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The high-achieving child

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Introduction

Amongst the many intriguing aspects of paediatrics is the phenomenon whereby children somatise stress and distress – 'the child speaking with his body' (Apley, 1976). This psychosomatic process, first recognized by Plato, has been clearly described and documented by many paediatricians in more recent years (Miller *et al.*, 1960; Schmitt, 1971; Apley, 1975; Apley *et al.*, 1978; Bingley *et al.*, 1980). However, we do not fully understand why some children respond to stress with physical symptoms, others develop behaviour or emotional problems, and a few show no obvious discomfort or disorder. It is likely that there is a complex interaction between environmental factors, the child's personality and temperament, and physiological vulnerability.

What is usually evident is the source of distress. Difficulties for children are created by a wide variety of environmental factors such as change of school, move of home, parental unemployment, financial problems, severe marital conflict, other obvious forms of family disturbance and dysfunction, or loss of a parent or other loved ones.

There are less obvious, but equally problematic areas of a child's life that can lead to physical disorders. Relationship or learning difficulties at school, and overprotective or overintrusive parents can be very stressful. Sensitive questioning usually uncovers such problems. Sometimes the paediatrician is unable to detect any obvious environmental factors, and yet instinctively feels something is wrong. Fortunately, perseverance combined with an awareness of the way in which families may disguise their difficulties can eventually lead to an appropriate diagnosis. Another condition which is often heavily disguised by physical symptoms is school phobia (Schmitt, 1971). When presenting in this way it is sometimes called the 'masquerade syndrome', and may eventually only be diagnosed when unsuccessful and vigorously resisted attempts are made to return the child to school.

This leaves a small number of children for whom no organic or psychological explanation can be found for their physical symptoms. Such children are frequently passed from one specialist to another, each considering that the problem does not lie within their area of expertise. Professor Wolff has proved to be particularly expert at having such children referred to him. The use of a combined paediatric and psychiatric approach (Bingley *et al.*, 1980) has proved essential in the successful assessment and treatment of this group.

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The high-achieving child

These children have various features in common. They are usually girls in the age range 10–14, and their symptoms often have an obvious precipitant such as a mild injury or a viral infection, but their persistence and disabling nature is out of all proportion to the original problem. The most frequent symptoms include recurrent abdominal pain, headaches, limb pains, nausea, vomiting, anorexia, fatigue and lethargy. Any of these may occur singly or in combination. Some children have recurrent upper respiratory or urinary tract infections, surprising in their frequency and disabling in their intensity. More obscure problems such as skin eruptions or genital pain have also been noted. The child may be disabled by the symptoms, but still attempts to go to school if told to do so. This is in contrast to the school phobic child who makes every effort to avoid return to school, and whose physical symptoms are dramatically intensified by such attempts.

The most striking similarity amongst these children is their tendency to be 'good at everything'. They are well-behaved, 'perfect children', top of their classes and successfully involved in many activities – e.g., sports, drama, dancing, musical instruments, etc. They regularly win prizes and diplomas of merit, captain the school teams and even represent their county or country at under 16 level. We have adopted the term 'high-achieving child', which seems to describe their attitudes and behaviour.

The families tend to be happy, well-functioning and showing no obvious problems. Family members get on well, there are few, if any, disagreements, everyone is kind and considerate, and the parents are neither high-achievers themselves, nor do they have high expectations for their children. A common statement is 'we

only ask that she does her best'.

Celia, aged 14, is typical of this group. She presented with an eighteen month history of leg pain and limp following an injury during practice for a school-girls' international netball tournament. Prior to the injury she had been top of her class, winner of various prizes for piano and clarinet playing and one of the most popular girls in her school. Since the injury she had suffered persistent leg pain which prevented her from participating in any games, and was sometimes so severe that she could not go to school. Her family had no problems and seemed to have good relationships. No psychiatric abnormality was found and Celia's school report confirmed her parents' description of her and indicated no difficulties.

Our sample

Over a two year period, 21 such children (17 girls, 4 boys) have been admitted for investigation, with an age range of 9–15 years, and a mean of 12.2 years. No social class bias has been noted, nor has the child's ordinal position been significant. Intelligence testing using the WISC(R) reveals an IQ range of 121 to over 150, with a mean of 137. Physical examination reveals only occasional 'soft' signs such as abdominal tenderness, or variable limp. Investigations are rarely abnormal, and even then are of doubtful significance; e.g., an X-ray suggesting an old injury or a marginally altered immunoglobulin pattern. On initial assessment no obvious behavioural or emotional abnormalities are detected, and all families are perceived as functioning well.

More detailed psychiatric assessment reveals a more complex picture. Underlying the perfect facade is a child with very high self-expectations who hates to be anything less than best. She denies and disguises her anxieties about her performance because she considers it unacceptable to be worried. Nor is it permissible to make demands upon the family – 'it's unfair to be a bother to people'. Anger, depression or any other negative feeling is unreasonable and unacceptable. The child's attitude is the same as that of her parents – 'so long as you do your best'. The family places more importance on consideration, caring and kindness than anything else. Conflicts are denied or detoured (see Lask, 1982 for a detailed explanation of this process).

Such children are in an intolerable position. Genetically well endowed they become high achievers with consequent high self-expectations. Their families support and take pride in them whilst asking no more than that they do their best. The high-achieving child persists in doing her best, and is allowed, and allows herself, no respite. She has no yardstick for measuring what is her best, so she can never know whether she has achieved it. As the pressures build up, so she becomes anxious, but is unable to show or share it. No one recognizes a problem. The tensions increase and there appears no way out. Suddenly a viral infection, or mild injury intercedes, activities are temporarily curtailed, and the pressure is removed. For a while everyone is contented, but the expected recovery does not occur; the injury, pain, fatigue or anorexia persists. Puzzled parents seek advice, caring physicians make perfectly reasonable comments such as 'sometimes viruses linger', or 'she's bound to have some residual pain for a while' – and so the scene is set. The high-achieving child no longer has to perform at all times. She has an excellent reason for failing to achieve, and medical opinion has stated that recovery may take a little longer. Everyone relaxes again. The weeks of ill-health stretch into months, however, and soon more investigations are thought necessary, but blanks are drawn, and esoteric explanations are sought. Obscure orthopaedic diagnoses are elicited to explain persisting immobility, food allergy is eagerly investigated at special clinics, and the mysterious ways of invisible viruses are used to account for anorexia, lethargy and fatigue.

Nicola aged 14 had been incapacitated for 3 years following a series of upper respiratory tract infections. Prior to this she had been everyone's idea of the perfect child. Eventually an exasperated physician told her parents that 'this particular virus can linger for years'. Long and patient talks with Nicola revealed a previously unexpressed anxiety about both her parents. In her desire not to upset or worry them she had not mentioned how worried she was that her father, a commercial traveller, might be involved in a car crash. She also had not mentioned how worried she was watching her mother nervously awaiting father's return, but denying it for fear of worrying Nicola and father! All this on top of her high standards, and feeling she must do her best at all times. At school she was disappointed after scoring 19 out of 20 in an end of term test!

Management

We find a comprehensive approach (Bingley *et al.*, 1980) to be essential. A psychiatrist (or psychologist or social worker) is involved at an early stage in the admission. We explain to the parents that such an approach is our normal policy, pointing out that it is artificial to divide a child into separate parts, body and mind. Following the usual investigations including psychiatric assessment of the child, we have a joint interview with the family. We explain our understanding of the problem and invite the family to discuss our view. Most such families, although surprised by our opinion, are willing to consider the possibility, and many recognize its significance. This is in contrast to some more disturbed families who totally reject a

psychological explanation. Indeed some of these latter families will state that they could *never* accept such an explanation, even after receiving a clear explanation of the meaning of 'psychosomatic' and an assurance that their child is not mad, malingering or imagining it.

Exploration of parental attitudes to success and failure usually reveals at least one parent who has high self-expectations, and an understandable pride in their child's achievements. However, they have little trouble in recognizing the difficulty their child is experiencing. We work towards helping the parents make it clear to her that imperfection is acceptable, that occasional failure does not matter. We ask parents to define what is meant by 'doing your best', and also to work out how their child can know when she is indeed doing her best. We try to help the parents make it clear that it does not matter if at times she does not do so well. We ask them to quantify what would be satisfactory in terms of exam marks and other forms of achievement. Much to Nicola's amazement her parents settled for 13 out of 20. This revelation led to a good deal of laughter, which helped us recognize how often humour is lacking. We try to help the family find the funny side of high-achieving – every family has its own brand of humour, and most enjoy such an exercise. It helps defuse the tension that so often underlies the problem.

Another way of helping reduce anxiety is to prescribe a 'worry hour'. Time is put aside (not necessarily an hour) during which the child is encouraged to discuss anything that is bothering her. The purpose of the prescription and formal structure is to underline the acceptability of having worries and the importance of talking about them. Self-relaxation is another useful exercise aimed at reducing levels of anxiety and consequently tension-induced symptoms. A number of techniques are available to assist relaxation, easily learned and enjoyed by children in this age-group (Ollendick & Cerny, 1981).

Parents are advised to discuss the problem with relevant school teachers for whom the diagnosis is just as surprising as for the parents. Similar forms of help are required in the school to those offered at home.

Conclusions

Sceptics may dismiss this particular syndrome as insignificant or even non-existent. They can rightly point to the fact that some patients do not fully recover from viral infections for months or even years and evidence suggests that lifelong latent infection of herpes viruses is subject to reactivation (Editorial, 1985a). Similarly, limb injuries are easily exacerbated with persistence of symptoms, whilst lactose intolerance as a cause of recurrent abdominal pain can be difficult to exclude (Barr *et al.*, 1979). Nonetheless this group does seem to have some common characteristics, including high-achieving, an excessive altruism, with caring and conflict-avoiding parents. Further, the children tend to recover and return to a normal life once school and parents have altered their approach, suggesting that psychological factors are of major importance. Nor should we lose sight of the increasing body of evidence showing that stress can modify the immunological mechanisms of the host and alter the course of infection and disease (Editorial, 1985b).

The high-achieving child should not be confused with the so called 'gifted child', who tends to be socially isolated, rather than very popular, skilled in one or two areas only, rather than several, introverted rather than gregarious, bored by school rather than excited by it, and the owner of an exceptionally high IQ (over 150). Nor should the high-achieving child be confused with the school-phobic. Unlike the school-phobic she is eager to attend school, makes every effort to do so, and does not resist attempts to assist her in this aim.

Acceptance of the existence of this syndrome should lead to its increased recognition with an enhanced understanding of its aetiology, presentation, variations and most appropriate treatment.

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