An Address ON THE PSYCHOLOGY AND PSYCHOPATHOLOGY OF CHILDHOOD.*

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EVERYONE knows that the last decade of medical work and thought has been characterized by nothing more than by an increasing appreciation of the importance of psychological factors in the production of ill-health. This re-discovery has been derived primarily from the study of adult ill-health; but one of its fundamental implications is that adult psychological disorders depend very often and very largely upon conditions, personal and environmental, which have existed in childhood. In childhood itself, the share of psychological factors is probably even greater than in adult life in producing illness; for the child's entire psychophysical system is more labile than the adult's, and emotional disturbances lead more readily to bodily effects. Moreover, in children, disturbances of a psychotic kind are absolutely rare, and the mental disturbances which do occur have usually a closer and more obvious connexion with immediate factors than is encountered in most adult disorders, no matter of what general clinical type.

There are consequently several principal directions of interest for the student of child psychopathology. These are the psychopathology of childhood for its own sake, the physical signs and symptoms produced by emotional factors and especially prone to occur in children, and the connexion of adolescent and adult psychological morbidity with childhood and its influences. The first and especially the second of these directions are of peculiar interest to the student and teacher of paediatrics; for a numerically important and varied group of physical disturbances of a fairly distinctive kind results from emotional and temperamental influences. The third is one which interests the professed psychiatrist more; but the paediatrician who explores it can make valuable contributions in a largely unworked field of preventive medicine.

General Fallacy of Interpretation.

One caution must always be observed. It is a caution of interpretation. We must be careful not to play the Lewis Carroll or the Kenneth Graham, measuring what we observe in a child's mind too much in terms of adult knowledge and experience. It may seem superfluous to issue such a caution to those who are brought face to face with a similar situation in treating the physical illnesses of children, but in psychological affairs we are far more apt to interpret what we see not merely in terms of adult experience in general, but of our own in particular. Not to do so is difficult, even for those who remember better than the majority their own childhood; indeed, this remembering may itself be a source of bias, experiences that are similar to our own being too readily attributed to similar causes. There are other errors of interpretation, of which I shall speak later.

PRINCIPAL CHARACTERISTICS OF CHILD PSYCHOPATHOLOGY.

There are three cardinal points for discussion in the psychology of children, considered apart from the psychology of adults, as far as distinctions in this field can be drawn. They are, first, the great influence of environment upon the child's mental processes; secondly, the plasticity of the latter; and thirdly, the prominence of egoistic tendencies, their substitution and frustration, in the production of symptoms. Environment means, of course, the personal environment of parents, brothers, sisters, teachers, and companions; and an important reflection occurs here, that when signs of morbidity appear, they arise at the surface of contact, so to speak, of the child's environment with his

aims and desires, rather than at some locus of conflict deeply within the psyche. It is far more often a question of some direct frustration than of a conflict between an introjected ideal and libidinous unconscious wishes.

Influence on Method.

This is a generalization which admits exceptions, but it is of sufficient importance, in theory and especially in practice, to warrant expansive discussion. For instance, it connotes that relatively simple adjustments of the environment, after careful consideration of the tendencies whose frustration or misdirection are indicated by the symptoms, will cause the latter to disappear; and that intensive intrapsychic exploration of the child's mind is usually unnecessary. Hence the psychiatrist's method of exploring the problem principally through interviews, with parents and other adults more than with the child himself, has its justification. There is, however, a small residue of cases in which intensive exploration may be desirable.

Prognostic Contrast in Children and Adults.

The second point, the plasticity of the attitude and behaviour of children, is another aspect of the first, and is of immense practical and theoretical importance; although this plasticity is limited in some degree by inborn disposition and temperament. Taking the most superficial aspect of the whole problem first, we are confronted by such a contrast as this, which shows the recovery rates in a group of adults, and in a number of children who attended the out-patient practice of the department of nervous disease and psychological medicine in Guy's Hospital two years ago.

The statistical analysis of 70 adult patients who were treated at that time and have subsequently been followed up gives this result.

Not traced	...	...	...	...	...	7
Dead, committed suicide, or disappeared	...	...	...	...	...	9
Condition little changed	...	...	...	...	...	28
Improved	...	...	...	...	...	14
Much improved or cured	...	...	...	...	...	12
Total	...	...	...	...	...	70

This gives a percentage of 37 improved or cured. A similar investigation among 60 children two years after their treatment gives the following figures.

Not traced	...	...	...	...	...	5
Condition little changed	...	...	...	...	...	16
Improved	...	...	...	...	...	15
Much improved	...	...	...	...	...	24
Total	...	...	...	...	...	60

This gives a percentage of "improved" or "well" of 65. The groups are statistically very small, but the figures are sufficiently in accord with general impressions to be considered reliable. One has the more confidence in the figures for the group of children, because it included all varieties, even such unfavourable ones as feeble-minded and epileptic children.

Controls.

The improvement all round was so marked and so invariable, where it could be expected, that the reflection readily arises that so-called "nervous" children would usually get better of themselves without the aid, sometimes nowadays very elaborate, of the clinic. Indeed, while giving proper weight to the immense effect of the child's environment in producing psychological disturbances, it is necessary to remember that all children are subjected to innumerable traumata, and the wonder is, not how many nervous or unstable children there are, but what a large proportion grow to be reasonably normal men and women. The urge to adaptation has been well styled imperative. Nevertheless, the comparatively few unstable ones are in the aggregate many, and their contribution to adult social inefficiency and ill-health is sufficient to make psychiatric work with children not only as worth while as any, but worth extending till every considerable hospital has the necessary facilities and has intimate connexions with other social organizations for child welfare, as well as with children's courts.

* Given to the International Paediatric Congress, Stockholm, August, 1930.

Role of Innate Factors.

Just as too much optimism may lead to a policy of *laissez-faire* on the ground of the self-adjustment of the majority of psychopathological phenomena in children, so on the other hand may a pessimism, preconceived on the score of the importance and immutability of inborn temperament and disposition, lead to a failure to grasp numerous possibilities of modification; for the limitations produced by inborn factors are much less than is generally supposed. It is a sound working rule to attribute nothing morbid, whether of behaviour, mood, or thought, to congenital, and therefore presumably less modifiable causes, until a complete investigation has exhibited nothing in the history of environmental influences and personal events that will reasonably account for the symptoms, and until the latter have been proved but little modifiable by any known therapy; and even then the matter may not have been congenitally engraved.

Prophylaxis of Adult Neuroses and Psychoses.

The practical importance of the plasticity of the child's mind in both its congenital and acquired aspects lies not only in the management of nervous children, but in the prevention of neurotic and psychotic disorders in later life. There are two principal views of the etiology of adult mental illness. Both of them place the primary focus in the formative influences of childhood; but one view regards the adult illness as the cumulative result of mental habits acquired and engrained throughout childhood and adolescence; while the other regards it as a regression to particular emotional "fixations" or attachments of an erotic kind at the same period. The apparent divergence of view lies perhaps more in emphasis and terminology, but they certainly agree in acknowledging the importance of early factors. It seems to me, however, that in its insistence on a set pattern, the Oedipus pattern, in the infantile foundation of neuroses, the second view does less justice than the first to the almost infinite plasticity of the young organism's mental and emotional equipment, the wide variety of the influences that impinge upon it, and the multiplicity of its responses.

Self-assertive Tendencies and Their Handling.

The third generalization, that symptoms in children centre principally round their egoistic, self-preservative, or self-assertive strivings, is derived from a study of the nature of the symptoms, their mode of production, and their therapeutic reactions. The point, although it must seem obvious to many, is worth making; for the alternative view invokes the same explanation for children's nervous disturbances that is so commonly advanced for those of adults—namely, the vital importance of infantile sexuality. My impression is that in children the origin of psychogenic symptoms in the greater number of cases is, properly speaking, neither infantile nor sexual. No one now denies the existence of infantile and childish sexual desires. But two fallacies seem to be committed by exponents of the more rigorously Freudian view. To say that infantile sexuality exists is an entirely different assertion from the statement that it lies at the root of all neurotic disorders of children and adults. The other assertion is that infantile sexuality is the same as adult sexuality in its aims and objects. This is a type of assertion that is hard to disprove, for a negative finding is no proof to the contrary. Careful observation by ordinary methods in younger children fails to furnish, as a rule, evidence of sexuality of this type at the foundation of their functional nervous disturbances; the special methods which have been employed to show it, from contemporary studies of children (not from retrospective accounts from adults), do not command confidence as valid scientific evidence. I am thinking of Little Hans and some of the other psycho-analytic work with children. It is possible, of course, by a sufficient complication of hypotheses, to regard egoistic tendencies as themselves libidinous. A child's desire for praise, possessions, and other outlets of self-assertion, may be said to represent libido which has been diverted towards egoistic ends, but it is more useful, as well as simpler, to take these tendencies for what they certainly are. There is another field of research here. Direct observation, unbiased by

esoteric pre-conceptions, is badly wanted. In the meantime, it is a safe working rule to regard the majority of children's psychogenic disturbances as disturbances of their egoistic strivings.

DISORDERS OF CHILDHOOD.

A general survey of the varieties of mental and functional nervous disorders of childhood will illuminate the generalizations which have been made. (The age range given in several of the groups is that of children attending Guy's Hospital as out-patients in the last four years. Patients over 14 years of age are not included.)

1. *Disorders of Personality.*—Timidity, obstinacy, irritability, outbursts of temper, sensitiveness, shyness, day-dreaming, lack of sociability, emotional disturbances, etc. (Age range in the Guy's series 12 to 14. Intelligence quotient 81 to 103.)

2. *Behaviour Disorders.*—Truancy, wandering, temper outbursts, lying, stealing, begging, cruelty, sex misdemeanours, food fads, refusal of food, etc. (Age range in the Guy's series 4 to 14. Intelligence quotient 67 to 103.)

3. *Habit Disorders.*—Nail biting, thumb sucking, incontinence—nocturnal and diurnal—constipation, vomiting, stammering, etc. (Age range up to 14. Intelligence quotient 77 to 127.)

4. *Psychoneuroses.*—Anxiety psychoneuroses (age range 7 to 14), hysteria (age range 5 to 14, intelligence quotient 64 to 93), phobias, obsessions, compulsions, ties (some).

5. *Psychoses.*—Schizophrenia (dementia praecox), manic-depressive psychoses, etc.

6. *Epilepsy.*

7. *Mental Deficiency.*—Dull and backward group, the result of general or localized defect—for example, word-blindness and word-deafness; feeble-mindedness; imbecility, idiocy; temperamental defect ("moral imbecility").

8. *Sleep Disorders.*—Insomnia, night terrors, somnambulism.

9. *Mental Disorders* occurring with, and probably dependent on, some physical disease—for example, chorea, epidemic encephalitis, trauma.

10. *Disorder of the So-called "Glycopenic" Variety.*—Migraine, crises of collapse, insomnia, night terrors, cyclical vomiting, etc.

This classification is proposed from experience as a convenient one, although it mingles symptomatic and diagnostic categories to some extent, and although there is also some overlap between the various subdivisions. The deviations of personality issue in abnormalities of behaviour, but of a less outspoken, less impulsive, and more consistent type than those of subdivision 2. Habit disorders are distinguished from behaviour disorders in so far as they involve only a part of the child's behaviour—that is, are a much simpler form of activity, and do not require conscious co-operation for their production. On the other hand, some of them probably begin in no other way than as hysterical symptoms, and deserve to be classified accordingly. This would hold especially for some instances of vomiting, of incontinence, and of constipation. Mental deficiency, especially in its lesser degree of intellectual subnormality, naturally interpenetrates the other groups. The extent is suggested by the results of systematic testing of every child who comes to a psychiatric out-patient department. Figures were compiled for fifty-two unselected children who attended as out-patients in the department of psychological medicine at Guy's Hospital during the first months of this year. A frequency curve exhibited well that the majority of the fifty cases of which detailed records were available had an intelligence quotient between 70 and 90—that is, belonged to the "dull and backward" group, on this test. The figures suggested what would be suspected on general grounds, that an intellectual equipment less than the average does tend, even at an early age, to produce additional difficulties in social adaptation, and to foster symptoms in a disproportionate percentage of the dull and backward. It occurred to us that the Binet-Simon tests might not do justice to these children. Accordingly performance tests were also given. Contrary to expectation, the results with performance tests

were inferior to those with the Binet-Simon scale, when compared with normal standards. The general results were suggestive rather than conclusive. The group was too small, and some other experience of the prognostic value of such tests for social adaptation after the school age has been passed makes me a little sceptical of their value in general. My impression is that many of the so-called dull and backward, who show abnormalities of behaviour and other symptoms of adaptive disharmony during the school age, often do remarkably well by comparison after leaving school. This impression is borne out statistically by some figures recently supplied to R. G. Gordon from school children at Bath. It seems, nevertheless, to be of great importance that a machinery for occupational guidance should exist which would begin to operate at the age of 12. This would go far to prevent much adolescent unhappiness, inefficiency, and nervous illness.

To return to the clinical classification already given, the first two clinical groups and the fourth are the most important for establishing our general propositions regarding environment, plasticity, and egocentricity. It is convenient, however, to deal first of all with the other clinical groups, in summary fashion, but sufficiently to place them in their proper perspective, and to indicate openings for research.

Habit Disorders.

Some of the so-called habit disorders, such as nail biting, thumb sucking, and the like, belong to a group of which some variant occurs in practically every child (Olsen). Their *raison d'être* is either pleasurable stimulation of the auto-erotic variety, or the non-specific expression of a disturbed mental state. Incontinence, although often similar in origin to these, has a more varied etiology. In our series at Guy's Hospital urinary and especially faecal incontinence has been most frequently associated with some degree of mental defect, and on this and other grounds (especially the evidences of parental inadequacy) it is presumably often the simple result of lack of educational influences or capability. But incontinence can also be present as the result of mental conflict, as the non-specific expression of an emotional disturbance, or, more directly, as a self-assertive phenomenon and sometimes as an erotic one. As a symptom, urinary incontinence can be cured by all kinds of methods, and all kinds of methods can fail. Fear is said to be a frequent cause of it; but I have known additional fear to cause it to cease. Urinary incontinence, especially the nocturnal form, is a problem not yet wholly solved, either in theory or in therapy.

Psychoses: Fallacies of Interpretation.

With regard to Group 5, psychoses in the adult sense are so rare in childhood as to furnish relatively little material for psychological investigation. It is important to remember that many traits which would be psychotic in an adult cannot be so regarded in a child. In some recent literature there is a tendency to interpret the behaviour and thought of certain children in the same terms as would be used if the patient were an adult. This is often fallacious, and disregards the basis of a fundamental conception—namely, that of regression. Certain forms of behaviour normal in a child, if persisted in till adult life, would make the adult a psychotic; and regression consists not in persistence in, but in return to, such behaviour—that is, it implies the reappearance of early traits in a late setting; but there has to be a certain depth of regression before these traits are regarded as psychotic. It is therefore not correct to say that simply because certain childish traits, such as suggestibility and negativism, are highly accentuated in a child, these traits betoken a psychosis. The case is similar with certain kinds of mental content. A child may believe itself a kind of god, and yet not be considered to have a delusion, in the adult sense; for such ideas are common to many, and perhaps in a sense to all, children at some time or another, and differ only in the length of time for which they persist. Most children feel omnipotence in some fashion at some time, and hanker after it when they cease to feel it. Often the more intelligent child disbelieves for a time the reality of anything but himself. The

tendency is to characterize such beliefs as psychotic only when they are expressed, and to ignore the fact that they are always present in some form at some time, although often not even consciously formulated except in the intellectually brighter children.

This matter of *conscious formulation* is important, and touches not only the interpretation of so-called psychotic traits in children, but the general psychotherapeutic accessibility of psychological disturbances in them. In the degree of awareness of his mental processes and in his ability to observe and to express them verbally, the child is inferior even to the average adult. In children we often feel that in the grave disorders of behaviour, the concrete reaction appears first, and the conscious formulation only afterwards, if at all. Not only is this one of the reasons why it is unwise to conclude that certain symptoms that are *prima facie* psychotic are necessarily so, but it is also part of the reason why disorders of behaviour and even the more habitual deviations of personality are usually so readily altered in children. There is little organized mental superstructure, conscious or otherwise, of the reactions. The external conditions are there, and the reaction takes place: let the external stimuli be removed, and the reaction dies out. It is not merely that the hypothetical "paths" are not deeply graven, but that there are no well-organized sets of motives, no complex intrapsychic elaborations, which will act to maintain and stereotype the abnormal reaction. The whole process is more closely analogous to a conditioned reflex than one meets anywhere in the behaviour of adults and their mental disorders.

The term psychotic is not, therefore, properly applied to such disturbances in children; but in so far as the term "regressive" can be truly applied, it can entitle behaviour or thinking to be labelled psychotic, and the latter term is thus sometimes applicable. This conception, as has been pointed out, also necessitates a certain "depth" of regression, and since depth is a misnomer for a time sequence, there is obviously less scope for manifestations of regression in children. Nevertheless, these manifestations frequently occur, but more often in the field of behaviour, and in simple form, such as crying and baby-talk, than in the domain of thought. When the regression includes much of the child's thinking as well as his behaviour, the temptation to think in terms of adult psychoses is stronger than ever, but it is more correct as well as safer not to be tempted to apply diagnostic terms borrowed from adult psychiatry to such instances. The rule should be here, as always, to deal directly with the facts of observation and to avoid obscuring them with diagnostic terms, such as schizophrenia, unless their use in a given instance is unimpeachable.

For example, I recently saw a child, aged 6, whose condition had been diagnosed schizophrenic. For the past eighteen months he had used only inarticulate sounds and cries. He was very restless and distractible. If presented with a book he turned over the pages rapidly in the manner of a child aged 2. Given a piece of paper, he scribbled at first wavy lines; then when some simple diagrams were placed before him he produced crude geometrical forms. He was not at all hostile or even apathetic, for he placed his arm round the doctor's neck and his cheek against his, smiling slightly. His entire behaviour, in fact, resembled that of a child aged about 18 months or less. It was certainly not schizophrenia, and it lacked the push and infectiousness of a manic reaction. Yet it was a much clearer instance of regressive behaviour than is usually found in adult mental disorder. It seems better to state the facts in such a case, and to leave schizophrenia aside.

The conclusion is, that when we say that psychoses are rare in children we are in a periphrastic way saying that the conditions are so different that as a rule the term psychosis, as used in psychiatry generally, is misleading.

"Glycopenic" Disorders.

The disorders belonging to the last three groups of our classification are very common and of great interest. Many of the instances of disturbance of sleep are suitably considered along with the cyclical vomiting group. Night

terrors, for example, and some cases of insomnia, are immediately dependent on the same general cause, and all of them are on that borderland of the psychological and physical which is of such fascinating importance, and for which the illnesses of children offer an unrivalled opportunity for study (cf. chronic epidemic encephalitis). The problem in the cyclical vomiting group should interest the paediatrician who is not also a professed psychologist, since the symptoms are usually the direct expression of environmental stimuli, and do not as a rule involve the intermediary operation of psychic "complexes." It is now well established by observation—and I can confirm it amply from my own experience—that not only cyclical vomiting and its varieties, anticipatory and otherwise, but night terrors, certain headaches, often of migrainous type, some crises of collapse, some insomnias, certain cases of enuresis, and many cases of fatigue, belong to a group with the same metabolic fault behind them. (Osman adds certain cases of constipation, pallor, anorexia, failure to put on weight, growing pains, pyrexia, recurrent diarrhoea, asthma, and cough.) Since it was found that the administration of glucose acted like a charm in these conditions (Cameron), the metabolic fault was originally called "glycopenia," and it was shown by Swedish workers that while these symptoms were apt to arise in emotionally unstable children of asthenic physical type, many of them could be produced in normal children by cutting down the carbohydrate intake. But curiously, it has now been shown by Osman that there is in fact usually no hypoglycaemia in children afflicted in these ways, and that what is found is an acidosis in the sense of a diminished plasma bicarbonate. In the majority there is also no ketosis. Osman suggests that glucose works because it builds up the glycogen reserve of the liver. The relationship between nervous constitution and symptoms is in any case a close one, and represents in simple form a general problem which has always interested psychiatrists. Here in children are the first beginnings of a biochemical description of constitutional characteristics; but the description is proximate and not by any means final. Presumably in emotionally unstable children adrenaline is more readily secreted, and the glycogen reserves are more often subject to mobilization, so that the danger point for the production of symptoms is more readily and more often reached than in stable children.

Disorders of Personality.

The group of children whom I have classified as exhibiting abnormal traits of personality are of very special importance from a social and a prophylactic, as well as from a human, point of view. There are also important theoretical considerations. It is now well established that many instances of mental disorder in adults present an antecedent history of peculiarities of personal make-up—often simply accentuations here and there of traits that otherwise pass for normal. I have pointed out that one school of psychiatric thought considers that mental disorder develops directly out of such traits, as a kind of cumulative resultant of their operation, after what might be termed a break in the psychic compensation that enabled an appearance of normality to be maintained for so long. Now if these traits can be modified while they are still in the plastic stage which is so characteristic of childhood, or, still better, if they can be prevented altogether from forming, a great work will be done, as far as adult mental disorders are concerned, and much human unhappiness and inefficiency will have been prevented.

It is an undoubted fact that many such morbid traits appear in childhood; and it is also a fact of observation that in childhood such or similar characteristics are modifiable. Whether the modifiable and the morbid characteristics are precisely the same remains to be seen, but some who have worked with children on these principles are already inclined to believe that what would become some day adult psychoses are being prevented. For example, Professor Hans Maier of Zurich, in whose asylum there is a cottage for psychopathic children, tells me he believes that something is being done there towards the prevention of schizophrenias.

It is most important theoretically that the formation of a child's personal traits should be carefully scrutinized.

At present some psychopathologists are somewhat obsessed by what might be called the prototypic hypothesis—that is, that a mental attitude or characteristic is explainable most completely, or even solely, in terms of the conditions of its first (supposed) occurrence. This would do less harm, were it not also assumed that the first occurrence must stand in relation to infantile orificial erotism. Obstnacy, to take one character trait as an example, is explained in terms of anal erotism and reaction between the latter and environmental conventions. But it is surely a matter of everyday observation that such traits can be formed and lost again in reaction to later desires and later influences.

All these questions form material for study at first hand, to control or replace psychopathological data at present derived solely from the retrospective statements of adults. This is a task for the psychologically minded paediatrician which will bring great rewards, both theoretical and practical. In particular he will be struck by the plasticity of even the most ominous-looking personal characteristics, when compared with their rigidity in adults. He will also be impressed by the rapidity with which environmental influences produce and modify these characteristics, and if he observes them in an objective way, without schematical preconceptions, he will probably find a dominance of ego-tendencies, in so far as the inner contribution of the patient is concerned. Even the clearly affective attachments are often more reasonably construed in terms of desire for self-assertion and of self-esteem than of erotic drives.

Behaviour Disorders.

The behaviour disorders are, for the most part, the manifestations of healthy self-assertive tendencies which have been frustrated. This becomes evident both from an inspection of their nature and from analysis of the motives in individual instances. The cases in which the disorder of behaviour indicates the frustration of some erotic goal in the narrow sense are comparatively rare. Much more readily than the personality disorders, they yield to environmental rearrangement, in conjunction with brief talks with the child, sometimes of a mildly hortatory kind. The social history of children of this group often bears an impressive resemblance to the history of juvenile delinquents. There is a suggestive field for co-operative research here.

Psychoneuroses.

The psychoneurotic anxiety states and the hysterias of children indicate in my experience much the same conclusion, with an especially direct demonstration of the effects of environmental imitation and suggestion. While we must be wary of using superficial and easy-going explanations, on the other hand a facile interpretation in more recondite terms is to be guarded against, as is illustrated in the following case.

A boy, aged 11, was brought for advice because he was afraid of the dark. He would not sleep in any room alone: at home he was often peevish, and did not get on well with his younger brother, aged 8, who was a rollicking boy and physically stronger. The patient was said to be very much attached to his mother. The latter claimed to be able to intuit his thoughts, yet she appeared to have no knowledge of the details of the boy's fears, and indeed knew virtually nothing of his inner concerns. A skilled psychopathologist who saw the boy said it seemed to be on first scrutiny a very obvious Oedipus position, but that of course he could not commit himself without further knowledge. His caution proved to be well justified, for on further inquiry the mother revealed that the boy had never been allowed to sleep alone, and that he had slept for years in the same room with her, and always with a light burning. The reason was that his mother hated marital intercourse, and dreaded having more children, and so kept the patient and the light near her as measures of protection. She made no secret of the fact that she was mortally afraid of the dark. In the circumstances it was therefore not very wonderful that her son was afraid of the dark and of sleeping alone. An insistence on a more hygienic regime produced a remission of the boy's fears for a month, when the mother, being no longer able to stand the anxiety induced by his deportation, took him back to her bedroom, with consequent relapse of the boy's condition.

This was an unusually flagrant instance of the possibilities of misinterpretation, but it shows what is evident in many instances of anxiety in children—namely, the immense influence of parental example (often direct

example of obvious anxiety). The anxious atmosphere surrounding the child becomes the natural one for it. Anxiety is there as a matter of course, colouring all its views and enterprises. The same holds for the genesis of many childish phobias. These are often the crystallization at one point of a general sense of insecurity easily engendered in a young child facing a big and difficult world. Similarly, with obsessive and compulsive conditions, the part played by the stage of development of thinking (sympathetic magic) in determining their almost universal incidence, must be investigated in their relation to instinctive tendencies. Of hysterical conditions it may be said that again a common-sense evaluation is required. The problems of the hysterical constitution and of hysterical dissociation have not by any means been finally met by the hypotheses so far advocated.

All these problems, about which there is at present so much speculation, offer a promising field for really scientific investigation. The psychiatrist, who so often sees only the end-results, envies the paediatrician his opportunities of seeing the beginnings, of watching personalities in the making, and of guiding them towards healthy, happy achievement.

RESULTS OF TREATMENT IN EXOPHTHALMIC GOITRE.

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THERE is considerable uncertainty in the minds of many medical men as to the place of surgery in the treatment of toxic goitre, by which is meant not only exophthalmic goitre, but also those closely related conditions in which there are manifestations of thyroid intoxication, such as the so-called "toxic adenoma." It may be of interest, therefore, to review the results of treatment in a series of patients, some of whom were treated by thyroidectomy, and others by various methods but without thyroidectomy.

All the patients in this series were admitted to the wards under my charge during 1920-25, and since then have been recalled from time to time; only those who have been seen this year, or of whom reliable reports have been received this year, will be considered. A period varying from five to ten years has now elapsed since their admission to hospital. They all remained under direct observation in the wards for several weeks at least, and in some instances for several months, during which time many lines of treatment and investigation were tried according to the ideas or clues we were working on at the time, but neither x-ray treatment nor radium was employed; so that, although the number is small, they have been carefully observed. They were admitted because they were the more serious cases, and they include such patients as those with heart failure in preparation for surgical treatment, and similar cases in which surgical treatment was not carried out for one reason or another. The two groups—those treated by thyroidectomy and those treated by other methods—though not strictly comparable as regards the severity of the disease, are similar to a considerable extent, since many patients in whom thyroidectomy appeared advisable refused to undergo operation, and because we are always ready to delay operation, if possible, so that other methods of treatment can be tried. As a rule, thyroidectomy was advised in the more severe cases, and in those that proved resistant to other methods of treatment.

Of the 60 patients, there is no report for 1930 in 10, and of the remaining 50, 24, with an average age of 38 years, were treated surgically, and 26, with an average age of 35 years, by means other than thyroidectomy. Of the 24 treated surgically, the results (Table I) are good (capable of full work) in 15, poor (working with difficulty) in 5, bad (leading invalid life) in 1, while 3 are dead. Of the 26 treated by non-surgical methods, the results are good in 10, poor in 4, bad in 2, while 10 are dead. The

principal difference in the results in the two groups is the much higher mortality in the non-surgical group. Even if two patients who died in hospital of conditions not apparently connected with the thyroid disease are omitted, the difference in the mortality in the two groups is striking.

TABLE I.

Treatment.	Total Number.	Average Age.	Results.			
			Good.	Poor.	Bad.	Died.
Surgical	24	38 years	15	5	1	3
Non-surgical	26	35 years	10	4	2	10
	50		25	9	3	13

The patients can be subdivided into those with primary and those with secondary Graves's disease, although this distinction cannot always be made with confidence. The essential disturbance that produces the thyroid intoxication is unknown, but is probably the same in both. In primary Graves's disease, however, there is no evidence of previous structural change in the thyroid gland; the characteristic histological changes are found throughout the whole gland, and the subjects are usually young adults. The signs of intoxication may be very severe; this group includes the typical cases of exophthalmic goitre with the eye signs, tachycardia, tremor, vasomotor, and nervous disturbances. In secondary Graves's disease the disturbance arises in a patient who has a damaged thyroid gland already, as shown by coarse or fine fibrosis, colloid goitre, local areas of degeneration, etc.; the histological changes characteristic of the disease are found distributed in a patchy manner, and the subjects are commonly more advanced in years. The signs of intoxication are usually mild, eye signs and vasomotor disturbances may be absent, but the functions of the other organs of the body may be seriously crippled, possibly because they are older. The patients with but slight evidence of thyroid intoxication, but with auricular fibrillation and heart failure, belong as a rule to this secondary group.

The classification of patients that were treated by non-surgical methods into the primary and secondary groups, reveals (Table II) that the good results are found mainly

TABLE II.—Treated by Non-Surgical Methods.

Type.	Total Number.	Average Age.	Results.			
			Good.	Poor.	Bad.	Died.
Primary	16	28 years	8	3	1	4
Secondary	10	47 years	2	1	1	6
	26		10	4	2	10

in the primary group (average age 28 years), and the mortality is greater in the secondary group (average age 47 years). Of the four fatal cases of primary Graves's disease, two patients died in hospital of conditions other than the thyroid disease, but the other two were young females, 15 and 25 years of age, who were not seriously ill when in hospital, but who did not remain under observation, and relapsed later and died at home. The six patients with secondary Graves's disease who died had an average age of 45 years; one, aged 39, had been ill off and on for twenty years and died shortly after admission with an acute severe intoxication; one, aged 53, died after discharge, but no operation was advised because of the presence of pulmonary tuberculosis; and the remaining four died after discharge in acute exacerbations of the thyroid disease, having refused operative treatment when in hospital. Of the six patients in whom the result is recorded as "poor" or "bad," two have since undergone operation and are now improving, and two others have refused operations. Of the ten patients in whom the result is recorded as "good," two, aged 65 and 36 years,