left alone; (3) providing rest, blankets, and hot drinks as appropriate; (4) encouraging timely ventilation of the affective component of the experience; (5) using reassurance and suggestion during the period of heightened suggestibility; (6) adopting the leadership role, issuing confident and easy-to-follow instructions, and encouraging purposive activity; (7) conveying accurate and responsible information to survivors, their loved ones, and the media and squashing rumours as they emerge; (8) transferring disturbed and disturbing patients to a special treatment centre; (9) using psychotropic drugs conservatively and only when definitely indicated; (10) referring patients showing emotional sequelae for psychiatric assessment or treatment, or both.

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Problems of Childhood

Disobedience and violent behaviour in children: family pathology and family treatment—I

ARNON BENTOVIM

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How to control disobedient and violent behaviour in children is a prime concern today. How should such problem behaviour be dealt with, contained, and helped in family, school, and society at large? How much is it the responsibility of the family and how much of society to socialise its children? Families have had little help from the pendulum of professional advice, which has swung from permissiveness at one time to restriction and control at another and then back again. Parents who themselves have come from small families lack the conviction of experience in knowing how to deal with their children. They seek help from a plethora of newspapers, magazine articles, and books, trying to find their way through what seems to be an increasingly uncharted sea. The importance of parents getting the right help and advice from early on is emphasised when it is realised what

a powerful influence each successive stage of development has on the next. The quality of the relationship formed between infant and mother acts as the foundation for the subsequent relationship with the father, which then acts as a base for the relationship with siblings, other children, and adults in play-groups, and nursery, primary, and secondary schools. Although certain changes may occur from phase to phase of development, temperamental, behavioural, and relationship characteristics remain consistent. In the clinic we may see a 10-year-old presenting with difficult, aggressive, or disobedient behaviour at home or school who can be traced through his infancy as having been a difficult baby, an active hard-to-manage toddler, a defiant restless 5-year-old in the reception class in school, an increasingly disruptive 8- and 9-year-old with learning problems, and possibly a delinquent antisocial teenager.

Such a 9-year-old boy was described by his headmaster as having been a problem for four years—that is, since starting school. He was said to be a source of trouble and concern to teachers, school helpers, and other children. At first he could be restrained, but latterly, as his tantrums were getting worse and more violent, it was becoming impossible to restrain him as he grew bigger and stronger. Wherever there was trouble he was to be found. Only the most experienced could cope. He

Department of Psychological Medicine, Hospital for Sick Children, London WC1N 3JH

ARNON BENTOVIM, MB, FRCPSYCH, consultant psychiatrist

lashed out for the most minor frustrations with arms and feet, getting into blind rages, bruising, and kicking staff. He was also impulsive and dangerous in his dashing out into the street ignoring traffic conditions.

To understand the problems of a boy like this and the way that such difficulties emerge from his earlier phases of development and relationships, the problems of disobedience and violence will be described as they occur.

Infancy

During the first weeks and months of life a baby's demands are imperative and imperious. There can be no trust or awareness in an outside world to come when called, so that demands are powerful and frustration cannot be brooked. Here is the paradigm of anger and rage. Emotions are felt to be overwhelming and his cry is saying "I must be loved and looked after, in every respect, by everyone without anyone demanding any effort from me, or claiming any return or it will be horrifying for the world and for me, and I may have to use desperate methods."¹ Once the baby teaches his mother how to meet his needs, his primitive, violent emotional response will lessen in intensity. Trust and awareness of an environment which is benign enable the infant to wait and postpone the need for instant gratification. He then may substitute signals instead of his all or nothing explosive outbursts, knowing that they will be observed and responded to whether his need is for feeding, changing, or just social stimulation and company.

For this process to occur satisfactorily some conditions have to be satisfied. The infant's biological responses and temperament must be modifiable by ordinary "good enough" mothering. Even the most experienced parent finds an irritable infant after a difficult birth hard to adapt to. Also the mother's capacity to respond—her "primary maternal preoccupation"—must not be impaired by unnecessary separations or overwhelming personal, family, or social concern. The father and the rest of the family must both support and take their turn in helping to make a satisfactory environment. The doctor faced with a continuously screaming angry baby who refuses to be pacified has to try to understand whether the problem originates primarily from baby, mother, or the environment. He has to support a baby's claim not to be regarded as naughty when he cries or gets angry. He also has to support the parent's claim not to have to be perfect and must respond to their distress, guilt, and anger.

BREAKING THE VICIOUS CIRCLE

It is essential to break the vicious circle which reverberates between parent and infant to prevent the violence and abuse which may follow. He needs to assess the baby's state, his birth history, mood, and general health, also the mother's mood, and the presence or absence of an evident or masked puerperal depression. He needs to observe carefully the meshing, handling, and interaction of the two and their ability to give each other pleasure as well as how tension and anger emerges. He also needs to consider the wider marital, family, and social situation. Does the marriage have sufficient resilience to stand up to the strain imposed by attempting to meet an infant's demands, particularly if they are atypical? Does the broader family and social environment of grandparents, neighbours, and professional caretakers give sufficient support to the couple to support each other? The environment in which the parents themselves grew up also needs to be asked about to assess personal resources. Parents whose legitimate demands as children were experienced by their parents as excessive and therefore punishable are liable to take a similar attitude to their infant and young child's demands in turn despite the best of intentions.

A situation which has reached fission point needs instant defusion in the short term so that a supportive strategy can be devised.

An example was a boy of 6 months admitted to a paediatric hospital as the mother found herself hitting the child on the legs because of his tense angry crying. She was frightened of her feelings, and he had proved a difficult infant to bring up for many months. He was difficult to feed, colicky, frequently holding milk in his mouth then vomiting. This behaviour disgusted his mother, who found it increasingly difficult to comfort him when he was crying, distressed, and angry. His whiney, miserable, demanding behaviour caused concern during the first week after admission when even experienced nursing staff found him hard to feed and irritating to hold. He responded gradually and could then be reunited with his mother when she accepted admission to hospital herself.

Meanwhile, exploration disclosed a network of family and social experiences which led to an understanding of the mutual rejection of mother and baby. The mother's parents had divorced when she was 7 and they had each remarried. She had had a tense unsupported distant relationship with them both, having been at boarding school for many years. She had also moved away from her family because of her husband's possible change of job, and she was isolated and lonely in her new home. Her marriage was based on a shared liking of clothes, furniture, and friends, but her husband withdrew himself from her increasing emotional demands. This response of his could be accounted for by his previous avoidance of the demands made by his own mother during a longstanding depressive illness. The result was increasingly aggressive, hostile feelings growing between husband and wife, affecting all areas of the marriage and spilling on to the child. Both during and after admission long-term emotional support and sharing of care of the child was essential to help promote the bonding process between parent and child, the parents' own relationship, and establishing a wider network of help to support them as parents and in their marriage.

The doctor needs to mobilise community resources so that health visitors and social service departments provide the regular visiting, day nurseries, mother and baby groups, and case-work that is essential to help parents learn the necessary skills.

The importance of intervention at this early stage is not only necessary to prevent abuse but also to ensure that the infant has a predominance of "good" pleasurable experiences as internal resources to face the inevitable pains of growing up. There is some evidence that when crying is responded to promptly during the first year² more confidence and better communication results. When babies are allowed to cry for longer periods more anger and less confidence in the outside world develop.

The pre-school child

The preschool child is caught up in the process of finding that his demands are met not by magic but by a person outside himself. He has to appreciate that the sources of comfort and discomfort are the same. The parent who is experienced as the source of goodness and pleasure also is the one who says no, associated with misery and pain. His feelings of being the centre and in control of his universe give way to a realisation that he is a small dependant individual with all the attendant fears of abandonment and loss. To cope with this he attempts to win back command. His assertiveness leads the toddler towards rapid development and actual competence, and he uses other devices to take hold of what is not within his grasp. Stubbornness and wilfulness are characteristic responses—insisting the parent stays with him while going to sleep, eating only what he chooses, wearing what he wants, not using the pot or feeding despite having the skills as if to say "I am the grown up one and you are the child who is going to do what I tell you to."

TEMPER TANTRUMS

Temper tantrums are one of the commonest means to this end. Tantrums often occur at time of tiredness, illness, or change, but they may grow to such an extent that the family becomes fearful of the child's rage and gives in on any account. He may hit at a new baby, smash and break objects in the home, lie in

the middle of the street or the supermarket screaming and kicking his legs. Parents become fearful of their own anger and interactions may become increasingly fraught with smacking and shaking. The family can reach the end of its tether. A child who may often be overactive appears in the doctor's surgery angelically at first, confounding the parent's complaints.

A boy was seen aged 3 years 8 months who had been becoming increasingly difficult over six months. Severe violent temper tantrums were the main complaint, often set off without obvious reason but sometimes provoked by minor frustrations. He had to have the last word, would shout "No" to any request, hurl objects around, smashing many of his toys, and demand the television at any time, even learning to plug it in himself. His parents had tried every way of stopping him, putting him in his room, but he showed a tremendous amount of strength. There was no evidence of any medical cause such as temporal lobe epilepsy. Sometimes he could be pacified and talked out of an attack but generally it was impossible to stop him.

He had always been a temperamentally difficult boy—on the go with considerable intensity of play. His development had been rapid, but he could only be got to sleep by being driven around the block in the early days. He was a finicky feeder and was very reluctant to chew—the only area he failed to "bite on" whole-heartedly. His controlling, disobedient, violent behaviour was limited to the home and did not occur in nursery school.

There were no obvious precipitating factors to his gradually increasing temper outbursts. Seeing the family together in a conjoint family interview, however, did offer some clues. His own pattern of play indicated a preoccupation with battles. His mother's angry posture, tone, and general attitude towards her son indicated that she was as angry herself. It appeared that she was provoked and was in turn provoking. Their battles seemed endless. She described her brother as having had similar behaviour with her own parents. The father, a rather more placid and controlled person but with a considerable temper when roused, seemed less concerned in the friction. Indeed, he had been able to stand back and observe the way the family behaved even before the consultation. He had realised that his son was almost deliberately going out of his way to irritate them, appearing to give himself a reason to have the tantrum, as if to say "Now you've been angry with me, I can be angry with you, even if I started it." The father encouraged his wife to ignore this behaviour, and when there was a severe tantrum his father together with a friend had held him firmly for an hour. They held on until he calmed down. On that occasion he could not convince himself that he really did have bad parents who were cruel and angry, making it safe for him to bully at whatever cost. He emerged from this tantrum in a far more friendly mood, and began to be affectionate and loving in a way that his parents had not experienced before. He also suddenly began to talk about events such as his sister's birth which he had not acknowledged previously. The doctor's task in this case was to help them understand what they had enacted spontaneously.

When such families are seen it is often striking how little there is in the way of warmth, praise, and reinforcement of good behaviour. Instead there appears to be communication by provocation. Normal communications, such as showing a parent a toy or asking a question, will be ignored, so it is expedient to use more noisy signals, provocation, and attacks. These may come to predominate so that when the child is quiet the family can get on with its affairs, thus the cycle of noisy signals to get attention is perpetuated. Aggressive interaction, even smacks, becomes the reward; the result is momentary relief of tension for parents and child but with the seed of repetition sown.

INTERACTIONS

Such interactions may have different reasons; a battle between a parent and child may divert and detour feelings from a marital conflict. Battling relationships between parents and their own parents or siblings also seem to be reproduced with the children, perhaps with the child who reminds a parent of himself, his own parent, or a sibling. This may be on the basis of temperamental or physical similarities, or it might be due to "unconscious" shaping of the child to respond in a way that confirms the belief and then brings it about. The system may become even more complex when the parents have chosen each other without awareness, on a similar basis of conflict. The

parent chosen for strength, consistency, and reliability may in fact be showing "false self" to cover a true "weaker, dependent, demanding, or dominating" side. The parents then shape each other into the role of the parent with whom they had conflict and in turn this becomes reflected on to the relationship with the children which leads to a situation perpetuating a cycle of violence and anger. The family system itself needs to be treated in such a case. To get some idea of how the family functions, it is important to see all its members together. Although they may wish to talk about the child without him there, it is important not to accede to such a request as the child usually knows only too well what the consultation is about. An example of openness of communication set by the doctor may start off a change in family functioning which may have far-reaching effects.

Parents need to be shown how to take notice of the positive communications from each other and from the children which are so often being ignored and neglected. To accomplish this a model of how to respond needs to be provided by the doctor. Attendance at a parent preschool child day centre³ may provide a setting where a child can be helped, and the parents can learn from and be supported in a new way of responding. At the same time various individual, family, and group approaches may help to clarify the roots and current factors perpetuating these problems. Many ways may be used to reinforce benign interaction, ranging from helping a parent not to feel the intense loss of face at occasional defeats by their children, and using star charts and specific rewards for periods of behaviour without anger and disobedience, to ignoring provocative behaviour that can be overlooked. Parents may be encouraged to respond to absolutely forbidden behaviour by brief periods of isolation rather than punishment so that the family can communicate the message that they will respond and reward what is appropriate but will ignore and not reward anger by anger. It has to be possible for the child to accept being dethroned and not be the king without loss of face, he needs to be given a feeling of security, affection, and love to accept his true status.

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A patient on one of the low-dose anovulants experienced break-through bleeding during her cycle. Around the time she was having this break-through bleeding, she was admitted to hospital for sudden chest pain, subsequently diagnosed as due to a pulmonary embolus. Is there any correlation between the break-through bleeding and the possible risk of pulmonary embolus?

There seems to be no known correlation between this break-through bleeding and pulmonary embolism. Such bleeding seems to be an effect of too little oestrogen, while thrombosis seems to be more associated with high oestrogen doses. The woman at risk of thromboembolism cannot be foreknown on simple clinical criteria though attempts are made to do this by the well-known "contraindications" to prescribing the pill. There is a margin of error both ways, and every prescription is in the nature of an experiment in an individual woman, though with an acceptably small statistical risk.

A young man wants to do underwater diving which will include the use of compressed air breathing apparatus. Until he was 11 he was treated for epilepsy and his EEG was abnormal. Since then he has had no treatment and no further episodes. Is it safe for him to dive?

It is as safe for this young man to do underwater diving as it is for anyone. If the apparatus were faulty and there were a lack of oxygen or an excess of carbon dioxide, he would be more likely to have a fit than someone without his previous history. But such faults in the apparatus would be a disaster for anyone.