REFRESHER COURSE FOR GENERAL PRACTITIONERS**THE NERVOUS CHILD**

BY

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Under the 1944 Education Act every local authority is empowered to provide help for the maladjusted child. This may take the form of a special school, either day or, more usually, residential, or special classes within an ordinary school. Just as clinics are provided for sight and hearing disorders, so clinics are provided for the treatment of the maladjusted child. Further, a department of psychiatry is now the rule rather than the exception in the general and teaching hospitals, so that a number of clinics dealing with the problems of the nervous child have also been set up by the regional hospital boards. As, however, it is estimated that 1 to 1.5% of all children will require some psychological help, it is quite obvious that even the growing number of child-guidance clinics and trained workers in child psychiatry will be inadequate to meet these requirements. The family doctor is therefore no stop-gap substitute for the fully staffed child-guidance clinic. He is in many cases the front line of the attack on childhood neurosis, and is in a good position to carry it, for he probably knows the home setting and will have watched the situation as it developed. Who is better able to assess the contributions, for or against, made by the grandparents, or the schoolteacher, or the next-door neighbours?

Methods of Approach

Because the teaching of child psychiatry can hardly be said to have existed in the curriculum of the pre-1939 medical student, there is still a tendency for doctors to regard the more severe behaviour problems of children as something which only an expert can touch, or to swing to the opposite extreme and imply that a touch of common sense, or forbearance, or the rod, depending on the particular school of thought, would have prevented all this happening, thus adding very materially to the harassed parents' feelings of inadequacy. Whatever the problem, it is unlikely to be solved by any psychological sleight of hand, and therefore nothing can replace in clinical importance the taking of a good history. Supplied with that, the doctor may succeed in giving some much-needed reassurance or caution. This should be based on understanding rather than direct advice or prohibition.

History-taking

The busy surgery is a bad place for history-taking: very often both mother and child are present, time presses, and the whole clinical picture is built up on a false premise. Nine-year-old John is wetting his bed. Perhaps his mother connects it with her brother's early death from nephritis. It may be a long journey to arrive at the fact that John is a dull boy who is being too hard pressed at school and challenged by his quicker younger sister.

In the long run (and therefore as soon as possible) it will save time to spend time on taking the history in a situation of privacy and away from the child. One thirty-minute talk will uncover more of the truth than

three ten-minute talks. Any psychiatric history must take the physician behind the defence lines, as any child's problem will in some measure be a family problem restated. Indeed, the art of history-taking lies not so much in leaving no stone unturned as in creating an informal situation in which a troubled parent will feel free enough to admit to herself, and to the doctor, something of what is worrying her. Premature reassurance will not stop her worrying, but it may discourage her from telling the rest of her story. Hence the fewer questions asked the better; those which are asked should serve to direct the course of the story rather than to elicit the facts. The actual words used can sometimes be noted: they are often revealing. Of John the bed-wetter's sister it was said, "Oh, Mary, she's a different child altogether, a joy from the first go." Such a remark may hint at family attitudes which may be of the highest relevance.

In obtaining a history of the developmental milestones the family doctor may know only too well that this child has always deviated from the average, but he may succeed in uncovering attitudes and feelings within the family setting rather than facts and figures as such. While the purpose of a history is to record information, the taking of it plays an important part in establishing a relationship and an entry into the tensions which are contained in any family.

Examining the Child

Children who are taken to the doctor have many odd ideas about it, and their previous experiences will determine whether they view it with fear or dislike. It is just as important to try to make some contact with the child as it is to get behind the parents' defences. Most children will use paper and pencil if given the opportunity and will often tell the physician a good deal about themselves in the pictures they make while waiting outside. A small girl, very jealous of her sister, drew a house. When asked to draw the people who lived in it, she added a mother and a father and a third figure. Asked about it, she said, "It's a boy; they have only *one* child" (very far removed from her own situation). This made a good opening for her to talk about the way she felt in relation to the baby sister. Active play, however simple, is always more revealing than books or games of the puzzle variety, and a history taken at home with the child at play in an adjoining room can reveal a good deal of the situation. It may be, however, that knowledge of the "nervousness" has been gained in helping the child through some physical illness.

However much a counsel of perfection, if the family doctor is to attempt any kind of alleviating treatment some time *must* be given to the mother alone, and wherever possible the father, too, should be brought into the picture. Time spent alone with the child is equally important, although the child will not be able to develop his contact so quickly. Even where outside help is

available, in a clinic or a residential school, work on these lines will be valuable to both patient and doctor.

This all takes less time than the more usual procedure of remedies and pointless investigations, at the end of which the parents are told that *as everything is negative* the problem must be psychological. This is always a disappointing diagnosis to have made on negative findings only, and an unconvincing one when arrived at after unsuccessful treatment. The psychiatric diagnosis, as any other, should be built up on positive findings, which may be confirmed by excluding organic possibilities as the final step.

Important Aetiological Factors

Approached in this way even a complex family situation will begin to declare something of the way in which it has come about. The idea with which the child was conceived—for example, to procure the mother's discharge from the Services—the circumstances of his birth and early nurture, these tell their own story. In hearing about his behaviour and his responses in babyhood, much will be learned of parental attitudes, and in the first year of life probably nothing is so important as the child being able to receive love and affection and a continuity of handling.

Separation in Early Life

Evidence is accruing that prolonged (say, upwards of two to three weeks) separation from the mother predisposes the child to a mourning reaction which may eventually result in what is tantamount to an emotional atrophy.* Not only is the child often ill but he fails to develop either his intellectual powers or his normal degree of emotional maturity. Eventually such children become indifferent. They appear to owe allegiance to no one. They are quiet and withdrawn, sometimes aloof, often easily led, and have a sustained sense of reproachful hostility. This can sometimes be seen as a definite negativism and lack of co-operation, as for instance in stealing, and sometimes as a more projected reaction of hostility based on a sense of persecution. The child feels unloved, however much is done to "make up" for his earlier loss by separation.

Position in the Family

This often has a bearing and is always worth noting carefully. The eldest child has a mother who is inexperienced and apt to take everything too seriously. He is the only one to be an only one, even if temporarily so. Similarly the youngest stays the baby and is never succeeded, while the middle of three has often to establish himself against bilateral competition. There are difficulties, too, inherent in the position of the only girl in a family of boys and vice versa. Grandparents are apt to establish favourites more readily than parents, and one child may have a particular handicap which singles him out for attention.

Physical Disabilities

Intercurrent illness has its own bearing, as it may make an already anxious parent still more inclined to over-react, or it may induce a feeling of irritation and frustration towards a child who is repeatedly ill. Enuresis in one child becomes a very real family problem when it prevents the whole family from taking a summer holiday.

In a general way, a child who has a physical illness is easier for the parents to accept than one with a psychological illness, hence perhaps the desire to find physical causes for what are really emotional ills. Where a child is seriously handicapped care will be needed to prevent a psychological overlay, associated with the period of abnormal living and with loss of schooling, reactions of siblings and others, and the real anxiety of being ill. The supposed "gain" in illness is more often an inability to dispense with the special props which have been temporarily necessary, and time is needed to regain confidence.

Stresses Outside the Home

It sometimes becomes clear that the child's difficulties have more to do with school than home. Many nervous children dread school and cannot tolerate the mild degree of "baiting" which is likely to come their way. This is perhaps more likely in only children and in those from small families who spend their time in carefully restricted lives mainly spent with adults.

Sometimes the school is at fault, but more often unhappiness at school is associated with all-round backwardness which has not been discovered in a large class, or with some degree of educational retardation associated with average ability but poor achievement. This is especially true of the child who has missed school through illness and long convalescence. While the history may point the way to this diagnosis, it will be clarified only by an intelligence test done under leisured conditions. Tests done in a group in class are particularly apt to be misleading in the case of educational retardation, for they are apt to fail in bringing out the latent ability.

Treatment by the Family Doctor

When these and other factors have been assessed, how far is the family doctor helped in deciding whether to send a case to a clinic or treat it himself? As has been implied, the decision may be forced on him by having no alternative to offer. He will still want to evaluate the task with which he is faced. If he has an alternative, such evaluation is even more important. Certain factors will help greatly in making the doctor decide that home treatment is feasible.

Stable Family Background

Of these, none is more important than a stable united family, interested in and aware of the problem in their midst, anxious to help, and not unduly perturbed by it. The expression "anxious to help" needs closely defining, because such an attitude must include a willingness to undertake the responsibility of helping, and indeed a willingness sometimes to tolerate the symptom continuing. There are occasions when such remarks as, "I leave it entirely in your hands, doctor," indicate a demand to be relieved of any further contact with the problem. The over-anxious mother who cannot bear her child to vomit may unconsciously foster the need for attention, as well as choice of this particular symptom.

Anyone attempting to carry out treatment in a family will find himself steering this difficult course between the parents' guilty feeling of responsibility for a problem child and their natural antipathy to having their own lives put out by it. In other words, they tend to be angry with themselves or angry with the child, knowing that either attitude is probably indefensible.

**Maternal Care and Mental Health*, by J. Bowlby. W.H.O. Monograph Series. No. 2. Price 10s. 1951.

Thus, an important part of the doctor's role is to be an Aunt Sally for either side, relieving both parents and children of some of the sense of failure, and accepting on their behalf some of the resentment. In this connexion one wonders whether children do enjoy their own bad behaviour. It seems clear that as a rule they are in trouble with it from the start. The resulting ostracism, whether at home or at school, is undoubtedly a source of much neurotic human suffering.

Limited Crises

When there is evidence that the disturbance is a passing phase, particularly when it occurs as a reaction to some environmental change, there is every reason for the family doctor to take the situation in hand and tide over the crisis. Children tend to over-react to changes, whether in people or in their surroundings. If this is understood and allowed for, many of these reactive problems can be quickly solved, as they doubtless have been for hundreds of years by the parents of a more leisured age.

Differing Standards

The extent to which a problem is localized is also of some diagnostic significance. The child who is no trouble at home but always in difficulty at school may need some quite simple step in adjustment. It may be that standards vary greatly in the two places, but often the localized problem proves to be a generalized one which becomes manifest in the less tolerant environment. At least, such a situation deserves carefully exploring to see whether the child really lives part of his life in a perfectly satisfactory way, and if so whether there is something seriously wrong, apart from himself, in the other place where he seems always to run into trouble.

The Difficult Years

Finally, there is the problem arising at an age when problems are rife. In the pre-school stage, named by Susan Isaacs "the period of normal negativism," a child who is fighting out his first battles with his much-loved parents, bewildered at finding himself on the wrong side, so to speak, will quite certainly produce much problem behaviour. Even in quite small children such problems may be very severe.

June, aged 3 years 4 months, reacted severely to her father's period of service abroad. She had a younger sister, aged 8 months. June woke screaming once or twice between 10 p.m. and midnight. Later in the night she would cry ceaselessly and her mother would be unable to leave her, often for some hours. This had begun within a few days of father leaving home; the single-handed mother had had only a few hours' sleep nightly for two months when first seen.

George, aged 19 months, had been clean as a baby, but relapsed into severe negativism over pot-training. He soiled himself daily for some months, and then would defaecate in one particular corner of the kitchen, and only if his mother was out of the room. Re-education to normal habits took upwards of one year.

Difficulties such as these try the patience, and so afford opportunities for an expression of exasperation or despair which may form the corner-stone of a more serious neurosis in the child's later life. The need for prompt care in handling these problems is mainly in order that they should not become a focus for bad feeling. Whether a child defaecates in his trousers, in the coal-bucket, or in his pot is of little importance compared with the way he and his family feel about him

doing so. The advice that "he will grow out of it" is, by itself, never enough to allay the feeling of despair which sometimes accompanies the problems posed at this notoriously difficult age. What makes them rewarding cases to treat is the fact that often quite a short time spent in understanding the feelings of both parents and children of this age goes far to reduce tension and, by so doing, to relieve the symptoms.

Contraindications to Home Treatment

If these are the points which may lead the general practitioner to try his hand, he may be wise not to undertake a case in which the child's family is divided against itself, or in which the material circumstances in the home—for example, overcrowding—hardly allow of a normal adjustment. The same warning applies to the very long-standing case in which every part of the child's life is affected by his maladjustment. The older the child, apart from those instances of an isolated reactive problem, the more likely it is that other and deeper factors lie behind an apparently sudden inability to conform. He will, however, even in the case of the older child, take a good look round to see whether the need for conformity is there, or the demand for it unreasonably pressing.

Simple Methods of Treatment

Are there any simple methods of treatment? I wonder how many psychiatrists would care to pass judgment on exactly what has brought about a cure in any given case. Is it good medicine to suggest that a simple remedy should always be tried first? Here, again, the keyword is good diagnosis, and a good diagnosis depends neither on flair nor on training so much as on good relationships and a good history. It might be reasonable here to illustrate from a physical analogy. Most of us would agree that to prescribe a tonic and a holiday for someone with early pulmonary tuberculosis before diagnosing the condition would be a dangerous waste of time. But most of us have discovered unsuspected healed foci of tuberculosis which have presumably responded favourably to just this kind of regime. In the psychiatric treatment of children, it is almost impossible to avoid this danger, for it is so often necessary to revise the diagnosis from time to time in the light of new information becoming manifest during treatment.

The role of the family doctor is therefore likely to be twofold. He will be called in early to advise on the first stages of a problem, and he may from time to time be in a position to forestall a problem by his handling of intercurrent illness or upset.

At all times the doctor must be on his guard against inadvertently causing a psychiatric problem himself. It is quite common to meet with children who are kept off exercise for years for supposed chorea, and a child is often made afraid of school by having missed an essential stage and so fallen behind. If the child then begins to have nightmares, or to go off his food, frequently we find that "three months' convalescence" is recommended without any reference to how these symptoms have arisen. Would we send our own children away for a term so light-heartedly?

Conclusion

In treating nervous children the doctor needs time to gain his facts. It will repay him to study feelings and family attitudes rather than actions, and he may well

find that the patient's or the parents' own words will tell him more than his own questions. His conclusions will be strengthened by his intimate knowledge of the background in which his child patient lives.

He should be careful to avoid creating physical anxiety because there seems no obvious explanation for a mental symptom, and he should seek to judge fairly between mental and physical suffering without letting the patient play one off against the other.

He may need to remind himself that if the child could "pull himself together" he probably would. A child does not enjoy the scenes he creates; indeed, he is often panic-stricken by them.

If the doctor decides to reassure a mother, it will be because he can feel sure that a symptom is not dangerous. He would be unwise to dub it unreal or imaginary on that account. He may do a lot, in a stable family, to restore mutual confidence. He can comfort the inexperienced mother with the knowledge that it takes most of the threescore years and ten to learn how to live, and that one function of family life is to provide a warm shelter where a child can safely display his deepest fears, knowing that they will be understood and cared for.

INTERNATIONAL CONGRESS OF CLINICAL PATHOLOGY

The Minister of Health, Mr. Hilary Marquand, opened the International Congress of Clinical Pathology at Friends House, Euston Road, London, N.W.1, on Monday, July 16. He was supported on the platform by his Chief Medical Officer, Sir John Charles, and the Adviser in Pathology, Professor S. P. Bedson, the President of the British Association of Clinical Pathologists, Sir Lionel Whitby, together with the officers of the International Society of Clinical Pathology and the chairman and secretary of the executive committee of the Congress. The Minister, who referred in his speech to the prime importance of adequate laboratory facilities both for hospital services and also for general practitioners, was thanked by Professor Robert Cruickshank (London) and Professor Tullia de Sanctis Monaldi (Rome).

The President of the International Society, Dr. S. C. Dyke, then presented to the Minister the vice-presidents of the Congress nominated by the Member Societies: Australia, Dr. Edgar Thomson; Belgium, Dr. D. Jaumain; Cuba, Dr. Antonio Sellek; France, Professor M. Polonowski; Great Britain, Dr. J. G. Greenfield; Italy, Professor Tullia de Sanctis Monaldi; Spain, Dr. D. Antonio Utrilla Dominguez; Turkey, Professor Burhanettin Tugan; U.S.A., Dr. Osborne A. Brines. The vice-presidents for Canada, Mexico, and Czechoslovakia, Dr. J. E. Pritchard, Dr. Luis Gutierrez Villaegas, and Professor H. Sikl, respectively, were unable to be present.

Immediately after the opening ceremony, Sir Lionel Whitby gave his presidential address on "The Science and Art of Medicine." In the evening the Minister of Health received members of the Congress and their ladies at Lancaster House; earlier the council of the British Association of Clinical Pathologists and the executive committee of the Congress had entertained the vice-presidents and the principal speakers to a buffet supper at Apothecaries' Hall.

In all 600 members of the Congress registered, and they came from 37 countries. The mornings and evenings from July 17 to 20 were devoted to scientific papers. In the afternoons visits were arranged to the Lister Institute, the Central Public Health Laboratories at Colindale, the National Institute for Medical Research, the Wellcome Museum, the Wellcome Research Laboratories at Beckenham, Glaxo Laboratories, and the Research Laboratories of

Messrs. May and Baker Ltd. Throughout the week a series of scientific demonstrations were on view at the London School of Hygiene and Tropical Medicine, where there was also an exhibition of scientific equipment. On three afternoons films of scientific and general interest were shown.

Official Entertainments

Receptions were given to the members of the Congress by the Vice-Chancellor of London University, the President and Fellows of the Royal College of Physicians, the President and Council of the Royal College of Surgeons, and by the President and Council of the British Medical Association. The British Association of Clinical Pathologists held a soirée at the Goldsmiths' Hall by kind permission of the Prime Warden and Court of the Worshipful Company of Goldsmiths. The Congress terminated on July 20 with a banquet, held at Grosvenor House, at which the speakers included Dr. W. Russell Brain, Dr. S. C. Dyke, Dr. D. Jaumain, of Brussels, Sir Henry Dale, Dr. F. William Sunderman, of Atlanta, Georgia, President of the American Society of Clinical Pathologists, Professor R. Kourilsky, of Paris, and Sir Lionel Whitby.

Scientific Programme

The scientific work of the Congress was divided among four Sections, dealing respectively with microbiology, haematology, chemical pathology, and histopathology. In addition there were two joint sessions on "Pigment Metabolism and Haemoglobin" (Sections of Chemical Pathology and Haematology) and on "Skeletal Disease" (Sections of Histopathology and Chemical Pathology). This week we print an account of the proceedings of the Sections of Microbiology, Haematology, and Chemical Pathology. Next week we shall give a report of the two joint sessions and of the meetings of the Section of Histopathology.

I. SECTION OF MICROBIOLOGY

Non-bacterial Pneumonias

Professor S. P. BEDSON (London) was in the chair at the opening session.

Professor C. H. STUART-HARRIS (Sheffield) opened with an account of diagnostic difficulties in pneumonia. Even with full bacteriological investigation, no pathogenic organism was cultivated from the sputum in a significant number of cases (13% of 109 cases of pneumonia in Sheffield during 1950-1). The majority of such cases were atelectatic or aspiration pneumonias in subjects with chronic bronchitis, but a few resisted chemotherapy, and such included possible cases of virus or rickettsial pneumonia. Cases of primary atypical pneumonia were often diagnosed by the discovery of radiological changes in cases thought to be simple pyrexia, bronchitis, or influenza. Laboratory investigations were needed to establish the causative agent concerned, which might be psittacosis or ornithosis virus, the rickettsia of Q fever, influenza virus, or an unidentified virus agent.

Professor G. LÖFSTRÖM (Uppsala) said that cases of atypical pneumonia with significant titres of cold agglutinins were not uncommon in Sweden and had occurred in several small outbreaks. In children such cases might be confused with pulmonary tuberculosis. No virus causative of atypical pneumonia had been recovered in Sweden. Psittacosis was uncommon. Q fever had not been found.

Dr. M. GATMAN (Sheffield) described the results of an investigation of the cold haemagglutination reaction in a variety of cases of respiratory infection. He referred to the need to standardize technique, and instanced factors, such as differing sensitivities of the red cells, effect of concentration of cells, and methods of reading, which influenced the titre. Though a high cold-agglutinin titre had been obtained in two cases of atypical pneumonia and in many of the relatives of such cases investigated in 1950, high titres had also been found in 1951 in pneumococcal pneumonia and influenzal pneumonia. It was difficult to accept that reaction as of value in differentiating atypical pneumonia from other respiratory tract infections.