From our experience

Mothers are easily worried

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SUMMARY Mothers are easily worried and this cannot always be avoided. But mothers are often worried unnecessarily by insensitivity, unwise choice of words, failure to determine what they are really concerned about, by criticising them for being over anxious and ignoring their fears, or by inadequate explanation and counselling. Much anxiety is caused by unwise remarks in an assessment clinic or by a doctor’s failure to know the normal and abnormal variations in development, behaviour, or physical growth and physical features with resulting unnecessary medicines, surgery, or special investigations. It is easy to implant a feeling of guilt by putting the blame for a child’s behaviour or handicap on the parents. Screening procedures in the newborn may cause much parental anxiety.

Some years ago we wrote an article addressed to young doctors entitled ‘How to worry mother’. We decided that now, after some years’ more experience and thought, we should write a more comprehensive paper, being unaware of other literature on the subject.

Probably all of us have caused a mother to worry about her child. Sometimes it was impossible to avoid—but it could have been avoided on many other occasions if we had been more sensitive. When a couple asks one to assess a baby whom they wish to adopt and there is doubt about some aspect of his development, one has to be honest and explain one’s doubts and the need to see the child again, although it will inevitably cause worry. When a well infant is found to have a cardiac murmur and it is uncertain whether it is organic or not, prolonged anxiety may be prevented by an echocardiogram, so that the parents can be told definitely whether there is organic disease.

Loaded questions

When giving a lecture there is a danger of causing worry. One of us, in question time after a lecture to midwives on prenatal factors affecting the fetus, was asked whether the continued taking of a contraceptive pill for the first four months of pregnancy could harm the fetus. The answer was in the affirmative and it was distressing to hear later that a midwife had been reduced to tears as she had taken a contraceptive pill for the first four months of her pregnancy and when she asked her doctor if that was in order, she had been told that it was harmless, it was ‘only a hormone’! When the audience includes parents, one should be ready for ‘loaded’ questions.

The anxious mother

It is always wrong to tell a mother that she is ‘just fussy’ or ‘over anxious’, or ‘worrying about nothing’. She may be unduly anxious because of her personality, or because this is her only child after years of distressing infertility and miscarriages, or because her husband has died or is separated from her. She may be worried because of something she has heard on the radio or because her child’s symptoms resemble those of a friend’s child who died of leukaemia. If the mother is a doctor or nurse one must assume that she is likely to fear the worst possible condition to explain her child’s symptoms.

Mothers are often afraid to express their real fears; the fear of the unknown is worse than the fear of the known. After listening to a long list of symptoms not suggestive of organic disease, one may get at the truth by asking, ‘Now be honest, what are you really afraid of?’ We have all seen innumerable mistakes by doctors who have rejected a mother’s fears, saying that she is ‘just over anxious’, or that ‘the boy is just putting it on’, or ‘hysterical’.
or 'just wants a good smacking' when there is serious organic disease. When a mother is seriously worried about her child and insists that there is something wrong with him she may be right, or she may be wrong, but it is highly dangerous to reject her fears. Neither is it ever sensible to criticise a mother for wanting to visit her sick child every day or even to be at her child's side when he is recovering from an anaesthetic.

Choice of words

Thoughtless or insensitive choice of words is a potent cause of worry. We believe that it is a mistake to use the words 'brain damage' or 'birth injury' because if a tragedy befalls any of us it is better to feel that it was unavoidable than that if due care had been exerted the tragedy would not have occurred. It is better to try to avoid such words as, 'it's brain damage' or 'brain dysfunction'. A speech therapist told a mother of a late talker, 'Part of his brain is not functioning properly': it took a long time to reassure the mother about her child, who was normal. The words 'idiot' or 'mentally defective' should never be used when counselling a parent. Nor is it ever right to tell a mother, 'Nothing can be done for him'. There is always a great deal to do to help the handicapped child and his parents.

The mother of a child with a mucopolysaccharidosis was told, 'He'll grow up to look like an animal'. Some years ago we saw a hospital consent form which parents were asked to sign when their child was being admitted; it was brief and to the point, with the words 'I agree to his being given an anaesthetic. I agree to his dead body being examined by the pathologist'.

Assessment clinics

We have seen many mothers upset by remarks made in an assessment clinic. The mere title 'assessment clinic' may worry some mothers. We believe that except in the case of a handicapped child the 'assessment' should be part of the routine examination of any infant or young child in a child health clinic, hospital, or surgery, rather than in a special clinic.

We are doubtful of the wisdom of handing a proforma, such as the Denver prescreening developmental questionnaire for the parents to fill in to determine whether the child's development is normal. Mothers (like many doctors) are liable to interpret 'milestones' incorrectly. They may be led to believe that there is a range of normality: it is claimed the Denver scale 'enables the examiner to determine whether the child is within the normal range'. It must be obvious that one can never draw the line between normal and abnormal so that the fact that some feature of a child's development falls outside, say, the 97th centile, by no means proves that he is abnormal.

We know of two cities in which health visitors in their routine 6 month assessment have 'failed' 40% of babies on the test (in a child health clinic), telling the mothers that their child has 'failed his test'. In a European paediatric conference psychologists said that they had referred more than 10% of 8 month old children in child health clinics to specialists (including psychiatrists!) for opinion—inevitably, one feels, causing parental anxiety. If a child is suspected of having a treatable condition, such as a visual or auditory handicap, or a dislocated hip, specialist opinion has to be sought, but for conditions for which there is no treatment it is better to avoid unnecessary worry. For instance, if there is doubt whether the child is slightly spastic or athetoid, there is nothing to be gained from early referral rather than merely observing the child at intervals until one is certain.

One has seen numerous mothers who have been worried by a nurse or doctor saying, 'Isn't he sitting up yet?' or 'His head is a bit big', or 'His head is lop-sided'. A mother was worried about her 12 month old twins because a doctor said, 'Their heads are growing': they were, they were normal.

Know the normal

A thorough knowledge of the normal and of normal variations—developmental, behavioural, and physical—can do much to avoid unnecessary worry but one must not make the mistake of thinking a condition is normal when it is not. In a child health clinic or hospital outpatient practice mothers need reassuring about the normality of their children who are backward in individual fields of development—sitting, walking, talking, and sphincter control—which are so often a familial feature. We must all have seen anxiety caused by incorrect diagnoses of mental subnormality, spasticity, or hydrocephalus when the children merely show normal variations not amounting to disease. One of us saw 12 month old twins who at considerable cost and inconvenience to the parents (and cost to the National Health Service) had received physiotherapy for many months for cerebral palsy because, 'they were not showing the right responses'—a misinterpretation of the significance of primitive reflexes: the twins were normal. It is often difficult to decide whether unusual signs such as ankle clonus in early infancy, hypertonia, or exaggerated tendon jerks are merely
temporary variations; again, as early treatment would not help, it is better to say nothing and see the child at intervals in order to reach a firm diagnosis. Then, when one is certain, the mother must be told because she has a right to know. One has seen tragedies result from doctors incorrectly diagnosing a developmental abnormality in the case of a child being assessed for adoption, so that adoption was prevented when there was nothing wrong with the child.

Normal variations in behaviour are another potent source of worry. One sees normal, bright children on whom the label ‘overactive’ or ‘minimal brain dysfunction’ has been attached, when there is nothing wrong with them and they merely take after one of their parents; or their referral merely reflects the parental level of tolerance. Some have even been given drugs such as methylphenidate for their non-existent abnormality. One has seen mothers worried by unwise advice given because of the boy’s normal handling of his genitals or displaying them to his sister.

When a mother of a toddler is about to have a few days’ break away from the child, leaving him in charge of a granny, it might well save much worry if she were told that on her return the child may reject her for an hour or two—a common but distressing psychological reaction at this age.

In every child health clinic one sees mothers who are worried because of normal variations in physical features such as the unusually early or late closure of the anterior fontanelle, ‘tongue tie’, bow legs, toeing in or out, a clicking hip, green stools, notably infrequent or notably frequent stools in a breast fed baby, or small physical build (like that of the mother). Ignorance of these normal variations leads to unnecessary drug treatment or investigation, or surgical procedures (with unpleasantness for the child and anxiety for the parents). A recent article declared that full investigation, including muscle biopsy and electromyograms, should be carried out on all ‘toe walkers’; but toe walking is frequently a normal habit and simple clinical examination is all that is required. A mother told one of us that purely for her baby’s sake she had taken the baby off the breast because of the numerous blood tests being done on account of his breast milk jaundice.

**Impossible advice**

Unwise advice on management may cause worry. Often the advice is impossible to carry out. Parents have been warned not to let their child with asthma or cardiac murmur get tired or catch cold; or they have been told or have read how many hours’ sleep a child should have but not how that can be achieved. A well known textbook gives the exact number of tablespoonsful of various foods which should be given to children (right up to adolescence). It is easy to say so much to the mother about the advantages of breast feeding that she worries and feels guilty if lactation is inadequate. One of us made a journey of over 300 miles to guide a mother of a child with defective physical growth due to a congenital cardiac defect and a very small appetite: she had been told to force him to eat more but had found that impossible. The problem of the overweight infant can be difficult to solve and one has to avoid worrying the mother by telling her that she must give him less to eat. Weight charts have their place but their unwise use causes worry and anxiety. One of us saw two doctors’ children who had been weighed after every feed every day for the first 9 months. Just as one cannot make a child sleep (except by drugs) or eat, one cannot make him use the ‘potty’ and advice to make him use it is bound to fail and cause worry.

‘I haven’t been told a thing’

Patients commonly complain (often on television) that they are not told enough about their disease or about possible complications of treatment, operations, or immunisation. Lay people cannot understand how difficult it is for a doctor to decide how much to tell a parent. Considerable worry, anxiety, and unhappiness may be caused by describing in detail the natural history and perhaps the terminal illness, in such conditions as Duchenne muscular dystrophy, cystic fibrosis, polycystic kidneys, epilepsy, haemophilia, or juvenile chronic arthritis. It would be absurd to describe in detail the possible brain damage which some claim may result from whooping cough immunisation. When a child has otitis media, one does not give a vivid description and list of all the possible complications. When a child is about to have a trivial operation, one does not list and describe possible anaesthetic disasters or all the possible complications of the operation. If a child is to be given imipramine or phenytoin, one does not give a list of the 50 or so possible side effects. Some doctors go into such detail about differential diagnosis that it can never be said that what proves to be the true diagnosis has not been considered. Many doctors are too afraid of saying that they do not know what is wrong.

Worries are caused not only by saying too much but by not saying enough. This is commonly due to the doctor not finding time for adequate counselling or not realising the mother’s fears. When a doctor is examining a newborn baby, an intelligent mother is likely to watch not the baby but the expression on
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Being sensitive to feelings

In discussing the diagnosis one has to try to be sensitive to a parent’s feelings. The mother of one of my patients with eczema was told, ‘Watch out to see if he gets asthma’. He did. The mother of a newborn baby who had an innocent cardiac murmur was told, ‘Watch him to see if he goes blue when he cries’. He did: and she overheard the doctor say, ‘Isn’t his heart beating fast!’ Though it may (possibly) be true, one does not tell a mother of a child with a certain congenital heart defect, that ‘He may drop down dead if he gets excited, or exerts himself too much!’ When a child had a benign febrile convulsion, a mother was told, ‘It’s the way epilepsy starts but it can often be controlled by drugs taken for the rest of life’. One of us attended a ‘grand round’ on adult patients when a doctor, in the patient’s hearing, said, ‘We shan’t know the answer until we see the PM: it will be interesting to see that!’ Grand rounds and clinical examinations for students are liable to be a source of serious worry to patients, as are discussions on medical matters on television.

Implanting guilt

It is easy to worry a mother and to make her feel guilty by implying blame for her child’s illness, physical defect, annoying behaviour, accident, or ‘cot death’. An innocent mother may be greatly worried by tactlessly worded questions suggesting the possibility of non-accidental injury. A mother may be wrongly blamed for her child’s urinary incontinence on the grounds that ‘children should be toilet trained by two years, if there are good child-parent relationships’. When a dead child is brought into the hospital, it is easy to allow questions to give the impression that it is the mother’s fault, that it is because she was out at work, should have called the doctor in sooner, or had forgotten to give the medicine. A mother’s worry or feeling of guilt about her first child may colour her management of the next one.

When establishing a diagnosis one needs to take a searching history but one has to try to avoid ‘digging too deeply into the family graveyard’ for genetic conditions, or suggesting that the handicap is due to postponed conception, coitus in pregnancy, smoking, alcohol or other drugs in pregnancy, overexertion, poor antenatal attendance, or the effect of a broken marriage.

When a child has a potentially dangerous illness like gastroenteritis or acute stridor it is difficult, in a busy practice, to avoid giving the mother the responsibility of reporting deterioration in his illness: but she is untrained for this and may be unduly worried about the responsibility. Where possible the doctor has to share in the responsibility and not leave it entirely to the mother.

Screening for disease

Screening a newborn baby for treatable conditions such as hypothyroidism, phenylketonuria, and often galactosaemia is now routine, but we wonder if it is justifiable in view of the anxieties which it would cause, to screen newborn infants for Klinefelter’s syndrome,6 other chromosome abnormalities,7 a risk of ankylosing spondylitis8 or of multiple sclerosis,9 or hyperlipidaemia.10 11 Screening of the newborn may be desirable if it is necessary for genetic counselling (as in Duchenne muscular dystrophy) but if screening is to be done purely for purposes of research, it should not cause worry and anxiety. It seemed hardly reasonable to screen babies for the XYY karyotype with the instruction to parents of affected children that they should watch out for behaviour problems, criminal and antisocial conduct. 12 13 A false positive result in a screening test may cause prolonged anxiety. In a study covering 200 000 screening tests for hypothyroidism,14 78 of 102 families in which there was a false positive result experienced ‘strong initial emotional reactions’ and in 18 families parental overanxiety 6 to 12 months later, was ascribed to the initial false positive result.

In conclusion, we suggest that though there are many occasions in which it is impossible to avoid...
implanting some parental anxiety, we should give thought to the ways in which by being more sensitive we can avoid worrying mothers unnecessarily.

References
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