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PSYCHIATRIC CONSULTATION IN THE PUBLIC SCHOOLS FOR THE DEAF

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Psychiatry has been a latecomer to the field of deafness. Extensive programs of treatment and research were begun only in the latter half of the 1950's; and despite accumulation of considerable knowledge of the emotional and behavioral problems of the deaf, expertise in the management of psychiatric problems has not been broadly disseminated. Few mental health professionals and fewer psychiatrists have become knowledgeable in the field; fewer still have acquired the communication skills necessary for immediate relationship work with the deaf.

Within the subspecialty of child psychiatry the dearth of clinicians is, if anything, more severe despite a growing body of evidence that profound early deafness may be associated with a high incidence of childhood emotional and behavioral problems – as much as five times higher than for hearing children.

In this paper we report some aspects of our experience during the first three semesters of a newly established program of psychiatric consultation to the Regional Schools for the Deaf of the Dallas Independent School District. The consultant (G. P.), a Fellow in the Division of Child Psychiatry of the Southwestern Medical School Department of Psychiatry, provided two hours per week of on-site services at four regional school campuses. The major focus of consultation attention was within the elementary school and multi-handicapped program (90 students), but services were also provided on the sites of the early pre-school program (30 students) and the middle school and senior high school programs (about 90 students each).

In the following discussion we shall describe the problems presented by the children referred to the psychiatric consultation program and comment on the role and functions of the child psychiatrist as a consultant in the deaf education setting. Sharing these experiences can allow others to evaluate the utility of having such consultant time available and perhaps be of help in their making comparable arrangements.

Presenting Problems of Children

During the first three semesters of this consultantship, 40 children received direct or indirect (consulting only) psychiatric attention (See Table I). Among these, by far the most frequent principal presenting problem was "delinquent" behavior (15), followed by "bizarre" behavior (8), and oppositional behavior, usually with temper tantrums (7).

Table 1. Presenting Problems of 40 Children Referred to Psychiatric Consultation Program.

1	"Delinquent behavior"	15	37.5%
2	"Bizarre" behavior	8	20 %
3	"Oppositional" behavior	7	17.5%
4	"Withdrawn" behavior	6	15 %
5	Special Problem MH	4	10 %

Withdrawn or overinhibited behavior leading to concern about depression was reported in six children, most of whom were already being seen by the school counselor. The remaining four referral questions concerned the spe-

cial problems of multi-handicapped children, their families' unrealistic expectations of them, and their at times irrational demands on the school.

"Delinquent" behavior (usually stealing, lying, fighting, manipulative behavior, and sexual misconduct) tended to be reported by administrators and direct psychiatric intervention was seldom requested (only once). Most of our direct work with children was with the "bizarre" behavior group in which, despite a high index of teacher suspicion, only one of the seven children proved to be psychotic. Four of these children exhibited deviations in social and affective development associated with varying degrees of mental retardation, one suffered from untreated minimal brain dysfunction, and one from a classical psychoneurotic disorder.

Five of the six "oppositional" children had difficulty regulating tension with a pronounced tendency to discharge (in one case associated with undertreated or untreated MBD, and in all with inversely varying degrees of intrapsychic conflict or characterological trends). The other opositional child suffered from an early psychoneurotic depressive disorder with severe narcissistic vulnerability. Most of the children who were reported to be withdrawn, inhibited, or "depressed" were already being seen by the school counselor and psychiatric input was given in a supervisory format.

Consultant Role and Functions

These will be described in terms of (1) the consultants' direct assessment of children (from a psychiatric and medical perspective) and (2) the consultant's work with staff (as an administrative consultant).

Direct Assessment of Children: An early lesson was that the psychiatrist had very little, if anything, to offer the deaf educators in the arena of classroom behavior management. He could, however, add both a psychodynamic and a medical perspective to the teacher's behavioral orientation. Psychiatrist contact with children was mostly limited to evaluation, either in the formal direct interviews or classroom observation, from which data were gathered for one or more of the following purposes: (1) To make a psychiatric diagnosis which could then be used to document the child's need for special services; (2) To assess the psychodynamic forces at work within the child in order to assist the teachers, counselors, and others working with the child to an understanding of the child more as a person than as an emitter of a particular kind of behavior; (3) To clarify some aspect of teacher-child, teacher-parent, or parent-child interaction; (4) To determine whether the child suffered from difficulties that resulted from unmet medical needs and, in some cases, to prescribe or recommend medication.

Psychodynamic Themes: In his role as psychiatrist the consultant was able to identify five recurrent dynamic themes which emerged from psychiatric evaluation of these deaf youngsters from classroom observation of teacher-student interaction:

(1) *Teacher failure to respond to more than one level in a student's overdetermined communication.* The concept of overdetermination — that more than one psychological meaning is expressed in a single overt behavior — was a novel one to the deaf educators. In one of the early requests for psychiatric attenton the consultant was asked to see a 12-year-old in order to advise the teacher on how to structure his classroom experience in a way which would discourage "disruptive behavior." Tony was signing to the teacher and to peers in the class,; "stupid," "bad," and ugly." When remonstrated with, he had temper tantrums. The teachers took these utterances for accusations (which they certainly were) and in their zeal to extinguish the "inappropriate behavior" they failed to recognize the message about himself that Tony was fairly clearly attempting to convey; that *he* felt stupid, bad, and ugly and was not able to bear these feelings alone. Thus he projected them and invited the special kind of interaction that invariably attended the behavior.

(2) *Child with narcissistic vulnerability.* Many children were found to exhibit extreme vulnerability to narcissistic injury related to problems of low self-esteem. These children usually had a less precise understanding of the terms of the student-teacher relationship than the teachers ascribed to them. The teachers felt themselves there to teach; the children experienced them as an important source of emotional supplies and sought recognition and praise. Under these circumstances, correction of either academic work or behavior tended to be experienced as rejection by the child and called forth disruptive behavior expressing protest and pain.

(3) *Child with overt neurotic or psychotic symptom formation.* Neurotic symptoms were seen in two cases. In both of these, the classroom teacher believed the child to be psychotic because of what seemed to be bizarre behavior. Psychotic symptoms were actually present in another child, a mentally retarded adolescent, and they were accurately perceived and reported by the teachers.

(4) *The variable presentation of deprivation in childhood and adolescence.* Depressed mood tended to be recognized by teachers in those few cases in which the child presented an understimulated, over-inhibited, or apathetic appearance in the classroom. Depression, however, was frequently an important dynamic issue in children who presented oppositional or "delinquent" behavior. These depressions were not of severe or psychotic levels, but nevertheless called for help and treatment.

(5) *Child with difficulty in tension regulation.* Problems related to a child's inability to sustain tension due to defective internal structure formed the basis of the most common referral questions. Teachers' approaches to "delinquent" behavior tended to be a unidimensional focus on the behavior and the application of consequences. A typical response to inappropriate behavior would be that the student "just does that to get attention". The consultant would ask, "What's going on inside the child that makes him feel the need for more attntion?" This type of intervention led to more individualized understanding of the child's difficulty with the handling of his inner tensions and, in many cases to refinements in management techniques.

Medical Themes: In his role as physician, the consultant was able to make three principal contributions to the deaf education program:

(1) The syndrome of minimal brain dysfunction (attentional deficit disorder) was encountered with fair regularity in this population. Most of the children who were seen as presenting clear evidence of hyperkinesis had not been previously diagnosed and teachers' indices of suspicion were surprisingly low. Making the diagnosis and prescribing psychostimulant trials allowed for dramatic improvements in these children's classroom behavior in a short period of time.

(2) One child with overt psychotic symptoms was identified and referred for appropriate therapy including neuroleptic chemotherapy and dose adjustments were made in regular follow-up activities at the school. When outpatient therapy failed, referral was arranged to a psychiatric hospital.

(3) Neuroleptic medication was prescribed as an adjunct in the control of aggressive impulsive behavior in one mentally retarded adolescent boy. This modality was undertaken after all other resources were exhausted and was not signally successful. However, it illustrates how an on-site child psychiatrist can add a dimension, which would not otherwise be available, to the total management of an especially difficult child.

Administrative Consultation. By far the largest portion of consultant time was spent, not with children, but with teachers and administrators. Some of the ways in which

this time was utilized were:

(1) *Interpreting children's problems to teachers.* Often teachers would request consultation on a child who was exhibiting a novel behavior. The consultant was often able to interpret the behavior dynamically, based on history and observation of the child in the classroom. This type of intervention served to alleviate teacher anxiety and reestablish balance in the teacher-student relationship, as well as to suggest changes in classroom management techniques.

(2) *Facilitating communication among teachers and across administrative levels.* Classroom teachers frequently differed with their administrative superiors in their assessments of the programmatic needs of particular children. Administrators tended to justify their own perceptions on the grounds of teacher inexperience, while teachers tended to feel the administrators were out of touch with classroom realities. Both levels were willing to talk to an impartial outsider whose interest in the children was as great as their own and these differences could usually be negotiated. The psychiatrist was also able to assist the deaf program in its dealings with the administrative superstructure; for example, by submitting a clinical opinion in support of having a "quiet room" available to emotionally disturbed deaf students. (School district policy had forbidden the use of such rooms in all schools, without taking into account the needs of specialized programs.)

(3) *Assisting teachers and administrative faculty in the handling of difficult problems in school-parent relations.* This could usually be accomplished by hearing the problem and advising the staff member, but on several occasions the psychiatrist met with the parents and staff together to clarify problems and help with negotiations.

(4) *Supervising the school counselor in her ongoing work with deaf youngsters.* This was particularly productive in that it enabled the counselor to maximize her own impact on troubled children. In regular brief consultations, sometimes on the telephone, the counselor was assisted in differntiating the situational-reactive from the psychopathological and could allocate her own limited time accordingly. In less frequent, more detailed supervisory sessions, issues of transference and counter-transference were explored and clarified and some therapeutic impasses were resolved.

(5) *Helping the school establish new relationships with child, mental health, deafness, and other social agencies in the community.* The poverty of communication between child agencies in our area is appalling and the deaf education system was even more isolated than others. The community mental health center was already offering counseling services to the deaf, a fact which had escaped notice in the school system. With our activities centering around the special needs of particular children, we were able to open a dialogue among the schools for the deaf, mental health center, the courts, the rehabilitation commission, the community's Deaf Action Center, and the state psychiatric hospital system, at one point involving most of these agencies in a joint staffing on a singularly difficult problem. Although the clinical results were not specatcular, some mutual interagency mistrust was at least temporarily ameliorated.

(6) *Working with the program administrators to identify subgroups of problem children; to set up more specialized programs for them.* Owing to the previous unavailability of a clinical diagnostician, very few children had been formally identified as "emotionally disturbed". We were able to make diagnoses "for the record" in many of these and to further differentiate them according to their need and for behavioral versus other approaches resulting in the establishment of two "ED" classes when none had previously existed.

Conclusion

We have discussed some aspects of a fledging program of child psychiatric consultation in a day school for deaf children. Our experience confirms the need for psychiatric attention to the problems of deaf

children and suggests that even limited psychiatrist time can be used to advantage in a "consulting" model of intervention.

The psychiatrist brings to the deaf education setting a psychodynamic and medical perspective which enhances the teachers' understanding of the child and his behavior, opening up new avenues of possibility for management. He may be helpful in a practical way by meeting such administrative needs as providing documentation of a child's need for special services which are unavailable without such documentation. Creative solutions to chronic problems can evolve from collaboration between imaginative administrators and the psychiatrist as together they identify subgroups of problem children and establish new programs for them.

By virtue of his understanding of the dynamic unconscious, the psychiatrist may be able to facilitate communication, even among experts in the field of communication, not only within the school program but among the school and the other agencies with responsibilities to handicapped children. Early failure to elicit sustained cooperative efforts among these agencies should be met with redoubled strivings to maintain communication and continued in-house working through of extenally-directed mistrustfulness.

The deaf educator and the child psychiatrist have much to teach one another. By helping the teacher make sense of the child, the psychiatrist may assist the teacher in managing not only a child's problem behavior, but the teacher's own feelings; what is understood is much less anxiety-provoking than what is incomprehensible. The psychiatrist learns from the teacher what the first-hand, emotionally charged child-teacher relationship demands and gets to sense the natural and inevitable consequences of dedicated work with the child. From this base, he can then help the teachers as a group to resolve the intrapsychic and interpersonal crises which result in impasse among staff and between teacher and parent. In short, the team of deaf education and child psychiatry is a formidable one. Collaboration multiplies the opportunities for both to serve deaf youngsters.

Fresh approaches to the use of existing resources can be developed and applied almost immediately. In the longer term, identifying the psychiatric treatment needs of emotionally disturbed deaf children, for whom makeshift programs will not suffice, should lead to the establishment of appropriate new resources in the future.

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