an interdisciplinary fashion, with important support from the National Institute of Mental Health. The indirect services of mental health consultation and education constituted one of the original five essential services of Federally-funded community mental health centers.*

A systems approach provides a most useful way to conceptualize the role of the psychiatrist in consultation and related functions. The systems approach also helps to conceptualize the dynamic interrelationships of the client, family, psychiatrist, professional colleagues, personnel, organizations, and community plus the related goals (held in common or competing) of each. For example, working relations and tensions between disciplines and organizations in a community come forcefully to the attention of professionals who engage in interagency consulta-

* In 1979 a review of children’s services provided by such community mental health centers nationwide revealed that consultation-education was the essential service most commonly provided (based on staffing grant dollars and staff time) for mental retardation. Exceptions occurred in states, such as Pennsylvania, where greater integration of mental health and mental retardation services within such centers were required by state regulations and administrative organization. For example, in such states more outpatient services were provided to mentally retarded children by Federally funded community mental health centers.
Psychiatric consultation in mental retardation

In indirect consultation, the consultant enters a system as an outsider, usually for a limited time or designated continuing role, for a limited specific function. He interacts with specific persons, designated as consultees, about other persons designated as clients—or with administrative consultees about service programs—with which the consultees have primary and continuing relationships. The consultee maintains responsibility and is free to accept or reject ideas and advice from the consultant. In direct medical consultation, education, administration, and community organization work, the psychiatrist may carry primary responsibility for specific functions, participate in a role that is otherwise designated by the relevant organization, or function without a professional role as an interested citizen.

The psychiatrist should keep all the above distinctions and perspectives in mind when engaging in consultation and related activities. As a simpler formula, the psychiatric consultant should be cognizant at all times as to who is requesting what of whom, and who—if anyone—is paying for the psychiatrist’s services.

Direct medical consultation

In direct medical consultation, the psychiatrist sees the patient and/or family members directly. The psychiatrist may see the individual for a diagnostic assessment, to render a second opinion, to evaluate for specific therapeutic approaches (i.e., pharmacotherapy, psychotherapy, social or group therapy), for admission to specific educational and vocational training programs, or for other specific purposes. Another professional, such as the primary physician, has the continuing relationship with the individual and family. The psychiatrist very often provides consultation to family members, as well as indirect consultation (Type II) to professionals. Extended assessment or psychotherapy functions may also occur.

Additional characteristics that tend to distinguish direct medical consultation activity include: (1) The patient or family often request the services of the psychiatrist or clinic directly, even if referred, and they are usually billed for the medical services of the psychiatrist. (2) As a usual part of medical case management, contacts and collaboration with other professionals or agencies are initiated by the psychiatrist consultant as indicated, acting on the basis of his implied contract and responsibility to the patient and/or family. (3) Indirect consultation (Type II) is often included, particularly if the case was referred to the psychiatrist and/or a psychiatric consultation was requested by another professional or agency. (4) If the direct consultation occurs in a hospital or other organizational base, the usual professional collaboration moves readily into more formal indirect consultation and education functions, in addition to team collaboration within the context of the psychiatrist’s medical responsibility to the patient. Examples are the hospital medical ward, where case “consultation” moves readily into “liaison” functions, or a court clinic where diagnostic assessment moves into consultation—education for legal or correctional personnel.

In office, clinic, or home

Direct medical (psychiatric) consultation often occurs when the retarded person and/or the family have a decision to make where psychiatric clinical judgment would be of value. Direct consultation may also be requested at the time of a family crisis, for instance the birth of a retarded multiply-handicapped baby, or when escalating tensions between siblings, parents, and a retarded child or youth reach crisis proportions. Often the retarded person’s symptoms or behavior have raised questions as to psychiatric treatment and home management, or there are mainly diagnostic questions with extenuating implications. At times psychiatric assessment is a routine component of interdisciplinary evaluation and guidance at a particular stage or transition in school, work or care giving. Such consultations usually occur in the office or clinic, and occasionally in the home.

In hospital or other residential care and treatment facility

Direct clinical contact with retarded individuals in hospitals, rehabilitation homes, residential schools, correctional institutions and other 24-hour care and treatment facilities occurs usually on referral from the primary attending professional. The relationship, especially in teaching hospitals, may be part of a consultation-liaison psychiatry service and may also involve graduate and post-graduate teaching or inservice training for staff. A consultant psychiatrist may be called for a number of clinical reasons, ranging from difficult diagnostic or behavior management problems to questions of surgical or other interventions, when
decision must take into consideration the psychological status of the patient and family involved.

In community settings, such as school or social agency Some community non-medical programs, such as private schools and day care centers for developmentally disabled infants and children, make arrangements for direct consultation services for children, youth and their parents by establishing a panel of psychiatrists, clinical psychologists, clinical social workers, and other professionals who are interested in and knowledgeable about child development, retardation, special education, and family problems commonly found with this population. The same applies to day programs or employment settings for adult retarded persons. These consultation services may be available at no extra charge (or for a very modest fee) to the participating families. The family and/or the retarded client are the “consultees” and confidentiality exists as in the case of any direct clinical service. Conferences with school or day-center staff which frequently accompany such direct clinical consultations fall into the category of mental health case consultation (II A, B), and signed release of information forms may be indicated. Such forms are less often required when the clinical consultants are actively involved in initial parent interviews, screening a child for admission or habilitation assessment interviews. In such instances, the clinical consultant is functioning more in a collaborative fashion as a member of the professional team of a school, agency or industrial health unit. Interagency collaboration of this type can be found in many communities.

Indirect mental health consultation

Indirect consultation occurs in many settings and by different terminology. Examples, in addition to mental health consultation and medical consultation-liaison, include consultation-education, occupational or industrial health consultation and organizational development consultation. Consultees include attending physicians, other professionals, staff, administrators, officials, and third party payers. The request is usually from the consultee individual or organization, as distinguished from collaboration initiated by the psychiatric consultant as part of direct clinical consultation.

Mental health consultation has been extensively developed as an activity of mental health professionals with clinical training and experience. Several useful articles and books are cited in the bibliography. See Caplan,55-56 Berlin,57 Hassol and Cooper,58 Grunebaum,59 Mannino and Shore,60 Haylett and Rapoport,61 Hirschowitz,62 McKegney,63 and Lipowski.64 Standard psychiatric texts, such as Freedman, Kaplan and Sadowski65 contain relevant sections. Psychiatric and mental health nursing consultants as well as special education teachers and occupational therapists have joined clinical social workers, clinical psychologists, and psychiatrists as mental health consultants in recent years.

Education, usually informal, is in the context of the consultation, which is primary. This type of education, which should be an integral component of indirect consultation, is distinguished from primarily education activities (Type III in the outline), but can usefully generate such education efforts.

Payment for indirect consultation is usually by the consultee organization, though it may be from patient fees or by contractual arrangement with the consultant’s employer. Unfortunately, the education component is often difficult to finance from service funds, even though the patients or clients may be direct beneficiaries of consultation-education efforts and ultimate health care costs may be reduced by the preventive measures induced.

Client-centered case consultation The consultant focuses on clinical aspects of the case under discussion, on diagnosis, prognosis, and on management issues. He may or may not see the client individually or observe the client functioning in the consultation setting. Direct consultation (Type I) may occasionally also be involved. The consultant’s knowledge and skills are used indirectly to help, through the consultee, with further assessment, specific treatment or the design and carrying out of a care and treatment program, or a special education and rehabilitation program. Usually the consultant seeks more information and may occasionally observe the client (student, patient) directly in the clinic, classroom, on the playground, with or without the parents and/or siblings, or while the client is at his or her usual work.

For example, the consultee requests the consultant’s help in managing a particular case or group of cases. The consultant assesses the
nature of the client's problem and recommends how the consultee should deal with the situation. This is, of course, the standard consultation with which most of us are familiar. We, as psychiatrists, are asked to see a patient and give an opinion as to the diagnosis and management. Very often the consultant is asked to respond to questions such as: "Is the patient depressed, psychotic? What should be done? What medication and dosage?" Or: "Is the client competent to stand trial?" "Is he safe to be alone with girls, unsupervised?" "Should she be sterilized?" "Will he harm or disturb other employees (or students)?" "When will he get over this (crisis) enough to return to work?" "Is her illness work related?" "Should we let him know about ...?" "How apt is she to do it again?"

The consulting psychiatrist needs to communicate to the consultee how the client can be understood and helped or provide a better informed basis for decisions by the consultee. Very importantly, the consultant should also help the consultee to use his own experience and consultation with this case to improve his knowledge and skills so that he will be better able in the future to handle comparable problems. For example, it is not sufficient for the psychiatric consultant in a teaching hospital, after examining the patient, merely to tell the pediatric intern, "The patient is psychotic. Begin therapy with chlorpromazine, 200 milligrams a day in divided doses." Rather he should explain why he is considering psychosis. What are the signs and symptoms? How might it be managed? Why is this particular drug recommended? What side effects should be watched for? Should the patient be treated on this service or should the patient be removed to a psychiatric setting? What are appropriate reasons to ask for the consultant to return on this case?

Commonly, when conducting client-centered case consultations in community settings such as schools and social agencies, the consultant only hears about the patient, though still focusing on diagnosis and management. Such sessions may have a group format as part of an agency's inservice training program. Client-centered case consultations, especially in programs with continuing scheduled consultation sessions, often begin to take on a consultee-centered approach.

Consultee-centered case consultation Emphasis continues on the management of a particular problem, but the effort is focused on identifying the nature of the consultee's professional work, his personal reactions and difficulties with the case. Consultee needs may be related to a lack of knowledge about the type of problem presenting, a lack of skill in making use of such knowledge, a lack of confidence which contributes to uncertainty about utilizing knowledge and skills, and, often most important, a lack of professional objectivity due to the interference of subjective emotional complications such as biases, stereotypes, conflicts or specific countertransference problems.

The consultant helps the consultee remedy whatever problems in professional functioning are found to be present. The consultant may help the consultee increase knowledge or skills, support the consultee in developing increasing self-confidence and professional objectivity, and reduce the distortions in the consultee's perception and judgment regarding the client's disabilities and problems. Berlin and Caplan have written extensively about consultee-centered case consultation. This form of consultation is most valuable in institutional and organizational settings when built into a regularly scheduled consultation service and an inservice training program.

Successful consultations should help the consultees to solve management problems and then to maintain improvement in their professional functioning in relation to future clients with similar difficulties. Thus, consultee-centered consultation educates the consultee, using his problems with the current client as the basis for a learning experience. This resembles supervision, as known to psychiatric teachers and trainees, in that it focuses both on teaching basic knowledge and skills (e.g., diagnosis and management) while also observing and learning about the process of countertransference. The psychiatric consultant observes and is aware of the consultee's psychodynamic reactions, but carefully avoids making the consultee feel he is being treated like a "patient."

Consultee-centered case consultation can be conducted individually or with a group of consultees in which there are goals for both the process and the content. In consultee-group consultations, there can be an examination of the group interactions and emotional responses (process) while also learning about the patient (content).

Program-centered administrative consultation Some experienced psychiatric consultants actively help in program planning and administration. Emphasis is on knowledge and application of mental health theory and practice, epidemiology, behavioral sciences, and social sys-
Psychiatric consultation in mental retardation

Psychiatric consultation in mental retardation is an important tool in planning new programs or improving existing ones. Principles of learning, adaptation, and organizational change are very relevant. From the analysis and recommendations, consultees learn principles which can be used in their own dealings with future administrative problems. Consultants must have solid working knowledge of the behavioral sciences and the study of social systems, as well as of clinical psychiatry per se. They must have intimate knowledge of the workings of the agency as a social system, and come to know agency personnel as individuals. This approach incorporates total, if indirect, patient care. In its broadest scope it has to do with public health and mental health planning for populations as a whole.

It is very important to recognize that the psychiatrist is not likely to be the only consultant or expert who should be involved. Consulting psychiatrists have made mistakes by assuming that their knowledge, even of the basic theoretical and applied behavioral sciences, was sufficient for the task. In reality, most program centered consultative efforts involving planning are of a team nature. For example, city or hospital planners concerned with mental health needs when planning for health or human services will commonly consult with school administrators, architects, and economists in addition to psychiatrists and other mental health professionals.

Consultee-centered administrative consultation In this type of consultation the focus is not on the collection and analysis of administrative data but on the elucidation and remedying of the consultee’s difficulties which interfere with success in the task of program development, organization and administration. In addition to problems involving lack of knowledge or skills, there are also problems involving interpersonal relations, self-confidence, attitudes, and objectivity. The problems of the consultee may be the result of group difficulties. These may include problems such as dealing with issues of authority, structure, lack of role specificity or definition, excessive competition, communication blocks, poor morale, group spirit, leadership, and the like. These may be day-to-day problems, or may become manifest only at the time of a crisis in the institution or agency.

The consultant’s task is to understand and help the consultee remedy these problems. Success with this task will enable the consultee to develop and implement appropriate plans to further the mission of the organization. This is a most complex and difficult area. One has to move from the specific content of a program to the process of how it is to be implemented. What are the individual or group problems which may interfere with accomplishing this task? Understanding of human behavior systems theory, organizational structure, and group dynamics, as well as clinical psychiatry is necessary.

Medical consultation-liaison

All the above direct and indirect consultation models are involved in the development of a medical consultation-liaison program. Related education and administration activities (Types III and IV) are also applicable.

In a well developed consultation-liaison program, prevention occurs on three levels: through anticipating and preventing the development of psychological symptoms (primary prevention), then providing early intervention by treating such symptoms after they have developed (secondary prevention), and assisting in the rehabilitation of patients who have manifested such symptoms in order to prevent their recurrence (tertiary prevention). Psychiatry liaison services provide ongoing and long-term participation in earlier case detection. Consultation-education programs promote more autonomous and knowledgeable functioning by direct care personnel in monitoring their patients’ psychological needs. Such consultation-liaison programs evolve over a period of time, and the role of the consultant expands from simple patient-oriented consultation to more complex interactions.

It is clear that the different models ranging from individual patients, to consultee, to organizational unit, increase in sophistication and in their demand of the consultant. It is easier to train psychiatrists and orient consultees to simple patient consultation with a focus on diagnosis, psychodynamics and psychopharmacology, than to teach a complex systems approach. Unfortunately, “one shot” consultations often ignore crucial related problems of the consultees, whether hospital ward chief, attending physicians, house staff or nursing service. The consultant must be skilled in identifying and providing help at these complex organizational levels as well. This process involves gradual orientation and education of the consultees as well as the training and experience of psychiatric consultants.
Liaison psychiatry, in adult tertiary care teaching hospitals and other community hospital settings, may have frequent occasion to deal with problems specific to mental retardation. Based on current trends, there is also increasing emphasis on the development of liaison psychiatry in primary care settings, such as pediatric and gerontology long term care. These different settings provide opportunities for psychiatric consultation and education about the interplay of biopsychosocial factors in all types of chronically handicapped persons and their families.

Education

Elementary, secondary, and college level education

Psychiatrists, especially child psychiatrists, can be useful resources at all levels of the formal educational system in their teachings to or about mentally retarded persons and their families. At high school and college level, psychiatrists can be useful contributors to courses such as psychology, sociology, and health. Psychiatrists can participate not only in class presentations and discussions but also when field trips are planned to schools or hospitals. Special student projects, supervised volunteer work, summer work-study programs, and career-related electives provide an excellent opportunity for students eager to “get out into the real world” and also explore career possibilities in mental retardation work. Psychiatrist participation also provides exposure of students to “a real live psychiatrist”—but not as patients—as well as an opportunity for them to pursue their interests in subjects such as mental handicaps, intelligence, emotions, growth and development, common syndromes, and treatment. Student curiosity is also stimulated by movies, television or experiences with relatives that involve a mentally retarded person.

Graduate and post-graduate education

It is at the graduate (including medical school) and post-graduate level in seminars, clinics, and in psychiatric liaison activities that the psychiatrist can play a particularly valuable role by integrating relevant biological, psychological and sociocultural factors to help students to achieve the broadest understanding of mental retardation. This is most successfully done through case presentations and discussions. Differential diagnosis involves consideration of a myriad of factors which are of prime importance in defining not only diagnosis but prognosis, and in suggesting ways of approaching care and treatment.

Some of the possibilities and questions about mentally retarded persons which may be considered by psychiatric teachers are as follows: childhood psychosis, organic brain syndrome from fetal distress or birth injury, learning disabilities and the dysphasias, the presence of neurotic character or personality problems, emotional problems related to physical illness and the trauma of early hospitalization, the impact on the small child of intercurrent febrile illness, nutritional deficiencies, the impact of sociocultural disadvantages and/or inadequate parenting in the early months and years, and the illness and/or death of parents. These are typical of the interests and concerns of the psychiatrist relevant to mentally retarded persons, in addition to core course content on retarded development and mental retardation syndromes. The pediatrician and other medical specialists may be additionally concerned with, or more focused on, genetics and abnormalities in metabolic pathways, chromosomal abnormalities, neurological and other somatic malfunctions, corrective surgery, all frequently of concern when considering mental retardation and other developmental disabilities.

Inservice training and staff development

Child psychiatrists have in past years participated actively in inservice training for institutions and for agency and school programs for retarded children. General psychiatrists have taught, and could do more to include mental retardation, in many institutional and organizational seminars and workshops. Bernstein\(^{46}\) has described a particularly comprehensive program developed in the late 1960's at a state school for the retarded. Psychiatry has apparently been even less active during the 1970's in teaching to institutional and organizational staffs who work with mentally retarded clients. One reason is the impressive development by special education and behavioral psychology of a large body of knowledge and additional skills in applying new techniques to the education, training, and behavior modification of mentally retarded children. Hopefully, psychiatrists will be encouraged to take a new look at their potential contribution to the field as medically oriented teachers of the psychiatric aspects of mental retardation.
Public education

Public education about mental retardation has involved psychiatry, especially for the parents of handicapped children and adults. Often organized under college or university extension and sponsored by parent groups, schools, clinics, or mental health centers, these programs invariably attract persons who are interested in the broad, integrative approach of psychiatry.

In addition, participants are interested in diagnosis, etiology, and emotional problems. They ask searching questions regarding resources, both for clinical diagnosis and treatment, and for education, training, and respite care. As a psychiatric consultant to programs dealing with mental retardation, and as clinicians who see retarded individuals and their families in their offices and many other settings, practicing psychiatrists have a major contribution to make in such public education programs.

Administration and Community Organization Activities

Administrator of mental health clinic, center, or other health or mental health programs

Psychiatric consultants should keep clear when they are functioning out of a position with administrative authority as compared to when they enter a system as an “outside” consultant. A psychiatrist may provide “consultation” within the context of his own organization, such as to staff or to families of patients. His administrative authority often carries overtones, usually not stated, that modify the consultation process, even if he feels he is providing professional expertise and not “orders.” When functioning outside his own organization, the consultant may be perceived as speaking for his organization when he does not intend it that way. In some consultations outside his administrative orbit, he may forget to leave his customary authority at home and unintentionally convey, or be perceived as conveying, an expected response from consultees that is not forthcoming or appropriate. At times such problems can be prevented or minimized by the consultant making explicit at the beginning which “hat” he is wearing. Not to be overlooked, one of the pleasures of consultation work is stated in the adage: “An authority (or respected consultant) is someone at least 25 miles from home.”

Psychiatric administrators of clinical programs may find opportunities to develop consultation and education services for chronically handicapping conditions. For example, a point made about medical consultation-liaison (page 680) can be applied here. That is, the director of a psychiatry consultation-liaison service in a general hospital or clinic may take initiative, or may be increasingly called upon, to provide consultation services in primary care for persons and families with chronic illness or long term mental handicaps.

Within the broader community, psychiatrist administrators of clinical programs may find opportunities to develop consultation and education services for agencies serving mentally disabled or developmentally disabled individuals and their families. Among sources of funding for such consultation services are the funds authorized by several types of Federal and state legislation, including funded components of community mental health services. A more recent example is the 1978 “omnibus” Federal legislation for rehabilitation, including services for developmentally disabled persons, Public Law 95-602. Relevant provisions include modification and extension of the Developmental Disabilities Assistance and Bill of Rights Act of 1975, P.L. 94-103. These rehabilitation programs and funding are administered by the Rehabilitation Services Administration, including the Bureau of Developmental Disabilities and Division of Special Populations, via state agencies which set priorities for funded services. Clinical services, consultation and staff education are among the activities funded, depending on state and local priorities.*

Interagency planning for psychiatric consultation services, leading to contractual understandings between the primary service agency and the agency providing clinical consultation, has to be done with much care and understanding. Haylett’s description and discussion of the development of consultation services in San Mateo County, California, are particularly valuable.70 Hassel and Cooper,71 and Van Buskirk72 have

* For further details interested persons should contact their local or state agencies, their Federal Regional Office or write to the Rehabilitation Services Administration, Department of Health, Education and Welfare, Washington, D.C. The above Rehabilitation programs (and Special Education Programs of P.L. 94-142, “The Education for All Handicapped Act”) will be relocated in the new Department of Education when it is established.
described this process, especially with schools, in the South Shore area of Greater Boston. Haylett's approach was particularly sensitive to the public health aspects of case finding and promoting optimal functioning in identified populations at risk. She predicted in 1969 that consultation services would become more hard pressed to compete successfully with clinical treatment and aftercare services for the mental health dollar, which is now indeed true. She advocated that consultation and education services be considered as "public health" services and be funded specifically as an essential component of prevention and public health costs. Such services are also cost effective for patient care, particularly in their preventive impact. They should be funded in part as a component of patient care and not be squeezed out (in competition with direct medical and hospital services) by third party payers and other sources of health care funding. The availability of criteria and peer review by competent consultants could help assure the quality and accountability for consultation-education services as a component of patient care and for prevention of complications.

**Member of a board of directors, professional advisory committee, etc.**

This type of professional-citizen function can usually be distinguished from direct and indirect consultation as described in sections I and II. Many psychiatrists, as well as neurologists, pediatricians and other physicians, have assumed leadership roles in health organizations for mental retardation, cerebral palsy, the neurologically handicapped, autistic children, the learning disabled, and others. As officers or board and committee members, psychiatrists contribute not only their professional expertise, but also their caring as concerned citizens interested in handicapped individuals and their families. Professional participation can also help to assure adequate accountability.

**Participant in social action**

Social action may represent either a professional or a citizen function, depending upon the situation, and should be distinguished from formal consultation as previously described. The knowledgeable psychiatrist who has participated in consultation and education concerning mental retardation can make major contributions to such activities as conducting needs surveys, developing a respite care program, and for providing an afternoon or weekend recreational and social therapy program, to name a few.

**Participant in political or legal action**

Legal and political action refers to activities initiated or supported by the psychiatrist as a citizen and differs from psychiatric consultation requested by others. Well informed psychiatrists can help to gain support for new programs, or for continuing established programs, by participating in the legislative process. Activities include meetings with legislators, their assistants, and with persons lobbying for the various health organizations. The psychiatrist has important information to share and can take a useful role in the legislative process as it moves along year by year. Actions in local and state public affairs, as well as at national levels, are especially important as human service programs are beginning to have to compete even more vigorously for shrinking public dollars. Class action suits and actions to protect privacy are examples of legal and political activities. Last but not least, the maintenance of informal respectful relationships with public officials, lawyers, and judges is a significant source of mutual exchange and education. Such relationships foster better informed participation by psychiatrists in legal actions and the political process.
REFERENCES


7. See citation 5 above.


11. See citations 2 and 4 above.


15. T.G. Webster. “Unique Aspects of Emotional Development in Men-

16. Ibid.


22. See citation 17 above.


42. Ibid.

43. See citation 30.


66. See citation 55 above.

67. See citation 54 above.


71. See citation 56 above.


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