ACUTE NEUROTIC BREAKDOWN IN CHILDREN WITH REFUSAL TO GO TO SCHOOL

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Introduction

A common problem in child psychiatry is the child who refuses to go to school, sometimes for long periods. Such children differ from those who exhibit simple truancy, and present a problem which is urgent from the point of view of both school authorities and parents.

These children always show a neurotic illness, which may involve the whole family circle. Acute anxiety is a prominent symptom, but other neurotic symptoms, obsessional or hysterical, may be found. Depression is frequent, and sexual preoccupations and fears are common. Such children often become aggressive and disobedient to their family, in contrast to their former dependent and timid behaviour. Of all their symptoms, the refusal to go to school is the most dramatic and soon becomes the focus of attention. The child clings to his home and may refuse to leave the mother: in two of the cases reported here, fears were expressed that some harm might come to the mother if the child left her. If the child is allowed to remain at home the acute symptoms tend to subside, only to reappear if any attempt is made to force him back to school: this impasse may continue for months. The mother at the same time often becomes anxious and depressed, and is soon quite unable to handle the child. To a less extent the father and siblings may become involved in what is now an acute family upheaval; this involvement of the family is important in treatment.

The whole situation springs up quite quickly and is unexpected by parents and school teachers; it may have been precipitated by a change to a new school or some such event. However, there may have been previous neurotic traits, including food fads and minor expressions of anxiety or disobedience. The subject is often an only child and is almost invariably spoilt. A neurotic and adoring mother is a common figure in the background, but the child's home and school are usually satisfactory in the material sense.

The behaviour of these children contrasts with truancy with which it is sometimes confused. These children are unadventurous, and have none of the more robust qualities, leading to active wandering from home or school, that characterize the truant;

the word truant is derived with good reason from the old French term for vagrant. In these children delinquent behaviour such as stealing and lying, so common in truants, does not occur.

It was considered of interest to describe a group of such children and their treatment, in contrast with a similar group of truants who showed no neurotic breakdown.

Previous Investigations.

Partridge (1939), reviewing the subject of truancy in general, differentiated from other truants ten children that showed the symptom here discussed, but he did not consider their treatment in detail. These ten children differed from the others: they were not undisciplined; they did not dodge simple difficulties; their behaviour was not a compensation for some lack in environment; nor did they revolt against circumstances. Only one was a truant from home; on the whole they liked their schools, and yet they refused to go. Their environment showed no obvious abnormality with which their behaviour could be linked; their symptoms were due to psychoneurotic states or deviations of personality, centring round the mother in seven instances and round the siblings in two.

Johnson et al. (1941) further differentiated and developed this special type of truancy. They likewise pointed out that it was due to a psychoneurotic disorder different from the more frequent delinquent varieties of truancy, that it was associated with intense terror at being at school, and that without treatment the child would stay away from school for years.

They described eight children, four of each sex, their ages ranging from six to fourteen years. Their absence from school lasted from ten days to two years. Their intelligence varied from low average to very superior, and in most cases was superior. All the boys were submissive and obedient to their mothers, while the girls were defiant. Their past histories showed neurotic traits and anxiety. The outstanding first symptom in all cases was anxiety, and equally important was a coincident increase of anxiety in the mother, due to some simultaneously operating threat to her satisfactions, such as economic deprivation, marital unhappiness, or illness. The children still showed an undue dependence on their mothers.

As Johnson et al. held that the mother was cardinal in the causation and treatment of these symptoms, they stressed that treatment should be directed to her as well as the child, and for this reason held that two therapists were necessary. The normal practice of a psychiatric social worker interviewing the mother was insufficient, as there was need to relieve guilt and tension and for 'a positive dependent transference' on the therapist to be established. Although it was sometimes evident that neurotic symptoms in the father also contributed to the situation, it was found more practical to cope with the mother. If the child was pubescent, however, such treatment of the mother might not be necessary. They found that with these measures out-patient treatment continued for six months to a year, and as a result seven out of the eight children had gone back to school. This length of treatment and the need for two therapists stress the complexities and difficulties they encountered.

In the discussion that followed this paper Marburg described his experience with similar cases and reported a less encouraging outcome. One child he found of schizoid personality, and another developed schizophrenia later. One girl developed a manic depressive psychosis later at the age of fifteen. It is evidently necessary to follow up these cases.

Klein (1945) in a more recent paper pointed out that whatever the original causes of the refusal to go to school, secondary gains soon become prominent, obscuring the original causes and leading to a chronic state. He considered that three component motives, anxiety, aggression, and secondary gain were involved in varying proportion in the refusal to go to school, of which the latter two only were often evident to the authorities concerned, the anxiety being deep-rooted and not at first apparent. He went on to show with clinical examples that the anxiety could superficially and conveniently be separated into fear of the teacher, of other pupils, or of school work with expectation of failure. Even so the underlying causes always harked back to the family circle, for instance fear of the father might be transferred to the teacher. A boy might be over-attached to his mother, the girl to her father, or there might be rivalry among siblings. Again, secondary gains might arise from thwarting the mother, separating the parents, or defying and dominating them.

In treatment he stressed that the child must if possible be got back to school at once, even if it meant only a stay of ten minutes perhaps in the headmaster's private room. Without this contact the anxieties might not be accessible to the therapist. In his seven cases, five returned to full school life in a short time with satisfactory adjustment but two did not before the examiner realized the importance of this. In all, their speed of recovery depended on the amount of time spent on their treatment.

Present Investigation

Eight such children have been treated at the Maudsley Hospital since 1946, and the etiology, symptoms, and treatment studied in detail; they closely followed the clinical patterns described above. They were compared with a group of twelve typical truants treated during the same period. In view of the ample descriptions of truancy elsewhere, there is no need to give the case histories of the latter. There were always obvious and simple causes to be found for their truancy: these included indiscipline, some lack in the environment for which truancy was a compensation, or some reason for rebellion, for example rejection by the parents. The truants, as already stated, were free from neurotic breakdown, and they showed other delinquent symptoms.

Etiology. The ages of the children of both groups lay between nine and fourteen years, and there was little difference between them in their range of physical development, but table 1 shows the differences between them in certain respects. There was a higher proportion of boys amongst the twelve truants, hereafter called Group B, the sex ratio being 10 boys to 2 girls; in Group A the ratio was 5 boys to 3 girls. The intelligence in the eight children who had a neurotic breakdown and would not go to school (Group A) showed a high average, the range of I.Q. being 98 to 152, whereas in Group B there was a wider scatter with a proportion of the cases at lower levels, the range of I.Q. being 78 to 146.

Disturbances or lack of both maternal or paternal influence were somewhat more common in Group B although common in both groups, especially in regard to the mother. The number of only children in Group A was much higher than in Group B, and there was corresponding gross over-indulgence in the material sense.

The social environment of these children showed more detrimental factors in Group B, suggesting that material circumstances are not the main cause of such neurotic breakdown as Group A showed, though they may be of considerable importance in truancy. The assessment of progress at school again showed little trouble in Group A as compared with Group B. Only one child was being educated beyond his powers in Group A as opposed to five children in Group B.

Finally the assessment of personality showed a much higher proportion of Group A as timid, sensitive, and submissive. Every child in Group A was over-dependent on the parents, but no child in Group B was considered to be so.

Symptoms. These are shown in table 2. Neurotic traits or past symptoms of emotional disturbance, especially faddiness over food, are somewhat commoner in Group A.

With the onset of the present illness every child in Group A showed emotional disturbance in relation to his mother, sometimes with aggression, whereas in Group B fewer showed it. The contrast in neurotic symptoms was conspicuous. In Group

A 100 per cent. were acutely anxious, 50 per cent. notably depressed, 25 per cent. showed obsessional symptoms, 25 per cent. hysterical symptoms, 12.5 per cent. hypochondriacal symptoms, and 12.5 per cent. well-marked ideas of reference. In

TABLE 1
ETIOLOGICAL FACTORS

	Group A Children with acute neurotic breakdown who refused to go to school		Group B Truants without neurotic breakdown	
	Number	%	Number	%
Total number of cases	8	—	12	—
Incidence of mental instability in near relatives	7	87.5	8	66
Emotional factors:				
Maternal attitude disturbed	7	87.5	12	100
Lack of maternal influence	1	12.5	8	66.7
Paternal attitude disturbed	4	50	9	75
Lack of paternal influence	5	62.5	9	75
Incidence of only children	4	50	2	16.7
Evidence of material spoiling	7	87.5	5	41.7
Environmental factors:				
Frequent breaks and changes in home	5	62.5	11	91.7
Poverty	1	12.5	4	33.3
Bad homes or neighbourhoods	1	12.5	5	41.7
Educational pressure too high	1	12.5	5	41.7
Personality:				
Timid and submissive	6	75	5	41.7
Over-dependent	8	100	0	0

TABLE 2
SYMPTOMS

	Group A Children with acute neurotic breakdown who refused to go to school		Group B Truants without neurotic breakdown	
	Number	%	Number	%
Total number of cases	8	—	12	—
Past history:				
Neurotic traits:				
Food faddiness	7	87.5	1	8.3
Sleep disturbances	3	37.5	0	0
Nocturnal enuresis	0	0	4	33.3
Gratification habits	2	25	1	8.3
Tension habits	4	50	2	16.7
Assertive habits	2	25	3	25
Present illness:				
Acute disturbance in relation to mother	8	100	7	58.3
Acute disturbance in relation to father	3	37.5	8	66.7
Acute disturbance in relation to siblings (percentage related to number having siblings, viz. 4 in Group A and 10 in Group B)	4	100	4	40
Acute disturbance in relation to school	6	75	6	50
Neurotic symptoms:				
Acute anxiety	8	100	4	33.3
Depression	4	50	0	0
Obsessional	2	25	0	0
Hysterical	2	25	0	0
Hypochondriacal	1	12.5	0	0
Ideas of reference	1	12.5	0	0
Delinquent symptoms:				
Disobedience	5	62.5	10	83.3
Truanting from home	0	0	8	66.7
Lying	0	0	6	50
Stealing	0	0	6	50

Group B 33.3 per cent. showed anxiety, and none of the other symptoms were found. On the other hand in Group B many truanted from home as well as school, or both lied and stole, whereas in Group A nothing of this occurred.

CONCLUSIONS. Children who refuse to go to school and show neurotic breakdown appear from these findings to have the following characteristics. They are mostly above average intelligence, and are timid, sensitive, and dependent. They are often only children and are almost always spoilt. Disturbances of emotional attitude in the parents, especially in the mother, are common. Unsatisfactory influences in the material environment are not important causes of the refusal to go to school.

The children studied have shown neurotic traits and particularly faddiness over food. At the onset of the present illness they all showed considerable emotional disturbance in relation to their mother, siblings, and schoolmates. They developed neurotic symptoms and especially acute anxiety, and although often disobedient and defiant they were not truants from home, nor did they lie or steal.

Treatment. Treatment of these children has been found to be difficult, prolonged, and in many ways unsatisfactory. Out-patient attendance often failed to solve the impasse that had arisen at home. Consequently three of the children were admitted to the in-patient unit at the Maudsley Hospital. This helped in their recovery, and as there is no record of such a step having been taken elsewhere, it suggests a line of treatment. Much, however, depends on the co-operation of the parents and the willingness of the child to come into hospital. In two cases considerable time was saved in their treatment, and in the other child administrative delays rather than treatment led to a long stay. It may be concluded that placement in hospital or perhaps in a suitable hostel or school for mal-adjusted children, coincident with psychiatric treatment, will lead to a speedier solution in suitable cases. The child is saved much anxiety and misery, and psychotherapy is easier in the neutral and emotionally uncharged atmosphere away from home. Other members of the family, particularly the mother, may have shared in the anxiety and aggression at home until recriminations or inability to control the child have led to a vicious circle.

Once away from home, the child must soon go to school each day from hospital or hostel while his treatment and in most cases that of near relatives continues. The co-operation of the educational authorities is needed, but the outcome will amply repay any such concessions made and will avert an otherwise inevitable charge of culpable non-attendance at school. In our cases the educational authorities concerned were very helpful in arranging a novel regime and disposal. The steps taken and their effect will be seen in the case records as well as the effects of too early discharge home (Case 1). Once a school had agreed to accept the child, he was taken by a nurse for a preliminary interview,

and then unobtrusively escorted each day until this was considered unnecessary. Unemotional and kindly persistence in all three cases led to regular and in due course happy attendance at the school.

Two typical cases (Cases 1 and 2) are given in some detail; the other six will be described briefly, particularly in regard to treatment and disposal. The individuals comprising such a group vary from those who were fairly easily managed to an extreme case in which medical treatment could not be undertaken. As always, treatment, whatever the generalizations that can be made from a study such as this, has to be adapted to the needs of the particular case.

Case Records

Case 1. John, aged 11 years 11 months, was first examined on Jan. 20, 1947. He had become increasingly difficult to manage at home, and later had refused to attend school; he had become depressed and aggressive to his parents and sister.

He came of a healthy and stable family; the home conditions were good, but the standards somewhat rigid. His father, aged forty-six, a lorry driver of quiet and colourless personality, took rather a passive role. His mother, aged forty-two, an unintelligent woman, had little insight and became depressed and aggressive towards her son. She had previously spoilt and overprotected him. There was a younger sister, aged ten, who was physically larger than her brother.

His birth and development were normal, but weaning was long and difficult. He was somewhat faddy over his food, always more difficult than his sister, and inclined to be jealous of her. His physical health had been normal. He had done well at school and won a scholarship to a grammar school, which he entered in the autumn term of 1946. A timid boy, he disliked cruelty, avoided being hurt, and feared low-flying planes since a rocket incident in 1944. He enjoyed the scouts, reading, and stamp collecting. His manners and speech were refined. He had no deep friendships with other boys and preferred quiet pursuits at home.

In the summer of 1946 he became difficult and disobedient at home, and, entering his new school in September, he soon stated that he disliked it and he refused to go again. He complained that other boys talked about him disparagingly but could not say in what way. He became anxious and depressed, was increasingly rebellious and bad-tempered at home, and talked of suicide. He was sulky, and so aggressive to his sister that she had to be sent away. Finally his parents gave up any attempt to control him and sought medical help.

He was found to be physically healthy, tall for his age, and on the verge of puberty. He was depressed and easily wept. Although polite and amenable, he could at first give no account of his behaviour, nor his reasons for disliking school but again stated

his ideas of reference. His intelligence was superior (Stanford-Binet scale I.Q.126).

It was decided to keep him under observation as an out-patient, with a psychiatric social worker to interview the mother while the doctor treated the boy. Beyond learning more details of the history and establishing some rapport, little progress was made. John became more disturbed, and after a quarrel with his mother refused to attend hospital. Admission was arranged, and on Feb. 20, 1947, the social worker had to fetch him in. He quickly settled down, and showed no abnormality apart from undue quietness. He employed himself in all group activities and appeared content. When his parents visited him he was polite but distant.

Rapport was further built up in a series of interviews with the doctor, and his difficulties in relation to his family and school, his timidity, and his upbringing were explored and discussed. His fears of school concerned the older boys and masters, although he had suffered no actual traumata there. His increased sexual urges were evident, and his ideas of reference found to be concerned with guilt over erections. Sexual education caused these worries to cease. Independence without overt rebellion was fostered.

Meanwhile his mother was treated by the psychiatric social worker, and later by the doctor as an out-patient. The extent to which she had overprotected him, for instance she still assisted at his bath, became abundantly clear. It was his refusal to accept further her attentions and affection that marked the start of his present behaviour, to which she reacted by being hurt and then antagonistic, until finally she rejected him. She was overtly depressed, anxious, and tense, but at the same time she was resistant to discussion of herself, to which her limited intelligence and ineffective personality contributed. She failed to gain insight, and efforts to explore her difficulties more deeply were defeated. However, the enlightening fact became clear that she had long been frigid with her husband; and now, with her son's antagonism to her, she realized stronger sexual desires which her husband was unable to satisfy. Advice was given to try to alleviate this, and there was considerable discussion on her relationship with her son and her management of the situation. She inevitably became antagonistic to the doctor treating her son, but because of her lack of intelligence and because her son was pubescent no deeper psychotherapy by another doctor was attempted. As her son recovered she slowly readjusted to his changed condition.

On April 2, 1947, John was discharged home as he had long shown no overt symptoms. He continued to spend his days at the hospital, and psychotherapy continued. It was arranged for him to join a new grammar school as a fresh start. His discharge was a tactical mistake as his mother had not much improved. A gradual deterioration in his behaviour occurred in relation to her, and he became tense and irritable. He liked his new school, but soon failed

to go there after developing minor hysterical symptoms to avoid it.

On May 17, 1947, he was readmitted to hospital and promptly returned to his former happy and co-operative state. Treatment again consisted of fostering further independence, and it was appreciated that long separation from his mother was necessary. A boarding school was sought, but for months there were insuperable administrative and financial difficulties in the way; to send him to live with relations was not possible.

On June 24, 1947, he was again discharged home at his own request. John had become bored with the restrictions of hospital, and no solution was apparent. It was realized that relapse was likely, and in spite of his good resolutions and self-confidence it quickly happened and he had forcibly to be removed from a bathroom in which he had locked himself.

On July 1, 1947, he was again readmitted and remained an in-patient until his final discharge on Dec. 12, 1947, broken by ten days at a scouts' camp and an interlude with scarlet fever. As a temporary measure it was arranged for him to attend a local secondary school from the hospital, where he settled without difficulty. His voice now 'broke' and he was quickly growing and maturing, important factors in his readjustment.

His final discharge came when it was arranged for him to go to a boarding school at the council's expense. He settled well and showed no further symptoms there or at home in the holidays. He held his own in work and took an active interest in games.

This case illustrates well the etiology of the problem and the intimate reactions within the family circle. Treatment was much helped by his removal to hospital, and his prompt relapses on discharge home bear this out. The most difficult problems were schooling and disposal, and it is considered that had these been readily available six months in hospital might have been saved, although provision for him away from home would have been necessary in the holidays. In the end this was not necessary, although sending him to boarding school was considered a wise decision because of his mother's mental state.

Case 2. Sarah, aged 11 years 6 months, was first examined on June 5, 1947. For six months she had been increasingly out of hand, had latterly refused to go to school, and was anxious and depressed.

The family was stable, with no record of mental or nervous disease. Her father, a civil servant aged forty-six, was an intelligent and co-operative man who exerted throughout a steady influence. Her mother, also forty-six, was intellectually dull and unable to manage the patient. She showed little insight and reacted to her daughter with irritability. There was an elder step-brother abroad in the forces. Their circumstances were comfortable.

Sarah was born after seven years of sterility, she

developed normally and was always healthy if highly strung. There was a history of mild sleep-walking and food fads. Her mother and to a less extent her father had spoilt and overprotected her. The war years were spent in a provincial town with her family, where they had a good home and garden. She was happily settled in her school and had plenty of friends. She was considered to be a bright child, enjoying outdoor activities, somewhat selfish but at no time a source of worry. Both father and patient were aware that she was cleverer than her mother.

In December, 1946, the family moved to London to a cramped flat, where she had to share her parents' bedroom. She became unhappy, disliked her new surroundings, and urged that they go back to their previous home. She was disobedient to her mother although her relationship with her father remained a good one. She made no friends except for a more mature girl of thirteen with whom she spent much time. Attempts to get her to go to two schools ended in uproar and failure. She was anxious and depressed, slept poorly, and made hypochondriacal complaints. If left alone she was fairly happy and content.

When examined she was in good health and on the verge of puberty: her breasts were developing. She was tearful, timid, and depressed. She talked freely but without insight of her dislike of London and school and of her hypochondriacal symptoms. Her intelligence level was average (Stanford-Binet scale I.Q. 98).

She was first treated as an out-patient, and a start was made to explore the situation more deeply. The mother was also interviewed by the doctor, but her lack of intelligence made it difficult to help her. The parents were advised not to force the issue of school, but meanwhile Sarah got more out of hand and the situation deteriorated. On Aug. 18, 1947, she was admitted into hospital.

For the first three days she was mildly depressed, occasionally wept, and her appetite was poor. She complained of headaches and pains in the legs. She quickly made friends with an older girl and avoided other children. She then lost all her symptoms and became a happy co-operative child, friendly with everyone and with no desire to go home.

In therapeutic sessions before and during admission her troubles were discussed—her relationship with her mother, her home, and her school. In addition it was found that her parents went out to a pub, leaving her alone in the house, and she was very frightened by a mouse one night. They were persuaded to stop this, and a separate bedroom was arranged for her. Although this was denied, it was probable that she had witnessed or sensed parental intercourse, and her refusal to go to school may partly have been due to her desire not to leave her mother because of this. She had many dreams, which further revealed the sexual nature of her fears and phantasies. She had once been mildly assaulted by a man in a cinema who had an 'ugly face.' She described the form master in her first school in

London as having an 'ugly face.' She appeared to be preoccupied with oral and anal phantasies of birth, and with fears of menstruation. She had been told by another girl that babies came after taking a pill, and she feared that she or her mother might be poisoned. All these ceased after adequate sexual information had been given to her.

In September it was arranged that she should attend from hospital a local school, care being taken to have a mistress in charge of her class. A nurse took her at first each day. She settled happily and continued there without interruption after she left hospital. All this time her relations with her father remained good, and he was always able to reassure and manage her. With her mother she was less aggressive, and coincidentally her mother became less disturbed. She was finally discharged home on Nov. 1, 1947, and continued to attend the out-patient department at progressively less frequent intervals. There was some return of her symptoms and fears, and an occasional day's schooling was missed because of some minor ache or pain. These finally ceased with further therapeutic interviews, and except for occasional quarrels between mother and daughter which the father always was able to patch up, there have been no further symptoms. In June, 1948, she began to menstruate.

This case again illustrates the etiology of the problem in a pubescent child, which was precipitated as in Case 1 by a change to a new school and in this case new surroundings. It was notable how easily she settled down and benefited from treatment in hospital. After the administrative experience of Case 1 placement in school was promptly and successfully made and much time was saved. The personality of the father and her relationship with him rendered her an easier problem than Case 1 in spite of the difficulty of treating her intellectually dull mother.

Case 3. Robert, aged 12 years 2 months, was first examined Nov. 11, 1946. He would not go to school as he feared his mother would not be there when he came home. This dated back some months, and he had also become anxious and aggressive. His father was a nervous and inadequate man while his mother was possessive and indulgent. There was one younger brother. Examination showed a pubescent boy of average intelligence (Stanford-Binet scale I.Q. 104). Little progress was made in treatment until he was admitted to hospital in April, 1947, his mother being very disturbed and equally difficult to treat. Once admitted he ran home twice and remained at first overtly anxious and depressed. He slowly settled and improved, and once again it was found that his anxiety centred round sexual matters which required elucidation. The next step was for a nurse to take him each day to a local school; he failed to stay there at first, but with persistence this difficulty was gradually overcome. He was finally discharged in July, 1947, and he became free from symptoms. His mother

became readjusted and he has since grown in independence and self-reliance.

Case 4. George, aged 12 years 7 months, was first examined on July 24, 1947. An overmothered boy with elderly parents and three grown-up siblings, he had always been timid, with phobias and fads over food. He was happy at his school until he won a scholarship to a grammar school, which he joined in September, 1946. He was unable to keep up with the work, greatly feared the gymnasium, and finally, after a minor incident there in which he was ridiculed, he refused to go any more. He became depressed, anxious, and lost weight, and his parents were unable to cope with him. Examination showed that his intelligence (Stanford-Binet scale I.Q. 111) and personality were not up to a grammar school and it was decided to move him to a modern secondary school. He was treated as an out-patient, and settled down fairly well in this less robust environment, but he remained timid and dependent. His mother again showed little insight, and was not easy to treat, and the outlook for his future self-dependence and stability appears to be poor.

In contrast to the first three children this represents a less severe instance where there was no overt rebellion. He subsided into his previous dependent state as soon as the stress of the grammar school had been removed. Admission to hospital was not necessary.

Case 5. Daphne, aged 9 years 4 months, was first examined on Jan. 29, 1948. An over-indulged only child, she had long shown neurotic traits. Her mother was a reserved, reticent, and rather suspicious woman, while her father was a heavy drinker who had deserted the mother a few months before. Daphne had shared her mother's bed since the father's unfaithfulness, and after his departure she became irritable and anxious and refused to attend school. She would not leave her mother and screamed if any coercion was used. Examination showed an overdressed girl, precocious in manner with marked histrionic traits: her intelligence was high (Stanford-Binet scale I.Q. 152). She was easily persuaded to go back to school, and out-patient treatment has continued to mother and daughter.

This child differed from the others in that she was younger but of high intelligence. The precipitating cause was a severe one, and the refusal to go to school was easily overcome so that again admission was not necessary. There were none of the adolescent traits of rebellion against parents or preoccupation with sexual matters to be seen in the more severe cases.

Case 6. Arthur, aged 14 years 4 months, was first examined on Dec. 10, 1947. This case, and Cases 7 and 8, are examples of increasing severity in which admission to hospital has not been possible. In the first two a charge for non-attendance at school has not been incurred as they are under treatment.

Arthur was over-indulged by his mother, while his father remained indifferent and little at home. He had had many neurotic traits, and due to the war several changes of home and school. Latterly he had become miserable; he said the boys at school jeered at him and he refused to go there any more. Examination showed normal pubertal development, and his intelligence was high (Stanford-Binet scale I.Q. 126). Treatment as an out-patient has in five months failed to alleviate the situation; and his mother, also emotionally disturbed, has been unable to get him to keep more than three appointments in all. It would seem that the only way to overcome this impasse is to admit him to hospital, but to this his mother has not yet consented.

Case 7. Mary, aged 14 years, was first examined on Jan. 1, 1948. This girl's parents had an unhappy marriage relationship and she had been sharing her mother's bed to keep the father out. Her father was said to be uninterested and difficult, while her mother showed overt anxiety and was under treatment by her private doctor. Mary had long shown neurotic traits, and with puberty and the onset of menstruation she became anxious and difficult to manage. She had refused medical examination at school and later ceased altogether to go there. She would not come to hospital, and finally only came with the bait of a dog with which to play. She would not co-operate in any examination, and no progress has been made with mother or daughter in six months' spasmodic attendance. It would seem that the best chance to alter this state of affairs would be to admit her to hospital, but this could not be done against the wishes of mother and daughter.

Case 8. Henry, aged 14 years 6 months, was first examined on Jan. 20, 1948. This boy represents the extreme where no medical treatment was possible. He was illegitimate, and his mother had died. He was brought up by three aunts and two women cousins who were responsible for him. He had been completely indulged and had shown minor tension habits and nervous traits. Although essentially timid, he had gradually become aggressive to them and uncontrollable; and having established a reign of terror in the house he had for a month refused to go to school. Finally in an outburst he broke up things in the house, and with the aid of the police had to be admitted to an observation ward. Examination showed him to be normally developed for his age, but with a cleft palate. There was some emotional disturbance. He refused to attend hospital. No further investigation was possible and it was necessary for the authorities to charge him with non-attendance at school. His guardians had refused to charge him as being beyond control. He was finally sent to an approved school.

Conclusions of Treatment

Although out-patient treatment was sufficient in two instances, admission into hospital helped to make recovery relatively quick and easy. Two further children whose admission was not feasible have failed at the time of writing to improve. The last case was notable in that delinquent and aggressive trends were more definite than in the others so that the child had to be charged and sent to an approved school.

A quicker return to school, as advocated by Klein, proved valuable when the child was admitted to hospital. Out of hospital such a step obviously depends on the parents' influence over the child, which was slight or ineffective in all these cases; no independent person from the hospital was available to escort the child each day from home to school.

It was not found expedient to get a second psychotherapist to treat the mother as Johnson advised. All but one of the children were at puberty or adolescent, so that the aim of therapy was to make them self-reliant. Their mothers from lack of intelligence or unwillingness to co-operate were in varying degree difficult subjects for psychotherapy, and in practice these women's anxiety settled down as the child improved.

Antagonism between the mother and the doctor who was treating the child occurred in some cases, and was circumvented with the help of a psychiatric social worker. Rapport between doctor and child might be hard to establish because the doctor was simultaneously treating the mother, but in practice it did not cause any trouble.

Summary

The child with an acute neurotic breakdown who persistently refuses to go to school is described, and the condition distinguished from truancy. Eight cases are outlined, and their etiology and symptoms contrasted with a group of truants without neurotic breakdown. The differences between these two groups are found to be considerable. Treatment is considered in detail and its difficulties are discussed; the advantage of admission to hospital, from which a return to school could be made is emphasized.

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