THE WORST HEADACHE IN THE WORLD

Headaches come in all sorts of quantities and qualities and are due to all sorts of different causes, but there is one special kind that most people know about

JOHN N. WALTON, M.D., M.R.C.P.

EVERYBODY knows what a headache is. Indeed, headache is one of the commonest of all symptoms. But there are many different kinds of headache.

The brain itself is comparatively insensitive to pressure or injury. But there are many other structures in the scalp and inside the skull which may give rise to pain if compressed or distorted. For instance, the arteries of your scalp, as well as those inside the head, are very sensitive to being stretched or pulled or expanded. Any one of these effects can give rise to a throbbing and painful headache.

A temporary increase in the diameter of these arteries on the morning after the night before is probably responsible for a lot of hangover symptoms. Also sensitive are the membranes which cover and protect the brain and anchor it within the skull. It is distortion of these membranes and of blood vessels within the head which causes the headache produced by a brain tumour. Inflammation of the membranes, as in meningitis, will also cause severe pain.

Increased tension in the muscles which are attached to the scalp, especially at the forehead and back of the neck, is yet another common cause of headache. The nagging ache in the neck and back of the head which comes on after a long and tiring day is probably due to this cause. So, too, may be an ache in the forehead following prolonged reading or close work. Particularly in someone who should be wearing spectacles but is not. Or if the same spectacles have been used for too long. In this way eyestrain can cause headaches.

Similar symptoms may follow worry or anxiety because there is a tendency to tighten the muscles when upset. Some headaches in tense and nervous patients who find it difficult to relax are very frequent and quite severe. Headache on top of the head, for instance, is merely always a nervous symptom and not due to physical disease.

Migraine is a name which has been applied to a very common kind of headache. The name comes from the Latin term *hemicrania* which was applied to symptoms of this type by physicians living almost two thousand years ago. This name was used because the headache commonly occurs on only one side, one half, of the head. Attacks of migraine are often referred to in everyday life as sick headaches. When the vomiting is more striking than the headache, which is a common event in children, they are called bilious attacks or bilious headaches.

Migraine

Migraine is more common in women than in men, though it occurs in both sexes. It tends to afflict the most intelligent and industrious people. Patients with this condition also tend to be over-conscientious, and a bit obsessional. They worry over trifles, take everything very seriously and strive for perfection in everything they do, sometimes to an almost ridiculous extent. For example, there's the excessively house-proud housewife, or the man who cannot bear a slightly tilted picture on the wall or a book out of place on the shelves.

Characteristically, patients find that their migraine tends to be worse during or after a period of overwork, anxiety, stress of any kind. In other words emotional factors have a considerable bearing upon the severity and frequency of migraine attacks. In women they often come just before or during the menstrual periods and add the rigours of an attack to an already difficult time.

What happens in an attack of migraine is now well understood. But doctors still know very little about the way the inherited tendency to migraine works.

An attack begins with a narrowing or contruction of the arteries of the head and neck, often only on one side. After fifteen to thirty minutes the arteries suddenly expand and this increase in size or dilatation may last for several hours or occasionally it may last for days.

The period of arterial narrowing is that of the aura or warning, the signal that a headache is shortly to begin. During this stage symptoms are due to a reduction in the supply of blood to various structures in the head and neck. When the arteries expand this gives a severe throbbing headache which may be accompanied by or followed by nausea or vomiting.

The most common symptoms of the aura of migraine are in the eyes. Sometimes they are due to diminished blood supply to the part of the brain which receives visual messages. Sometimes it is the arteries of the retina, the sensitive membrane at the back of the eye, that are at fault. Commonly a blacking out of one half of the field of vision occurs. Objects to the right or left are no longer visible, or else half a line of print suddenly disappears. Or there may be jagged lines, dancing pin-points of light, bright flashes before the eyes, often to one side only.

In some cases, when the blood supply to a part of the brain is reduced, the patient may experience some tingling and pins and needles, or, very rarely, a passing weakness and clumsiness of the face, lips and hand on one side of the body. Often during the aura, a feeling of listlessness, lack of interest and malaise develops.

Quite suddenly the aura passes away and the headache begins. Usually as a dull ache, but often with some throbbing, in one side of the forehead and one temple. Gradually it mounts in severity and may spread to the opposite side. Indeed in some cases the headache affects almost the whole head from the beginning. It is made worse by moving, stooping and coughing. Nausea and vomiting usually follow and in a severe attack the patient is prostrated and may need to lie in bed in a darkened room.

Feeling better

Generally the attack passes off in a few hours and the patient feels better after a night's sleep. But sometimes a dull headache and some listlessness lasts for several days.

This is the typical picture of an attack of migraine, but many variations occur. For example, the aura usually begins soon after waking in the morning but in some patients the actual headache is there when they wake up and they never have an aura. The aura can occur without the headache. Sometimes the attacks are infrequent and mild, sometimes so severe and frequent that they make life a misery.

The most characteristic feature of migraine is that attacks occur periodically. Patients with constant unvarying headache are not suffering from migraine.

Attacks begin most often in an adolescent who has suffered bilious attacks as a child, often they cease in middle age, though in some few women they do not begin until after the change of life. Most sufferers otherwise enjoy good health. There are rare cases with small clusters of abnormal blood vessels in the brain who

suffer from frequent attacks of migraine. But the headaches occur only on one side of the head and there are other abnormal features. Treatment depends a great deal upon the individual patient and there are no hard and fast rules.

To some the attacks are no more than a minor inconvenience, occurring infrequently. Aspirin or codeine tablets may be enough to relieve them. To the woman who is compelled to spend one or more days in bed each week, however, migraine constitutes a serious disability. The first thing for her to do is to lead a quiet life. After a period of overstrain a holiday may help. This is easy advice to give a mother with several young children. It is much less easy for her to follow it. Nevertheless, nervous factors may be important in increasing the frequency of her headaches. Rest and sleep and sympathetic understanding from the family, but not over-solicitous pampering, do make a deal of difference.

No single drug is one hundred per cent. successful in preventing or reducing attacks. Many for which claims have been made have been successful more through the personality of the doctor giving them than from their own effects. Sometimes, when attacks are severe before the menstrual periods, regular restriction of fluid intake at this time may help to prevent them. And a medicine first prescribed by Sir William Gowers in the last century is occasionally very effective. Many other remedies are available and their effects vary from person to person. Only trial and error by your doctor will prove which are most likely to help. Most sufferers from migraine do find one which is particularly helpful to them.

So far as the treatment of the actual attack is concerned, the most effective remedy is ergotamine tartrate, a drug which temporarily reduces the diameter of arteries. However, it must be given early in the attack, preferably during the aura, if it is to be successful.

Personal injection

It can be given by mouth, alone, or in combination with caffeine and other drugs, all of which are designed to counteract depression and to reduce nausea and vomiting. Severe attacks are often controlled only by injections of the drug. Patients can often learn to give these themselves and if they lie down for half an hour after the injection the attack usually passes off. There are also other useful remedies which can be tried when the headaches are difficult to relieve.

Only the sufferer can appreciate the misery which a migraine attack can bring. Incidentally, this is an illness which many doctors suffer from. So medical knowledge is strengthened by personal experience in many cases.

Fortunately, however, although the headaches may occur at intervals over many years, general health remains unimpaired. With your doctor's help, and with patience, persistence and understanding, this is a condition which, though it may not be cured completely, can often be conquered. And that is a fact that should be known by any victim of this, the worst form of headache.

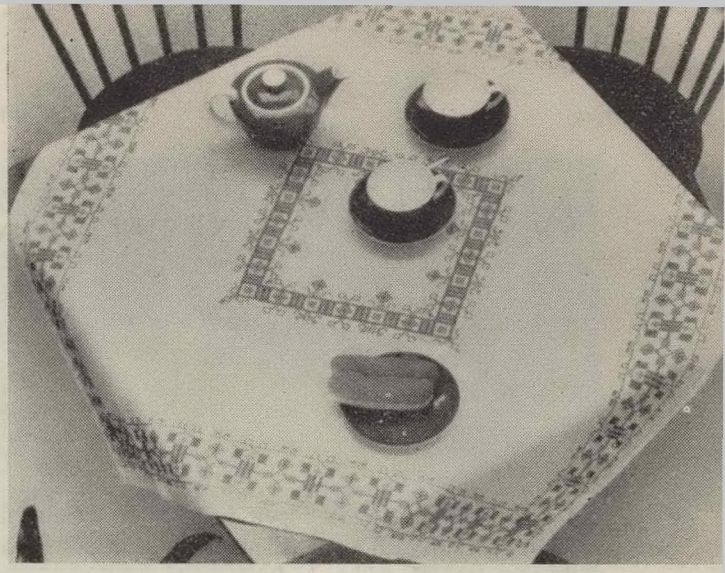
Diagram 11

Binca Embroidery

Make this Beautiful HOLBEIN and CROSS STITCH TABLE CLOTH

This lovely cloth is very simple to work. The design has been worked on Binca or Panama type canvas in which a number of threads are interwoven to form a texture of squares. The Cross Stitch is worked over these squares — one cross to one square on all articles. The cloth makes working the design very simple and quick, and the results are far more attractive and professional-looking than cross-stitch designs worked from a transfer.

Binca cloth in many lovely colours and similar materials are obtainable at several Johannesburg shops, and if readers have difficulty in obtaining the materials they require, please write to the Editor, Childhood. We will tell you where you can obtain them.



The original was worked in Clark's Anchor Stranded Cotton in Scarlet, Grey and Parrot Green (numbers and quantities given below.) You can, of course, use your own colour schemes. The strong, bright colours of the design are specially suited to the bold texture of Binca cloth, and would look particularly attractive in modern settings.

We have given instructions for making a cloth, but the design is adaptable to other uses. The centre panel, for instance, could be used on a cushion, the border on runners, traycloths, chair-backs, etc.

Working instructions

Two stitches are used throughout. In working *Cross Stitch*, it is important that the upper half of the cross of all the stitches lies in one direction. Each square on the chart represents a square of canvas. Holbein Stitch, sometimes named Double Running Stitch is simply worked from right to left, working a row of Running Stitch over and under the squares with all stitches equal length. On the return journey, work in the same manner from left to right, filling in the spaces left in the first row.

Materials

Clark's Anchor Stranded Cotton: 12 skeins 469 (Scarlet); 11 skeins 420 (Grey) and 6 skeins 463 (Parrot Green). Use the full six strands throughout.

1¼ yards Ivory Binca cloth, 42 in. wide, 6 squares to 1 in.

1 Milwards tapestry needle No. 21.

The finished size of the cloth is 39 in. square.

To work the cloth

Mark the centre across both ways of fabric with a line of basting stitches. (There are approximately 6 crosses to 1 in.). Diagram 1 gives a quarter of central square and Diagram 2 gives half of one side of border with the corner turning, all centre rows marked by arrows (turn diagram on side). Work the given quarter of the central square first, commencing the Cross Stitch on the basting stitches 30 fabric squares down from exact centre (top arrow on diagram). Work in reverse from row next to centre row to complete each quarter of the square. Count 51 squares of fabric from outer edge of central design and work the given section of border. Work in reverse from row next to centre row to complete one side of cloth. Work the other three sides to correspond. Cut margins even and finish with ½ inch hems.

Finishing and washing

Mitre corners and slipstitch or hemstitch edge of hem. Use warm water and pure soap flakes. Wash by squeezing gently. Rinse in warm water, squeeze by hand, leave until half dry. Iron on reverse side while still damp, using moderately hot iron.

- **We intend to publish other embroidery designs in coming issues of CHILDHOOD. We would like to hear from readers about these designs—if you want designs for any particular articles, please write and let us know.**

KILLING FLIES — A NEW WAY

LEFT undisturbed, the female house-fly will lay 100 to 150 eggs a day, a process that can be repeated several times. The eggs hatch in a few hours. Last October we published an article giving some gruesome details about the life of the house-fly.

It's good to know, therefore, that more effective means of dealing with the menace of disease-carrying flies are being found. The latest, known as Saxane Junior, is an electrically operated appliance. All you do is to plug in (any electric point of 200 to 250 volts will do) and switch on the machine in each room in the house for just a few hours every two to three weeks. A small tablet placed in the top of the apparatus is vapourised and an invisible film is deposited on every surface of the room. This microscopic film is highly toxic to insects but absolutely harmless to humans and animals. The vapour will not stain or damage any surface or fabric.

'N EEU VAN DISTRIKSVERPLEGINGSDIENS

Die oorsprong van 'n bekende figuur in Brittanje.

Deur

WENDY HALL

DIE distriksverpleegster per fiets of met dapper en stapper op pad na pasiënte is 'n bekende gesig in Brittanje. Ons vind haar in haar netjiese uniform en met haar verplegingsak in die digte nywerheidsgebiede of ver in die landelike gebiede, waar sy gewoonlik per kar reis, in die voorstede van die groot stede of op die eilande buite die Skotse kus, waar sy soms haar pasiënte per boot moet besoek.

Oral op haar pad word sy dankbaar en vriendelik deur haar oudpasiënte gegroet. Want die distriksverpleegster is veel meer as net verpleegster. In die verantwoordelikheid wat sy aanvaar, in haar rol as vriend en raadgewer van die pasiënt en sy gesin, het sy baie eienskappe van die geneesheer en haar pasiënte beskou haar dan ook as iemand na wie hulle in tye van nood kan opsien.

Die Probleme van die Siekes word opgelos

Daar is meer as 10,000 distriksverpleegsters in Engeland en Wallis wat meer as 25,000,000 besoeke per jaar aflê. Hulle verpleeg die siekes in hulle eie huise, leer hulle familiebetrekkinge hoe om vir die pasiënt te sorg tussen besoeke, en haar geoefende oog sien al die probleme wat die siekte van die pasiënt in die huishouding meebring met een oogopslag raak en sy kan hulle gevolglik met raad en daad bystaan.

Die Distriksverplegingsdiens vier vanjaar sy eeufees. Dit is in 1859 gebore met die dood van 'n ryk Liverpoolse handelaar, William Rathbone, se vrou. Sy is tydens haar siekte met veel toewyding versorg deur 'n verpleegster genoem Mary Robinson en haar agterblywende eggenoot het meteens besef dat sulke verpleegsters in daardie dae nie vir die armes beskikbaar was nie om hulle in tye van siekte by te staan nie.

Hy het Mev. Robinson oorgehaal om op sy onkoste drie maande te wy aan die verpleging van armes in hulle huise in Liverpool. Daarna het hy die voorsitter van die Liverpoolse Siekehuis omgepraat om 'n opleidingskool vir distriksverpleegsters, weer op sy onkoste, te stig. Liverpool is toe verdeel in distrikte en aan elke distrik is 'n verpleegster toegesê om die armes te verpleeg. Só het distriksverpleging ontstaan en van hier het dit oor die hele wêreld versprei.

Stigting van die „Queen's Institute"

Uiteindelik het die noodsaaklikheid vir behoorlike opleiding van distriksverpleegsters duidelik geword. Toe Koningin Victoria haar goue jubileum in 1887 gevier het, het die vroue van Brittanje 'n groot som geld ter ere van haar geskenk. Hierdie bedrag het sy gegee om die Queen's Institute of District Nursing te stig, waar die oorgrote meerderheid van Brittanje se distriksverpleegsters vandag opgelei word.

As 'n vrou die kursus vir 'n distriksverpleegster wil volg, moet sy alreeds as 'n staatsgeregistreerde verpleegster opgelei wees, belangstel in maatskaplike probleme en die gesinslewe en gewillig wees om op haar eie te werk.

Uitgebreide Opleiding

By een van die sentrums wat deur die Queen's Institute goedgekeur is as 'n opleidingssentrum vir distriksverpleegsters, volg sy 'n kursus van ses maande (of vier maande as sy alreeds haar kraamopleiding voltooi het). Gedurende hierdie tydperk leer sy hoe om in alle soorte privaat huise te verpleeg. Sy ontvang voorligting in verband met haar verhouding tot die pasiënt in sy eie huis, tot die pasiënt se gesin, tot die algemene praktisyn, onder wie se leiding sy werk, en haar verhouding tot die plaaslike bestuur, wat sedert die instelling van die Nasionale Gesondheidsdiens in 1948 distriksverpleegsters aanstel.

Sy moet ook kursusse volg in higiëne in die huis, voeding, beroeps- en fisioterapie, die optel van pasiënte (wat die tingerigste verpleegster in staat stel om 'n groot pasiënt om te draai sonder om haar in die minste te ooreis), die verpleging tuis van siektes soos tuberkulose, suikersiekte, kanker en geestesongesteldhede, en ook die versorging van bejaardes en van klein kindertjies.

Praktiese en teoretiese werk word nou saamgesnoer. Vir 'n maandlank versorg die kwekeling pasiënte in hul eie huise saam het die instruktrise-distriksverpleegster. Sy leer hoe om huishoudelike gereedskap te steriliseer, hoe om in moeilike omstandighede met beskikbare toerusting klaar te kom, hoe om verslag te hou en haar dag se werk te beplan. Sy bring ook minstens drie dae deur in 'n landelike streek waar die omstandighede hemelsbreed van die stad verskil.

Wanneer sy gekwalifiseerd is, ontvang die nuwe distriksverpleegster haar eerste pos. In 'n dorp sal sy miskien saam met 'n groep verpleegsters onder 'n superintendent werk, maar in die landelike gebiede sal sy heelwaarskynlik op haar eie moet werk. Oor die algemeen besoek sy pasiënte in opdrag van 'n algemene praktisyn of 'n hospitaal. Dikwels egter, roep die pasiënte self haar hulp in, maar dan mag sy nie voortgaan om hulle te behandel nie, behalwe in die geval van baie geringe ongesteldhede, tensy 'n geneesheer geraadpleeg is.

'n Tipiese Dag

Die distriksverpleegster kry amper net so 'n groot verskeidenheid pasiënte as 'n algemene praktisyn. In die oggend sal sy miskien 'n inspuiting vir suikersiekte en later een vir hartmoeilikheid gee. Daarna sal sy moontlik 'n ou man besoek en hom 'n kombersbad gee. Haar volgende geval kan iemand wees wat 'n been operasie ondergaan het, wie se wond sy gaan verbind, terwyl 'n ander pasiënt behandeling ontvang voordat hy gaan om X-straal plate in 'n hospitaal te laat neem.

In twee of drie huise help sy om ou mense te rehabiliteer — sy moedig hulle aan om meer dikwels op te staan en iets aktiefs te doen, terwyl sy aan hulle familiebetrekkinge verduidelik hoe hulle die proses kan aanhelp. As sy in 'n landelike gebied werksaam is waar daar nie 'n afsonderlike kraamdiens is nie, mag sy in die nag uitgeroep word om 'n bevalling te doen.

Baanbrekerswerk Oorsee

Baie lande het vandag hulle eie dienste, geskoei op die Britse lees. Superintendente en administrateurs het na ander lande gegaan om plaaslike dienste daar in te stel en verpleegsters uit alle dele van die Statebond gaan na Brittanje om daar as distriksverpleegsters opgelei te word. Die Queen's Institute het reeds in Malta, Jamaika en Tanganjika baanbrekerswerk verrig en beplan tans ook 'n diens vir Brits-Honduras.

Inmiddels word daar jaarliks in Brittanje meer waarde aan die distriksverpleegster geheg. Aangesien die aantal bejaardes in die land steeds styg, is daar 'n groter behoefte aan deskundige tuisverpleging, al geskied dit dan net af en toe. Die druk op hospitale en die hoë koste om pasiënte in hospitale te onderhou kan aansienlik verminder word indien meer pasiënte tuis verpleeg kan word. Toe William Rathbone die Distriksverplegingsdiens van stapel gestuur het, het hy dit net vir die armes bedoel. Vandag is dit 'n diens wat deur die hele bevolking gebruik en gewaardeer word, afgesien van inkomste.

WOMEN WITHOUT FAMILIES

THE most distressing by-product of industrialisation and urbanisation in South Africa has been the disruption of family life. The reasons, fairly widely known, are first of all the lack of economic security, the very foundation and basis for marriage and family life; the impossibility of projecting tribal cultures and traditions into modern urban civilisation; together with migratory labour and the compound system on the mines and big industries.

Most white South Africans can see what is happening, even if they look no further than among their own domestic staff. Domestic servants living on their employer's property may not have their husbands living with them. Even visiting is usually illegal, and backyard raids frequently net in husbands for the crime of visiting or sleeping with their wives. Loose relationships spring up between the women and male domestic servants, cooks, house and garden workers and flat workers. In compounds men lead unnatural lives, and on weekends flow into townships and shebeens in search of companionship, pleasure or forgetfulness. Children are left alone all day; young babies may not stay with the working mother. Adolescents have no healthy outlets whatsoever.

In undertaking a study of the sex-life of African women in and around Johannesburg, Laura Longmore was aware of the fact that many of the problems of urban Africans are those *"that have beset unorganised proletariats in previous times in other parts of the world."* Yet there are also differences. The blunders and tragedies of industrialisation in other countries took place in other times and settings. We are supposed to have advanced since then. And the change here is taking place under particularly violent and disintegrating conditions.

She is alarmed at the results of her investigations. *"Immorality among the urban Africans has become so prevalent that unless the traditional integrity of family life is regained the African people are in danger of moral collapse."*

If we accept the family as the basic unit of human society, then that appears to be the position. *"There is a decay of a sense of responsibility on the part of men for women and children in the community, a breakdown of authority within the family group, and an inevitable increase in general lawlessness and juvenile crime. Vast numbers are indulging in promiscuous sexual relationships and a great many families no longer have any real family life."*

It is not through internal decay, says Miss Longmore, that traditional integrity has been smashed, but through colossal external pressures. The problem is how to meet the challenge that this presents to each and every one of us, if we are responsible South Africans. We have to restore social order. But how? *"Breakdowns in human relationships affect not only the safety of the person, but of society generally. So many crimes are indirectly a result of imperfect conditions in society. We have a common concern here, because we are all members of one another."*

White South Africans, she feels, can no longer ignore the reality and urgency of the urban African population.

Miss Longmore's interesting study was confined to Eastern Native Township, which is a pity for in many ways it is not a typical urban African community. Her book is in the nature of a sociological treatise, and of greater interest to social workers than to the general reading public. It would be more useful for the man in the street if her most important findings and conclusions could be sifted from the mass of material.

Those working among children of all races should find this book fills in important backgrounds, contributing to greater understanding of the problems that confront them and those among whom they work.

- *THE DISPOSSESSED.* A Study of the Sex-Life of Bantu Women In and Around Johannesburg, by Laura Longmore. Jonathan, Cape. Price 30s.

BOOKS FOR CHILDREN

ACROSS THE SEAS

LIFE among children in other lands and books about the countryside are prominent among the new books for children this month.

Lavish and beautiful photographs illustrate the first four books on our list. They give more than a passing interest to the contents.

Michel of Switzerland and *Jan of Holland* are two new "Around the World Today" books; the first two in the series were *Luis of Spain* and *Cesare of Italy*.

They are stories of the day to day lives of ordinary families in other countries, told around one little boy in each family. The author is also a photographer, and the pictures are part of the story. They are often striking, unusual, yet essentially natural, conveying both the character of the countryside and the families that live there. Adults will certainly appreciate these books, and will enjoy reading them to children and discussing the contents.

Another book about Switzerland is *Children of the Hidden Valley*, the story of life in the Lotschentak Valley. This book is also one of a series. Photographs that illustrate the book were taken by A. Revel of Lausanne and Lex van der Pol of Amsterdam. They show the valley both snow-covered and mantled with flowers, and being in colour throughout give glowing life to the text.

Striking photographs are an important part of *The New Mayflower*. Readers may remember that the new *Mayflower*, with Alan Villiers as her captain, sailed from Plymouth, Devon to Plymouth, Massachusetts in 1957, as had the original Mayflower with the Pilgrim Fathers on board in 1620. Alan Villiers describes the voyage in a simple and straight-forward way, explaining the ship and the life and work of the men who sailed on her. Fascinating reading, particularly for boys who fancy the life at sea.

Photographs and diagrams illustrate *A Boat of Our Own*, a book about boats and fishing. The setting is Guernsey in the Channel Islands, and this is calculated to whet the appetites of children for boats and the sea. We can expect high-veld fathers to start boat-building schemes in their back gardens.

MICHEL OF SWITZERLAND and JAN OF HOLLAND, both by Peter Buckley. Chatto and Windus.

CHILDREN OF THE HIDDEN VALLEY. Hutchinson. Price 8s. 6d.

THE NEW MAYFLOWER, by Alan Villiers. Brockhampton. Price 10s. 6d.

A BOAT OF OUR OWN, by Anna West. Hutchinson. Price 8s. 6d.

When the twins go on holiday to Sweet Briar Farm they are fortunate enough to have a wise old Uncle who takes them on excursions to woods, ponds and country lanes, where they meet and learn about the insects, animals and birds in the English countryside. This is *James and Susan in the Country*, with illustrations in colourful litho.

A nature-lover's book is *And The Running of the Deer*, by A. Windsor-Richards, the story of the life of a roe-deer from birth to mating. Fine illustrations by Edward Osmond, and a story with plenty of action.

A novel with a country background and an original story: *Foxy*. David goes from an orphanage to live in the country. The author makes one aware of the fact that the country is as terrifying to a town boy as the town can be to a child from the countryside. "They've come to take you away, Dave, that's what they've come for. That's what happened to Charlie Bell; we never saw him again." Never to be seen again seems dreadful. David satisfies his longing for a pet and companion with a fox cub which he cares for secretly until it is

discovered by his foster-father. Through the cub he adjusts to his new parents and home.

In a different category, but all about animals, is *The Fables of La Fontaine*. These classic tales of the crow and the fox, the turtle and the rabbit, the grasshopper and the ant, and so on, are translated from the french verses of La Fontaine. The book, reasonably priced for a fine production, has wonderful illustrations; but I personally would have preferred the tales re-told in prose, rather than the clumsy and sometimes difficult sentences of the translation.

JAMES AND SUSAN IN THE COUNTRY, by J. Clement Jones. Hutchinson. Price 9s. 6d.

AND THE RUNNING OF THE DEER, by A. Windsor-Richards. Hutchinson. Price 7s. 6d.

THE FABLES OF LA FONTAINE, illustrated by Simonne Baudoin. MacDonald. Price 10s. 6d.

YARNS FOR BOYS

Best of the novels I have read in the past couple of months is definitely *The Tendrills in Australia*. The central figure is a boy who wants to go in for a scientific career instead of taking over his father's cattle station, which is what his father expects of him. He reaches a satisfactory compromise at the end between his ambition and his father's, after several exciting chapters in which he and his friend foil "poddy-dodgers" (cattle thieves).

Several things appealed to me in this book. The boy's relations with his father have a ring of truth about them; the poddy-dodgers are human beings; in fact all the minor characters are well-sketched. We do get a little tired of yarns in which the villains are all so Springbok-radio evil, the heroes all so brave and clever. This writer has a more mature approach, and the excitement is not lessened by this understanding of thieves as well as heroes.

Mistaken Identity and *Double Matthew Walker* are two adventure stories for older boys in which the villains are all very, very bad. Good enough for an evening's entertainment, but not to be taken seriously.

Before his tragic death, Mike Hawthorn began writing a series of books for boys centred around racing motoring. The first of these books has been published, and while Mr. Hawthorn was obviously a much finer motorist than writer, boys who are keen on fast cars (and which of them is not?) may find the racing theme sufficient to keep them interested in *Carlotti Joins the Team*.

Spiked Shoes is another novel in which the writing cannot be commended, but the theme—running—may well keep the reader's interest.

THE TENDRILLS IN AUSTRALIA, by Allan Aldous. Chatto and Windus.

MISTAKEN IDENTITY.

DOUBLE MATTHEW WALKER, by John Maurice. Blackie. Price 7s. 6d.

CARLOTTI JOINS THE TEAM, by Mike Hawthorn. Price 10s. 6d.

SPIKED SHOES, by Jim Peters and Robert J. Hoare. Cassell. Price 10s. 6d.

FOR ALL AGES

For young children, *Mr. Hare Makes Stone Soup* has lively and humorous stories in the Brer Rabbit tradition. Mr. Hare is the clever fellow who outwits the other animals, but sometimes they get their own back.

The Real Book of Dolls and Dolls Clothes explains how to make and dress all sorts of dolls, from a little twist of cotton wool, a "doll's baby" to character dolls.

Children of about 6 to 8 are catered for in *Bobby Brewster's Camera*—rather magic things happen to this little boy; *Henry to the Rescue*—Henry is a helicopter; and *Secret Seven Fireworks*, yet another Enid Blyton yarn, as readable as all her books.

Lobster Boy is a novel for the 9 to 12-year-olds with a fishing village setting.

For older boys, and girls, those in the teens, there is a very workmanlike book, *Rockets and Satellites Work Like This*, by John Taylor. The information is up to date, including the Sputniks.

And finally *Instructions to Young Golfers* by David Thomas, useful information for boys fortunate enough to learn golf.

MR. HARE MAKES STONE SOUP, by Muriel Holland. Brock. Price 6s.

THE REAL BOOK OF DOLLS AND DOLLS CLOTHES, by Catherine Roberts. Dobson. Price 11s.

BOBBY BREWSTER'S CAMERA, by H. E. Todd. Brock. 6s.

HENRY TO THE RESCUE, by Dora Thatcher. Brock. Price 6s.

LOBSTER BOY, by Kitty Spender. Harrap. Price 10s. 6d.

ROCKETS AND SATELLITES WORK LIKE THIS, by John W. R. Taylor. Phoenix. Price 9s. 6d.

INSTRUCTIONS TO YOUNG GOLFERS, by David Thomas. Museum Press. Price 12s. 6d.

VICTORIANA

YOUNG LADIES AND YOUNG PERSONS

AROUND the middle of the last century, women's fashions became increasingly elaborate. Skirts spread and widened, were flounced and frilled, trimmed with ruching, puffs and knots of ribbon, draped with contrasting overskirts.

Dressmaking was the approved occupation for the "superior young person". At that time, some 15,000 girls were apprenticed to dressmakers and milliners in London alone, most of them between the ages of fourteen and sixteen. A twelve-hour day was considered the "ideal", for many worked literally day and night. Tuberculosis, often blindness and early death were the result.

"We cannot look at the Victorian fashion-prints," writes Marion Lochhead in her fascinating book *Young Victorians*, "especially those of girls in foaming skirts of tulle or tarlatan, ruched and garlanded and looped with flowers, without seeing behind that rosebud garden the shadows of others, less happy: creeping, beyond midnight, to bed, too weary to sleep, walking aimlessly through the London streets on a dreary Sunday afternoon, sometimes making an assignment and receiving one of those letters, and so going down an easy slope with none to guard their feet. The Victorian ballroom is haunted; the sad little shadows lurk even about Her Majesty's drawing-room."

However, this sombre picture is only one side of the rich and variegated life presented of Victorian youth at work and at play, at home and at school. The book gives enchanting sketches of many famous Victorians, men and women, when they were in their school-days; of life in some of the famous schools; and in Victorian homes.

It is a fruitful period to cover. In spite of the restrictions and conventions of the times, wider vistas were opening up, particularly for women; which may be why I found the descriptions of Victorian girls' schools more fascinating than the boys'.

The author describes the life of both the upper class "young lady" and the less economically endowed "young person". And many of the young ladies we read about are more spirited and independent than we had imagined possible in the Victorian period.

A most fascinating and readable book, filled with absorbing information and details, presenting a panorama of what life was like for young people over the whole period, from early to late Victorian times.

- *YOUNG VICTORIANS*, by Marion Lochhead. John Murray. Price 21s.

FOR CHILDREN

PARENTS with poetry in their souls are going to fall in love with I WILL TELL YOU OF A TOWN, something special and different for children of about 7 or 8 up. The author, Alastair Reid, is a poet, and this is a book for reading aloud to obtain full appreciation of his poetic prose.

The town is any small fishing village, the day described is any ordinary day. But text and illustrations are both so out-of-the-ordinary and imaginative, that I give this book special mention. I have a feeling that the charming drawings will appeal more to adults than children, but I may be wrong. In the slang of our children "I smaak that book."

- **I WILL TELL YOU OF A TOWN, by Alastair Reid. Hutchinson. Price 8s. 6d.**

HOME COMES FIRST

A good home is really far more important than a good school

HENRY HARRIS, M.D., D.P.M.

WHATEVER you do for a child, home comes first. It cannot help being the first and major influence.

If the home is right, the child can benefit from all these things. The wrong sort of home may make it difficult for the child to benefit from any of them.

Even the best of schools can only work with the parents. And no boarding school can entirely replace the home. For it cannot supply the affection only a home can give, the fundamental sense of security that prepares us to withstand the insecurities of life.

Normally home and school should work together in the same direction. But if they don't, it is the home that wins for better or for worse. I used to know two pairs of sisters who went to the same school. They illustrated pretty well the relative importance of home and school influences on the child.

Pauline Parker was fourteen and her sister, Patricia, twelve-and-a-half. Jean Hope was thirteen-and-a-half and her sister, Jennifer, twelve. All were brightly intelligent girls from good comfortable homes with decent conscientious parents who did what they considered their best for them. But from what transpired, obviously one pair of parents did not exercise their influence so wisely as the other.

Jean was one of the brightest girls in the school and the best all-rounder for games, studies, leadership and a general sense of responsibility. Her sister Jennifer was quietly coming on and between them there was firm friendship and no trace of jealousy.

Pauline Parker was the problem girl of the school. Always untidy, shock-headed, intensely earnest but lamentably awkward and ham-handed. No question of her being wilfully bad or defiant, or unwilling or stupid. Her innate intelligence was quite as good as Jean's, but somehow she never seemed to get round to using properly what abilities she had. If a question were asked, she was sure to be the first with an answer. As often as not the wrong one in her anxiety to be first.

She was quick to resent other girls doing well and to think they were getting privileges which she wasn't. The commonest words in her vocabulary were "It isn't fair." Either someone else was being asked to do the things she specially wanted to do, or was the teacher's favourite. Or she was being reprimanded when it wasn't her fault.

Her sister Patricia was a doll-like little paragon of neatness and goody-goodyness. Her fair curls always in perfect order around her neat little head. Her dress always spotless and uncreased. Her work always neat and careful and adequate. Everyone could see she did her best and did it always. But there was not a great deal of life and spontaneity about her, and perhaps a suspicion of complacency.

Patricia's virtues were always being extolled by both parents. She couldn't do anything wrong in their eyes. Pauline's mother made it quite clear that she expected Pauline to be a dud in everything and that she had been a difficult child and a nuisance from the start. Pauline's father was a sharply intelligent professional man. Not especially kind in his manner, not very good with children and inclined to tease and be sarcastic. He adored doll-like little Patricia and she was respectful and paid attention to his every word. Pauline was the perfect butt for his sarcasm. She seemed to invite it. And always Pauline protested, "It's not fair, it's not fair!" That was her slogan, her universal excuse, her protest.

But there was a reason for her "It's not fair." It was only too obvious that Pauline, their first-born, had been rejected by both parents from the start. Although of course there was no question of their consciously neglecting her in any way.

Her mother had a difficult time when she was born. There were difficulties in feeding her that took some time to clear up. There were other reasons too which we need not go into here. As a result of which both parents felt in some way disappointed with her. With the result too that, to make up for this feeling of disappointment, Pauline got far more fretful-fussing than true warm affection in her first eighteen months of life. And then Patricia was born.

The age of eighteen months is a critical age for a child to cope with a new arrival in the family. Inevitably it means less attention. At an age when a child consciously craves attention. It may mean less show of affection, though it should mean more over a certain critical period, certainly never less. You can't very well prepare an eighteen-month-old child for this sort of thing. But, when it comes, with a lot of tact and kindness, you can get the child to accept the arrival without feeling it to be a threat. So, you see, Pauline's "it's not fair" was quite true. It wasn't really fair.

Jean Hope was about the same age when Jennifer was born and at first didn't take well to it. When Jennifer was being bathed she would say "baby-tot", indicating that baby should be put back into her cot. She herself would try to climb into the bath so that she could get the attention that Jennifer was getting. But

the Hopes quickly noticed Jean's jealousy and promptly gave her the little extra attention and affection that served to allay her fears. They were wise in sharing their affection equally between the two sisters who later became the closest of friends.

Pauline was not so fortunate. From the start she felt she was blamed for things where an excuse would have been found for Patricia. Patricia's prettiness was made so much of, that Pauline lost interest in her appearance and almost flaunted her untidiness. Hearing her mother and her father openly say disparaging things about her, she had reason to feel it was unfair.

Unfortunately she transferred this feeling, as she was bound to, to every relationship at school and at play. The result was that her home life failed to prepare her to make good use of her schooling — even in a good school. Whereas Jean and Jennifer would probably have survived even a poor school.

Parents and teachers

I don't see much point in comparing parents with teachers, to the disparagement of either. Obviously both are looking after the same child and both are important people in the life of the child. As a parent, you have the child almost to yourself, to mould and influence, for five years. Then, for the next ten years or more, you share him with his teachers.

By the time he reaches his teachers the basis of his personality will have been laid down. How he gets along with others and how he is prepared to work and play with others. This basis must be soundly laid in the home otherwise the schools, the churches and the other organisations in the community can have nothing solid to build on.

Educationalists are the first to point out nowadays that education is not merely another word for schooling. They accept that the home is the principal educator, and the parents the first teachers of the child.

If the home cannot provide an affectionate and secure background right up to late adolescence, say eighteen, then the child will lack a quiet but real sense of security and confidence. And it will be difficult for anyone else to provide it. An inner basic sense of security, that only the home can give, enables one to cope with the insecurities that beset everybody sometime in life.

To fuss and worry about the child undermines this sense of security. So does being too critical, too strict, too demanding, or deliberately withholding affection, either as a punishment or a deterrent, so that a child feels hopelessly inadequate. Being a child, if it has any spirit, it will lash out wildly in the hope of catching attention and affection. To over indulge a child is also confidence-lowering for, in the nature of things, over-indulgence is capricious and ever-changing and follows no rules or laws. And a child likes to know where he is in the scheme of things, or he feels insecure.

There are other important ways in which the home can help a child's schooling, or hinder it. A child from a home where the parents care for education and do not despise books or reading or an interest in good music or art has advantages that the child lacks where such things are despised or not appreciated. Or where the family may be ill-housed and unable to provide privacy or quiet for reading or study.

The children of unskilled manual workers are still not making good in the grammar schools, where they have the opportunity of going to a university, in the proportion that they should. It is not the intelligence that is lacking, but the interest in education and the encouragement and backing from the home. Such children are still less likely to develop to the full capacity that their intelligence permits. And they tend to leave school earlier than their fellow pupils of equal intelligence.

As standards of housing and living improve, it should become easier for such parents to help their children to reap the advantage of whatever abilities they have. But no legislation can compel them to. And opportunities are wasted if parents fail to encourage the right interests in their children. Even good laws and good schools cannot create a true democracy where all have equal opportunities to develop what is in them. The parents in the homes must do their bit—an all-important bit. Home and school, they're both very important. But the home influence really must come first.

These three bright and bonny children are Hilton, aged 6, Rhonda, aged 8, and (below) Vernon, aged 1 year. They are the children of Mr. and Mrs. Lever of Johannesburg.

PARENTS' PROBLEMS

CONSTIPATED TWO-YEAR-OLD

● A MAFEKING MOTHER is rather anxious about her little girl who is just over two years of age, and has suffered from constipation for some time. She writes: My doctor tells me that the cause is lack of drinking water. I have to give her glycerine suppositories, which frighten her. I have tried several medicines, but they have little or no effect. I feel that the constant straining that she does is not good for her, and it is a great worry to me. In all other ways she is fit and healthy. Is there anything that can be given in such a case, or is it a case of time will cure?

Our specialist says that this trouble in a two-year-old will take time and patience to put right. At this age children are particularly liable to have difficulties with the bowels. Small children are also extremely sensitive to their mothers' feelings, so it is important that you should not let yourself worry about the temporary difficulty. Appear to be unconcerned, but see that your little girl has regular opportunities each day to try to pass a motion. As the motions have been hard they may have caused soreness of the back passage. A little witch hazel ointment will soothe this if she has any discomfort.

Perhaps she uses a pot and does not feel very comfortable on it. A commode chair gives more support, and she is less likely to strain. She can be left alone and allowed to take her time. As the glycerine suppositories frighten her, I am sure your doctor will do his best to stop them as soon as he thinks it possible.

It is good that the little girl is now drinking more water as this will certainly help, especially if some fruit juice she likes is added. You say she takes a varied diet so she will be getting enough fresh fruit and plenty of vegetables.

Perhaps her muscles are a little inclined to be flabby, so see that she gets plenty of exercise, running, jumping, climbing and so on. You can make up games of some exercises. For example, let her lie on her back with hands above her head and pretend to ride a bicycle with her feet. And she can go on all fours and try jumping about like a little frog.

The trouble will gradually clear, but it will be a real help if you treat it with quiet encouragement, and without fuss and try not to worry too much about it.

CRIES EACH EVENING

● WHAT CAUSES a contented and healthy baby to cry every evening, asks an East London reader: I have a son, aged four months, my first baby. Although he settles down and sleeps very well during the day and night, he cries every evening after his 6 p.m. feed until his 10 p.m. feed. It is the only time of day that he really cries, but we seem to be unable to find any solution to it. I always make sure he is not cold, has no wind or pain, but nothing seems to calm him at all, apart from bringing him downstairs for a while.

However, we do not want to start a habit of this, and therefore try to avoid bringing him downstairs too often. This situation can be extremely nerve-wracking, especially when it is continuous. I would therefore appreciate any advice you can give. I have been told that it is necessary for a healthy baby to cry two to three hours a day to develop their lungs. Is this so?

It is not often that one reads such a sensible letter about such an intractable, but common problem, says our paediatrician, and this mother will obviously find her own solution to it. The last sentence, though, is in a different category. The belief about crying being good for the lungs is one of the old wives' tales that is absolute nonsense.

Babies certainly do not all cry in the evenings, but it is quite common for babies who are easy and quiet all day to become difficult and to cry when they are put down after the last feed.

No one knows for certain why this should be, but a very likely reason is that it is in the evening that mother is getting tired. She does not handle the baby quite so gently and efficiently, but becomes a little jumpy and hurried. If she is breast-feeding she has less milk then than at other feeds. Also her husband is coming back and there is the evening meal to prepare. And everything adds up to increase the tension until it spills over and upsets the baby.

Knowing all this, it is sometimes possible to do something to put things right. There is nothing better than an hour's rest in the afternoon for mother, unless it be keeping the baby out of doors all day. But like many simple problems, there is no simple answer, except that as your baby is healthy and contented at all other times, he will certainly grow out of this present phase of crying every evening. I hope it will be soon.

Knock-Knees and Flat Feet

Mrs. G. R. writes from Johannesburg that her son of two years walks on the inside of his feet and appears to be knock-kneed. He is a plump, heavy boy, and new shoes are quickly trodden over on the inside.

The fact that he is a heavy child should not affect this little boy's feet, as if they are allowed to develop freely, they are able to support him. Many toddlers appear to be knock-kneed because of posture defects, that may be due to a minor upset in muscle balance. This usually recovers in time, but recovery is speeded up by special exercises.

If you are very worried about his posture, it is worth while taking him for an examination. But it is very probable that it will right itself in time. It is important, however, that he should wear shoes that give his feet proper support, and that he should not continue to wear shoes that are trodden over. You should not have difficulty in Johannesburg in getting his feet properly fitted.

SYLVIA PHINGLE'S COOKING PAGE

FAVOURITE DESSERTS

WHILE I still think that raw fruit in one form or another makes the finest finish to any meal, we all like a little variety. These fruit desserts are suitable both for routine family meals, and also for dinner parties. They include a couple of firm family favourites, enjoyed by children and adults alike. They use apples and pineapples.

BAKED APPLE CRISP

This is one of the best, heartily recommended.

Peel, core and slice **7 or 8 good cooking apples,** and put them in an oven-proof dish. (The dish should be 6" x 10" and at least 2" deep—or an equivalent size). If the apples lack flavour, as unfortunately they so often do, at least in Johannesburg, sprinkle them with a little lemon juice, grated rind, and also cinnamon if you wish. Mix together **1 cup Gvt. sugar** and **1 cup flour** and **pinch of salt.** Work in with the fingertips **½ cup butter**— in this case, it must be butter, not any other fat. Just work the butter until it is completely broken up, don't bother about getting the mixture to hold together, which it won't until cooked, and you shouldn't let the butter get soft and oily. Spread this topping over the apples, and bake in moderate oven (375°) for about 30 mins. Equally good served hot or cold, with or without cream. And the better the flavour of the apples, the better this pudding.

PINEAPPLE AND APPLE CRISP

Pineapples have been cheap for so long that they are worth using in different ways. The original of this recipe used canned pineapple; we are fortunate—we can use fresh.

Peel core and slice thinly **1 lb. cooking apples;** peel, core and slice thinly **1 large or two small pineapples.** Arrange alternate layers of apples and pineapple in a buttered casserole, 2" to 3" deep. Sprinkle each layer with a **few grains of salt,** and **a squeeze of lemon juice.** Make a topping in the same way as for the first recipe, only using **½ cup (4 oz.) flour** and **4 oz. Gvt. sugar,** and **3 oz. butter.** Bake until apples are tender and top is crisp and crunchy. Serve with custard or cream.

APPLE-ORANGE DELIGHT

One more with apples. This one, popular with children, makes a surprisingly good dessert for a buffet supper party. If made in double quantities and arranged in a big, round, clear glass bowl, it can look most attractive and guests can help themselves. Peel, core, slice **2 medium cooking apples.** Stew in just sufficient water to prevent burning, and sweeten to taste. Put apples through sieve when cooked. They must not be too watery. Meanwhile make up **one packet of orange jelly,** using only **¾ pint water.** When jelly begins to set, but is still fairly liquid, stir in the apples. Put in cold place to set—the consistency will be slightly soft when cold.

UPSIDE-DOWN PINEAPPLE CAKE

The idea of an "upside-down" cake is that you first put a topping of fruit in your baking pan, and over that pour a cake batter. When cooked, the cake is inverted onto a plate, so that the fruit comes on top. My recipe is for sliced pineapple, but you can vary this as you wish. You can put candied cherries in the centre of the pineapple slices (after removing the core) or use an equal quantity of sliced bananas and cubed pineapple. In summer, sliced peaches, apricots or other fruit can be used, and of course you can become quite artistic and arrange the fruit with cherries and almonds into attractive designs. This recipe makes a light, lovely cake.

Melt **4 tbs. (2 ozs.) butter** on top of the stove in the pan in which you will cook the cake—it can be round, square or any other shape. Add **½ cup Gvt. sugar,** and when the mixture is thick and syrup-like (but do be careful not to let it burn!) add the fruit (sliced pineapples or others) quickly to cover as much of the bottom of the pan as possible. Then pour over this cake batter:

Cream **3 oz. butter or shortening with ¾ cup sugar.** Add **2 slightly beaten egg yolks** and **½ teas. vanilla,** and

(*Continued on page 39*)

A MOTHER'S STORY

The CHILDHOOD *reader who sent us the true story that we publish here, said to us "If you don't want to publish it, don't worry. I just felt like 'airing my heart,' as it were."*

She also wrote: "My story is absolutely true, so I would appreciate it if you do not publish my name; I am not looking for sympathy, and I want to forget the past and live for the future."

We found her experience a moving one, and hope that our readers will share that view.

How often we hear mothers complaining about their children, or worrying over the way they behave.

They seem to have no ears for what we tell them, and too often there are arguments, fights and tears among the children, while mother is exhausted and nerve-ridden by the end of the day.

We ask ourselves, what will they grow up to be? What does the future hold for them?

I would like to pass on to all mothers my own experience, and perhaps this true story will cheer them up.

★

Three years ago I was just about a nervous wreck. I had three young children, as lively as they come, particularly my son, then 1½ years old. He never slept at night. Doctors could offer me no solution to this problem. They simply smiled because he was a picture of health, with rosy cheeks and a mop of fair curls. The children thrived, but mother expected too much, and gave too much.

The result was that I suffered a nervous breakdown, and this was followed by spinal polio. I was in an iron-lung, and in hospital for a period of 1½ years.

My eldest daughter, 13 years old, took over the household duties as far as she could when father was away and school was over. She did everything for her little brother—bathed and dressed him, and disciplined him when necessary. My second daughter, 7 years old, made her duties the laying and clearing of tables for meals, making beds, and tidying up generally.

Between them, they managed perfectly for 1½ years, and were proud of what they were doing. I began to see that all my efforts and teaching had not been in vain.

I have now been home, in a wheel chair, for a year. I cannot raise my arms at all, so I am fully dependent on others for washing, dressing, etc.

My eldest daughter, now 15½, offered, of her own free will (I never would have asked her) to do everything for me. The second, now 9½, washes my face and teeth, combs my hair and puts on my shoes. Number three, now 4½, is also a wonderful help. He insists on doing his share and is very quick to see for himself when I need anything. He never shows the least sign of irritation if I call him for anything.

They still have a good squabble or fight among themselves from time to time, but I am proud to say that I am convinced they will come up with flying colours when the need arises.

I now have a Coloured maid in daily to assist. As soon as she leaves in the afternoon, there is always one of the three to say: "Just call if you need us, mother."

My four-year-old now baths and dresses himself, so they are all quite independent.

The other night I must have looked tired, for he climbed on to my knee and said: "When are you going to let *me* put you to bed, instead of waiting for Daddy or Peggy to finish her homework?"

So this is what I say: "Dear mothers, don't worry too much. Just set a good example, and do your best. Have faith in God, and life will be worth while. In the past I shed many tears of hopeless despair, but now, after I have known real pain and trouble, I more often shed tears of joy at the wonder of the pure love of children."

In spite of the formidable title of this article, we believe it will be of general interest to our readers. The problems outlined by the writer apply not only to children suffering from heart disease, but generally to children suffering a physical handicap or disability; and the parent/child relationships apply equally well.

This article appeared in the South African Medical Journal, and is reprinted here by permission of the editor and author.

PSYCHOLOGICAL ASPECTS OF CONGENITAL HEART DISEASE

By A CHILD SPECIALIST

DURING the last few years, a great and sudden change in the prognosis of many congenital heart lesions has been brought about by dramatic advances in cardiac surgery. Children who were previously condemned to a limited life of invalidism can now often be restored to healthy activity and a normal life expectancy.

Now that satisfactory surgical techniques have been perfected it is most important that every possible care should be taken to ensure that the maximum advantage is derived from these operations. A new era has been opened in this field and, with the advance, certain problems for which there was previously no particular reason for concern have now to be faced. The excitement and drama have quite naturally been centred upon the activities in the operating theatre and there has been a tendency to overlook other aspects of the handling of these cardiac children.

There are several psychological considerations pertaining to the management of these patients which, though hitherto neglected, deserve most serious attention. Many of these problems arise during the years before the child is operated upon. Before discussing these, however, I propose to devote a little attention to the question of psychological handling at the time of operation.

At the time of operation

When a child with congenital heart disease is admitted to hospital for operation, the attention, thoughts and efforts of the surgeon are, of course, directed to the nature of the cardiac lesion and to the necessary steps towards its surgical repair. Unless the surgeon and his team have become psychologically orientated, there is a tendency to diagnose and treat the anatomical defect without giving adequate regard to the child's intellectual, emotional and personality structure. Such an approach fails to recognize the importance of treating a cardiac child as a total individual. The mere act of hospitalization, the surgical assault, the post-operative pain and discomfort, and the sudden removal of parental love and care, together constitute a psychological trauma of considerable magnitude. If this fact is not given the attention it deserves, the fundamentally important emotional security of the child is threatened and this, I venture to suggest, will interfere with satisfactory post-operative progress.

A few months ago, I had the opportunity of observing the methods employed at the cardiac surgery unit in the Mayo Clinic in Minnesota, USA, under the leadership of John Kirklin. Kirklin is acutely aware of the importance of a correct psychological approach in the handling of his surgical patients. He obviously considers this approach to be an essential part of surgical management and insists on its thorough application. In dealing with this aspect of congenital heart disease, I can do no better than describe my personal experience of Kirklin's routine:

Before the child's admission to hospital, Kirklin makes a point of establishing a friendly and reassuring relationship with the child. Before discussing the operation with the patient, he ascertains from the parents

what they have already done towards preparing the child psychologically for the ordeal that lies ahead. He then proceeds to tell the patient all about the operation. The exact form which this discussion takes will depend upon the age of the patient, and other circumstances, but subterfuge is always avoided. The surgeon explains that there is something wrong that needs to be put right by an operation which will make the patient perfectly normal like all other children. The child is reassured concerning his parents' presence in the hospital throughout the operation and afterwards. The method and purpose of anaesthesia is carefully explained. Post-operative conditions are then outlined. He is warned to expect a few days of pain and discomfort, but is reassured of the minor severity of the ordeal. The necessity for post-operative restriction of food and fluid by mouth is explained and this leads on to the story of intravenous feeding. The child is warned about his wound, the stitches and drainage tubes. The purpose of an oxygen tent is explained and, in these modern times, it is usefully compared with the interior of a space ship. Kirklin has the ability to make the child feel that he is in for some great adventure, rather than an ordeal of which to be afraid. He is most sympathetic in his manner and concludes by inviting the child to ask questions on any points that he may or may not have raised.

Having done his utmost to reassure the child by eliminating as far as possible elements of mystery and fear, he then gives his attention to the parents. They, too, are reassured and invited to ask questions. If the patient is to be brought into hospital on the evening before the operation, the parents are requested to remain with him until he is asleep. The following morning, they must be with the child during the half-hour period before his removal from the ward to the operating theatre. After the operation, as soon as the patient has been bedded and has regained consciousnesss, the parents are instructed to come to the bedside. It is considered most important to reassure the child that his parents have not abandoned him at this crucial stage. Visits to the bedside are curtailed to about 5 minutes but are repeated regularly once an hour for at least 48 hours. Once the child has survived this critical post-operative period and is making satisfactory progress, visiting continues on a more casual and less frequent basis.

During the first week or two after operation, these patients suffer a good deal of pain and discomfort. Not unreasonably, they sometimes develop intense feelings of resentment towards the parents for having landed them in this predicament. Parents are warned of the possibility of this emotional reaction and are so enabled to cope with it, with a minimum of alarm and anxiety.

Kirklin's psychological approach, based on common sense, is simple and easily applied. At the same time, it is positive and well directed. Surely its value is beyond dispute.

The years before operation

The cardiac lesion is usually recognized at a fairly early stage and from then onwards the heart condition is kept under constant observation and assessment. The assessment, however, is to be considered grossly deficient if it does not include an evaluation of the child as a total individual. These children are subject to profound and most important psychological reactions to which the numerous writings on congenital heart disease make no significant reference.

These psychological problems may arise from two main sources, viz. (1) the physical handicaps produced by the cardiac disease, and (2) faulty parental attitudes.

Physical Handicaps

From the day of its birth every normal child sets about the task of establishing a psychological goal of emotional security. Anxiety-provoking situations are encountered all along the line of normal emotional development, and it is the way the child deals with this anxiety that determines his ultimate personality structure. In the child physically disabled by congenital heart disease, the anxiety-provoking situations become magnified and his ability to deal with them reduced.

For every infant, the first natural source of emotional security is found in satisfactory feeding from its mother's breast. An infant with cardiac disease may encounter difficulty with feeding and at once becomes the victim of anxiety. The anxiety produced by a perpetual

struggle for breath is readily understood. The strain and exhaustion which accompany the passing of excreta and the dyspnoea that may interfere with sleep add to the infant's fears. As he grows older, new difficulties arise. At every stage he finds himself at a disadvantage. The development of motor power, co-ordination of movement, and ultimately walking, all represent an uneasy struggle. Every new phase calls for a supreme effort and nothing comes easily to the cardiac child. The world appears unsafe, threatening and frightening.

His daily activities soon become involved in the battle to keep up with other children. To a greater or lesser degree, he finds himself failing in this task. His activity is restricted, his ability to take part in games is limited, and his general relationship with other children is thwarted by obvious difficulties.

Sibling rivalry

It is common knowledge that problems of emotional maladjustment very often arise out of rivalry and jealousy between different members of a family unit. It is not necessary to elaborate on the various types of emotional situation which might arise; I only wish to point out that the problems of sibling relationships tend to become accentuated and complicated for the cardiac child, for instance, when he finds that he cannot compete with the physical attributes of his younger brother. A consideration of the constitution of the family must never be excluded in the assessment of the emotional problems of a cardiac child.

Psychological results

Thus, once a cardiac child is physically handicapped, psychological handicaps must follow. Very soon, unhealthy psychological defence mechanisms may develop. There are many ways in which these children may try to defend themselves against anxiety. Some may deal with the problem by abandoning the struggle and avoiding situations likely to confront them with anxiety. These children become increasingly asocial and withdrawn and adopt the attitude, 'I cannot manage, leave me out of it'. They may gradually become grossly introvert personalities, unable to establish normal interpersonal relationships.

Another group may react to their anxiety with a markedly over-dependent attitude towards their parents. They cling to their mother and become acutely anxious if threatened with any attempt to emancipate them from their emotional dependence. These are the children who are afraid to be left alone, cannot face going to school and generally fail to achieve that degree of emotional independence so essential to the satisfactory integration of any personality.

Resentment, frustration, jealousy, and an inability to compete with other children, may result in various forms of aggressive behaviour. Temper tantrums, crying spells, and other attention-seeking mechanisms may develop. More direct expressions of anxiety such as thumb-sucking, enuresis, nightmares, and nail-biting are often encountered.

Parental Attitudes

The recognition of the psychological reactions of these children leads naturally to a consideration of their parents. An adequate appreciation of the stress and strain to which these parents are subjected, and an understanding of their emotional reactions to the situation, become fundamentally important to a proper understanding of the psychological problem which I am attempting to outline.

When a mother learns for the first time that her child is suffering from congenital heart disease, she is obviously being confronted with a psychologically traumatic experience of considerable magnitude. Her immediate reaction and her subsequent behaviour and attitude towards her child will depend on a host of factors. If she is an emotionally well-integrated personality she will deal with the situation with a minimum of emotional disturbance; not so if she is already neurotically orientated. Her intelligence will be of some importance but of less significance than her emotional make-up. In addition to these personality factors, there will always be a variety of environmental circumstances which will influence the situation.

Feelings of guilt

In a great number of psychiatric disorders, guilt is the seed from which a host of emotional disturbances germinate. The problem under discussion is no exception. When a mother learns of her child's congenital affliction, one of her first thoughts is to wonder whether she might be in any way to blame. It is, after all, not easy to accept that cardiac malformation 'just happen'. The idea that the child's condition may represent some form of punishment readily asserts itself. A woman with an over-developed super-ego, particularly, will tend to find what in her mind would seem to be reasonable explanations for the calamity which has befallen her. In surveying her pregnancy period she will find evidence on which to pronounce herself guilty. Minor quarrels with her husband, the fact that she had not rested as she had been advised, or not attended adequately to her diet, and many other trivialities come rushing into her mind to assume tremendous significance and add fuel to the fire of guilt. Guilt is readily aroused in the woman who has made it clear from the start of her pregnancy that she did not want this child (a reaction from marital strife, financial insecurity, or other reasons). The woman who gives birth to a daughter after a persistent pathological insistence that she must have a son falls into a similar category.

The arousal of severe guilt feelings is then a not infrequent occurrence in the mothers of these children,

NYLON CARPETS

A NYLON carpet centre—claimed to be the first in Europe—was opened in London recently by Sir Gordon Russell, director of the Council of Industrial Design, and a man internationally known in the art world.

The aim is to provide a showroom where a vast range of pure nylon carpets and rugs, designed to match any colour scheme or any style of decor, are on display.

We may assume that nylon carpets have all the properties that we have come to attribute to nylon generally—easy washing, quick drying, long wearing, etc. South African housewives will undoubtedly welcome nylon carpets in their own homes, when they are available here.

and to a lesser extent in the fathers. Severe depressive reactions may develop as a consequence of these feelings of guilt.

Anxiety

It is perfectly normal for parents to react with anxiety concerning their child's illness. It is abnormal only when this assumes pathological proportions. It does not always flow directly from feelings of guilt; in many instances it simply represents an accentuation and reinforcement of previously established neurotic anxiety patterns. In such cases, a great deal will depend upon the nature of the inter-relationship between the present anxiety situation and the psychodynamics underlying the previously existing anxiety pattern. In these unfortunate parents, the problem of their disabled child becomes all-absorbing, influences their every activity, and precludes them from anything resembling a normal way of life. The fear of impending disaster is ever with them.

Parental behaviour

The obvious question of how guilt feelings and pathological anxiety are likely to influence the parents' behaviour towards the child remains to be answered. In this connection, parental attitudes of rejection and over-protection become particularly prominent.

Rejection may express itself quite openly, when the parent will display an obvious lack of affection for the child. An unreasonable demand for perfection in behaviour and a generally over-critical attitude may develop. Failure is not tolerated and expressions of hostile aggression towards the child will be encountered. In extreme cases, emotional outbursts may arise during which such remarks as 'I hate you; I wish you were dead' will emerge from a neurotic mother who cannot escape from the torments of her inner conflicts of guilt and anxiety.

Gross *over-protection* is common. This faulty attitude may be the direct outcome of pathological anxiety or may represent a cover-up for a repressed attitude of rejection. It is a great temptation to over-protect a disabled child and it is only the parent who has made a completely adequate adjustment to the situation who will avoid falling victim to this pitfall. Once a mother's attitude towards her child becomes influenced by her own emotional maladjustment, extreme degrees of over-protection will occur. The children who become victims of such over-protection are kept 'wrapped in cotton wool', protected from every possible stress, strain and frustration, and deprived of the chance of a development of emotional independence.

It should not be necessary to belabour the fact that attitudes of rejection and over-protection are likely to produce in the child profound emotional disturbances and markedly abnormal personality integration. To discuss the details of the effects of these abnormal attitudes would involve an unwarranted description of a host of emotional reactions that might be encountered in any child subjected to these unfavourable influences.

Psychological handling of the cardiac child

It is hoped that the value and, indeed, the complete necessity of approaching the cardiac child as a *total individual* has been satisfactorily established. The serious consequences of emotional maladjustment and defective personality integration in these children cannot be over-emphasized. Consider the child who goes to operation with an already seriously damaged personality. The surgical repair of the cardiac lesion might be completely successful but the patient remains psychologically crippled. Instead of being made fit for a normal life ahead, he runs the risk of an unsatisfactory school and employment record, a poor future marital adjustment and generally unsatisfactory interpersonal and social relationships. In this way, the success of cardiac surgery becomes intimately related to the patient's satisfactory pre-operative psychological development.

The first essential to the correct psychological handling of congenital heart disease must be a thorough understanding and appreciation of the precise nature of the relevant psychological problems, as well as their possible implications and consequences. It is hoped that in following the course of this discussion, such understanding has been achieved.

By quoting the example of Kirklin at the Mayo Clinic, I have pointed out the steps which can be taken to overcome psychological difficulties pertaining to cardiac surgery itself. I only wish to draw the attention of thoracic surgeons to the efficacy of the approach which

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