PSYCHOGENIC DISORDERS IN CHILDREN

AN EXPERIMENT IN MANAGEMENT

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The Problem

We start with two impressions which we believe will be confirmed by many general practitioners and paediatricians. First, that the proportion of children referred to hospital but found not to have organic disease is high and is increasing; and, second, that there is sometimes a bias against referring children to psychiatric clinics.

What, then, is to be done if, as at a recent paediatric clinic, among eight new cases five were "little belly-achers" with no organic disease to account for their abdominal pains? Or if, as a colleague innocently remarked, among seven new cases at one clinic "there were four enuretics running"? Should they just be sent away? This may be done, after negative physical examination and investigation, with the statement that "there is nothing wrong" or that the child "will grow out of it"—the first always, and the second often, untrue. Or should they be treated by the paediatrician, who, from the psychiatric aspect, is untrained or self-trained? Or should they be referred, sometimes against the inclination of parents or doctors, to a psychiatrist? To assume that each case can promptly be disposed of on its merits is to assume also that these cases can be accurately assessed at an early stage, an assumption which experience shows is often incorrect.

To use a modern analogy: the traffic, already too dense for old roads, is increasing; traffic jams are worsening and bottlenecks are more obvious. To meet such difficulties a by-pass was opened two years ago. As an experiment, we have been trying to deal with some psychogenic disorders by direct co-operation between paediatrician and psychiatric social worker (P.S.W.), with reference to a psychiatrist only in exceptional instances.

One P.S.W. was invited to take a direct part in the work of a paediatric clinic in a general hospital, and another in a clinic at a teaching (children's) hospital.

The Paediatrician's Part

Children with complaints of various sorts, most of them with bodily symptoms such as recurrent pain, enuresis, tics, or tiredness, but some with frankly emotional disturbances, are referred to these clinics by general practitioners in the customary way. A preliminary task is to separate the sheep from the goats, the ovine organic from the caprine emotional disorders—though this statement is a simplification of a complex subject. It is with the non-organic cases that this report is concerned.

In these cases the paediatrician explains in simple terms to the parents, and to older children, how bodily as well as obviously "nervous" symptoms can be associated with emotional stress. The mother is given to understand that the symptom in her child is part of a wider disturbance for which primary organic causes have been carefully ruled out. What does the mother herself think may be the cause? What sort of person does she consider her child is? And what does she feel about the possibility of an associated or underlying nervous disturbance?

When the paediatrician considers that more than simple explanation and reassurance is necessary he may enlist the help of the P.S.W. We find that parents are nearly always willing to co-operate. Possibly because they themselves have experienced such disturbances as headache with worry, "butterflies in the stomach," or diarrhoea before examinations, as a rule they are able to accept the suggested connexion between emotional tension and bodily symptoms.

Another appointment is made for the paediatrician to see the child and parent at a later date, so emphasizing his continued interest and responsibility. Subsequent appointments with him are generally more widely spaced than with the P.S.W.; but he remains readily accessible, affording continued support both to the family and to the P.S.W.

The child and the parent are introduced to the P.S.W. by the paediatrician himself whenever possible, with some preliminary explanation of her functions. In this way the family accepts the P.S.W. as another member of the hospital group concerned in diagnosis and treatment.

The P.S.W.'s Part

The introduction to the P.S.W. is effected in the paediatrician's consulting-room or in the P.S.W.'s own room, which is near by. At the first meeting with the family she tries to make friendly contact, and discusses her part in diagnosis and treatment. According to circumstances she makes further appointments, either at the hospital or in the home, sometimes with the parent alone and sometimes with the child. Subsequently she and the paediatrician discuss the case together and make decisions about management and possible reference elsewhere.

The techniques employed by the P.S.W. are not discussed here. To summarize them would be misleading, and they will form the subject of a further report.

Results

From the therapeutic point of view our cases have been placed in three groups. In the first, the reaction pattern is so set that the situation seems unalterable. In the second, parent or child needs specialized treatment in his or her own right. In the third, which is much the largest group, it is considered that we can help the child to adapt, often with guidance to parents or school-teachers in modifying stresses.

We give figures to illustrate our results, realizing that the material is selected, that methods of selection are not defined or constant, and that there are differences between different clinics.

In two years we have dealt with more than 150 cases by the methods outlined. In about two-thirds the result was satisfactory; symptoms were abolished or relieved, often very promptly but sometimes over a long period,

and the general attitude of the patient (and often of the parents) was improved. One case in five was referred to a child-guidance clinic, usually because treatment by a psychiatrist was necessary, but occasionally for the convenience of the family. In one-tenth of the cases the parents discontinued treatment.

Advantages and Disadvantages of the Method

We set out some obvious or potential disadvantages and advantages, with brief comments.

Disadvantages.—(1) Are serious cases, needing skilled psychiatric care, mishandled or dangerously delayed? We have not found it so. In the event, the approach through a paediatric clinic in which an experienced P.S.W. works often leads to earlier rather than later treatment. (2) Is the participation of a paediatrician a disadvantage? Not, we think, if he is interested in the problems, realizes his limitations, is willing to go on learning, and is fortunate to work with P.S.W.s with whom integration is satisfactory. (3) Can informal, rather superficial, psychotherapy create or bring to light new problems? Occasionally, yes: but these are promptly recognized, and management and disposal adjusted accordingly. (4) Is our method an economic way of deploying P.S.W.s, who are in such short supply? On the whole we think so, as our list of advantages indicates.

Advantages.—(1) The method appeals to parents, patients, and family doctors, with few exceptions. Many of our patients would never reach a psychiatrist, and would remain untreated. The lay public in our districts clearly prefer a medical to a psychiatric centre; this preference may in part reflect the attitude of family doctors. (2) The children attending are, as a rule, much younger than those sent by family and school doctors direct to psychiatrists, and in many the disturbance is milder. The response to treatment is accordingly likely to be better. (3) Psychiatrists, already overburdened, can devote themselves to obviously serious cases in which their skill and experience are essential and irreplaceable. (4) When cases are later referred to a psychiatrist the P.S.W., who already knows the family, may act as a go-between, with obvious advantage. (5) P.S.W.s, paediatricians, and junior medical staff are constantly learning from each other. (We suggest that family doctors benefit indirectly in the same way.) (6) A comprehensive service is provided which in most cases avoids the necessity for transferring patients from one consultant or department to another.

Conclusions

In paediatric practice the tide of physical disorders (due to infection and malnutrition, for example) is receding, and psychogenic disorders are becoming more prominent. Doctors and their associates must adapt to meet changing circumstances. One way might be greatly to augment the number of psychiatrists. We prefer, for many reasons, to expand the interests and scope of paediatricians (and, incidentally, of general practitioners).

Our experiences represent an attempt to improve the services given in paediatric clinics for the common minor emotional disorders of children. The experiment is tentative and preliminary. We have welcomed suggestions and criticisms among ourselves, and also from our colleagues. This preliminary report is

published in the hope of evoking them from a wider field, and of comparing methods with others who are attempting to meet the changing circumstances of modern medical practice.

In disorders which are not primarily physical one hesitates to speak of "cures"; but we have been impressed in many cases by the improvement, often quick and dramatic, not only of a symptom but also in the patient's attitude to difficult situations which previously would have provoked a reaction. We do not know what the long-term results will be, but the short-term results seem encouraging. We have no means of comparing our "cure" rate with the spontaneous cure of untreated cases, but most patients serve as their own controls: the improvement with treatment occurs in too many instances, and often too promptly, to be merely coincidental. It is indisputable that most children referred to paediatric clinics with psychosomatic or emotional disorders can be improved with appropriate treatment, without having to be referred to psychiatric clinics.

In this experiment we have been most impressed by the opportunity of dealing with younger, and usually less severely affected, children than those customarily attending psychiatric clinics. This semi-preventive treatment, with interesting new lines of progress which may stem from it, must be important if we believe that "as the twig is bent so the tree will grow."

Nova et Vetera

CHEHOV THE PHYSICIAN

BORN JANUARY 17, 1860

Anton Chehov was born on January 17, 1860, at the small town of Taganrog on the Azov Sea in the south-eastern corner of European Russia. He was the third son of Pavel Chehov, a shopkeeper, and the grandson of Yegor Chehov, a freed serf and bailiff on the estate of his former master, Chertkov. From this grandfather, a man of exceptional will-power and perseverance, Anton may have inherited some of the qualities which characterized him in later years. He himself used to say: "We the children inherit our souls from mother and our gifts from father." His father was a domestic tyrant, and Anton preserved some bitter memories of the whippings he received from him when quite small, and of the brutal way in which the father reprimanded the mother for such minor matters as not putting enough salt in the soup.

Anton's early years were bleak and strenuous. Pavel Chehov had two absorbing hobbies: icon painting and church music. Anton and his two brothers had to rise before dawn on cold winter mornings and were marched off to sing in the church choir. Many years afterwards Chehov wrote of this experience that they "felt like small convicts doing a term of hard labour." Nor was this all that was expected of them. The father's artistic interests made him neglect his shop; money was scarce, and the boys had to take turns behind the counter. The evenings spent at the shop instead of doing his homework were no doubt responsible for Anton becoming backward in his school studies and having to spend a second year in the same class twice running. At the age of 14, while still at school, he was for a time taught tailoring in the evenings, but this scheme was not pursued.

These additional labours, combined with the custom of keeping long religious fasts, must have played their part in undermining Anton's health and reducing his resistance to the disease which subsequently killed him. He fell seriously ill (with peritonitis, probably tuberculous) at the age of 15,