especially the cessation of smoking, losing weight, and the encouragement of exercise. A common finding too has been that when no prescription is offered the patient seems more ready to declare the real problem that bothers him—for instance, a psychiatric or marital problem. Over-reaction to, and prescribing for, the minor illness itself can prevent the major problems being discovered. As with any teaching it became necessary for the doctor to know his subject. Hence there has been some extra study of the virology of common respiratory infections and a closer look at studies of minor illness in general.

Some patients have been delighted with this new style of consultation, sharing with doctors an anxiety about the number of pills, medicines, and antibiotics currently being consumed. Patients are well aware of iatrogenic disease and are pleased to see attempts made to prevent it. Some patients' attitudes to the consultation have changed in that children particularly are brought "just for you to check him over doctor," without any expectation of a prescription if nothing is found after the examination.

A regrettable shortcoming of our methods was that the local pharmacists were not told in advance that it was to take place and therefore were unable to anticipate economies in supplies and staff. As a result of this, however, moves are taking place to include the chemists more actively in the primary health care team.

Although the new policy was meant to rationalise and reduce prescribing for minor illness only, the savings effected no doubt partly reflect a greater awareness of prescribing as a whole in any consultation about any problem. The end result has been a

considerable saving in the cost of the drug bill for the National Health Service, coupled with more time becoming available for more serious illnesses and more patients.

A leader in the *BMJ*⁸ suggested that "attitudes cannot be changed overnight and it would be unrealistic to expect habits and beliefs established over 30 years to be eradicated easily." Although perhaps not achieving its end results overnight, we have certainly achieved far more than any of the team members expected in a comparatively short time. We think that to some degree there has been the hoped for "return to the old virtues of self-reliance and independence."⁸

Without the co-ordinated effort and support of the whole primary health care team in Norton Medical Centre this paper could not have been written.

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Contemporary Themes

The other handicap: brightness

M E LOBASCHER, N P C CAVANAGH

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Summary

Because of changing attitudes to the measurement of mental abilities, only the slow child is assessed and receives special educational help. By contrast, the bright child may remain undetected because unassessed. For these children there are few special provisions, and they may present as behaviourally disturbed or educationally retarded. We describe four such children, and we feel that more facilities should be devoted to helping bright children, both at home and in school.

Introduction

The concept of the intelligence quotient (IQ) has lost some of its importance over the last 10 years for various methodological,

political, social, and ethical reasons. The testing movement and the proliferation of written tests used by schools, industry, and vocational guidance have more often assessed social status, educational opportunity, and literacy rather than the individual's ability to think, reason, and plan effectively in a verbal and motor setting, as was originally intended. Children who are socially and linguistically impoverished or immature often do badly in such tests, and the results, as in the 11-plus examination, can prejudice a child's educational opportunities and future. To balance out such inequalities, measurements of differential mental abilities have been largely abandoned within the state educational sector. Instead, the emphasis has rightly been on helping the child to develop and fulfil himself, whatever his level of skills.

Despite the disquiet felt by the critics of the IQ test, there must still be means by which to measure an individual's performance with the use of a reputable, individually administered test. Few educationalists and paediatricians would dispute the need to recognise and provide special educational facilities for children whose IQ is less than about 70. These children constitute about 2.5% of the school population, and there are excellent schools available for them in Great Britain.

A similar number of children occupy the upper end of the Gaussian curve of the distribution of intelligence, having an IQ greater than 130. Nevertheless, there is little agreement

Hospital for Sick Children, Great Ormond Street, London WC1N 3JH

M E LOBASCHER, MA, MPHIL, principal clinical psychologist
N P C CAVANAGH, MB, MRCP, senior registrar in neurology

about the need to recognise their abilities or to provide adequate educational facilities for them, and at present such attempts within the state educational sector are limited to out-of-school and holiday enrichment courses. Ogilvie¹ has proposed that the term "gifted" should include any child who is outstanding in either general ability or a specific ability such as mathematics, science, language, art, music, sport. This definition would raise the initial figure of 2.5% of the school population to 5%.²

The Court Report makes much mention of children with learning difficulties,³ "children in special need,"⁴ and recognises that "psychiatric problems commonly develop in association with... educational problems."⁵ The concern, however, is entirely with the educationally subnormal, and nowhere is there mention of the gifted child. These children are also the hapless victims of present state educational policy, and providing for children of high intelligence has become associated with meritocracy, racism, and a particular stand in genetics.

Some gifted children are accommodated within the private sector or the sixth forms of comprehensive schools. But some children can never show their special talents, and they do not survive intellectually or educationally long enough to be selected for bands and disciplines adequate to their needs; they may become behaviourally disturbed⁶ or chronic under-achievers.¹ They may make their plight known by developing hysterical or psychosomatic symptoms, or they may be referred to the school psychologist for reading retardation.

The idea that intellectually able or very able children may not reach the level of their own potential at school, or may even fail to achieve the level of most of their own age group, has been slow in gaining acceptance, despite the evidence.⁷ We wish to draw attention to such children and to emphasise that they as well as retarded and handicapped children need to be recognised and provided for. We present details of four patients selected from a large sample presenting at the hospital within the last 18 months, which illustrate the predicament of the undetected bright child.

Case reports

CASE 1

A girl was 11 years old when first referred to this hospital with a one-year history of pain and blurred vision in the left eye and a thick file of notes. Her parents were 30 when she was born, and she was their first child. Her father suffered from sarcoidosis. She had one brother 3 years younger, who had a history of refusing to go to school. The details of her developmental milestones were not recalled, except that she had walked at 13 months, and was "early at everything."

From the age of 4 years she had suffered from intermittent vomiting and abdominal pains, which were investigated without result. When she was about 7 her headmistress had referred her for psychological assessment because of concern about her tendency to be withdrawn. Her IQ was found to be around 120. At 8 years of age she started to complain of non-specific headache. There was also concern about her behaviour at school.

Her presenting complaint was initially a corneal abrasion that healed rapidly and normally. Nevertheless, she continued to complain of pain in the eye and intermittent blurred vision, variable loss of visual field, and double vision. She was seen regularly by a consultant ophthalmologist, later by a paediatrician, who considered her symptoms to be an "escape mechanism," and later still by a child psychiatrist, as her symptoms were thought to be hysterical. On admission to this hospital no organic lesion could be found. When asked about school she complained with some bitterness about being bored and rejected there: "I'm bored stiff at school. I have done the same work for three years." Psychological assessment showed her to have a superior IQ of 138 measured on the full battery of the Wechsler Intelligence Scale for Children (WISC) and a reading age three years in advance of her chronological age on the Neale Scale.

Within a few days of being in hospital she ceased to complain of visual symptoms. On follow-up she continued to complain of intermittent headaches, which sometimes kept her away from school. She continued to be seen by a child psychiatrist, who reported that she was much happier at school.

CASE 2

A boy of 7 years presented with headache, behavioural problems, overactivity, and suicidal threats. He was the first child of parents who were in their late 20s when he was born, and who as children had both rejected school. Labour was prolonged and delivery rapid, but there were no problems in the newborn period. Developmental milestones were not accurately recalled, but gave no cause for concern. At 5 months he had had a convulsion. Convulsions with fever, requiring admission to hospital, recurred often until the age of 4. He was treated with barbiturates. At 1 year he was considered to be hyperactive and later was treated with dexamphetamine and chlordiazepoxide hydrochloride (Librium). In the past year he had complained of migraine-like headaches. His family complained that he had behaviour problems, such as refusing to cut up his meat or to clean himself after going to the toilet.

He was entirely normal on general and neurological examination. His electroencephalogram showed excess of fast activity compatible with the administration of promethazine hydrochloride (Phenergan) and Librium, and no other abnormality. On the ward his behaviour was completely normal, and he claimed that he had invented his headaches. Psychometry showed him to have an IQ of 137. When speaking about his dislike of school he said: "I used to put my hand up because I knew the answers, and the teacher told me not to be a 'smarty pants,' then I sat quietly not saying anything, and the teacher told me to stop falling asleep and pay attention. I am miserable at school and wish I could stay away." He responded well to psychotherapy and showed considerable insight into his own behaviour, and his headaches and suicide threats diminished. His parents, however, continued to look for physical causes of his symptoms without acknowledging his high intelligence.

CASE 3

A 5½-year-old Indian boy was transferred to this hospital with a one-month history of apparent seizures. He was the third child of parents who were in their mid-20s when he was born. They had separated before he was born, and had been reunited for a year before his referral here. There was no relevant family history. His developmental milestones were not clearly remembered, though they were said to be "normal." There was no history of any relevant illnesses, and he was thought to be a happy child both at school and at home.

At first his attacks occurred only at school, but later they were observed in hospital. During attacks he seemed to lose consciousness, and his eyelids flickered. His limbs remained normal, and he was never incontinent or injured himself. Attacks might last from 4 to 30 minutes. Afterwards he would recover instantly and behave quite normally. There was no alteration of respiratory or heart rate or blood pressure. He did not respond to mildly painful stimuli, but jumped when pinched. Large doses of anticonvulsants produced no improvement. His electroencephalogram showed no paroxysmal features, even during an apparent seizure, and routine biochemical investigations gave normal results. These episodes were thought to be hysterical.

Psychometry on the total battery of WISC tests showed an IQ of 135 and a reading age two years in advance of chronological age (Neale). When followed up the child had had no more fits and no other problems. The school, though contacted by telephone and letter, did not respond.

CASE 4

A boy was referred to this hospital at the age of 8 years because of eczema, which had been present since he was a baby. His skin condition had deteriorated considerably since he transferred from infant to junior school. He was the youngest of six boys, his parents being in their 40s when he was born. There were family and social problems. His father worked night shifts as a fitter, and his mother therefore took her youngest child to bed with her. She expressed a need always to have a baby near her. Both parents had little insight into the child's needs, and their management had been inconsistent.

Developmental milestones were not recalled, but had given no cause for concern. His mother had encouraged him to avoid school because of embarrassment about his appearance, and his progress in reading and writing had been slow. At night he was kept awake by itching and the prospect of recurrent frightening dreams.

On admission he had generalised dry and ichthyotic skin with

many lichenified areas and scratch marks. There was no other abnormality. In view of his poor school progress he was referred for psychological assessment, which showed him to have an IQ over 140, but a reading age on the Neale Scale of 6.7 years. Boarding school was recommended but not accepted. The boy and his parents were given supportive help, and there was some improvement of his eczema. He still attends an unsatisfactory school, where no specific remedial help has been offered, apart from half an hour's reading practice a week.

Discussion

Both the clinical history and the negative results of investigations suggested that the presenting symptoms in the first three children were wholly functional, and this was also partly true of the fourth patient. Their symptoms were diverse—hysterical blindness, headaches and behavioural disturbance, functional seizures, and exacerbation of ectopic eczema with associated lack of progress in school. The brightness of three of the children had not been recognised by the parents or by the school, and the fourth child's intelligence had been underestimated and the cause of her distress signals had been misunderstood (case 1).

Full assessment of intellectual ability is not always central to understanding behavioural problems in children, but without this information management and counselling cannot be meaningful. In all four cases the first presentation to a hospital clinic occurred within two years of beginning school, although there had been pre-existing disorders in two. The first child (case 1) had complained of abdominal pains, which had been investigated without result, and the second (case 2) was considered to be hyperactive in infancy and early childhood.

The schools generally denied the children's high intelligence when contacted, and did not offer any special help. When an alternative school placement was suggested for one child (case 4) to provide more academic challenge, his headmistress feared that this "might make matters worse." The children themselves were articulate about their plight, and three of them actively disliked school (cases 1, 2, and 4). One child (case 3) did not express any concern about school.

Verbal fluency was a notable feature of all four children, but only one (case 1) was considered to have been advanced in his speech or had any other precocious developmental milestones. These observations are confirmed by other authors, who have attempted to define both the early characteristics of gifted children^{8,9} and the features by which they may be recognised in class.¹⁰

After recognition of giftedness comes the problem of its management on an individual and national level. We think that discussing the child's special talents with the child himself is central to remission of symptoms. Three of our patients' symptoms improved greatly from admission (cases 1, 2, and 3), after acknowledgement of the child's problems and his boredom

at school. The parents may also need help to come to terms with the implications of the child's particular gifts, especially when they are less able themselves, as in three of our cases (1, 3, and 4).

The extent to which the brightness of the patient contributed to the presenting symptoms is uncertain. Possibly these four patients were psychologically vulnerable and coincidentally gifted. We think, however, that lack of insightful management and awareness of the child's giftedness by both parents and teachers were important contributory factors, and that the best way to help such children would be for schools to offer greater educational challenge to those of high ability. Proposals have been made for identifying gifted children at school, but facilities for doing so vary considerably within boroughs and counties.¹¹

The outlook both for the four children we report and for others who have not shown hysterical behaviour is uncertain in the present educational climate, and must depend on the enthusiasm and resources available for special help within each educational authority. Despite Plowden's and the Schools Council's¹² acknowledgement that gifted children have special needs, we think that these are not being met by the part-time, out-of-school enrichment programme so far devised. We feel that there has been a covert denial of intellectual excellence, and that teachers and others fear to acknowledge and help intelligent children, as they themselves may be branded as élitists. We seek to draw attention to the considerable distress that many such children suffer and to their need to be helped.

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WORDS Not surprisingly the HEART, as prime seat of the emotions, surpasses all other organs in the richness and variety of phrase and usage to which it has given rise. It owes its prime position to the very obvious sensation of palpitation perceived when one is under acute emotional stress. Love gives us dear heart and sweetheart. Overwhelmed by grief is broken-hearted. Affectionate approval is after one's own heart. Heart of oak indicates bravery, and encouragement is given with take heart. A coward is chicken-hearted, implying a small heart. Despondent is disheartened, and profound despondency yields a sinking heart. Sudden fear brings one's heart in one's mouth (? dynamic pulsation of the aorta and its major branches in the neck). Unfeeling and callous is heartless, and resistant to the emotional needs of others is hard-hearted. To pine is to eat one's heart. To expose one's feelings to everyone is to wear one's heart on one's sleeve. With hand

on heart is a declaration of sincerity. A mutually frank and sincere talk is heart to heart. Occasionally the heart could think as well as feel, as when learning by heart. Where, by the way, are the COCKLES of the heart, and why does the application of warmth thereto give satisfaction? Studies in anatomy, physiology, and psychology leave these questions unanswered. The edible bivalve mollusc of that name, however, belongs to the genus *cardium*. Tart, meaning prostitute, was originally sweetheart without derogatory implications. In the early 1920s it was spelt t'ear, having dropped the swee and h. It meant what would nowadays be called bird or chick, and was in a transitional stage as regards spelling and meaning. Here lie pitfalls for foreigners. A French lady, wishing to compliment my wife on her cooking, declared, "You are the Queen of Tarts."