

Who Will Have My Tummy Ache If I Give It Up?

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Children's physical symptoms that stubbornly resist diagnosis threaten both doctor and patient with failure—the doctor because he cannot find the cause, and the patient because his symptom has not been recognized. To avoid this crisis of confidence between the two, the author suggests the doctor should identify the symptom as an independent member of the family, with a mind—even grand designs—of its own. Naming the symptom frees it, and the doctor, from an immovable attachment to the child's insides.

For a little over two years I have worked for three sessions a week as a consultant child and family psychiatrist within a busy pediatric department. During that time I have had many referrals from the pediatric staff, the majority of them children with behavioral and temperamental problems that are familiar to child psychiatrists everywhere. A few of the cases, however, are the rather specific ones where there is a physical symptom which defies investigation and which does not go away. These children do not seem to be very ill, but are extremely disabled by their symptoms which also disturb their parents greatly. Furthermore, there does not seem to be any obvious emotional or psychological problem to account for their complaint. Typically these patients are very nice, even sweet children between the ages of six and 13, who suffer a baffling, sometimes very distressing symptom and get themselves admitted into hospital because of it. I suppose the very disruption and expense of admitting a child to the pediatric ward and doing the whole range of investigations are quite sufficient to justify my case that these problems are serious even though, because they can disappear so quickly with the kind of intervention I am describing, we might suspect that if left alone they would have cleared up by themselves.

Here is a case that I saw recently: A ten-year-old Chinese boy was admitted for investigation of asthma; his previous history was unremarkable. He had been in hospital briefly aged five, with a high fever, and he had a cousin with asthma. I was asked to see him because the pediatricians could find nothing wrong with him. Although I make a habit of not seeing children on their own until I have met one or both par-

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ents, I had a spare moment and went with the Pediatric Registrar to see the boy on the ward. The medical findings were that the examination of the chest, both clinically and radiologically, were normal and so was the peak flow rate. The boy was grunting in an odd way, but was obviously alert and attentive when I met him. I asked him why he was here and he said, "Because of my asthma." I asked him to tell me about himself—his age, his school, his family and so on—and within a minute he had told me that his grandfather had died of asthma. This was his father's father and his vivid description of it suggested that the event had been a very important one to him. I asked who had been most upset by the death and he replied, "My father of course." I then inquired what was this grandfather's name, but he did not know. So I told him to ask his father what name it was, because that was the name of his illness and not asthma. He looked astonished as if I were a bit crazy. That afternoon I met the parents for a moment to arrange a family meeting for the following week and repeated what I had said to the boy without asking any more questions.

The next week the whole family came as arranged, our patient being the eldest of three boys. His grunting had stopped. I asked how this had happened and father said they had just ignored it. I was all ready to end the meeting there and then when I noticed that the youngest child was playing with a toy coffin with a plastic skeleton inside it. So we had a short discussion about the children's different ways of sharing their father's grief and as the eldest boy began to grunt again I thought that I should leave well alone. I hoped that now the connection was made, the parents would not need to react as if their child were suffering from some mysterious illness. It is not in fact possible to ignore a symptom in yourself or in your children unless you can account for it in some way, otherwise the parents in this case would have done so before the boy's admission.

Unless it was a coincidence that the symptom stopped after my brief meeting with the child, I suggest that what made it possible for the parents to ignore the symptom was that a connection had been made between it and something that mattered to them all very much, which they could now attend to; so the symptom became superfluous. In this case the connection was made by giving a new name to the boy's grunting so that it was no longer a mysterious problem that they could do nothing about, but was instead to be seen as something normal, however painful, which they would now be able to deal with. After all, grandfather had been dead for over a year.

When making a diagnosis of psychosomatic disorder, John Apley and Ronald MacKeith (1) always emphasized the importance of establishing positive evidence of psychological or emotional stress. It was not sufficient, they said, simply to find no evidence of organic disorder in the child. In my view this is easier said than done. Most of you will be familiar with the tense silence you can get when, having failed to find any physical disease, you start to search for emotional problems in these children or in their families. These children have no idea what is worrying them and, quite often, neither have their parents. Nor should this be very surprising. There is quite a lot of support for the view that a symptom which has an emotional origin can operate effectively as a screen for the emotions that started it, so that they are really blotted out by the symptom. For example, if you are worried about something and you get a terrible headache because of it, you forget about whatever it was and worry about the headache instead. Although he was not previously aware of it, the Chinese boy was unusually helpful and forthcoming in that he made the connection himself between his symptom and a critical development in the family's life cycle—in this case a bereavement; but notice that I did not ask him about any problem he might have.

A useful piece of research by Crossley (3) shows, amongst other things, that children admitted to hospital with abdominal pain, but who turn out not to have appen-

dicitis (or any other organic disease), have many more family problems than those with appendicitis. The sort of problems he means are serious quarreling between the parents, serious mental or physical illness in one of the parents, chronic handicap in one of the siblings, and father living or working away from home most of the time. So in some cases, the presence of other problems is relatively easy to detect, although you may have a hard time making the link between them and the symptom you are being asked to treat. But in the kind of case I am describing you do not find problems like these. The family atmosphere seems to be very nice and nobody wants to complain about anything, except of course about the symptom.

If you do ask what possible stresses or anxieties might be affecting the child, sometimes the parents would have a theory about difficulties at school, that the child had been bullied, for example. They may have even considered changing school, but very rarely, in my experience, will they volunteer difficulties in the family itself. Yet the difficulties are there and are not hard to find. The reason why they are not considered relevant is that they are just normal processes, like the death of a grandfather, for example. I am talking about the natural stages in the family's life cycle.

It is precisely because these are natural events that they do not come into people's minds when they are asked if there is anything that could be worrying the child, but it is a good strategy to try to make a link between the child's symptoms and these essentially normal difficulties of family reorganization. Of course, it is possible to search for and to find more sinister processes, such as deep dissatisfaction in the parents' marriage, or even a depressive state in one of the parents. Parents are, however, inclined to put up a resistance to looking at their own problems, since it is their child they have brought for treatment, and they do not expect to be offered treatment themselves. The psychiatrist is likely to be more successful if the child's stubborn and insoluble problem is linked not to an equally insoluble parental problem, but to something which, though it may be a serious difficulty for them, offers the parents a chance to demonstrate their superior competence in dealing with it, once the connection is made. My submission is that the Chinese boy's grunting stopped when he realized that one of his parents could survive the loss of a father. Because he could not imagine how he himself could survive such a loss, he assumed with the egocentricity of a child that no one else could either. His symptom in an absurd and self-defeating way served to keep the grandfather alive, though of course the boy was not thinking of this at all. Actually, the parents did not have to do anything to prove that they could cope, except that they were able to ignore his grunts which they had not been able to do before.

Although these connections between symptom and family life event may seem obvious to an outsider like myself, there are several good reasons why they are not obvious to the family. First, the symptom, if it has held the family in its sway for weeks or even months, has done its job well and put other anxieties in the shade. Second, these anxieties are often not discussed in front of the children in any case, so the parents quite reasonably assume that the sick child knows nothing of them. The third and, in some ways, the most powerful reason why the family are unable to think of any problem that might have triggered the psychosomatic symptom is that *the problem has often not yet occurred but is still in the future*. So although they can tell you about the engagements of the elder children or the illnesses or deaths of the grandparents, it may not yet have dawned on them what fundamental changes these will eventually bring to the family. But anxiety about these changes is revealed to the children in all sorts of subliminal ways.

The psychosomatic symptom in such cases is all alone ahead of the field. Even its owner, the child, cannot say what is going on, but the symptom has become a sort

of early warning device for the family as a whole. In the short term this works quite well so that any anxieties about the future are quickly replaced by anxieties about the child. The symptom literally takes everyone's minds off other problems. But time and development wait for no one, and any attempt to turn the clock back, or to hold it still, will eventually collapse.

Casting the symptom in this light reaches in a very compelling way the grandiose notions of these loyal and conscientious children, who at some level secretly believe that it is possible to control time and resist changes that are in fact inevitable. In addition, and more important for the effectiveness of this therapeutic strategy, it also gives the parents a chance to show that they know better than the children about the passage of time and that they can learn to deal with their own difficulties.

So it is definitely not a good idea to suggest to the parents in these cases that their child has a tummy pain because he misses his grandfather or because he doesn't want his big sister to leave home and get married. When parents have become demoralized and defeated by a child's persistent complaints, it is not helpful to suggest that the child will recover if a dead relative is brought back to life, or someone's marriage plans are halted. Some families are so desperate that they might even try to do something like that to placate the child, as if such things were really possible. These attempts only increase the child's anxiety and reinforce his or her omnipotent belief that he or she can stop the world.

I am often asked by pediatric colleagues, "How do you know that this is what is going on?" My answer is that I am not looking for causes but for solutions and that I am not so much concerned about how the child got into this state, but about how the parents can get him out of it. There is always an aspect of a child's symptom that depends on how well he thinks his parents can cope with him, so that when he sees that they know what to do with him when he is ill, he is less anxious than when he sees that they obviously have no idea whatever.

There are several strategic advantages in this approach, the first of which is that it brings into focus aspects of the problem that no one is likely, up to that moment, to have thought of. The idea that symptoms are helpful (though obvious in the sense that a productive cough is helpful to the lungs) seems to come as a surprise to most people, who think that the doctor's job is simply to remove them, rather than find a good reason for having them. So there is an element of novelty which is important in cases where rigid patterns of behavior have been established, with a lot of bad feeling building up around them in the family.

Another advantage of this method is that it protects you, the doctor, from joining in this negative game and behaving as if you were the victim of some kind of deception, as if the patient were playing a mischievous trick on you.* However well you try to conceal it, there is always a risk of reacting with irritation, even with contempt, when faced with problems like these. It is hard to resist the feeling that the child is just putting it on. Any strategy that keeps you from challenging the child directly or, even worse, telling him off, is likely to be helpful. I suppose there are cases of malingering in children, but they are very rare and rather sinister. Just as it is futile to blame the child for his symptom, so it is ruinous to blame the parents, and the third advantage of this approach is that it forces you to go for the strengths of the parents, rather than their weaknesses.

*The fact is the patient is playing some kind of trick on himself and is miserably stuck with it, for at some level he does not dare to get well. I think this powerful sense of duty or compulsion to be ill is probably more widespread in psychopathology than many doctors realize. Failure to recognize the patient's obligation to be ill must account for at least some therapeutic failure in medicine and psychiatry.

I am sure that most of us have felt intense irritation with the anxious or overprotecting parents of these children and wanted to say something like, "If only you would just leave the child alone," or "If only you would be firmer with him," or "If only you would stop bringing him into your marital relationship," and so on. As far as I know, talking like that is ineffective mainly because the family members already know, even if they cannot put it into words, that they are trapped in these frustrating and repetitive ways and are quite unable to free themselves.

If the finger of blame is to be pointed at anyone, it is not at the parents, nor at the child, but at the symptom itself, because what is being attributed to it is an ambition of impossible proportions, like King Canute's attempts to turn back the tide. But before challenging the authority of the unfortunate symptom, it is necessary to define it as an independent force, with wishes and intentions of its own. One way of doing this is to welcome it as if it were, or belonged to, a separate and perhaps powerful member of the family, previously unrecognized as such. Taking this line allows me to pay respect to the symptom and to say to the child: "I know that your pain has a very important reason for being there, and we shall have to give it a name and see if we can try and find out what it is trying to do. Maybe then we can talk to it and see what it has to say in reply. At the moment it is only saying one thing, and you and the rest of the family must be really fed up with that by now."

This is an attempt to dislodge the symptom from within the child and to introduce the idea that it is the symptom itself that is the one who needs help, because it has not been successful enough in its very important task. The trouble is that the symptom has not been very imaginative up to now; all it has been able to do is to groan monotonously. So I offer to coach it, to enlarge its repertoire, and help it to succeed.

For me this is an opportunity to do some clowning with the child, perhaps to call out to the pain in the belly and wait for a reply, pretending to just hear something very faint but not clear enough to understand, or to be mockingly respectful and subservient to it like a court jester with his king. In any case, with children of this age and personality it is not usually difficult to engage them in play like this with some immediate if temporary relief for them, because they generally have to be very serious about their pain and don't let themselves, or their symptoms, go very easily.

It is important to emphasize that this playfulness is not intended to distract the child from his preoccupations and the pain; that would simply not work, or not for long anyway. The idea, on the contrary, is to go along wholeheartedly with the child's earnest and necessary attachment to his symptom and to play with that fact, knowing that at some level he is doing the right thing by harboring it. As far as I know, it was Groddeck (4) who first said that the patient is always right. So this playing with the child is not anything that could be called reassurance in the usual sense. I am sure that reassurance *is* a powerful piece of medical equipment, but in these cases it is clearly insufficient. Otherwise I can assume that the pediatricians would have used it already and no psychiatric referral would have been necessary.

Here is a case that illustrates some of these points. The patient is a nine-year-old Pakistani girl who was referred to me after an urgent admission to the ward for investigation of abdominal pain. She had a history of ureteric reflux, which had been diagnosed when she was two, and for which she had been on prophylactic antibiotics since then. There had been two hospital admissions for urinary tract infections, one when she was five and the other when she was seven years old. Three months previous to this referral she had had that mysterious condition, Bell's Palsy, which had fortunately completely remitted with steroid treatment. All medical investigations on this occasion were negative and I saw the child in a side room off the ward, together with her parents and the Pediatric Senior Registrar. What emerged was what I now regard

as a classical picture, the patient being one of the younger children in a family where the eldest are leaving home and getting married, and where there is illness in one or more grandparents.*

In this particular family our patient is the youngest of four girls: The eldest has left home and is recently married; the second eldest is married with a child and still lives at home, but is planning to emigrate. The father is a successful businessman, a member of an aristocratic caste in the Pakistani hierarchy, and the mother is a housewife who does not work outside the home. After a detailed inquiry about the pain and the family's reactions to it, I asked about the rest of the family and heard about the two eldest sisters. I asked the child which parent would miss the eldest children the most and she said, without any hesitation, that mother would since, as father was so often away on business, she relied on them so much for company. I also heard that the father's mother was quite ill in Pakistan and that both parents were naturally worrying about that. I suggested that the pain this child had was like a very busy person who wanted to do all sorts of jobs, like being a doctor for the grandmother, and a companion for the mother. Accordingly, I told the child to give her pain a chance as it was clearly confused and overworked. Each day of the week, at a set time to be arranged with her parents, she was to sit with her mother for half an hour and practice having the pain, which was to be devoted to a separate duty on each occasion.

With this task I was trying to get the family members to behave differently towards the pains by instructing them to do something together which actually dramatizes the symptom's protective function for them, particularly for the mother.

The child took a pencil and paper and wrote down all these tasks very diligently and we had a lot of fun arranging them. This meeting, which lasted over an hour, concluded with the child being discharged from hospital and another appointment was made to see me two weeks later. However, ten days after our meeting she was readmitted and I arranged to see the family on the ward as soon as I could. This time I took more trouble to find out what actually happened when she got the pain. The pattern was stunningly familiar: She would be taken into bed with her parents. We talked about the pain again and I asked her what it should be called and what animal it would be like. She gave it the name Timmy and said he was a bear. The fact that it was a male immediately led father to talk of his desire for a son; they had had two daughters, then after a gap of nine years had planned to have another child. They had a third girl and finally yet another, our patient with the pain. For this proud, aristocratic Islamic man, no son was quite a blow, so I could say that the pain was a royal pain (the joke was lost on the family) that was trying to be a boy for the father, which he clearly now would never have. But the next stage was the most important: I advised the child that Timmy was too much for her to deal with and that she should give him to the parent of her choice, whichever she thought would be best able to cope with

*My clinical impression is that these families with physical symptoms have had more than their fair share of premature deaths, particularly in the grandparental generation. (In the Pakistani family, father lost *his* father when he was 14. Mother lost hers when she was 20. All three older brothers of father are dead, the third having been murdered.) The connection could be that parents who miss a developmental stage through illness or death of their parents have difficulty in handling that stage in their children. As a preliminary study it should not be difficult to compare the rates of early grandparental death in populations of child psychiatric, pediatric, and control children. There are studies showing the connection between childhood illness and recent life events (2) and an important one relating *onset* of diabetes mellitus to parental loss by death or marital disruption (7). Froma Walsh has linked schizophrenia with grandparent death (10). Thus, it would be a good idea if physicians were to make a three-generation family tree a routine part of history-taking.

him. So when she had a pain during the night she was to go to her parents' room, leave it there, and return to bed.

Father got into the spirit of this right away and announced with finality that his daughter had stolen his pain and that he wanted it back, she had no right to keep it, he and his wife could take care of it themselves. I thanked the father for his innovative idea and soon we ended the session. Again I should say that these sessions lasted well over an hour, so that I am summarizing quite drastically.

At the follow-up meeting a month later only father and daughter attended and they reported, in father's words, "95% improvement" in the pains. A further follow-up meeting two months later showed that there had been only one bad episode of pain and the child had been seen in casualty, only to be sent home immediately because she was already well.

I think my earlier intervention was a failure, first because I didn't attend to the family's actual and regular way of responding to the symptom and, second, because father had been given nothing to do, yet was clearly deeply involved and very keen to take an active part. If parents find that there is something they can do to effect a change in the symptom, then there is a chance that one of the child's principal anxieties, namely that the parents are not going to be able to cope, is eased and the symptom diminishes; this sets up a benign spiral in place of the vicious one that preceded it.

In the two examples I have mentioned, there were symptoms which had no diagnosis except that they were suitable for referral to a child psychiatrist. This is not a very respectable problem to have. To say that a symptom, especially a pain, is psychosomatic or psychological is a very damning diagnosis because it is so often misunderstood to mean that the patient is putting it on for some mischievous purpose. So there is an urgent need to reverse that impression and allow the child gracefully to give it up. The method I have outlined here involves making a link between the problem and an important development in family life, so that a positive function is found for the symptom that at one and the same time gives it a respectable pretext for having been there and a good enough reason to disappear, since there are obviously better ways of being helpful to one's parents than suffering from a mysterious illness.*

Although I cannot always expect parents to be as inspired as the Pakistani father, interventions like these are successful if the family discovers through them new ways of dealing with the dilemmas that they face. I don't think this discovery is always a conscious one, which is why it seems better to recommend various tasks for the family, which they may not immediately see the significance of, but are still willing to try out. I think we have to accept that there are other ways of discovering solutions to psychological problems than through intellectual insight. Without having told them in so many words, I believe the final intervention with the Pakistani family was effective because it hinted to the parents that they could be a couple still, even though the coupling of the mother with the older daughters was coming to an end, or at least changing in a very dramatic way. The youngest girl could learn that she did not immediately have to take their places—if she just gave the parents a bit of time they would

*Doctors who prefer not to be so playful can quite properly ask the child to record the symptom systematically (e.g., time, location, duration, and strength) on a chart of his/her own making, for presentation at the next appointment. Implicitly or explicitly the patient is thus being asked to keep the symptom going for the time being in order to help the doctor understand it better. I have found this procedure remarkably effective with a 14-year-old severe asthmatic who still relied entirely on his mother to keep track of his attacks. In this case, both of them were encouraged to keep a record.

work out a new balance for themselves, that would at least be good enough for her, if not for them. The little girl's idea of what changes are possible is far more conservative than her parents', so she blocks their development with her desperate solutions. But, as I say, this is the theoretical thinking behind this work, which helps me to think about families that are in transition. The family's actual experience will be quite different, and I do not necessarily get to know about it.

The idea of a psychological problem as a useful function rather than a baffling and unnecessary irritant was developed mainly in the United States by the very creative mixture of therapists, anthropologists and system-thinkers who congregated around Palo Alto in California in the 1950s. Don Jackson (6) proposed the idea of prescribing the symptom and Jay Haley (5), adapting the medical hypnotist Milton Erickson's unique way of sidestepping resistance, devised with his colleagues ways of redefining the patient's activity so that it could no longer undermine the authority of parents and others trying to help. Several authors have written more recently about the application of these ideas to children with psychosomatic complaints, notably Michael White, an Australian family therapist who gets children to practice having their symptoms so that they can get better control of them, and the parents are actively involved in these exercises (11). Giving a name to a symptom is derived from another tradition, that of Gestalt therapy, in which pain in particular can be treated by getting the patient to accept it, which is done by having to describe it in detail: the color, location, shape, weight, size and so on. Both the systems and Gestalt therapists have stressed that explanation is not much good without demonstration, so that therapeutic interventions tend to take the form of instructions to be put into practice, rather than simply as ideas to be thought about.

There is support in the literature, too, for the idea that psychosomatic patients are significantly detached from their feelings. Nemiah and Sifneos (9) have described a kind of emotional indifference that they (and many others) have found in psychosomatic patients. These people, they observed, cannot talk about feelings; they can only talk about symptoms.

Then Witkin (12) showed, with psychological tests, that individuals with the classical psychosomatic diseases—ulcers, obesity, childhood asthma and diabetes—are overinvolved and highly responsive to the people around them. Putting these findings together, the idea of going beyond the individual to the intimate family group in the attempt to do psychotherapy with them makes sense, since the tension in the patient can be distributed around the family in a way that may be seen as helpful, but which is essentially unstable, so that the arrangement is bound to break down sooner or later, with a crisis resulting.

Finally, I should mention Minuchin's remarkable findings with the families of children with labile diabetes (8). During a structured interview, in which the child watches the parents having a discussion, he measured the Free Fatty Acid (FFA) levels in the child and in the parents. The parents' FFA levels were raised when they got into an argument, but quickly fell when the child intervened. However, the child's intervention cost her a considerable rise in FFA levels, thus putting her at risk of diabetic symptoms. Furthermore, the FFA levels in the labile diabetic children did not return to normal during the recovery period, in contrast with other diabetics, thus leaving the child at risk for some time afterwards.

These findings suggest a physiological pathway through which sensitive children can respond to tensions in their parents, findings which are consistent with the ideas in this paper: namely that, whether they like it or not, these children find themselves trying to rescue their parents when they seem to be in trouble. It is not known what

mechanisms exist in children who are not diabetic, but it is clear that stress in childhood disease can be changed by intervening at a level which is outside the child's body yet can have effects inside it.

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