Current Practice

CHILD CARE IN GENERAL PRACTICE

Emotional and Behavioural Disorders: Part I

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Introduction

If only our babies and children could discuss with us their troubles. The infant changed from breast-feeding to the bottle might demand to know why he has to break the habits of a life-time. The toddler experimenting with independence would ask why adults encourage him to stand up physically, but not for his rights. The young schoolchild would complain of the incessantly changing demands imposed by a world of giants and dictators, which he does not understand but to which he is expected to submit.

Though the child has no words to express his difficulties, they are reflected in his actions and his behaviour. It is our responsibility to interpret them. Not to do so may make his path unnecessarily rough; to do so may ease it—not by attempting to abolish all the rough patches, but by smoothing them where necessary so that he will not be injured in getting over them. A child who never had any emotional or behavioural problems would be abnormal. All children are expected to have some, but if they are excessive or persistent the doctor has to consider whether there are harmful factors that could be minimized with his help.

Mothers and fathers nowadays are perplexed about rearing their children. In the past parents were nearly always confident, even if they were sometimes mistaken; now they seem to have lost their confidence and feel they are usually wrong. If "children are no longer pock-marked but Spock-marked" it is because parents, having lost their reliance on family traditions, are turning increasingly to the medical profession for advice about their children's upbringing and deviations from what is expected. Doctors can hardly refuse to accept their new responsibility, but they need to prepare themselves to discharge it well.

More and more children who are now brought for medical advice are suffering not from physical but from emotional and behavioural disturbances. In consequence, the generations of practising doctors who were taught almost exclusively about "hospital diseases" have to teach themselves to deal with many disorders for which they were not prepared. What they learn the hard way, from experience with their own families as well as with those of their patients, will be incomplete or even misleading; they will wish to broaden their understanding by reading and discussion if they are to keep abreast of the discoveries in psychology that are continually being incorporated into general medicine. (Introductory reading is suggested in the bibliography.) Common sense is very helpful, but it is not a satisfactory substitute for informed knowledge.

What follows here is not a "potted psychology" but a brief account of emotional and behavioural problems which the family doctor is likely to be asked about. If he takes an interest he should be able to deal safely and satisfactorily with most of them. What is more, by taking an interest he will be the

better able to recognize those for which specialist advice should be sought. This group includes the children who are seriously disturbed (two important questions to answer here are: "Has their mental development been slowed or arrested?" and "Are they making normal relationships?"), those whose problems he does not understand, and those not responding to his management. It includes also those children whose parents are seriously disturbed and those whose parents make the doctor feel unsympathetic or angry.

I have divided this discussion on emotional and behavioural disorders into three parts: in the first are discussed tics; thumb-sucking; nail-biting; head-rolling and banging, and rocking; and masturbation. The second part deals with disorders of sleep and appetite; and the delicate child. The third part covers shyness, timidity, and fears; jealousy; temper and tantrums; aggressiveness; and learning difficulties.

A few general remarks apply throughout. Attention to the presenting symptom alone is not enough; the doctor has to broaden his perspective to include the whole child, and the whole child in the context of environment and family. In all the disturbances described information about the family is essential, for the child's behaviour is often a barometer that indicates the family emotional climate. The disorders of the whole child are complex, and, both in diagnosis and management, the approach should accordingly be broad and multifactorial. In management the doctor will be more successful if he prefers discussion to drugs and offers advice for the parents rather than a prescription for the child.

Tics

A tic can be reproduced deliberately by the "tiqueur"—or by his imitative schoolmates. This is because a tic is a movement performed by a group of muscles which normally act together; it is a tic when it is purposeless and involuntary. The movement may be deliberately inhibited, but once started it cannot be interrupted. Unlike chorea, it affects only one group of muscles, or a very few groups. Tics become more obvious with emotional stress; they are less marked if the child's attention is distracted; and they do not occur during sleep. The performance of other movements is unaffected, and there are no other abnormalities of muscle function or tone. By these features tics can be distinguished from chorea and athetosis and other rare disorders of the nervous system.

A tic is not a disease in itself: it is a sign of underlying disturbance. It is the motor expression of psychological tension occurring in certain predisposed individuals. The tic occasionally persists for years, even into adult life, but usually it clears up after some months, and is the more likely to do so quickly if the underlying emotional tension is relieved.

Tics occur in children of average intelligence, and in boys more often than girls. Blinking, winking, tossing the head, shrugging the shoulders, or jerking an arm or hand are the commonest forms, either singly or in combination.

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Precipitating Factors.—Sometimes an immediate precipitating cause is discovered, such as blinking after conjunctivitis; here, a movement which was originally purposeful has become meaningless. But usually no precipitating cause is apparent, and in many tiqueurs evidence of emotional disturbance precedes the onset of the tic. If the very rare lesions of the central nervous system are excluded it is helpful to start from the basis that in secure, well-adjusted children tics rarely develop and never persist. There is some underlying emotional tension, though patience and care may be necessary to unearth it.

The Family.—There are tiqueur families, but, even where the child is the only one with a tic, a high proportion of parents are morbidly anxious or suffer from a psychological illness. The conclusion is obvious—the family, as well as the child, needs attention.

The Child.—A careful and complete clinical examination is essential, if only to rule out such disorders as chorea and athetosis. A careful history is equally important. It will usually reveal that the child has long been excitable and “highly strung,” and it will elicit other evidence of emotional tension and anxiety—for example, bad dreams, temper tantrums, abnormal behaviour, undue fears, inattention, lack of concentration. The doctor will need to probe sympathetically into the intimate details of the child’s day-to-day life, at home and at school.

Treatment.—The child with a tic should not be shamed, ridiculed, or punished for it. In the large majority of cases, where the tic is mild and where the child is not seriously disturbed emotionally, I do not consider that formal treatment is indicated. The child is in a phase of adjustment, and with sympathy and the modification of excessive strains the disturbance and the tic will pass off. The few children whose tic is grotesque and becoming worse, or in whom there are obvious signs of emotional disturbance, need prompt treatment by a paediatrician or child psychiatrist. In intermediate cases the family doctor must decide whether he has the psychological understanding—and the time and patience—to unravel and deal with the problem. If not it is prudent to refer the child, early rather than late, for skilled assistance.

It is a mistake to fob off the parents with reassurance that does not reassure, or to prescribe drugs (such as phenobarbitone) which at best do no more than put a smoke-screen over the underlying disturbance.

Thumb-sucking

Babies need to suck. After the first few minutes at the breast their satisfaction must be largely due to sucking rather than to obtaining milk, and, probably because they had less opportunity for sucking, thumb-sucking is commoner among children who were bottle-fed in infancy.

Thumb-sucking, finger-sucking, dummy-sucking: what is all the fuss about? The notion that they are harmful is comparatively recent. Is it due to the Freudian teaching that thumb-sucking is a sexual activity? The claims that thumb-sucking leads to all sorts of disorders, including colic and scoliosis in childhood and alcoholism and perversions in adults, have now been abandoned. The belief that it distorts the growth of the teeth is being modified. With persistent thumb- or finger-sucking in the first few years the upper teeth may be pushed out and the lower teeth pushed in. But the jaw structure is not permanently affected, and, unless the habit persists after the sixth year, the permanent teeth are not crooked when they erupt.

Many babies and children suck their thumbs at times, particularly when they are falling off to sleep. Nearly all of them gradually lose the habit spontaneously, with temporary relapses that may be associated with boredom, illness, or insecurity. After the age of 5 or 6 it is rarely more than occasional.

Violent efforts to stop thumb-sucking are more likely than the habit itself to do harm. Neither physical device (“rakes” on the teeth or bitter aloes on the fingers) nor mental torture (nagging or ridiculing) is advisable or effective. After the age of 5 or 6 the child will almost certainly stop by himself—an occasional lapse is of no importance—and will be encouraged to do so when he understands that he is becoming too grown up to do what little babies do.

Nail-biting

The mother of an enuretic child told me: “His father is always at the boy to stop biting his nails, but he’s biting his own while he’s telling him.” This mother herself used to bite her nails, and a grandparent on each side of the family still does. So nail-biting is another of the many habits that run in families, and may be due to imitation.

More than half the school population bite their finger-nails occasionally or frequently, and some of the more acrobatic bite their toe-nails. Because so many children have this habit it cannot by itself be a sign of significant emotional disorder. Nevertheless, nail-biting may increase when the child feels worried or insecure, or when he is bored and has nothing else to do.

Though it worries the parents, and is not aesthetically pleasing, nail-biting is not serious and drastic treatments are out of place. Ridicule, criticism, and punishment are likely to do more harm than good. Painting the nails with nasty-tasting substances seems often to increase the enjoyment of nibbling once the paint has been licked off. When he is biting his nails vigorously the child’s attention may usefully be distracted; and if he is tense or worried the causes of these emotional states deserve attention. If no fuss is made he will almost certainly abandon the habit when he is encouraged to feel grown up and begins to take a pride in his appearance.

Head-rolling and Banging, and Rocking

Towards the end of the first year many infants begin to roll the head from side to side, or to bang it rhythmically on part of the cot, or to rock backwards and forwards on their arms and knees. These movements occur particularly before they fall asleep. Some infants rub off their hair, others bruise themselves, and the more violent may break the bars of the cot or jerk it across the room.

Such rhythmical movements seem to soothe and give satisfaction. By analogy with adults, who tap their fingers on a desk or cross their knees and swing a foot, they may relieve tension.

If the parents fear that the child is masturbating or is mentally defective they can be reassured. The doctor will need to ask himself the crucial questions: “Is the child making good relationships, and is his general mental development proceeding evenly and at its previous rate?” If not, a specialist’s opinion should be sought. It will help the parents to know that most children lose the habit by the second or third birthday, though, if general development is satisfactory, no harm will come of it if it persists longer. One of my most effective ploys is to quote the story of a very successful West Country general practitioner who still bangs his head while asleep in bed after an exasperating day with his patients—so his wife says.

Phenobarbitone is often prescribed, but, like other drugs, it is useless. The movements can be made as harmless as possible for the child by padding the inside of the cot. They can be made less obtrusive and disturbing for the parents by padding the castors and outside of the cot. A sailor father achieved both these objectives together by slinging a hammock for his child.

Masturbation

In contrast to other topics in this section masturbation is one which parents are embarrassed to broach and which both they and the doctor often find particularly difficult to discuss. In consequence, some misdiagnoses are made, and management is too frequently at fault. If a subject beset with taboos is avoided the parents are left floundering. If the doctor dismisses it with a breezy, "It doesn't matter; everyone does it," they will feel rebuffed and antagonized. He will probably find that he can be most helpful by discussing it factually and calmly in the context of normal development.

He may start by describing the normal impulse of the infant to explore. One way in which the small child learns is by handling anything within reach, including parts of his body, and he cannot be expected to attach any special significance to the genitalia. As the child gets older some pleasure is normally experienced when the genitalia are touched or rubbed, and he may learn to do this purposely. Nothing in this is abnormal or perverted. If no attention is paid it will, in almost every instance, occur less frequently and later cease. It is generally agreed that children obtain pleasure by stimulation of the genitalia, and that many masturbate to some extent, either by pressure from the thighs or the hands. This is so common as to be a normal phase in development. It is not sinful, and it is harmless to healthy development.

Nothing need be done about the child who masturbates occasionally, and the parents should do their best to accept the fact that their child is as normal as anybody else's and will

grow up healthy. (It is extremely rare for the child to indulge in frequent, compulsive, or uncontrollable masturbation; if he does it will be an expression of real psychological difficulty, and specialized treatment will be necessary.) The parents' fears should be ventilated and discussed. Their feelings of disapproval and disgust are usually compounded of religious, moral, and cultural attitudes, with a flavour of medical mythology. Many disorders have been attributed to masturbation in the past—including acne, prostate enlargement, epilepsy, and psychosis. It should be agreed that, though the child's actions are based on natural impulses, they do not meet with approval and are certainly not to be encouraged; but thrusting a burden of depravity and guilt on his shoulders will not help him when he is in difficulty. The parents may suggest sending the child away from home, thrashing, drugging, or circumcising him. To all this the doctor's reply is to explain, time and again if need be, that the child is like other children and will grow up healthy and normal.

(The second part of this article will appear in next week's issue.)

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ANY QUESTIONS?

We publish below a selection of questions and answers of general interest.

Cyanocobalamin by Inhalation

Q.—Can cyanocobalamin be administered in the form of snuff or as an aerosol in the treatment of pernicious anaemia?

A.—The use of cyanocobalamin by inhalation for the treatment of pernicious anaemia was suggested by Monto, Rebuck, and Brennan.¹ They treated three patients. Two were given crystalline vitamin B₁₂ in saline solution by means of a nebulizer and the third patient was given the drug in a base of lactose powder by means of an inhaler. A satisfactory clinical and haematological response was obtained in all three patients.

In a subsequent paper Monto and Rebuck² reported further satisfactory experience with this method of treatment both for patients in relapse and for maintenance therapy in patients in remission. In this country Israëls and Shubert³ obtained similar results. They used cyanocobalamin in the form of a snuff which was made up in capsules each containing 100 µg. of vitamin B₁₂ in a non-irritant powder, and the method of administration was by a simple insufflator. A few vigorous puffs blow the powder into the nose while the patient breathes deeply, so that it is inhaled into the lungs and the active drug is absorbed via the pulmonary capillaries. There have been no reports of sensitization or toxic effects from this treatment.

It is clear, therefore, that this is an effective way of administering cyanocobalamin, except for patients with nasal obstruction or pulmonary disease, and it is an alternative route for those who object to intramuscular injections.

The doses required are of the same order as those given by the intramuscular route and treatment is relatively inexpensive. From the reported results there seems to be no reason why this method should not be satisfactory for prolonged maintenance therapy. But I do not know of any instances in which inhalational therapy has been used for more than 18 months, and if the method were to be adopted careful haematological control would be essential.

REFERENCES

- ¹ Monto, R. W., Rebuck, J. W., and Brennan, M. J., *Amer. J. med. Sci.*, 1953, **225**, 113.
² ——— *Arch. intern. Med.*, 1954, **93**, 219.
³ Israëls, M. C. G., and Shubert, S., *Lancet*, 1954, **1**, 341.

Vi Reaction in Typhoid

Q.—What is the characteristic Vi reaction response in typhoid fever, and has any association been noted between the Vi titres and subsequent clinical relapses? Is the Vi reaction accepted as an accurate screening test for typhoid carriers or do other salmonella organisms and shigella organisms also cause a rise in titre?

A.—The typhoid Vi (T.Vi) agglutinin usually appears late in typhoid fever and may not appear at all. It rarely exceeds 1:80 but may on occasion reach much higher levels. Its persistence during convalescence, especially in static or rising titre, may indicate that the carrier state is being established. I do not know of a significant association between T.Vi titres and clinical relapse.

Opinions vary as to the value of T.Vi agglutination as a screening test for typhoid carriers. Felix¹ claimed that it detected about 90% of chronic carriers, but other workers have been less optimistic about its value, because they have encountered too high a proportion of false-positive reactions. There is no doubt that the test needs to be reassessed in whatever country it is being employed in.

In the United Kingdom, where the incidence of typhoid fever is low, a positive T.Vi agglutination rarely occurs in the absence of infection,² so that it is a reasonable screening test for the chronic carrier state. In countries of high typhoid endemicity, in contrast, experience of the typhoid bacillus in the population at large may be so general as to give a high proportion of positive T.Vi agglutination tests in the absence of demonstrable infection.³

Salmonellae or coliform organisms other than *S. typhi* may possess the Vi antigen, and it has been suggested that such organisms may be responsible for some false-positive T.Vi reactions.

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- ¹ Felix, A., *Brit. med. Bull.*, 1951, **7**, 153.
² *J. Hyg. (Lond.)*, 1961, **59**, 231.
³ Miller, W. S., *J. Egypt. publ. Hlth Ass.*, 1950, **25**, 45.

Dosage of A.T.S.

Q.—What is the optimum dosage of A.T.S. in the treatment of tetanus?

A.—It was only in 1960 that satisfactory evidence from West Africa and the West Indies was obtained about the value of tetanus antitoxin (A.T.S.) for the treatment as opposed to prevention of tetanus in man.¹ In this investigation each patient was given a large dose (200,000 units) of A.T.S. and this was shown to be beneficial. Sanders,²