

---

**ASSOCIATION OF**

---

---

**PAEDIATRIC**

---

---

**CHARTERED PHYSIOTHERAPISTS**

---



---

**NEWSLETTER**

---

# ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS

Newsletter No. 38

February, 1986

## LIVING — AND DYING

### *Chairman*

Miss Ann Grimley  
Physiotherapy Dept  
New Royal Preston Hospital  
Preston, Lancs.

### *Vice-Chairman*

Mrs. Maggie Diffey  
Jenny Lind Unit  
Norfolk & Norwich Hospital  
Norwich

### *Secretary and Membership*

Mrs. Sandra Holt  
43, Westwood Park  
London SE23 3QG

### *Treasurer*

Mrs. Linda Hanraads  
18, Main Street  
Ashley, Market Harborough

### *P. R. O.*

Miss Elma Bell  
Scottish Council for Spastics  
5, Rillbank Terrace  
Edinburgh

### *Editor*

Mrs. Jeanne Lamond  
22, Whernside Road  
Cross Hill  
Lancaster

## EDITORIAL BOARD

Miss E. Bell, Miss N. Hare, Mrs. C. Ball, Mrs. M. Clegg,  
Miss G. Riley, Mrs. M. Diffey.

## CONTENTS

Holidays for Physically and Mentally Handicapped Riders .....	3
Holiday of a Lifetime .....	5
Canoeing for Disabled People .....	6
Activity for Asthma .....	10
From 'Curing and Caring to Caring' .....	13
Counselling the Bereaved Child, The role of the School Nurse .....	15
Extracts .....	22
Snippets .....	23
Equipment .....	25
Toys .....	26
Publications .....	29
Audio-Visual .....	29
Book Reviews .....	30
Articles of Interest .....	31
Course Diary .....	32
Regional Reports .....	35

The Editorial Board does not necessarily agree with opinions expressed in articles and correspondence, and reserves the right to edit material submitted.

## EDITORIAL

Planning a Newsletter is not always an easy task, although we receive much help from our very willing contributors to whom we owe so much. Planning this edition, we felt there was much that handicapped youngsters do in spite of their disabilities, which help to enrich their lives, and often the lives of their families and friends. At the other end of the scale, the reality of death and coping with the associated problems is something that perhaps most of us have to face at some time. We therefore offer no apologies for putting the two subjects together, joined by the thread of Caring, that is apparent in all the articles.

The Annual Conference at Canterbury with the intriguing title 'Canterbury Tales' will soon be here, hopefully well supported! It promises to be an excellent week-end and the more people who come the more information is exchanged, so hurry up - Book Now. Finally best wishes to all our rapidly increasing membership for 1986.

---

### ALL MEMBERS PLEASE NOTE —

The National A. G. M. will be held at the Annual Conference on Sunday April 6th 1986. There are two vacancies on the National Committee, nominations for these vacancies should be sent to the Secretary - Mrs Sandra Holt - by March 15 1986, together with name and membership number of the proposer and seconder. Candidates will be voted for by paper ballot at the A. G. M.

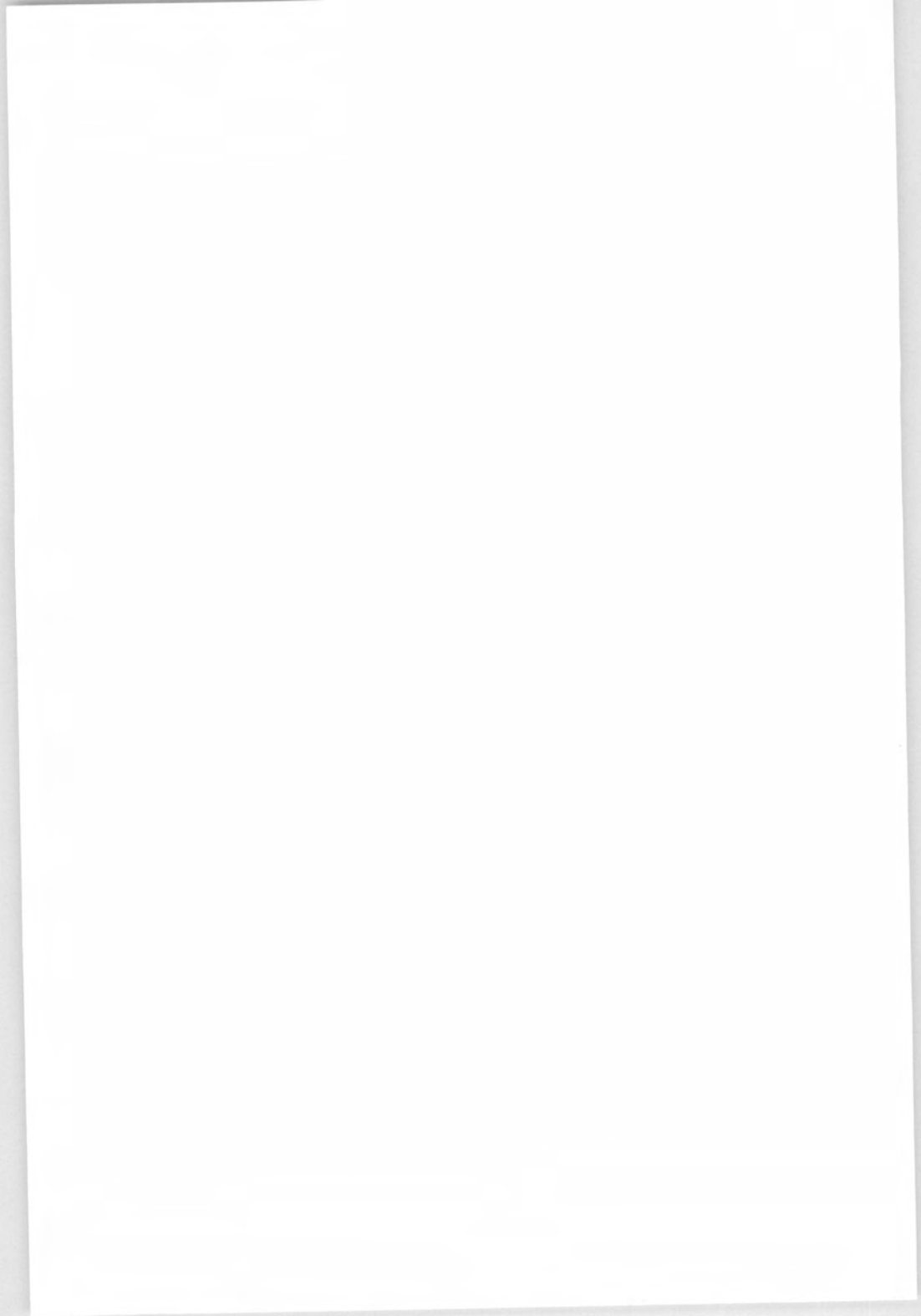
Annual Subscriptions now due (£7) should be paid by cheque **NOT Bankers Order**. We are of course very appreciative of the people who have paid us by both methods at the same time!

The **LAST DATE** for submission of material for the May Newsletter will be **March 31st**. Material other than Conference reports will **NOT** be included after that date.

---

**ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS  
SUMMARY OF ACCOUNTS FOR THE YEAR ENDED 31 DECEMBER 1987**

	1987	1986	EXPENSES	1987	1986
<b>INCOME</b>					
Courses	20,859	17,798	Lecture Fees & accommodation	18,342	15,781
Books: Sales	962	749	Newsletters	3,773	2,531
1987 Stock	2,213	2,830	Books: 1986 Stock	2,830	3,057
Subscriptions	6,036	8,579	Purchases	322	-
Bank & Building Society			Committee Expenses	4,598	3,329
Interest	1,020	984	Administration	5,083	5,435
Sponsors & Donations	2,737	1,841	Corporation Tax Transfer	382	(300)
	<u>33,827</u>	<u>32,781</u>	(Deficit)/Surplus	(1,494)	2,948
				<u>33,827</u>	<u>32,781</u>
<b>ASSETS</b>			<b>LIABILITIES</b>		
Stock of Books	2,213	2,830	Creditors	743	604
Banks & Cash	7,426	6,556	Receipt in Advance	100	-
Building Societies	10,311	11,519	Balance brought forward 1986	21,199	18,251
Corporation Tax	-	300	(Deficit)/Surplus for Year	(1,494)	2,948
Word Processor	598	598		<u>20,548</u>	<u>21,803</u>
	<u>20,548</u>	<u>21,803</u>			



## **HOLIDAYS FOR MENTALLY AND PHYSICALLY HANDICAPPED RIDERS — SOME EXPERIENCES**

*Mrs. Kay Brown, Manager - The Clwyd Special Riding Centre*

The Clwyd Special Riding Centre is taking bookings for its third season as a national holiday centre for disabled riders. The holiday facilities at the Centre are in addition to riding therapy given weekly to two hundred physically and mentally handicapped adults and children and, for this reason, holidays start on Thursday afternoons and end on Tuesday mornings.

The Clwyd Special Riding Trust, which administers the Centre, is a registered charity; the holidays offered are open to every member of The Riding for the Disabled Association. Our holidays differ from those offered by the Association in that - apart from providing accommodation, horses and other facilities - the riders and their friends or families ride as and when they wish. As the two six-bed units offer self-catering accommodation there are no set mealtimes: the weather, physical fitness and personal inclination - not a timetable - will dictate when and for how long they ride. The Centre also puts no restrictions on the disabilities eligible for holidays at Llanfynydd; if the Association's area representative feels he/she will benefit then our doors are open.

Riders and helpers/friends/parents are welcomed when they arrive and given time to unpack, explore and make a cup of tea! The initial impression of relaxed informality coupled with cheerful orderliness I feel is very important: if our visitors have doubts about our competence this will permeate their stay and, particularly with the less confident, can spoil the rider/pony relationship from the start. An assessment ride on the first afternoon is when the new partnership is tested; this is the time to make adjustments as, although I will have carefully consulted details on the booking forms I do occasionally 'get it wrong'! The child described by mother as 'timid and nervous' I soon realise will be exasperated by the steady pony I have allocated and needs something more unpredictable to leave him no time for idle neurosis! The young spina bifida adult turns out to be two stones heavier than admitted, or the middle-aged spastic lady has abduction problems and needs a narrower mount. I find this first hour both fascinating and revealing. The awkward, stiff unsmiling new arrival metamorphoses into a confident, relaxed and communicative horseman; hugs and pats are endlessly given and received and the new partnership is seen to work! Very rarely does a rider ask to change horses, but as far as possible this is agreed to - and always if the rider is physically-handicapped and there is a 'comfort' problem.

The first night I notice - and expect - lights burning into the early hours; nevertheless everyone is ready, after an early breakfast, to catch ponies. Those being used by visitors are put in a separate field for ease of identification and safety for those riders with mobility problems. The 'one to one' pony/rider bond is greatly strengthened by the morning greeting, slice of apple and walk back to the yard. Those helpers who bring in all the ponies as a kind gesture are, I think, misguided; even a chairbound rider can catch for himself, with assistance. Grooming, including cleaning out all four feet, and tacking-up

(putting on saddle and bridle) precede the day's riding. When we began holidays at the Centre we put each pony into a separate stable for this preparation, but found with experience that tying together on the indoor riding school allows better supervision and communication - and potentially difficult situations are spotted before they develop. The busy, noisy and often competitive atmosphere on a bright Summer morning is quite thrilling; even the most severely handicapped can help and the sense of achievement which follows is immense. This is the aspect of riding most RDA - and for that matter, non-handicapped - riders miss out on: the pony is invariably ready for the riding session and given over to helpers or staff afterwards. The horse behaves and reacts in a different way from other domestic animals and we believe it is of immense benefit to the therapy we provide if an understanding of the horse can be acquired at the same time as riding skills.

Holiday visitors to The Clwyd Special Riding Centre have a choice for their riding: the 120' x 60' indoor riding school (with viewing gallery, lighting and sound amplification system), the fenced outdoor arena of the same size, with its all-weather surface, those fields on the seventeen acres which are not being grazed at the time or, best of all for those from urban areas, a variety of hilly lanes and tracks surrounding the property. On these rides out we always provide a guide who is not only a competent horseman but knows the local bridleways, which hills are less steep than others and where pigs and dogs lurk! The choice of time, direction and duration is left to our visitors; the more able and ambitious will want to 'go faster' while the more sedentary prefer stopping to examine the flora, lambs or calves or to pick blackberries. Imagine how marvellous it must be to move at speed despite one's own useless legs, or to see over hedges when, normally chairbound, life is spent at a lower level than everyone else!

As their stay proceeds and riding is interspersed with visits to the sea, to the local Craft Centre, swimming, games of cricket, barbecues, etc., so each individual is extended. Perhaps in his 'institution' John is never allowed to get dirty - or Jane cannot give release to her desire to wobble/run unaided and unchecked; maybe making decisions about meals, hitherto just delivered, is a new responsibility. Underlying all activities is the constant stimulus of the pony and often this consideration of another living creature is a novel and strange experience. Many of our riders never get wet or cold in their daily environment and physical activity is limited to visits to the loo and getting in and out of bed and the mini-bus!

As the holiday progresses the 'blossoming' process continues and it is quite obviously the horse or pony acting as a catalyst which makes it all possible. Bedtimes become earlier and rising later as the Welsh mountain air and unaccustomed exercise begin to have an effect. Quite suddenly - and far too soon - the holiday is over . . . and it is always the ponies who receive the lengthiest 'goodbyes' and promises to return. We must turn our thoughts to the next holiday group, due to arrive in two days, and prepare for them.

When I look back, it is revealing how many pre-conceived and ultra-cautious restrictions have been set aside happily here. 'Of course, I can't do that' or - even worse - 'of course he/she can't do that' is an instant challenge! Obviously there will be innate restrictions and these must be respected, but we

try to inspire and encourage, often with surprising results. Riding is a risk sport and the incentive this offers must be accepted - for surely this is when achievement counts? All those involved with the horse know of the immense benefits of riding; how privileged we are here to be able to apply and witness its therapy in such a variety of ways.

---

Kay Brown is married, with two children, and has been resident Manager at The Clwyd Special Riding Centre, Llanfynydd, Wrexham, Clwyd, for two years.

A Veterinary Nurse by profession, she has been involved helping with and teaching disabled adults and children to ride for eight years.

## **HOLIDAY OF A LIFETIME**

*Mrs Sheila O'Malley - Parent*

My daughter Lisa is now sixteen, and has suffered from Rheumatoid Arthritis from the age of two. Lisa and I will always be grateful to Threshold Travel for giving us the opportunity to completely change our outlook on life, when they gave us two weeks of magic in the most magical place on earth, 'Disneyland'.

The last fourteen years have been spent going backwards and forwards to hospitals, with Lisa undergoing over twenty operations, during which time, through pain and heartache, we built up a special bond between us - in Disneyland we learnt to laugh together.

The trip was specially organised for disabled people, and we became very friendly with a married couple, John and Pat Langley, who both suffered from polio. John in particular became a great inspiration to Lisa, he could only move his hands, and it was wonderful to see Lisa sitting next to him at mealtimes, forgetting her own disability, helping him all she could and lifting glasses for him to drink from.

In the very hot weather Lisa had two wonderful pain free weeks, swimming daily in the hotel pool she has never been as fit and mobile as she was then. It was lovely to see the pale, sick child who had left Manchester, slowly turn into a tanned healthy young lady full of the wonders of Disneyland, the Kennedy Space Centre and the wonderful Epcot Centre.

During those two weeks, I think both Lisa and I realised that having a disability doesn't mean Life can't be lived to the full. Although over half the people on the trip were disabled, the thing I remember most is the laughter, there were no complaints or self pity, just a group of holiday makers enjoying life.

We spent the first week of our holiday at the Sheraton Hotel, comprising a series of buildings spread over a large area and all joined by a winding brick path. We must have been a funny sight each morning going to breakfast with three wheelchairs in convoy, and all singing 'Follow the yellow brick road'.



The day we went to Disneyland was fantastic. To get to the magic kingdom, you have to travel on an old Mississippi river boat, and we will never forget the sight of the kingdom coming in to view, I am not sure who was most excited - Lisa or myself. The American people were warm and friendly, always ready to help. Going round Disneyland we were never short of offers to help push wheelchairs up hills, and soon Lisa got over her embarrassment when people came up saying how lovely her hair was or what a lovely smile she had; unlike this country where many people treat a person in a wheelchair as if they are invisible.

Harry the Threshold courier was heaven sent, never speaking down to anyone and seeming to sense the needs of individuals. Lisa became his shadow and it was lovely to hear them laughing together and tormenting each other. I think it was Harry, whose attitude and obvious joy at being with disabled people, made me realise that I had been so involved in Lisa's medical condition, that I had neglected her social life, and therefore when we came home we both joined our local group of Arthritis care. Now Lisa and I thoroughly enjoy our involvement with the disabled of all ages and this year I have become the secretary.

To sum up what America did for both Lisa and myself, I would say it taught us that nothing is impossible and somewhere there is always someone worse off than yourself, also laughter is a great cure. We still keep in touch with Harry, and have become great friends with John and Pat who live in Croyden - whenever we see them laughter and memories are always present. So thank you Threshold for giving us some lovely friends and a chance to live life to the full.

## **CANOEING FOR DISABLED PEOPLE**

*Mrs. Flók de Rijke, Senior Physiotherapist, Trengweath School, Plymouth.*

The Trengweath Canoeing group for disabled people has been in existence in Plymouth for some ten years. This is an account of how this sport has enriched the lives of many of its members and what an asset it became in my work as a paediatric physiotherapist.

During long term physiotherapy of a disabled child there are times when the therapist has to be creative in his/her approach in order to maintain the child's interest in the often repetitive treatment. I wanted to share my sailing hobby with some of my teenage patients and introduced them to dinghy sailing at a local adventure centre where I instructed part time. This was obviously enjoyed, but the amount of help needed by the young sailors did take away some of the value of the sport. When I myself was introduced to canoeing at this same centre, I became aware how suitable this activity could be for some of my patients. To be master of their own boat was a great boost for their morale, so often bruised or low among young disabled people. The symmetrical aspect of paddling, requiring both hands grasping the loom, arms reaching forward, seemed ideal exercise for people with a moderate hemiparesis.

For people with cerebral palsy, fixating the sitting position with leg abduction and outward rotation, balancing the boat with trunk righting, and co-ordinating paddling strokes, moving the boat forward and directing it on the right course, was enough to keep them very busy, not to mention getting in and out of a wobbly boat on water that would never keep still!

My pupils and I were firmly hooked on canoeing after the first experience that took us to rivers, lakes, tidal estuaries and the sea. The Spastic Society by whom I am employed, supported the activity, and a regular weekly session with a small group of moderately disabled children was started. It has grown steadily in numbers and now totals fifty people, including instructors, helpers, parents and siblings of the disabled students.

Running a canoeing group successfully needs some key people willing to lead.

(A) Qualified canoeing instructors who will invite other instructors and experienced canoeists to help and be responsible for maintaining a high standard of safety, and take care of regular staff training.

(B) Medically qualified people whose work brings them into contact with disabled people, enabling them to encourage enrolment, particularly those students who are timid or inhibited, this is a suitable role for therapists, whose other responsibilities include: advising the team of instructors and helpers on medical conditions, and pointing out what considerations are necessary, i.e. awareness of multiple and hidden handicaps, sensory loss, respiratory problems, needs for protective padding, or sitting support. Caution about over exertion or encouragement to exert a little more.

You may ask who is eligible to take part in this risk sport? In the early days we found safety was in small numbers, and only students with good swimming ability were accepted. Over the years, as experience and expertise made us more daring, we have pushed back some early barriers. The minimum swimming requirement now is having sufficient confidence to float after capsizing, whilst wearing a life-jacket. It is now possible to accept more severely handicapped students since some of the canoes in our fleet are specially designed for more stability with built-in backrests and larger open areas around the seat, allowing easier access and exit. Special lightweight paddles have helped overcome difficulties with the learning of paddling techniques. Unfeathered paddles (with parallel blades) are often easier to handle than the customary feathered paddles (with blades set at right angles) which require more wrist extension for an effective stroke.

Winter training in a heated pool, leads the students step by step into all the basic skills, from how to get into a boat to how to cope with a capsized. It gives the staff an invaluable opportunity to get to know their pupils, and their abilities whilst training together for any event that may occur on open water.

It is not my intention to go into the technical details here, of canoeing. I recommend anyone interested to read the publications listed in the bibliography. Although our overall aim in canoe training is to use standard equipment, special aids and specialised equipment play an important part, and have enabled many people to participate who would otherwise have been excluded. It has helped the initially timid students to overcome fear and has

aided the beginner to progress to more advanced equipment.

The following diagrams are copied from the B.C.I. publication: Canoeing for disabled people. Booklet 10. Courtesy of Ron Moore B.C.U. coach.

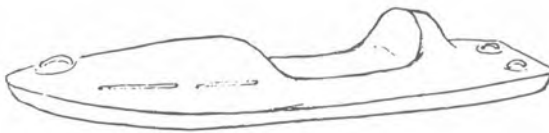
Special stable boats with large cockpits and integral backrests.



Caranoe

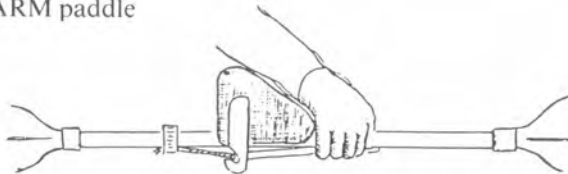


Cadette



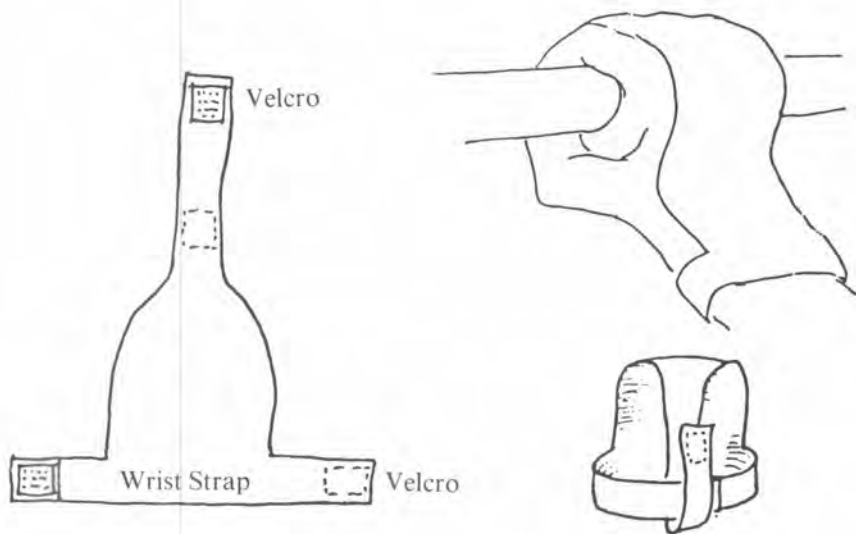
Beaver

The ONE ARM paddle



Paul Van Der Molen's fitting

Sharon Lambert's velcro glove binds the fingers of a weak hand round the loom with velcro. In emergency this has to be detached with the other hand so it should normally be used singly and not in pairs.



I should like to list the wide range of benefits canoeing has given disabled people. The young students enjoy the comradeship of the group activity, and are expected to make a commitment once they have joined the group, they must let the leaders know when they cannot attend. The weight and size of the equipment necessitates teamwork and everyone is expected and reminded to play a full part in carrying, loading and unloading and washing the gear after use. There is a great deal to see and learn on the waters we explore.

A canoe can reach where other boats can't. The delights of paddling among the rocks along the seashore, into caves and lagoons or through the reeds in the estuaries, can be imagined. Wildlife is not much disturbed by silently mooring boats. Commercial and naval shipping on the same water as our close group of colourful canoes tells us much about our city with its harbours and dockyards. The Plymouth area offers such a variety of suitable water that we can always go out in any weather condition. At times we trail the boats to an offwind shore to avoid cancelling the session. This exposes the participants to the great British weather and helps them to ignore discomforts.

Finally it is the commitment of the older students who have taken on a large share in running the group as trainee instructors, as organisers of equipment or by providing transport for their fellow students, that remind us how disabled people are full members of society and are capable of making a very real contribution.

### **Bibliography**

British Canoe Union, Flexel House 45 - 47 High St., Addlestone, Weybridge KT15 1JV.

Booklet 10 Canoeing for disabled persons. Published by EP Publishing Ltd., Bradford Road, East Ardsley, Wakefield, West Yorks.

Video - Winter Training in an indoor pool.

B. S. A. D. - Watersport for disabled people.

## ACTIVITY FOR ASTHMA

*Mrs. C. A. Hanson, Senior Physiotherapist, Burnley General Hospital*

Growing up with or living with asthma, is an experience known to at least one in ten of the population. In childhood asthma a number of different patterns may be seen and an awareness of the possibilities is helpful in the early identification of the child who is likely to present problems in long term management. Parental attitudes play a crucial role in determining the quality of life for an asthmatic child.

It is a fallacy to consider that all children with asthma grow out of their disorder on or around puberty as many people believe. Long term studies indicate that about 50% of childhood asthmatics have asthma as a life long disorder or one which recurs in adult life. (McNichol and Williams, 1973 : Blair 1977). Since the late 70's there has been a growing community interest in the role of asthma self-help groups. The activity group movement has grown from a single group in 1978 to a nationally distributed network of some 200 groups. The growth of the activity movement in the UK is due mostly to the support it receives from professional interests. The swim group movement is affiliated to the Asthma Association and has close links with the Institute of Swimming, who teach and coach the dry land exercise groups and usually have considerable hospital support, mainly from physiotherapists.

In Burnley in 1978 we found the need to start a group primarily for the large number of children with exercise induced asthma. This has been defined as an acute, reversible, usually self limiting, airway obstruction which develops in patients with asthma, (Cropp 1975). Typically in children, early during a period of exercise, most children whether asthmatic or not show evidence of bronchodilation, probably as the result of increased sympathetic activity. In asthmatic children however, this is followed by a sharp increase in airways obstruction which begins towards the end of the exercise period and becomes fully developed shortly after the exercise is stopped.

There has been a variety of controlled studies which provide evidence that some forms of exercise are more provocative of asthma than others. Godfrey (1973) has demonstrated this fact in children who carried out the same amount of work in a series of exercise tests. It is clear that running, either freely or on a treadmill, induces more bronchospasm than swimming or walking, the intensity and duration are of course relevant. No one actually seems to agree about the incidence of EIA due largely to differences in the exercise tests used by different people, and in the incidences chosen to measure lung functions. Godfrey and colleagues have reported an incidence of 95% in asthmatic children when they run on a treadmill for 6 - 8 minutes at a speed of 5 km/hour with a gradient of 10 - 15%. It is now generally accepted that most children with asthma develop EIA in response to strenuous exercise, and although these attacks are mild to moderate in severity, they are obviously distressing to the child and their family and are often allowed to limit the child's ability in games and sport. This can be particularly detrimental to the normal physical, mental development of children.

## **The Burnley Project - Base A**

Our overall aim is to enable all young children suffering from asthma, to lead a 'normal' life within all areas of the community, without any restrictions being imposed upon them. In Burnley, an allergy clinic is held weekly and all children are seen by the paediatrician, in attendance are a dietician and a physiotherapist. The children are seen frequently until the asthma is well controlled and then they are seen at six monthly intervals. Admissions to hospitals have been drastically reduced since the clinic and programme began. Children are referred for the programme by consultants and also by a lot of general practitioners.

### **Aims of the Base A programme**

1. To improve exercise tolerance to an acceptable level so that the asthmatic is more able to compete with peers.
2. To restore self confidence and enjoyment in sport so that asthmatic children will need little or no encouragement to participate in games at school and in the community.
3. To demonstrate to parent and child how to cope with acute episodes of wheezing by positioning, relaxation and diaphragmatic breathing.
4. To give a sense of good postural awareness both through discussion and extension exercises during the warm up period.
5. To give a good understanding of the use and administration of the drugs prescribed.
6. To make parents aware that they play an important role in the programme which will lead to a better understanding of asthma on their part and therefore improve their ability to motivate their children to cope with asthma.

The first session of physiotherapy is an assessment of each child's physical tolerance and from this a personal exercise schedule is calculated, and then performed at the twice weekly exercise class. Each time the child attends he does an increased proportion of the original figures in the assessment. This is continued, until it is considered that he can comfortably join in with or even compete with his peers at school.

Each class begins with premedication, each child's technique being individually watched. This is followed by a warm up of at least ten minutes which prevents bronchoconstriction by sudden exercise. As mentioned earlier, if exercise begins slowly then often some bronchodilation is evident, this is obviously advantageous and children must learn the importance of this. The exercise programme follows, each child performing his own tailored list in his own time, and following it with relaxation and diaphragmatic breathing. Each session ends with a robust game introducing an element of competition. Once a child and his family are firmly established in the programme, they are invited to the local leisure centre. Here the group is primarily run by parents, but supervised by physiotherapists, who upgrade the exercise programmes. The leisure centre programme follows exactly the same pattern as the hospitals, but ends with a swimming class instead of a game. The leisure centre attendants also offer a wide spectrum of sports activities in which they encourage the children to take part.

## **Double Blind Prospective Study of the Effect of Physical Training in Childhood Asthma.**

### **Methods**

Children attending the Asthma clinic with proven exercise induced bronchospasm (20% fall in peak expiratory flow (PEFR after exercise) were, with consent, randomly allocated to one of two groups. The first underwent a graduated physical training programme, designed and supervised by a paediatric physiotherapist, the second took part in relaxation classes supervised by the same physiotherapist.

### **Physical Training Group**

The physical training group began with a warming up period of exercises, interspersed with short rests in positions suitable for controlling wheeze. This was followed by an intensive programme of exercises comprising step-ups, squat thrusts, star jumps, sit-ups and press-ups. These were performed in the same order at each session, and were repeated daily at home. Each child's exercise tolerance was individually assessed before entry to the group, and the exercise programme determined from the result. The sessions were held twice weekly for three months, and the exercise load increased at each session. Children received premedication with sodium cromoglycate by spinhaler, fifteen minutes before exercise.

### **Relaxation Group**

Children in the relaxation group attended once weekly for three months, and repeated the programme daily at home. Their routine comprised contrast relaxation in various positions appropriate for use during an episode of wheezing and controlled diaphragmatic breathing. Sessions began and ended with a short period of activity selected by the children themselves - relay games were the most popular choice.

### **Both Groups**

On introduction to the project and at monthly intervals for three months each child underwent a free running exercise test. This consisted of running along a level corridor for six minutes at sufficient speed to achieve a pulse rate of 170 beats/min or more. After exercise PEFR was measured at 0.1.3.5.10 and fifteen minutes. Each child was supplied with a Wright Mini Peak Flow Meter and performed daily PEFR measurements in the morning and at night for the duration of the study. A daily score of asthmatic symptoms was recorded. Symptoms of wheeze, breathlessness, cough, chest tightness and sputum production were scored from one to ten according to severity, both by day and night.

### **Effect of Physical Training on Childhood Asthma**

Seven children completed the relaxation course and fourteen the physical training. The characteristics were similar in both groups. Normal values were taken from the Data of Godfrey and his colleagues. Daily PEFR measurements did not vary significantly between the groups during the study,



nor was there any significant variation within the groups. Analysis of the daily card data, similarly showed no difference between the groups and no variation during the study. As the study progressed there was a significant increase in the minimum PEF after exercise. This effect was seen however, in both the relaxation and exercise groups, suggesting the influence of factors other than exercises. At the end of the study the children in the exercise group increased their exercise capacity by 100%.

## **Discussion**

The trend to a reduction in exercise - induced bronchoconstriction during the study may be explained in several ways. Involvement in the trial tended to increase the general knowledge and understanding of asthma, in both parents and children. It may be that routine asthma medication was taken more regularly and effectively. Psychological influences may also have been at work, but we would stress that the numbers involved in the project were small, and the results should therefore be interpreted with caution. The improved exercise capacity in these children would be seen to be a very desirable outcome, and this was achieved with apparent complete safety. There are currently about 50 children on role at the leisure centre, they all agree they feel fitter, happier children than prior to the beginning of the programme. As physiotherapists, we feel we are offering something worthwhile to them, and find it a most rewarding and interesting area of paediatric physiotherapy.

## **FROM 'CURING AND CARING' TO CARING**

*The Rev. David Stoter - Chaplain - University Hospital, Nottingham*

You care! You have to if you are to fulfill your role in working with children. Whether the children are those handicapped from birth, those impaired by trauma or those struck down by serious illness; the physiotherapist has to form a close relationship with the child and the family. They need to trust you and you need their trust if any real progress is to be achieved. To win this trust means investing a great deal of yourself getting to know them and helping them to know you. With children, not only do you work with them, you play with them, learn about them, their likes and dislikes, their skills, their areas of difficulty, their hopes (some of them agonizingly impossible) and their fears. With the parents you become an important part of their lives. Someone who 'can do something' for their children, someone they need, someone they may well talk to of their hopes and fears, their pain and sadness, their helplessness and their love. With the children and their families you become united. Together you share pleasure and joy at every indication of recovery, every new achievement, each newly acquired skill. Together you share the sadness and disappointment of each set back. You share their tears of frustration and despair. And then one day you realize as you look at a family - this is not just a patient and family to simply care for professionally - no, this is now a family you feel part of and who view you as part of their family. You are involved and you are vulnerable. For to care is to be vulnerable - to care means sharing and it inevitably is costly. The cost becomes



### **Loss of both parents**

Sula Wolff<sup>2</sup> tells us that all children who need to be cared for outside their own homes are children at risk. Common sense and kindness do not suffice. Those who have lost both parents and who are without close relatives capable and willing to rear them, are usually cared for by local authority social service agencies. It is considered preferable that such children be fostered, in order to avoid the setbacks of residentially orientated upbringing, especially when very young.

Various child studies, dating from the 1940's to the present day, indicate that young children require more than stimulation through environmental exploration and play. They also need continuous care from a mother figure, who is capable of interpreting their individual needs and who can be used as a basis for comparison of experiences.

According to Rheingold (as mentioned by Wolff<sup>2</sup>), very recent studies of institutionalised children show greatly enhanced degrees of both social and verbal stimulation, where they have been cared for by a single mother figure, rather than by a succession of shift-based nurses/caretakers.

In my discussions with childminders and foster mothers, together with speech therapists, the general opinion seemed that those fostered earliest made the greatest intellectual, emotional and physical progress. Children who had spent longer in residential care seemed more socially and practically able, but verbal skills were weak and incidences of lying, stealing and truanting were more frequent.

An interesting study by Freud and Dann (as quoted in Clarke and Clarke<sup>10</sup>) of the first six children liberated from a concentration camp in 1945 and brought to England showed that in spite of having been orphaned before their first birthday and reared by successive inmates for at least three years, they had developed considerable social skills.

### **Telling the children**

The opinion that children are too young to understand is commonly used to explain two familiar, but contradictory approaches to "life and death" matters affecting them.

Firstly, children are considered insensitive and are consequently exposed to adult emotions without explanation. Secondly, children are considered very vulnerable and must therefore have the true facts of death hidden from them. In both cases, parental attitudes are usually dictated by their own personal needs, rather than by any realistic appreciation of the feelings of the children.

We can best help children by encouraging surviving parents to express thoughts (including hatred) which do not fit in with stereotyped grief. Having acknowledged their own negative feelings, they can then begin to tolerate them in their own children.

The ease with which we accept death by accident and war today may indicate a degree of callousness common to many of us. On the other hand, excessive disgust or over-reaction to death leaves the experience corruptive for some and certainly unpleasant for others. The fact that it can be furtively enjoyed, as in a horror comic, or sometimes condemned, as in violence on television, is a manifestation of an irrational attitude towards death and a denial of mourning.

### **The bereaving effects of divorce**

Jobling<sup>11</sup> equates divorce with bereavement for many children. They experience not only conflict of loyalties, but also the same form of stress, fear, guilt and loss associated with mourning - divorce usually being a process, not an event. They may manifest varying degrees of clumsiness and apathy, having been made to feel partly responsible for the break-up.

According to Benians<sup>12</sup>, it is not possible to grieve for a parent who is actually alive, but does not visit the child. It is suggested that the self-esteem of such children is greatly damaged. They feel deeply rejected, which in the end, turns into feelings of rejection within the children themselves.

When a child loses a parent other than by death, a set of complicated crises precedes the event. Such a train of circumstances leaves it difficult to distinguish between the gravity of losing a parent and the effect of being reared by a couple who are powerless to build an enduring relationship.

### **Conclusion**

Our description of death is usually in accordance with our own beliefs. For the child, seeing and touching the body, as well as attending the funeral may help in appreciating the reality of the event. Children need to know the whereabouts of the loved one's last resting place, so that they may occasionally visit the spot, perhaps even alone.

They may want to know later on what was thought of the dead person, so it is prudent to keep notes of sympathy.

We are largely without adequate guidance and lacking in social skills, when attempting to come to terms with loss and mourning. Members of religious sects traditionally receive assistance associated with sectarian ritual. Members of some religious cults have support in their denial of the importance of death<sup>13</sup>, but many of us are outside such groups.

Child bereavement is a complex experience of change and loss of a parent incorporates great suffering. Such loss has much potential for continued maturation. Given the trusted support of a caring listener and the assurance of recovery, the mourning child can be placed on the path leading to a successful resolution of grief.

### **References**

1. Illsley R, Thompson B, Broken Homes. In: Butterworth E, Weir D (ed). *The Sociology of Modern Britain*. Glasgow: Fontana, 1975
2. Wolff S. *Children Under Stress*. Middlesex UK: Penguin Books Ltd, 1973
3. Bowlby J. *The Making and Breaking of Affectional Ties*. London: Tavistock Publications, 1979.
4. Ilg FL, Bates Ames L. *Child Behaviour*. London: Hamish Hamilton, 1972
5. Ray R. The Mentally Handicapped Child's Reaction to Bereavement, *Health Visitor* 1978; 51: 333-334.
6. Lansdown R. *More Than Sympathy*. New York: Tavistock Publications, 1980
7. Herbert M. *Problems of Childhood*. London: Pan Books Ltd, 1977
8. Parkes CM, *Bereavement*. London: Tavistock Publications, 1972.
9. Tuckett D. Social Causes of Disease. In: Tuckett D (ed). *An Introduction to Medical Sociology*. London: Tavistock Publications, 1976.

10. Clarke AM, Clarke ADB. Early Experience. London: Open Books Publications Ltd. 1976
11. Jobling M. Children of Divorce - a review of research. In: Jobling M. Highlight No. 13. London: National Children's Bureau, 1975.
12. Benians R. The Bereaved Child. Maternal and Child Health 1984; 9.1: 4-8.
13. Gorer G. Death, Grief and Mourning, London: Cresset Press, 1965.

We are indebted to the Health Visitors Association for allowing us to reproduce this article from their Journal.

## EXTRACTS

### **Management of the Child with School Referral for Scoliosis**

*From: Paediatric Clinics of North America. Vol. 32, No. 5, October 1985.*

*By: Ben L. Allen Jr., MD, Prof. of Surgery & Paediatrics, University of Texas, Medical Branch, Galveston, Texas.*

Scoliosis screening is becoming more prevalent in American schools and any physician who is involved with children and adolescents can expect to be called upon to assess the needs of the child who has been screened positive. As a result of all this screening the biology of adolescent ideopathic scoliosis is becoming increasingly understood. The article summarises various methods of treating scoliosis and summarises -1 in 40 children screened positive for scoliosis in a school screening programme can be expected to require a brace or surgical treatment, and most will be girls. The remainder can be managed by observation only, until skeletal maturation has been realised.

### **Social and Familial Factors in the Development of Early Childhood Asthma.**

*From: Paediatrics Vol. 75, No. 5, May 1985.*

*By: LL. J. Horwood, B.A., B.Sc., D. M. Fergusson, B.A. Hons and F. T. Shannon, F.R.C.P., F.R.A.C.P. Christchurch Child Development Study, Dept. of Paediatrics, Christchurch Clinical School of Medicine, New Zealand.*

The role of social and familial factors in the development of childhood asthma was studied in a group of children during their first six years of life. It was found that there was no significant association between social and familial factors such as parental smoking, methods of feeding during infancy, keeping of pets and the development of asthma. However, twice as many boys as girls developed asthma early in life and the factors varied between them. Genetically susceptible boys expressed their asthmatic tendencies developing wheeze during infancy and early eczema. It was therefore concluded that asthma in early childhood appeared in some degree to be inherited, its method and age of expression to be related to the child's sex.

## **Effect of Diet and Controlled Exercise on Weight Loss in Obese Children.**

*From: The Journal of Paediatrics Vol. 107, No. 3, September 1985.*

*By: Leonard Epstein, Ph.D., Rena R. Wing, Ph.D., Barbara C. Penner, M.S., Mary Jeanne Kress, B.S., Pittsburgh.*

This article describes a study to evaluate the differing effects of two programmes used in the treatment of obese children, one programme using a regime of diet and exercise and the other using a diet alone.

Twenty two families agreed to participate in this evaluation, each family involved a girl between 8 and 12 years of age, who was approximately 20% over her ideal weight, had no medical problems to contraindicate weight loss, and with at least one parent willing to take part in the programme.

All 20 children completed the initial 8 weeks treatment phase, 20 attended the 6 month follow up, and 19 attended the final assessment at one year.

The two groups received identical information on diet, nutrition, and behaviour management techniques. Children in the exercise group participated in an aerobic exercise session three times weekly for six weeks. The sessions included static aerobics etc for 10 minutes, warming up games, and a 3-mile walk and run. Parents also walked 3 miles three times a week, one session with the therapist, in order to gauge the necessary fitness to keep up with the children. During the maintenance phase, parents walked 3 miles with the children three times a week. Behaviour techniques included: self monitoring, praise and modelling, regular therapist contact, contracting in financial payments. Significant decrease in overweight was observed in both groups, however the children in the diet only group showed decreases only in the 0-2 month period, whilst the children in the other group showed significant weight loss in both 0-2 month period and 2-6 month period, and additionally improved in fitness.

## **SNIPPETS**

### **\* Inventions**

If you have designed an original plaything and have thought about getting a patent, you can send to the address below for a booklet, "Introducing Patents — A Guide for Inventors".

Patents Office, Dept. of Trade, 25 Southampton Buildings, London, WC2A 1AY.

### **\* Social Inventions**

The Institute for Social Inventions is offering £1,000 in prizes for the best social inventions proposed by members of the public.

What is a social invention? A social invention is defined as a new and imaginative solution to a social problem, or way of meeting an unmet social need — for instance, a new social service, a new way for people to relate to each other, a new organisational structure, or a new combination of existing ideas.

The Institute for Social Inventions' address is: 24 Abercorn Place, London, NW8. Telephone: 01-229-7253.

\* **Extending "Lets Play"**

Another addition to the NAHPS "Lets Play" series is in the pipeline. The pamphlet will be compiled from material drawn from a paper written by our president, Susan Harvey, which was presented at the XVIIth World Congress of OMEP (Geneva 1983). The subject is: "children in hospital from different cultural backgrounds".

\* **Adimed Boots and Footwear**

Folowing the query in Newsletter 37 there have been various comments of which the following may be of further interest:—

1. Hard-wearing, attractive to look at and acceptable to children.
2. Can be adapted with caliper socket and velcro fastening, T straps as required.
3. Heel of the boot is narrower than a piedro so the socket may need an extended heel spur, to prevent calipers rubbing against the malleolus.
4. Velcro as a standard fastening would be an advantage.
5. Odd-sized trainers not available, which seems a pity as many handicapped children have feet of differing sizes.

\* **Letter from Mr. Owen McGhee, Elizabeth Fry School, Suffolk Road, London, EC13.**

I have attended a number of wheelchair study days recently, and there appears to be a great divergence of opinion as to how we should teach a child in a wheelchair to cross the road. Many people teach a child to back off the kerb on to the road, my own opinion is that this practice is dangerous on several counts:

- 1) If the kerb is high, there is danger of the wheelchair tipping backward.
- 2) Child cannot see the oncoming traffic with his back to the road.
- 3) Once in the road, the child has to turn round to proceed.

I would welcome comments.

\* Best wishes to Miss Elizabeth Carrington who has gone to work in India. Liz was the original editor of the Newsletter and worked hard for it for many years. She is also well-known for her work on Vibration therapy. We hope that she is very happy in her new post.

## EQUIPMENT

### \* **Tumble Forms Corner Chair**

In an effort to offer the best possible products in the paediatric Tumble Forms line, the Tumble Forms corner chairs have been re-designed. The New Universal Size Corner Chair PC 4590 replaces the PC 4596N Child Size Corner Chair and PAC 4596P Adolescent Size Corner Chair.

Available from: Camp Therapy, Northgate House, Staple Gardens, Winchester, Hampshire, SO23 8ST. Tel: (0962) 55248.

### \* **Jiffie Desk**

Will fit any size of flat arm chair or wheelchair. Attaches with hook and loop fasteners.

### \* **New Tumble Forms Vestibulator**

Includes frame, prone net swing, platform swing, flexidisc, roll swing and mat.

Both the above from Camp Therapy.

### \* **Orthopaedic Bootee**

An ordinary comfortable bootee, with multidirectional hinge underneath allowing adjustment of the forefoot in all three planes, for use in congenital foot deformities.

Bebax, designed and made in France by Inter Axial France. Head Office and Order Dept. Camp Ltd. at the above address.

### \* **Parastand Standing Frame**

A versatile standing frame for children aged 2½ - 11 years.

Ellis Son and Paramore, Spring St. Works, Sheffield.

### \* **Baby Snugglers**

Made of Flectalon, comprising aluminised polymer filaments in a quilted fabric case which reflects 95% body heat. It breathes to allow moisture to pass through, can be washed and sterilised to acceptable hospital standards without damage to the filaments. It is expected the snugglers will be useful for swaddling premature babies and insulating sick infants in transit between hospitals. Developed by physicists at University College, Cardiff, it is hoped that they will go into production next year.

### \* **Paediatric wrist supports** in five sizes, available in left and right hand versions. Easily removed for laundering.

Details:— The Sales Office, Spencer (Banbury) Ltd., Spencer House, Britannia Road, Banbury, Oxfordshire, OX16 8DP.

## HELP WANTED

Lancaster District Special Olympics Committee will hold a major fund raising event in August this year. Eight mentally handicapped people (with staff support) will cycle from Lancaster on August 23rd to Brighton for the opening of the 2nd National Special Olympic Games on the 29th August. Tricycles and bicycles will be used to enable those of less ability to participate. We plan to travel 70 miles a day, which considering the handicaps involved, will be quite a challenge for the participants. Four overnight stops are planned before we reach Sussex University, where all competitors will stay for the duration of the Games. The route will take in Preston, Bolton, Manchester, Nottingham, Leicester, Northampton, Milton Keynes, Reading and Brighton. Overnight stops will hopefully be at Universities en route.

All money raised will be used for Local and National Special Funds to enable the development and promotion of sport and recreational opportunities for the mentally handicapped to be developed, as a means in the positive integration of the handicapped within the community. People are wanted to help distribute and collect sponsor forms in relevant areas, or even offer encouragement by coming out to wave! If you are interested please contact the Editor for further information.

## TOYS

### Cimbala

The cimbala (price £20) arrives in a strong box, ready-tuned and, being strung with piano wire, the strings retain their tuning well. A tuning key is provided, also a plectrum which may be used for plucking the strings instead of using the fingers if wished. (Spare piano wire is also provided.)

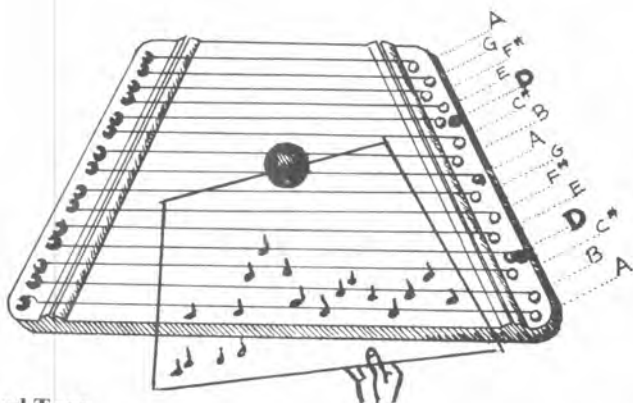
It will fit neatly on your lap or can be placed on a table top.

The music is presented in a dot-to-dot format so that those who have little or no musical background can still enjoy playing tunes straightaway, i.e. a sense of achievement and fulfilment is gained without hours of arduous practice.

A varied set of six cards comes with the instrument. These are slipped in under the strings one at a time and are easily removed and replaced (there is a half inch space between the strings and the sound-box) 16 more sets of music are also available (6 cards in each set at £2.50 per set).

Marouskha, 1 Riverside, Totnes, Devon, TQ9 5JB. Tel: Totnes (0803) 866462.





### Well-designed Toys

The following well designed toys are available from Lego Group, Lego U.K. Ltd., Wrexham, Clwyd, LL13 7TQ.

2024 — Duck Rattle-Teether

2033 — Shape Sorter and building toy

2038 — Bath Activity Toy with removable fish.

### Booklet of Games

John Adams Toys produce a booklet ("Play a waiting game") entirely of games that need no props or movement.

John Adams Toys Limited, Wargrave, Berkshire.

## INFORMATION AND CONTACTS

Youth Department, British Diabetic Association.

Address:— 10 Queen Anne Street, London, W1M 0BD. Tel: 01-323 1521.

Aims: "The department services the education and welfare requirements of diabetic children and young people, together with meeting the demand for information on diabetes in children."

The main functions of the department are:—

1. Two weeks holiday for children aged 5-6, 7-9, 10-12, and 12-15 years\*.
2. One or two week adventure and arts holidays in the U.K. for 13-16, 14-18 and 17-25 year olds.\*
3. Parent/child week-ends (throughout U.K.: September to May).\*
4. Parent/teenager week-ends. (2 per annum).\*
5. Evening meetings for parents of newly-diagnosed children.
6. Updating and improving publications.
7. Foreign penfriends and exchanges.
8. Surveys and written articles re. education of teachers/career officers, residential schools, employment, general services for and rights of children.



9. Information for projects/studies on diabetes in children.
10. Individual advice on careers, welfare, residential schools, travel etc.
11. Liaison with British Paediatric Association (conferences etc.).
12. Conferences for parents (forum for pressure group action).
13. Talks to school children, teachers, hospital staff, B.D.A. branches etc.
14. Implementation of Children's Committee policy (e.g. production of school pack).

\* These events are spread throughout the U.K. and are always attended by adequate numbers of medical, dietetic and lay staff for purposes of supervision and education.

Comments:— A pack of B.D.A. publications relevant to young people would be a useful resource to have on any paediatric unit. They produce posters advertising their holidays, and their publications are always of a high standard. They rely entirely on voluntary contributions and, although many of their publications are free, they would obviously appreciate it if requests for information are accompanied by a donation, at least to cover costs incurred.

## WARNING SIGNS OF INSULIN REACTIONS

From "Babysitter Notes" B.D.A.



Blurred  
vision



Perspiring  
Paleness



Shaky,  
Nervous



Headache,  
Nausea,  
Stomach-  
ache



Changes of mood  
Confusion,  
Irritability,  
Tearfulness

## PUBLICATIONS

Bedford Square Press, National Council for Voluntary Organisations, 26 Bedford Square, London, WC1B 3HU. Tel: 01-636 4066.

Publications listed under the following titles:—

Social Administration/Social Policy  
Voluntary Action/Participation  
Practical Guides

Social Services and Welfare  
Reference  
Local History

National Children's Bureau

Help starts here: for parents of children with special needs

(2nd ed.) London: N.C.B.

(Available from: Book Sales, N.C.B., 8 Wakley Street, London, EC1V 7QE.)

1985 £0.50

Freeman P.

The deaf/blind baby and programme of care

London: Heinemann Medical

1985 £7.95

Ylvisaker M

Head Injury Rehabilitation: children and adolescents

London: Taylor & Francis

(First published by College-Hill Press, San Diego, CA).

1985 £28.00

Gemma

Disabled Gay's Guide.

London: Gemma

(BM Box 5700, London WC1N 3XX. — postage 18p).

£0.30

Hawkrigde D et al (Eds.)

New information technology in the education of disabled children and adults.

London: Crom Helm

1985 £16.95

## AUDIO VISUAL

A Programme for Compassion: Paediatrics in the 80's.

38 slides, 38 minutes. Importance of compassion where care cannot end in cure.

Babies are people too: The making or breaking of early relationships.

66 slides, 23 minutes. Understanding the importance of close sustained relationships.

Both the above by Dr. Janet Goodal, Consultant Paediatrician, North Staffs Hospital Centre, Stoke-on-Trent.

Child Development: The First Year, by Penelope and John Hubley. Text edited by Felicity Savage. 24 slides, 39 minutes.

Origin of these films — Graves Medical Audiovisual Library.

Disabled Living Foundation  
Electric wheelchairs. (Tape/slide programme).

London: D.L.F.

(Can be hired from: Graves Audiovisual Library, Holly House, 220 New London Road, Chelmsford, Essex, for £6 + V.A.T.).  
1985 £37.00 + V.A.T.

## BOOK REVIEWS

### **Arts for Everyone by Anne Pearson — Guidance on Provision for Disabled People. Carnegie U.K. Trust & C.E.H.**

This book is a well illustrated and practical guide to those wishing to provide venues for art exhibitions of all kinds which are accessible to disabled people.

The book is divided into sections dealing with venues — theatres, churches, historic buildings, etc. Technical information, legislation and appendices dealing with definitions of disability, helpful organisations, T.V. & radio, grant-making organisations, technical aids and transport.

Arts for Everyone includes many photographs of improvements which have already been made in public buildings and detailed diagrams showing how other building could provide better facilities. It also points out that such improvements made for the benefit of the physically or visually handicapped and those with hearing impairment can result in much better assembly provision which benefits the whole community. This book includes a great deal of valuable information at a very reasonable price (£6).

I found the lack of page numbers at the beginning of each section annoying in an otherwise extremely useful and informative book.

### **ARTS AND DISABLED PEOPLE — THE ATTENBOROUGH REPORT CARNEGIE UNITED KINGDOM TRUST**

This book is the result of an Inquiry into the provision of Arts for disabled people, conducted by a Committee of Inquiry under the chairmanship of Sir Richard Attenborough. It deals with the availability of all forms of art provision for those suffering from any kind of disability and the ways in which provision can be made to enable the disabled to have access to the arts. It has concerned itself with two principle factors, that the present high unemployment totals include a disproportionately high number of disabled people, and that as people grow older, more are affected by disablement and the ratio of pensioners to working people has risen sharply in recent decades and will continue to do so.

The Report makes a series of specific recommendations to a wide variety of government and national bodies. All the recommendations seem simple and clearly stated and if implemented would vastly improve the chances of disabled people being able to enjoy all forms of artistic pursuits.

The report compliments those Authorities who have transformed cream and grey hospital corridors with humerous murals and signposts, e.g. St. Mary's Hospital, Manchester. The appointment of the Music Advisor to the Disabled Living Foundation is another step forward. On the other hand it was observed that in one new arts building the doorways were deliberately made wide enough for wheelchairs but had to be made narrower again to suit the fire regulations. Provision should also be made for those with impaired vision to touch some art objects on show to the public, while those with impaired hearing can be helped by venues displaying the sympathetic hearing scheme symbol, and by the installation of induction loop facilities in some theatres.

This is a very comprehensive book with useful Appendices and a good index.

### ARTICLES OF INTEREST

Copies of the following articles can be ordered from: Mr. Martin Saunders, Assistant Librarian, National Demonstration Centre, Pinderfields General Hospital, Wakefield, West Yorkshire, WF1 4DG.

Please quote the Bulletin Date, the number of the article and full details of the citation. You will be invoiced at 9p per sheet. Do not send money with order.

#### October, 1985

- (1) Frauman AC Gilman C.  
'Normal' life: a goal for the child with chronic renal failure  
ANNA J 1985 Jun; 12 (3) : 192-5.
- (11) Goldberg RT et al  
Prediction of rehabilitation status for young adults with cystic fibrosis.  
Arch Phys Med Rehabil 1985 Aug; 66(8) : 492-5.
- (24) Stern LM Davey RB  
A team approach with severely burned children in a multi-disciplinary rehabilitation setting.  
Burns Incl Therm Inj 1985 Apr; 11(4) : 281-4.
- (33) Bar Or O  
Physical conditioning in children with cardiorespiratory disease.  
Exerc Sport Sci Rev 1985; 13 : 305-34.
- (37) Breslau N Marshall IA.  
Psychological disturbance in children with physical disabilities: continuity and change in a 5-year follow-up.  
J. Abnorm Child Psychol 1985 Jun; 13 (2) : 199-215.
- (65) Bernhardt DB  
Recreational resources.  
Phys Occup Ther Pediatr 1984 Fall; 4 (3) : 101-10.

## November, 1985

- (19) Hirst M.  
Dependency and family care of young adults with disabilities.  
*Child Care Health Dev* 1985 Jul-Aug; 11 (4) : 241-57.
- (38) Smith NJ  
Handicapped children: sports in chronic illness.  
*Consultant* 1985 Apr; 25 (7) : 123 - 31.
- (39) Graham P  
Handling stress in the handicapped adolescent.  
*Dev Med Child Neurol* 1985 Jun; 27 (3) : 389 - 91.
- (40) Steel KO et al  
The satellite clinic: a model for the treatment of handicapped children in towns and rural areas.  
*Dev Med Child Neurol* 1985 Jun; 27 (3) : 355-63.
- (65) Ohry A et al  
Pediatric traumatic spinal cord injuries in Israel.  
*Isr J Med Sci* 1985 Jun; 21 (6) : 526-8.
- (68) O'Brien K Wit S  
A return-to-school programme for the burned child  
*J Burn Care Rehabil* 1985 Mar-Apr; 6 (2) : 108-11
- (77) Bice Tr et al  
Preparing blind and visually-impaired youth for a technocratic-information world of work  
*J Rehabil* 1985 Apr-Jun; 51 (2) : 65-8.
- (83) Kosowski MM Sopczyk DL.  
Feeding hospitalized children with developmental disabilities  
*MCN* 1985 May-Jun; 10 (3) : 190-4
- (86) Reid-Campion MJ  
The person comes first: Conductive Education for young and old  
*NZ J Physiother* 1985 Apr; 13 (1) : 21-2
- (94) Smith LH Harris SR  
Upper extremity inhibitive casting for a child with cerebral palsy  
*Phys Occup Ther Pediatr* 1985 Spring; 5 (1) : 71-9
- (98) Pandya S et al  
Reliability of goniometric measurements in patients with Duchenne muscular dystrophy  
*Phys Ther* 1985 Sep; 65 (9) : 1339-42
- (113) Kohen MD  
Educational and exercise programmes for asthmatic children  
*South Med J* 1985 Aug; 78 (8) : 948-50

## December 1985

- (24) Newton P et al  
Rehabilitation of the Disabled Adolescent: experience with a local authority assessment centre.  
*Br. Med J (Clin Res)* 1985 Aug 24; 291 (6494) : 521-4

- (28) Tew N. Laurence K.M.  
Possible personality problems among 10 year old spina-bifida children.  
Child Care Health Dev 1985 Nov-Dec; 11 (6) : 375-90
- (35) Stewart-Brown S. et al  
Educational attainments of 10 year old children, with treated and untreated visual defects.  
Dev. Med. Child Neurol 1985 Aug 27 (4) : 504-13
- (42) Kaslon KW Stein RE  
Chronic paediatric tracheotomy: assessment and implications for habilitation of voice, speech and language in young children.  
Int J. Paediatr Otorhinolaryngol 1985 Jul; 9 (2) : 165-71
- (64) Issenman J et al  
Transcutaneous electrical nerve stimulation for pain control after spinal fusion with Harrington rods: a clinical report.  
Phys Ther 1985 Oct: 65 (10) : 1496-500
- (73) Appel SE  
Infant stimulation of the handicapped child in a hospital setting.  
Rehabil Nurs 1985 Sep-Oct 10 (5) : 20-1

## COURSE DIARY

**1986**

**February 8th**

Developmental Delay in the Pre-School Child - for details see below -. Richmond Park School, Glasgow. Application forms from:— Mrs. E. Hazelwood, MCSP, Physiotherapy Dept., Royal Hosp. for Sick Children, Edinburgh. Course fee inc. lunch £15 members, £16 non-members.

**February 13th**

Child and Adult Muscle Disease. Details Mrs. B. Hindley, Higher Clerical Officer, Rehabilitation Unit, Withington Hospital, Nell Lane, Manchester, M20 8LR. 061-447-3409. (Price: on application)

**February 18th-19th**

Exhibition of Technical Aids in Communication. Robens Suite, Tower Block, Guy's Hospital, London, SE1. (Details: The Secretary, National Hospitals College of Speech Sciences, 84a Heath Street, London NW3 1DN) (Price: on application).

**February 27th**

Paediatric Physiotherapy - Handling the Handicapped. Details: Mrs. B. Hindley, Higher Clerical Officer, Rehabilitation Unit, Withington Hospital, Nell Lane, Manchester, M20 8LR. 061-447-3409. (Price: on application)

**March 3rd**

Ankle-Foot Orthoses for the management of the Cerebral Palsy Child (Seminar). Details: Prof. J. Hughes, Director N.C.T.E.P.O. Univ. of Strathclyde, Curran Building, 131, St. James Road, Glasgow G4 0LS. Quote NC715. Price £10.

**April 26th**

The Clumsy Child. The Victoria Hospital, Kirkcaldy, Fife. Applications from: Mrs. E. Hazlewood, Physiotherapy Dept., Royal Hospital for Sick Children, Edinburgh.

**May 7th, 8th, 9th**

The Management of Cerebral Palsy (0-19 years). — Sophie Levitt — Physiotherapy Dept., Doncaster Royal Infirmary, Armthorpe Road, Doncaster. Applications to: Mrs. D. Raper at the above address. Course Fee £60.

**March 8th \***

A New Challenge-Therapies available for treating the Multiply Handicapped Child. Springwater School, Hartlepool. Applications to: Mrs. Sue Norton, 12 Kings Gardens, Leeds LS17 6PB. Fee: Members £6.50. Non-members £8.

## COURSE DETAILS

**February 8th**

**Developmental Delay in the Pre-School Child.** The course will cover the causes, identification, assessment and some treatment techniques for 0-3 year old children with motor problems. Lectures and practical demonstrations by Jenny Bryce of the Bobath Center, Morag Booth from Aberdeen, Dr. McWilliams, Consultant Paediatric Neurologist.

**April 26th**

**The Clumsy Child.** Speakers include Miss Ann Grimley, Miss Trish Gavin O. T. and Dr. C. R. Steer, Consultant Paediatrician.

**May 7th - 9th**

**The Management of cerebral palsy 0-19 years. Day 1.** Seminar with Sophie Levitt. Defining the motor problems, creating a framework for assessment and therapy; role of therapists, child care staff and parents in treatment programmes; child development.

**Day 2.** Assessment and treatment planning. Morning - Demonstrations - Sophie Levitt. Afternoon: Assessments by students on the course/2 students per child. Case presentation by students.

**Day 3.** Techniques and Equipment. Babies, pre-school, school age children and adolescents. Demonstration. Case discussions. Solving the motor problems with techniques and equipment.

## WANTED

### **Superintendent 111 Physiotherapist, Paediatric Physiotherapy Service, Cambridge Health Authority.**

An informal invitation to all interested physiotherapists to consider the above post, is being extended because previous suitable applicants have withdrawn owing to personal circumstances. We are looking for someone with flair and enthusiasm to co-ordinate and develop our paediatric service, and to care for a small number of mentally handicapped adults. We are in the process of integrating services provided by Special and mainstream schools and the Child Development Centre, together with the Ida Darwin Hospital for the Mentally Handicapped. There is an excellent multi-disciplinary team in which physiotherapy plays a major part. The purpose built Child Development Centre acts as a focus for the team and provides comprehensive treatment facilities for children alongside the services from Addenbrookes Hospital.

Physiotherapy Staff are involved in teaching to all disciplines and staff development is encouraged by all forms of post registration education.

If you think you have the qualities for the leader of our team, and would like to meet us, we shall be happy to arrange it.

Initial enquiries to : Miss Brenda Samuels, District Physiotherapist, Chesterton Hospital, Union Lane, Cambridge CB4 1PT. Tel. Cambridge (0223) 63415 Ext. 265.

## REGIONAL REPORTS

**East Anglia** Reg. Rep. Mrs. L. Weekes, 37 The Cedars, Milton Road, Harpenden, Herts. AL5 5LQ.

There will be a Study Day on Thursday April 17th 1986 1.30 p.m. - 4.30 p.m. at Harper House, Harperbury Hospital, Harper Lane, Radlett, Herts., on Laban analysis of movement considered in relation to the mentally subnormal, referring to a case study on Downs Syndrome Child.

Cost £2.50 APCP members £3 non-members.

Closing date for applications - March 31 1986 - to:— Mrs. L. Weekes MCSP Physiotherapy Dept. Harperbury Hospital. Numbers limited to 30 people. Please note change of Regional Representative.

**London** Reg. Rep. Miss Fiona Graham, 27 Vardens Road, London SW11

Our next Study day will be on March 1 at The Hospital for Sick Children, Great Ormond Street, London WC1. The subject will be the "Management of the Mentally Handicapped Child and the required Family Support". Our A.G.M. will take place at 12 p.m.



**South West** **Reg. Rep. Miss Gillian Riley, "Meadows", Bower Chalke, Salisbury, Wilts.**

Plans are in hand for a Study Day in the Spring. The subject will be Neonates - and will be held in Plymouth probably in early March. The Autumn Study Day is also being projected - probably on Seating and availability in the South West Region. Venue to be decided.

**North East** **Reg. Rep. Mrs. Elizabeth Barron, Sandy Lane, Ripon, North Yorks.**

A successful Day Course on Orthopaedic Management of the Handicapped Child, was held in Bradford in October. Orthopaedic Surgeons from Sheffield, Leeds and Great Ormond Street Hospitals, and a Remedial Gymnast from Gt. Ormond St. spoke on the treatment of the Foot, Back and Hips. At our evening lecture in Leeds in November, a Speech Therapist spoke on Feeding problems of the Handicapped Child.

Our next meeting 'Childrens Special Needs' - The new Challenge - will be held in March '86 at Springwater School, Hartlepool. It will be organised by Mr. E. Anderson, and Mrs. Orritt. The Course will cover the different therapies available for the treatment of severely multiply handicapped children. This meeting will include the A.G.M.

**Scotland** **Reg. Rep. Mrs. E. Breckenridge, 19 Langside Drive, Newlands, Glasgow C43 2EP.**

The Scottish Committee is now formally structured and it is intended that a Constitution should be drawn up, following closely the National Committee but taking into account local needs. At present there are seven members of the Committee, but provision will be made to allow up to ten members if necessary. The aim is to attempt to cover the whole of Scotland as far as is practical.

Office Bearers.

Chairman: Mrs. E. Breckenridge. Secretary: Miss M. Grant. Treasurer: Mrs. A. Lyon. Committee Members: Miss M. Booth, Miss E. Bell, Mrs. E. Hazlewood, Mrs. A. Watson.

Study Days.

The Study Day on Developmental Delay has been postponed until January because it was not possible to contact the main speakers until October. The Clumsy Child Study Day will be held in April, and Temple Fay and Vibration will be held in June. The Study Day on Developmental Delay will be held in Glasgow, the one on the Clumsy Child in Fife and Temple Fay and Vibration in Edinburgh.

**Post Registration Validated Paediatric Course.**

It was felt by the Scottish Committee that time was too short to organise this course to commence in May 1986 and it has been

suggested that it could either commence in September 1986 or early May 1987. It is hoped that this course will be held between two centres i.e. Glasgow and Edinburgh, and overtures are being made to both Health Boards and to the main Paediatric Centres in Scotland.

**South East** **Reg. Rep. Mrs. Shirley Raymond, 58 Gates Green Road, West Wickham, Kent.**

The South East region is delighted to be host for this years Annual Conference. We are offering a full and varied programme, and we look forward to welcoming you to the beautiful city of Canterbury for an enjoyable and informative week-end. Late applications should be sent to Miss C. Young, Supt. Physiotherapist, Royal Alexandra Hospital for Sick Children, Dykes Road, Brighton.

There will be only one other Study Day this year, in October, we plan a lecture on 'The problems and rewards of working in an underdeveloped country' - if our members can be persuaded to return from Fiji!

**North West** **Reg. Rep. Mrs. K. Jones, 66 Mellor Brow, Mellor, Blackburn, Lancs.**

The regions A.G.M. has been organised for February 15 at 9.30 a.m. at Dorins Park School, Chester. The programme includes a study on Spina Bifida and it is hoped that the studies will not be interrupted for long by the necessary business of the A.G.M.

The Study Day at Rochester in October on the Adolescent Knee was very interesting and successful, the Supt. Physiotherapist taught the group how to assess and treat teenage knees. The exercise programme concentrated on work within a pain free range of movement.

**West Midlands** **'Introduction to Paediatric Physiotherapy' APCP Validated Course.**

We will be running the above course, primarily for physiotherapists in the West Midlands Region, in conjunction with the Wolverhampton School of Physiotherapy.

This course follows directly from the C.S.P. Validated course run in the North West Region in 1984, for Physiotherapists and Senior 11 physiotherapist. The dates will be from October 1986 to March 1987 when there will be blocks of lectures, practical work and private study. Details will appear in 'Physiotherapy' and the APCP Newsletter. Any enquiries will be welcome and may be made to the course organiser:— Mrs. Mary Clegg MCSP, Deputy Spokesman, Post Registration Education (APCP) Supt. Physiotherapist, Childrens Unit, Wordsley Hospital, Wordsley, West Midlands.

## Wales

**Reg. Rep. Mrs. V. Williams, 5 Larch Grove, Lisvane, Cardiff.**  
The Day Course 'Problem solving in Cerebral Palsy' with Colin Stevens, was over subscribed and a tremendous success, it included demonstrations and discussion on the older child and surgery.

Courses are planned for 1986 as follows:— 'The Paediatric Therapist and Bereavement' on January 23rd, a workshop led by Dr. Mike Shooter.

March 11/12/13 at Duffryn House "The Bobath Approach", an introduction to the treatment of Cerebral Palsy Children.

May 17/18 Workshop on Behaviour Modification.

We hope to hold the postponed course "The Therapist and the Teacher in the management of the visually handicapped child" when the current dispute is settled.

## Midlands & Trent

**Reg. Rep. Mrs. M. Tarry, The Mullions, Peatling Parva, Lutterworth, Leics.**

There is to be a course on the Clumsy Child, in Lincoln in May — see course programme — and one on Cardio-Thoracic Surgery, in Birmingham in February. We had an exceptionally well run course at the beginning of November last, tutored by Jenny Bryce. Congratulations to Ruth Williams OT and Judy Normal, physiotherapist, for superb organisation. We also had a well attended evening meeting in Sheffield on Paediatric Intensive Care. The A.G.M. will be held on March 10th at 6.30 p.m., followed by a buffet at 7.30 p.m. The lecture will be on Perinatal Care.

## COME TO LANCASHIRE

Interesting, stimulating, Paediatric post available end of March in Burnley, Lancashire. Join a small team of enthusiastic Physiotherapists whose work includes wards, out-patients, physical handicap, school community etc.

Ask for more details from:—

Mrs. Margaret Jones, Superintendent Physiotherapist,  
Burnley 25071 or Nelson 602754 — work.  
Padiham 72327 — Home.

## Further Course Details

### 20th February.

Play and Recreation for Handicapped Children. (Half-day: p.m.).

(Details: The Secretary, National Demonstration Centre, Pinderfields General Hospital, Wakefield, WF1 4DG. Tel: 375217 ext. 2510).

Price: £7.50.

### 11th April

Applied Technology for Physically Disabled Adults (and Children).  
Littlewood Hall, Leeds General Infirmary.

(Details: Mrs. J. Packter, Rheumatism Research Unit, 36 Clarendon Road, Leeds 2).

Price: on application.

#### **14th - 16th April**

Introductory Conductive Education.

(Details: The Secretary, Exeter Demonstration Centre, Royal Devon & Exeter Hospital (Heavitree), Gladstone Road, Exeter EX1 2ED. Tel: 0392 77991.)

Price: on application.

#### **15th - 17th April**

The Computer as an Aid for those with Special Needs.

(Details: Conference Secretary, ACTIVE, Sheffield City Polytechnic, 37 Broomgrove Road, Sheffield, S10 2BP. Tel: 0742 665274 ext. 3360.)

Price: on application.

#### **23rd - 25th April**

Spina Bifida and Hydrocephalus.

(Details: Mr. A. E. MacKinnon, The Children's Hospital, Western Bank, Sheffield, S10 2TH.)

Price: on application.

#### **25th - 27th April**

Teaching the Child with Cerebral Palsy to use the Hand.

(Details: Mrs. J. W. Knowles, Principal, Castle Priory College, Thames Street, Wallingford, Oxon, OX10 OHE. Tel: 0491 37551.)

Price: £47 (+ 40 residence).

## **COURSE PROGRAMME**

### **May 10th 1986 — "The Clumsy Child".**

Learning and Movement problems of the child in mainstream education.

- 9.0 Registration.  
9.30 Introduction by Chairman.  
9.45 - Philosophy and Approach to Problem Identification and Assessment —  
11.15 —  
a) by Physiotherapist — Ann Grimley.  
b) by Occupational Therapist — Gay Hall.  
11.15 - Coffee.  
11.30.  
11.15 - Gross Motor Activities — Ann Grimley.  
12.30  
12.30 - LUNCH  
1.30  
1.30 - Fine Motor Skills — Gay Hall.  
2.00  
2.00 - Writing specifics — Gay Hall.  
3.00  
3.00 - Play Time student participation — Ann Grimley.  
3.30

3.30 - Questions and depart. Tea.

4.0

This Study Day is for physiotherapists, occupational therapists and teachers, and will be held in the Physiotherapy Dept., St. Georges Hospital, Lincoln. Details from:— Mrs. M. C. Hogarth, St. Frances School, Wickenby Crescent, Lincoln.

### **Paediatric Cardiothoracic Surgery**

February 15th 1986, at the Post Graduate Centre, Birmingham Childrens Hospital.

Speakers:— Dr. E. Silove, Dr. J. Beesley, Mr. L. Abrams, Sister Barton, Miss A. Clewes MCSP.

Time: 9 a.m. Coffee and registration. Cost (including lunch £10 members, £12.50 non-members).

Further information may be obtained from — Mrs. M. Moore, Victoria School, Belhill, Northfield, Birmingham B31 1LD to whom postal applications together with course fee should be sent by January 31st 1986.

