Current Practice

CHILD CARE IN GENERAL PRACTICE

Emotional and Behavioural Disorders: Part III

JOHN APLEY,* M.D., F.R.C.P.

Shyness, Timidity, and Fears

Shyness represents a normal and often attractive stage of development through which most children pass without too much trouble. It starts as a rule at five or six months of age, when the infant begins to differentiate one person from another and to appreciate that some are strangers.

The element of reserve towards persons he does not know is understandable and should be respected—hence the indirect approach, usually through the mother, of doctors who “get on well with children.” There is probably also an element of fear in shyness, and it is likely to be exaggerated when a child is ridiculed or forced into situations which he finds unfamiliar or difficult. To point and say even, “Look at him, he’s being shy,” may create an agony of embarrassment which is surely unnecessary and does not help.

Almost every child can outgrow excessive shyness if he is neither thrown in at the deep end nor isolated and over-protected. When shyness becomes excessive, even pathological, probably as a result of mishandling and conditioning, the element of fear has come to play a large part.

Some fears—of pain, sudden movements, loud noises—are normal even in babies, but most fears develop later. They are learned from others, but need not be.

To be afraid on appropriate occasions is a healthy, temporary reaction which is necessary for protection against real dangers. To be timid or fearful is an unhealthy state of mind in which the individual is permanently afraid of what he imagines may threaten him. The borderline between the two is not always clear, but in crossing it the child is susceptible to many influences.

Many children pass through a phase when they fear darkness, desertion, isolation, animals, or machinery. The fears are likely to persist in the imaginative, the insecure, or the threatened, in the over-protected or the over-exposed. Imitation and conditioning play a part, for fear, like courage, is contagious. If the child has many or undue fears other behavioural disorders are often associated. Prevention is easier than cure.

The child with fears should not and cannot be bullied into bravery. If he fears the dark he should be given sympathy and a light. Ridicule and punishment are dangerous weapons that condemn the users. Most fears can be outgrown or tolerated if the child receives understanding and is actively helped in the gradual task of building up his self-confidence. The doctor can be of most use through discussion with the parents, particularly by offering advice regarding their own attitudes and by putting the fears in perspective.

Jealousy

The “artless jealousy” of the child, though it is a normal reaction and may be a source of amusement, should not be

allowed to get out of hand. Jealousy, which implies a desire to monopolize, can lead to real unhappiness and difficulties in social adaptation. Within one family it has many possible permutations in which grandparents, parents, nanny, and children may be involved. Its exaggerated forms can be prevented or avoided if the adults, at least, understand the problems and are willing to discuss them.

Jealousy is commonest in the first child, when his undisputed reign is threatened by the arrival of another child, and in twins, especially when adults are always making invidious comparisons. It is likely to be exaggerated in the child who has been over-protected, or in one whose parents do not get on well together, indulge in favouritism, or, as a disciplinary measure, use the threat of leaving the child.

Jealousy does not always show itself by physical violence directed towards the rival. The child who feels himself slighted may revert to infantile behaviour, as shown by thumb-sucking, clinging to the mother, or bed-wetting. He may withdraw into himself, sulk, or lose interest in school work. He may develop behavioural disturbances or attention-seeking devices.

In the prevention of jealousy the parents are rightly advised to prepare their child for an addition to the family. This should not, however, be overdone—if a child is told too often that there is nothing to be afraid of he may begin to suspect that there is. Children are not exactly alike, and cannot be treated exactly alike, but parental favouritism is an insidious addiction which should be combated, and justice must not only be done but be seen to be done. The difficulties disappear or are lessened when the jealous child can be brought to realize by his parents’ cherishing words and deeds that he is secure in their affections.

Temper and Tantrums

Perhaps the most difficult thing to understand is why children do not lose their tempers more often. They must so frequently be intensely frustrated, but, unlike adults, they cannot reason abstractly about it or channel away their emotions. Children are not born with self-control, they have to learn it—and adults make it easier or harder for them to do so.

Temper is not due only to anger; there is often a background of helplessness, anxiety, and insecurity. This helps explain the rarity of outbursts in most children, as compared with the frequent, almost habitual, tantrums in children of families whose emotional barometer is set at “stormy.” It helps also explain why some children rarely, if ever, have a tantrum, while others continue to erupt all their lives in different ways—breath-holding attacks in infancy, tantrums in

* Consultant Paediatrician, United Bristol Hospitals and Bath Clinical Area, Bristol Royal Hospital for Sick Children.

the "period of resistance," sulks in later childhood, and ingrained irascibility in adult life.

When the doctor is consulted about a child's bad temper he will want to know much more about the child and the family. An occasional outburst of temper means nothing, but the situation must be quite bad if the doctor has become involved. The child may well show other signs of emotional disturbance. The parents are likely to be either domineering (and to punish their child for his temper) or doting (and always giving in), or to zigzag inconsistently between the two extremes.

As in other behaviour problems the most important and rewarding—if often the most difficult—task of the doctor is by discussion and explanation to influence for the better the parents' attitudes. The proper treatment for temper and tantrums is prevention, by obviating the causes. Prevention and cure are more likely to be achieved if the parents believe it worth their while to set a good example of self-control and calmness, and if they do their best to be consistently neither over-strict nor over-indulgent. The mere fact that they can discuss and think about the problem is helpful.

When their child is actually in a fit of temper the parents will have discovered that spanking and shouting at him help neither him nor them to regain control, while bribery will only encourage him to repeat the performance. With support most parents can successfully cultivate the calmness which serves best during outbursts, but it is during the intervals between outbursts that the most effective treatment is carried out, for the child learns best by example.

Aggressiveness

Even a baby 10 weeks old gets into a rage if his movements are restricted too much. In the older child excessive restraint can be physical but is more often non-physical (coercion, chivvying, nagging, "unfair" prohibitions, and all the techniques of over-disciplining). The child can hardly be blamed for responding, either by passively resisting (negativism) or by actively fighting back (aggression), and he will get all the more satisfaction if he learns that aggression can be a potent means of attracting attention.

Every healthy child shows aggression, the boy more than the girl. When he is over-aggressive and the aggression is increasing, not inborn devilment but excessive restraint and excessive discipline—often alternating with over-indulgence—are the likely causes. It is through attention to these that the aggression can best be modified, and for this purpose the doctor needs to win the parents' understanding and co-operation. The child himself should be given opportunities to "blow off steam" in games, and be encouraged in hobbies and pursuits at which he does well. Admittedly the persistent aggressor or bully may need punishment, but, though this may solace his victims, it will not often cure him. Probably he became a bully because he himself was and is being bullied, and the surest way to help him get over it is by modifying the cause.

Learning Difficulties

The child is born with an urge to learn. How well and how much he learns will depend not only on inborn abilities but on many external influences. In the modern view intellectual growth is a cumulative process in which the pace and extent are largely determined by early stimulation. The child should be exposed to a wide range of stimulating experiences from early life. Education starts in the home, and his ultimate achievements may be determined before ever he goes to school.

When a child experiences difficulty in learning there are many factors to consider. To blame him by saying, as so many school reports do, "He could do better if he tried,"

gets nowhere at all. We are ourselves to blame if we do not try to find out why he is not trying.

His intelligence may be lower than average, and in assessing intelligence one useful though by no means infallible or permanent guide is formal intelligence testing. An I.Q. score may improve considerably when, for example, anxiety is allayed, and it is essential to know if emotional factors are holding him back. He may have been impeded by lack of stimulation and opportunities for gaining experience at home—for instance, the parents who persist in "baby talk" for years are making it difficult for the child to acquire a good vocabulary. He may be resistant to learning because of domestic quarrels, or disinterest, or parental coercion, or sibling rivalry, or incompatibility with a teacher or schoolmate. It is important to appreciate that he may suffer from a physical handicap, such as partial blindness or deafness, or a specific difficulty with articulation or reading. Any doubt about these makes prompt and expert assessment essential.

The encouraging fact is that in some children there is a factor which, if modified, will improve learning ability. A thorough search may be necessary to reveal it, and to this the child with a learning difficulty has an unquestionable right.

Dislike of School and "School Phobia"

If we are to believe everything we are told a dislike of school is an accepted tradition. In fact most children enjoy schooling, and it reflects an unfortunate adult attitude when they are unwilling to admit it.

It will be more difficult for a child to like school if he has been isolated from other children or over-protected at home; if the parents have bad memories of their own schooldays or show they are disturbed when the child goes to school; if a father overloads the child with his adult ambitions; if he finds learning difficult for any of the reasons already discussed. If he is unpopular with his schoolmates there may be some good reason, which should be discovered. Teachers are often blamed by parents, but not very often with justification. The family doctor is often the person who can best put his finger on an underlying difficulty and may be able to do something useful about it.

In "school phobia" an extreme position is reached. School phobia is not a distinct entity: it is the result of an interaction primarily between parents and child, and only secondarily between child and school. In the background, as a rule, are a disinterested father and a dominant but inadequate mother who discourages the child's independence. She may go through the form of insisting that the child goes to school, but finds all sorts of reasons—bad health, bad teachers, bad weather—to stop him.

The longer the child is absent from school the harder it becomes to get him back. Blandishments, home teaching, doctors' certificates all make matters worse. The doctor's task is made more difficult when the child complains of symptoms, even if they are clearly psychosomatic, and he may need specialist help not only to deal with these but for the more fundamental task of promoting the child's independence. If the doctor meets with lack of co-operation the matter is urgent, and a child psychiatrist should be called in. It may even be advisable to admit the child to hospital, for from there the child is more likely to be induced to go to school while the underlying difficulties are tackled.

Truancy

Any ordinary boy may stay away from school without permission for an adventure; but if he makes a habit of it he is probably already in trouble and will get into further trouble.

Unlike the intellectual capacity of children with school phobia, that of truants is quite often not up to standard.

They may dislike school because they learn with difficulty (see above) or for many other reasons. They may fear punishment or bullying by another boy or by a teacher. In many instances their attitude towards schooling has been undermined at home by parents who despise both education and educators, who take no interest in their progress, or who use them for personal convenience. The persistent truant tends to be a lone wolf. Because truancy leads to lying and deception, to ganging up with undesirables, and, as has been shown, to juvenile delinquency, the truant needs help.

The family doctor is probably in the best position to explore the contributory causes. He may be able to modify the causes

of learning difficulty, particularly if he has the respect and gains the co-operation of parents and school authorities. He can suggest ways of canalizing a natural urge for adventure into healthier channels, such as those provided by boys' clubs. By his example he can show the boy (and his parents) that his welfare does matter. The old-fashioned remedy of repeated thrashings is a poor substitute for constructive action based on understanding.

My thanks are due to Dr. J. Hargreaves for helpful comments and suggestions.

ANY QUESTIONS?

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

Powdered Linseed

Q.—Many people cannot tolerate linseed oil but can take powdered linseed. Are there any toxic factors in the powdered seed which would make it dangerous to take instead of the oil as a prophylactic against thrombo-embolic episodes?

A.—Trease¹ gives the following constituents of linseed: fixed oil 30 to 40%; mucilage 6%; protein 25%; small traces of a cyanogenetic glucoside linamarin, which is the glucose ether of acetone cyanhydrin. Samples of linseed yield about 25 mg. of hydrocyanic acid per 100 g.

Martindale² states that preparations of linseed are administered for their demulcent action in the treatment of cough. The seeds, 1 or 2 teaspoonfuls in a tumbler of water, may be taken to increase the bulk of the intestinal contents in the treatment of constipation. A mucilage (1 in 8) prepared by pouring boiling water over the seeds and straining has been used as a demulcent drink.

Senior³ stated that hydrocyanic acid is produced when a mixture of linseed meal and water is distilled. There is only a small quantity with fresh meal but more with old. Vogel⁴ stated that linseed tea prepared by prolonged boiling of a tablespoonful of the seeds with about 800 to 900 ml. of water and subsequent straining was used for treating diabetes. The dose was 200 ml. three times a day.

Linseed meal in the form of cattle cake has long been used as feeding material for cattle. It seems that the toxicity is negligible.

REFERENCES

- ¹ Trease, G. E., *A Textbook of Pharmacognosy*, 8th ed., 1961. Baillière, Tindall and Cox, London.
- ² *The Extra Pharmacopoeia*, Martindale, Vol. 1, 24th ed., 1958, p. 79. Pharmaceutical Press, London.
- ³ Senior, W. O., *Yearbook of Pharmacy*, 1885, p. 518. Churchill, London.
- ⁴ Vogel, W. W., *ibid.*, 1897, p. 166.

Cleaning Urine-soiled Bottles

Q.—Is there any way of cleaning bottles contaminated with solids deposited from specimens of urine?

A.—The bottles will probably be satisfactorily cleaned by soaking for two hours in a

warm 1% solution of a laboratory detergent, such as Pyroneg, followed by brushing and rinsing. If they are still soiled any traces of deposited solids should disappear if the bottles are treated with one of the proprietary preparations (such as R.B.S. 25), which are claimed to be as effective as chromic acid but of relatively low toxicity. Soaking for one hour in a 5% solution followed by rinsing should be effective.

Colouring Artificial Teeth

Q.—Is there any way of colouring artificial teeth so that they tone in with the natural teeth?

A.—The staining of individual teeth on artificial dentures has been undertaken for many years. A suitable range of dyes which can be mixed with acrylic resin monomer for painting on individual acrylic teeth are available and are often used by dentists. If they are painted as a thin film on the surface of the tooth the veneer of stain may eventually wear away. A longer staining effect can be produced by removing from the appropriate areas of the artificial tooth some of its surface so that a thicker veneer of stain can be applied. This technique demands skill and good colour appreciation and is time-consuming, and therefore influences the cost of production of the dentures greatly.

Stains for porcelain teeth are now rarely used, since a large selection of porcelain teeth, which are rather expensive, are made with stains already incorporated into them to simulate the natural staining of teeth or even of restorations. These can be individually selected by the dental prosthetist to copy closely the patient's natural teeth.

Pityriasis Rosea

Q.—Are there any advances in knowledge of the aetiology and treatment of pityriasis rosea?

A.—Disappointingly and surprisingly there does not seem to be any published evidence of recent advances in the understanding of pityriasis rosea. There is much tentative evidence to suggest that this benign and self-limited disorder is related to infection, prob-

ably viral, and that an attack produces immunity in 99% of patients. True epidemics have not been observed, but sporadic cases tend to occur in the same locality within a few weeks and even among medical students, especially during the spring and autumn. Three cases occurring in the same household (not confined to the same family) were reported by Shelton.¹

The natural resolution of the eruption can be hastened by ultraviolet irradiation given in mild erythema dosage two to three times a week. If lesions are conspicuous or itchy topical corticosteroids will prove helpful; usually zinc and starch dusting powder is adequate as local application.

REFERENCE

- ¹ Shelton, J. M., *Arch. Derm. Syph. (Chic.)*, 1949, 59, 115.

Diathermy for Intermittent Claudication

Q.—Is short-wave diathermy of any value in the treatment of intermittent claudication?

A.—Vasodilatation secondary to heat is a direct reflex response to the heat. Sclerotic arteries cannot produce a normal increase in the flow of blood when the tissues are heated, and a burn may therefore result. Hence short-wave diathermy to ischaemic legs is contraindicated.

On the other hand, there is a case for heating the abdominal aorta with short-wave diathermy and thereby causing a peripheral vasodilatation without danger of peripheral burning. But the results of such treatment are disappointing.

Diagnosis of Haematomyelia

Q.—Is there any way of confirming the diagnosis of haematomyelia?

A.—Haematomyelia means bleeding into the substance of the spinal cord. This may result from injury but may occur "spontaneously," sometimes as a complication of a vascular abnormality or an intramedullary neoplasm. The onset is usually acute with the clinical picture of an intramedullary spinal lesion. Unless blood escapes into the subarachnoid space the C.S.F. is likely to be normal. Myelography may show an expanding lesion of the spinal cord but will not give definite evidence of haematomyelia. Even at exploratory operation the diagnosis may not