would, for example, pay for two years' regular nursing surveillance of all the over-65s on an average general practitioner's list.⁶ Nevertheless, even with such a poor economic cost:benefit ratio, it is still possible that decision makers might consider that the schools' BCG programme remains worthwhile in order to avoid the non-economic costs—such as the pain of illness—or in order to aim at eradicating the condition. The decision model is elaborately presented by Waaler and Rouillon.⁷ In this case it is necessary to ask whether the schools' programme is cost effective, or whether the same or greater reduction in morbidity could be achieved more cheaply by alternative immunisation programmes.

A cheaper programme would be selective. Two factors should be considered. Firstly, the incidence of tuberculosis is much greater in immigrant communities.⁸ Secondly, notifications of tuberculosis are clues which often lead to identifying and immunising groups of people who are at risk and sometimes lead directly to the source of infection or to other infectious cases. A positive reaction to a Heaf test at age 13 is a very poor clue, but the same may not be true of a test at 5.

Research designed to test the advantages of selective immunisation programmes, and considering the possibility of changing the age at which immunisation is offered, could yield results by

the time when the present programme would be relatively so expensive that the health service would find it very difficult to justify its continuation.

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References

- ¹ Department of Health and Social Security, *Health and Personal Social Services Statistics for England, 1974*. London, HMSO, 1974.
- ² Medical Research Council, *Bulletin of the World Health Organisation*, 1972, **46**, 371.
- ³ Campbell, I, (1975). Private communication.
- ⁴ Springett, V H, *Practitioner*, 1975, **215**, 480.
- ⁵ British Thoracic and Tuberculosis Association, *Tubercle*, 1975, **56**, 129.
- ⁶ Shaw, S, in *Probes for Health*, ed G McLachlan. London, Oxford University Press, 1975.
- ⁷ Waaler, H, and Rouillon, S, *Bulletin of the International Union against Tuberculosis*, 1974, **49**, 1, 166.
- ⁸ British Thoracic and Tuberculosis Association, *Tubercle*, 1973, **54**, 249.

Problems of Childhood

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

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The child of school age

Unlike the young child, who has a tendency to attribute all discomfort to others and blame them, the child when ready for school should have a sufficient sense of himself as a person to be able to distinguish clearly what he is responsible for and what he is not. He should have a reasonable conscience which guides his actions without needing constant reminding and which is not overstrict or too controlling, leading to passive behaviour—or defiance. He should have a reasonable ability to relate assertively to other children and adults—sharing, taking turns, and postponing gratification sufficiently to wait rather than to have what he wants immediately. These are all satisfactory conclusions to the preschool period. Epidemiological findings¹ indicate that disorders of emotion and behaviour are seen significantly during the preschool period when children are brought up in families where marriages are in difficulties, one or other parent has a psychiatric problem, particularly the very common depressive symptoms in mothers, and there are major social difficulties and breaks in caretaking by one or other parent.

Marital separations and anomalous single parent upbringing also make the child's adjustment to starting school more precarious. The relationship with teachers and other children then has to carry the unresolved problems and crises from the earlier period. Similar factors—marital disturbance, family psychiatric and physical illness, parental separations, and social difficulties—are also seen in the families of children showing disturbance during the school age period.²

AGGRESSIVE BEHAVIOUR—ANTISOCIAL OR EMOTIONAL DISORDER

Characteristically children with antisocial difficulties are belligerent, uncooperative, and disobedient in family, school, and society. Such problems occur more often in boys, and the children are often restless at home and in class, impulsive, and attention-seeking and fail to exercise self-control in the face of provocation. Learning becomes difficult and may lead to poor educational achievement; a continuing sense of failure; and a need to gain status within the classroom or family by bullying and aggressive behaviour. A false sense of triumph is gained by putting down other children and teachers, but this may be accompanied by a feeling of emptiness, misery, and depression. Depending on the quality of parental control such problems may spread outside the family and school into society itself, with older children playing truant, stealing, or behaving in an aggressive and violent way towards property or other children and adults.

It is important to distinguish between children whose aggressive behaviour is part of an emotional disorder—that is, the child who is predominantly anxious, fearful, or depressed—

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and those in whom aggressive behaviour predominates and emotional symptoms are secondary. Children with antisocial disorders may be seen as "socialised"—that is, as part of a delinquent gang sub-culture—or "unsocialised," where the personality is far more disturbed and problems are seen more widely. Contact with schools often provides important information about the child and his family which will enable the physician to make such a distinction and confirm his own observations.

A girl aged 7 was seen and found to have an emotional problem basically, but she was also very disobedient and difficult to handle in the family. The major problems were of severe nightmares, worries about attending school, and bed-wetting. At the same time she was highly disobedient and furious with any discipline imposed by her mother. She refused to get up and had tantrums when asked to get into the car or to change her dress. This led to frequent confrontations with her mother like those of the preschool child described in my earlier article.

When seen with her mother the reasons for her disturbance became clear. Although her mother thought that her daughter knew little of her father's illness she was only too well aware of the facts but in a confused way. It is important to stress to families that it is a myth to believe children will not know unpleasant family secrets if they are not talked about openly. Whispering and silence will give rise to much worse imaginings and the truth is often less harmful.

This girl's father, although an able professional man, had had severe psychiatric problems in the past. He had had drinking episodes and violent marital disputes with his wife. It could be seen that this child's nightmares—full of violent monsters—were a response to her experiences of her father during his past illness. There was also, however, the question of why this particular girl was disturbed rather than her younger siblings, who were relatively unaffected. An interview with the whole family showed that the father favoured this girl over her siblings. She was seen as having a similar temperament and character to her father, so reinforcing the identification with him. Much of her mother's frustration and resentment seemed to be expressed towards this girl as a substitute, the girl responding like her father with absolute opposition, stubbornness, and bossiness. Yet she was full of conflict and anxiety at the position she felt herself to be in, a burden which needed to be lifted from this child so that she could live with less anxiety.

It is important to ask to see all the members of a family including both parents and siblings, and other important family figures at a later date. The task is to help them as a group to realise that the disturbance shown by one of the family members needs to be understood as part of their whole way of living, including the rules which they have laid down for children's conduct and control.

ANTISOCIAL BEHAVIOUR AND FAMILY DYSFUNCTION

When families are seen together and encouraged to discuss their difficulties it is often discovered that the family's rules are not clearly spelt out so that the child can really comprehend what is required of him. One or the other parent, although saying one thing, may be providing a model of too easy anger and rage in the face of frustration. He may also be giving a rejecting response to an appropriate communication or not spelling out clearly what the choices are for the child to follow. An over-punitive method of control within the family may well result in such tension in one or the other of the children that this has to be discharged elsewhere, to a sibling or a child in class, using the model provided. Alternately, intense guilt may be aroused with depression, punishment-seeking, or hidden aggression—soiling, wetting, or even suicidal wishes or gestures.

A 10-year-old boy with an antisocial problem told his doctor that he was bored at school, and to liven things up he interrupted the teachers and started arguments. He admitted losing his temper easily, he liked rows and thought of them as a bit of fun. Other children called him names and took "the mickey" out of him. This, he claimed, made him lose his temper. He also said he could not bear to be blamed without being given the chance to explain, but he was always shut-up, which upset him and made him even more angry. He also complained

that his mother was always telling him off, never accepting his version of the incident. He thought he was no different from anyone else but they were sly and avoided trouble. His parents found him quite uncontrollable and reported that he had been excluded from two schools already. A school report stressed the problems in management. They added that he was always keen to help, but could not wait to learn, so never did anything properly, shrugging off any attempt to teach him with a tantrum. Although apparently bright his educational attainments were poor. He was also a particularly big boy for his age.

He was seen with his parents and younger sibling, and he rapidly demonstrated his ability to dominate, complaining about everyone else in the family. He also boasted of his own sense of self-importance and achievement, sounding false and self-reassuring rather than this having any basis in reality. What was striking during this unusual diatribe was the parents' complete flatness and lack of emotional response. When confronted with this they agreed that as people they were unemotional, were both very independently minded, and had won a great deal by hard work and self-reliance. They had coped with a good deal of hardship and deprivation in their own upbringing. They had earlier regarded their son as showing all the strength they were trying to achieve. His mother felt that he had been born advanced, like a baby of 3 months. She saw him as doing everything early and easily in his development well ahead of his contemporaries. This myth was supported by his height and had led to an expectation of him being stronger and better than anybody else. This omnipotence and feeling of invulnerability could be maintained only by his pattern of aggressive controlling behaviour. He rejected any evidence of weakness and had developed a "false self." Underneath the parents' apparent lack of emotion was considerable depression and hopelessness, obliterating what had been an over-idealised love of their son, replaced now with vehement rejection. The sibling was apparently untouched by this intense triangle of mother, father, and son.

The boy himself was able to show something of his true position by reluctantly sharing a recurring dream. In this he was the captain of Europe. He was voted to this office by the whole population with the rest of the world making a treaty with him to be friendly. He then arranged all the explosives of the world to be deposited in space. Through this dream he showed his family ideas of omnipotence with a wish to try to get rid of all the explosiveness and rage. It was then possible to discuss with the whole family the way that power seemed to be vested in him which he so tried to live up to. There was, in fact, a shared feeling of weakness and vulnerability in all the members of the family and a powerful fear of failure. Once the family was shown how similar they were to each other, some change was possible towards an ordinary expectation of each other. His new school was also contacted to share the understanding reached of this boy and his family. His teacher was advised to bring him down to earth when he tried to cover up his difficulties with bluffing and boastfulness—but with understanding not rejection.

FINDING THE BALANCE

Families need to find a balance for themselves out of the tensions, backgrounds, roles, and history of all the members within it. Patterns of family life may be transmitted from generation to generation almost in a genetic fashion—for instance, one family might find themselves always creating relationships of two, so that one person, becoming an odd one out, has to be excluded.

A boy of 10 was antisocial, stealing outside the home, defiant, sulky, and uncooperative at home. In his family the mother was very closely identified with the younger daughter and they formed one couple. The father appeared to be peripheral in the sense that he worked very long hours outside the family, and the boy was left in an isolated position. He had related closely to a grandmother, who over-indulged him early on, but this had lessened as he grew older. He stole to comfort himself and protested angrily at his exclusion from the family. The situation was helped by the father taking his son to work with him at weekends and beginning to make a relationship with him. Needless to say the mother and sister had to be encouraged to separate themselves from their over-close relationship.

It is important for the doctor to help the family to make a "new" beginning and to see that anger and stealing can be a cry for help, and that it is never too late to change. Even small changes may start a benign cycle of success in place of the vicious cycle of failure.

Inflexible and rigid patterns of relationships do not meet the changing needs of children as they grow up, since a child will need close contact with one parent during one phase of development and the other or both parents at a different time. As a result of rigidity a child may be made to feel a scapegoat—unloved, unrecognised, and sensitive to criticism. When there have been actual separations at significant periods, with the absence of one or other key parental figure through death, illness, or marital breakdown with all the accompanying disturbances that accompany such events, feelings of rejection and devaluation of the self may become extreme. This may lead to ever more powerfully angry reactions whether directed to others or to the self. A child may also become a scapegoat if his birth was associated with a period of the family's life when there was strain or strife; a parent may have been depressed and could never get on to terms with a particular child.

FAMILY DYSFUNCTION AND FAMILY THERAPY

To change rigid patterns of feelings and living in a family the doctor often needs to take a highly active role in pointing out discrepancies in communication among family members. He needs to model different ways of relating to the child showing the family how different his response can be. Painful secrets in the family's history associated with the child need to be talked out. Hidden problems unfaced in the marriage need to be brought to light, taking the heat off the child. Fortunately, many families have considerable resources of strength and once changes are made then the families may take over themselves. Interventions do not have to be made frequently and fairly few interviews are often sufficient to make quite major changes in a family's way of functioning. The therapist needs to respond to his own feelings about the family with some force; the family system is a resilient one and may bounce back despite being dented.

As well as changing families, schools also need to organise themselves differently to help with unsocialised aggressive children. Smaller groups need to be provided, with more

consistent relationships, reward systems, and few changes of teachers and staff. Nurture groups may help the immature to begin to trust and work through some of the growing-up stages left out previously. Special school settings may be necessary, although there is a danger that such institutions could be completely overwhelmed by the many antisocial children seen in urban areas. Aggressive children and how to help them and their families are some of the most difficult problems that have to be faced and dealt with today. So many of the families seen have so few resources to build on; there may be no family in the true sense. Parents may be absent or there may be a single overwhelmed parent. In a social setting full of deprivation and violence the child's trust gained from school or clinic may soon be dissipated when the environment cannot reinforce with sufficient consistent and structured positive interest and response. Residential therapeutic settings may then be necessary to provide a complete community for the child.

Once the child has become an adolescent, then society itself has to step in, either through care or court proceedings, using a wide variety of custodial and therapeutic interventions, often, unfortunately, of limited success. Perhaps an important preventive action would be for children showing persistent aggressive and disobedient behaviour during the preschool and early primary school periods to be picked out in school health clinic and general practices and helped, together with their families. In this way it might be possible to find some way of living which could adequately socialise, nurture, and provide an appropriate model of behaviour for children. The aim for them is to be able to show concern and caring as a way of enhancing their feelings of self-esteem rather than through disobedience, violence, and destructive triumph.

References

- 1 Richman, N, Stevenson, J E, and Graham, P J, *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 1975, **16**, 277.
- 2 Rutter, M, Tizard, J, and Whitmore, K, *Education, Health and Behaviour*. London, Longman, 1970.

Is the ampicillin sensitivity that occurs during glandular fever specific for the presence of the latter, or is it long-lasting?

Ampicillin sensitivity is almost universal in glandular fever and is probably related to the disease. It is unlikely therefore to be long-lasting, but since maculopapular rashes occur frequently with ampicillin treatment they may be expected occasionally in people who have had a similar reaction with glandular fever. The cause of this type of rash is not known with certainty but is thought to be due to impurities rather than to penicillin allergy.

Could a child aged 7 months born with congenital rubella be infectious to mothers or children?

Rubella virus may be detected in the nasopharyngeal secretions of about 85% of new-born babies with severe manifestations of disease whose mothers acquired rubella during the first trimester of pregnancy. Virus may also be recovered, but less consistently, from the urine and stools. From 1-3 months of age about 60% of these babies are still excreting virus; by 5-8 months about 33%; but by 9-12 months the proportion has declined to about 10%. Babies excreting virus may certainly transmit infection to susceptible contacts of all ages. Whenever possible, attempts should be made to isolate virus from such infants. Until virus is no longer being excreted, women of child-bearing age who may be in the early stages of pregnancy should be dissuaded from nursing or visiting such babies unless serological tests confirm that they are immune. Although some babies may have serological evidence of infection and, if followed up for long enough, such subtle defects as some degree of perceptive deafness or retino-

pathy may occasionally be detected, when maternal rubella is contracted after the 16th week of pregnancy neonatal virus excretion rarely occurs. Rubella virus has been recovered from surgically removed cataracts in children up to 3 years old² and from the brain of a congenitally infected child who developed a subacute sclerosing panencephalitis-like syndrome during the second decade of life.³

- 1 Cooper, L, and Krugman, S, *Archives of Ophthalmology*, 1967, **77**, 434.
- 2 Menser, M A, *et al*, *Lancet*, 1967, **2**, 387.
- 3 Weil, M L, *et al*, *New England Journal of Medicine*, 1975, **292**, 994.

Occasionally small quantities of dangerous drugs prescribed on EC10 are left unused when a patient dies. Is it illegal to take these into stock, entering the source of supply in the Dangerous Drugs Register as "left unused on the death of . . ." and if so what action should be taken to ensure the destruction of such dangerous unused drugs?

Under the Misuse of Drugs Act 1971, Section 4(1)(b) it is illegal for a person to supply a controlled drug to another person otherwise than in accordance with the provisions of the Act or of the Misuse of Drugs Regulations 1973. Strictly speaking, therefore, a doctor should not take into stock, or even into his possession, any drugs left over when a patient dies or otherwise no longer required by a patient. There seems to be no specific reference to this eventuality in regulations, but the accepted custom is to advise the relatives to destroy the drugs, commonly by burning them or flushing them down the lavatory pan; the doctor may think it wise to supervise this destruction in some cases. Regulation 24 of the Misuse of Drugs Regulations 1973 sets out the formal conditions regarding the destruction of controlled drugs by persons required to keep records of having them in their possession, but this does not apply to a patient or his relatives.