cannot manage to open the door or is not visible over the receptionist's counter, offer the necessary help but do not fuss or consider other difficulties until they arise.

(6) If an examination is necessary, offer help on to the bed but do not lift the patient except by mutual agreement.

(7) Listen to the patient's suggestions and explanations because he may know more than you do about the condition causing restricted growth, which may or may not have a bearing on the problem of the moment. Do not be too eager to deny a link.

(8) When prescribing a drug, remember that the patient's weight is likely to be less than average.

(9) Encourage the patient not to put on extra weight.

(10) More thorough information is available in the *Layman's Guide to Restricted Growth* and *Coping with Restricted Growth*, both published by ARRG.

II—Children

VRELI FRY

The first way in which the doctor can help the unusually short child is to recognise that there is indeed a problem. So many parents are dismissed as being over-anxious when they are convinced that their child has grown inadequately for a period of time. The observation that shoe or trouser size has remained unchanged for an unusually long time is an important clinical clue. Proper assessment, including reference to a growth chart and allowance for parental heights, is essential. If there is still doubt after assessment, then the child should be seen and remeasured three to six months later to assess the growth rate and if necessary to take appropriate diagnostic steps. One of the major reasons for false reassurance is that many growth disorders do not affect general health and the children seem well and misleadingly normal.

A child with a recognised disorder of growth leading to short stature has various problems. These arise broadly from two aspects: firstly, coping with a world designed for children of average stature, and, secondly, the attitudes of adults and other children to them. Their reactions to their growth problems depend upon their likely medical progress. Children with a treatable disorder are usually optimistic and are often more able to cope with everyday problems. In contrast, a child with an untreatable disorder, with the corresponding pessimistic prognosis for final height, is much more sensitive to difficulties.

Doctors may contribute to their relationship with an affected child by a correct understanding of the child's true age and intellectual abilities. It is all too easy to relate a chronological and intellectual age to the child's size without recognising the fact that they are truly older and more understanding than one realises. It is fairly obvious that the child may resent being treated as younger than his years and as being less responsible than he feels he should be. What is not so obvious, but equally damaging, is that a child continually treated as younger than his age may indeed regress and behave as expected. Thus he will achieve less than he is capable of at school and consequently a future career might be compromised. The doctor should make the family aware of this problem. It is surprising how many parents themselves come to treat their child as if he were younger. If the parents are fully aware of this problem then they also are more likely to prevent the same pattern spreading amongst the more peripheral family, friends, and school.

Recommendations

The following are a series of particular recommendations that should be made to parents:

(1) Always treat the child as much as possible as a normal human being, only making those allowances which are absolutely unavoidable.

(2) Try to encourage independence. If a child can't reach a tap or light switch encourage him to use a chair or stool rather than performing the operation yourself.

(3) In the context of the above, try to forsee such problems and have the necessary help immediately available. This avoids the embarrassment of the child having to ask and the frustration when you are not around.

(4) Do not allow your friends and family to talk down to the child and to treat him as a special case. Bring them into the picture about the child's height and make clear your feelings on how they react to the child.

(5) Do not allow brothers and sisters either to become overprotective or to adopt a bullying role. Include them in discussions of the problems of the short child and encourage an atmosphere of openness within the family.

(6) At school make sure that the staff are aware of the problems and of the child's need to be treated appropriately for his chronological or intellectual age and not according to his appearance. On the other hand, do not be bullied by the school into allowing the child to do quite inappropriate activities. Physical education, while generally perfectly good and safe for a short child, may sometimes demand quite impossible tasks. Small hands cannot always grip climbing frames, etc, and small bodies may not respond well to being thrown about by other larger individuals.

(7) Also in the school be alert to teasing, which may become cruel and psychologically damaging. It is equally important, however, to strive against mollycoddling, either by friends or members of the school staff. Being the school mascot may be fun at times but may also be cruel.

(8) With the older child and adolescent be aware of their frustrations with clothes. Sometimes the fashions that they wish to wear are unavailable in their small size. Although this may seem trivial it may be yet another way in which the child is singled out as different from his peers. This deficit may often be made good by careful shopping or home manufacture.

Finally, some of the above recommendations may lead the family into conflict with authorities concerning special provisions. The doctor must be prepared to support them with authoritative statements about the child's needs.

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