less responsible attitude to contraception or that there has been an actual increase in the number of promiscuous pregnancies in unmarried women. The hope that the type of patients previously having criminal abortions would request legal termination after the Act of 1967 is not supported by our experience, which suggests that the number of criminal abortions has increased since the Abortion Act.

Illegitimate Births

Any anticipated fall in illegitimacy after the Abortion Act has been slow to appear in Bristol (Table III). The number of illegitimate births remained virtually unchanged between 1967 and 1970. It remains to be seen whether the modest fall in 1971 will be maintained.

TABLE III—*Illegitimate Births in Bristol Expressed as Percentage of Total Number of Births (Live Births and Still Births)*

Year	1964	1965	1966	1967	1968	1969	1970	1971
Births ..	7,610	7,720	7,410	7,094	6,834	6,542	6,340	6,417
Percentage Illegitimate Births	8·8	9·7	9·8	10·6	10·4	10·6	10·4	8·6

Discussion

Clearly the hope that the increased work load resulting from the Abortion Act could be easily absorbed into existing gynaecological services has been unjustified. We doubt if the Act has caused any reduction in birth rate or illegitimacy, and possibly criminal abortions have increased. Whatever has been achieved in socioeconomic benefits has been at great cost to ordinary gynaecological patients. In our experience the waiting list for inpatient treatment has increased by 200%. No estimate can now be given for the waiting time for non-urgent operations as the department can only just keep pace with urgent admissions and legal abortions. This is in spite of the fact that we have increased our surgical load by 45% and generally reduced the duration of stay of patients to levels which we consider undesirable.

On a general note we feel that the Act has had a serious effect on the quality of training which we can provide for nurses, medical students, registrars, and house surgeons. Certainly in our unit all nursing and medical staff have experienced a reduction in job satisfaction, with a frustration resulting from our inability to treat gynaecological patients in need.

The plea for special abortion units has already been made. These include provisions of beds, theatre facilities, and nursing and medical staff. Such units could not be isolated but should be part of a general hospital with all the necessary auxiliary services. It could well be that if such units were working on a five-day week basis married nurses would be prepared to staff them by working part time, knowing that there was no weekend duty involved. On the medical side it is unlikely that any suitably qualified practitioners would be prepared to undertake abortions as a full-time job unless it involved enormous financial rewards. We must therefore accept legal abortion as part of our gynaecological duties but only if such work is drastically diluted. This plan can be achieved only by an urgent increase in available beds and by a corresponding increase in consultant and junior medical staff of all grades.

The *Daily Telegraph* on 1 February 1972 contained an article suggesting that Roman Catholic gynaecologists were having difficulty in obtaining posts in this country. In the present state of gynaecology it is not surprising that prejudice is shown to such doctors, and we feel it our duty at present to advise young doctors to avoid gynaecology if their conscience prevents their participating in legal abortion.

We would like to thank Mr. S. D. Loxton for permission to study cases under his care. Our thanks are also due to the Department of Health, University of Bristol, for supplying the vital statistics concerning Bristol. Requests for reprints to A.H.J. at Bristol General Hospital.

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Emotional Problems of Childhood and Adolescence

School Refusal

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Absence from school which is either recurrent or of long duration is a constant problem for education authorities and school teachers. The commonest reason for absence is illness, for which about 80-90% of children are kept at home. Others are unlawfully withheld from school by their parents to help at home, to keep a parent company, or to do the shopping for a phobic, house-bound mother. Another kind of illegal absence from school is perhaps the best known—namely, "truancy," which is non-attendance on the child's initiative, more often without the knowledge or consent of the parents and certainly without the consent of the school. Such children ostensibly set out for school but never reach there, or attend only long enough to be registered as present before leaving school alone or in the company of other truants to wander about or return home to an empty house. They often show antisocial behaviour to a greater or lesser extent in addition to school attendance problems.

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Clinical Features

The fourth reason for absence takes the form of persistent inability to attend school, often starting as reluctance and progressing to total refusal to go to school or remain in school in the face of persuasion, entreaty, recrimination and punishment by parents, and pressure from teachers and educational welfare officers. This behaviour may be accompanied by overt signs of anxiety or even panic when the time comes to go to school, and most children cannot even leave home to set out for school. Many who do, return home halfway and some children, once at school, rush home in a state of anxiety. Those who are unable to go may insist that they want to go to school, prepare to do so, but cannot manage it when the time comes.

When the syndrome of school refusal presents in this way the diagnosis is hardly in doubt. When it assumes a somatic disguise careful assessment is needed by the family doctor, who is usually the first to be consulted. The complaint may, however, take the form of loss of appetite, nausea, vomiting, syncope, headache, abdominal pain, vague malaise, diarrhoea, limb pains, tachycardia, or even inexplicable recurrent low-grade fevers, in the absence of identifiable organic illness. These features occur in the mornings before school, or even at school, without any overt expression of fear about school.

The absence of the symptoms over weekends and during school holidays and their rapid disappearance once the decision is made to allow the child to remain at home draws attention to the association with school attendance. At times the somatic symptoms are not actually experienced but fearfully anticipated, so that the child may avoid school in case he faints or vomits in situations such as school assembly.

IRRATIONAL FEAR

Behind this facade of behaviour and diverse symptoms lies an irrational fear of some feature of school. If the child can put his fear into words he may complain of a teacher as critical or punishing, of schoolmates as bullying or unfriendly, or he may bring out his fear of failing an examination even though his school reports are consistently good. Events such as games, school dinners, physical education, undressing in the showers, the rude talk of schoolmates may be fixed on and offered in explanation. Parents may see these as reasons for asking for a change of teacher, class, or school or may request medical backing for their child to be excused from taking part in certain activities, often with little or no effect on the behaviour or symptoms. When no improvement occurs attention is often drawn for the first time to the fact that the reasons offered for the difficulties are not the real ones.

It may be said that many, if not all, children complain at some time about these and similar matters but are still able to attend school. Nevertheless, there is a qualitative difference between the transient stomach ache or urinary frequency on a Monday morning which many children have at some time or another, and the persistent complaints of the school refuser which lead to repeated absences often amounting to a surprisingly large amount of time spent at home in any one term. There is also a difference between the inexplicable fears mentioned earlier and the realistic fears of the average child either about a threatened beating by the class bully or about an impending examination, both of which disappear once the threat is removed or the examination is over.

ONSET

An acute onset is more often seen in younger children and is shown as sudden and unexpected clinging to mother and refusal to leave her to go into school. A formerly independent, outgoing, and active child may become anxious, demanding, and stubborn, showing surprising resistance to firm efforts to induce him to attend school. He may be reported to carry on normally in other respects, playing actively with friends in and around the home, and retaining his interest in reading and learning by watching school television programmes. When asked why he cannot go to school he may be able to pinpoint and describe his fears of some aspect of school or else cannot say what it is that he fears. He will say in truth that he wants to overcome his fears and return to school, that he is ashamed of himself, but is unable to surmount the anxiety or panic each morning.

Many of these cases are true cases of "school phobia"—that is, a special form of fear out of proportion to the real demands of the school situation, which is beyond voluntary control and cannot be reasoned or explained away. The feared situation is avoided and safety is sought in the mother's company at home. In other cases the apparent fear of school may hide a fear of harm befalling the mother in the child's absence, so that the child is compelled to remain at home to reassure himself of mother's safety. In these instances the inability to go to school is really a fear of leaving home because "separation anxiety" is aroused by attempts to do so. Such behaviour can be triggered off by apparently innocuous events—a minor illness and accident or operation, leaving home for the weekend to go to camp, a move to a new house, a change of class or school, the departure or loss of a class friend, or a death of a relative. All these events represent a threat to the child, arousing anxiety which he cannot control.

In some cases a parental quarrel with the threat by one or other parent to leave home or commit suicide may be a realistic precipitant of anxiety. The experience of a specific humiliating situation at school, or one producing anxiety, such as teasing or bullying or being shown up by a sarcastic teacher, may lead to the school or classroom becoming a phobic situation which the child cannot bear to enter.

Features in Older Child

The onset may be more insidious in the older child, who is often pre-adolescent with an earlier history of frequent periods of reluctance to attend school or even outright refusal. There is often no abrupt or definite change in personality but a gradual withdrawal from peer group activities formerly enjoyed, such as Scouts or Guides. The youngster ceases to go out, clings to the mother, and expresses a general dislike or fear of the world outside the home. He may become stubborn, argumentative, and critical in contrast to earlier compliant behaviour. Very often there is no clear precipitating factor other than a change to senior school, which may have occurred as long as a term ago. There may be other behaviour problems, or symptoms of a depressive disorder, or more rarely evidence that the behaviour is part of a psychotic illness. In many instances without clear precipitants, inquiry may disclose complex earlier family psychopathology of long standing and evidence that the earlier personality development of the child has been deviant. Here the school refusal is an indicator of the child's inability to cope with the demands for an independent existence outside the family.

Characteristics of Children and Families

The condition is equally common among boys and girls and intelligence is usually average or above, but those with low average, or even dull intellect are not immune. Behaviour at school usually presents no problem, and teachers are often extremely puzzled why an apparently quiet, conforming, hard-working child should suddenly fail to attend. There is a striking absence of antisocial behaviour—in contrast to truants, where conduct disorder is a frequent accompaniment. Educational attainment is usually on a par with intellectual

level, but there are instances where retardation may be severe and this possibility should never be overlooked as a factor in the disorder. Some children have a history of always being unusually timid and apprehensive in new situations and inquiry shows that they have been over-protected and over-indulged, especially if they are the only child after a long period of infertility or the youngest child of elderly parents whose earlier children are now independent or grown-up.

The families of these children are more often small or of average size, and the fathers are mostly in professional, semi-professional, or skilled occupations, but may be in all classes of work. They are usually good providers in the material sense but often too passive and inadequate to exert any authority in the home. Many mothers of school refusers suffer from neurotic illnesses with anxiety and depression. Both parents overprotect the child from the demands of real life, make an issue of conformity and success at work, but succumb to their child's demands when the need for firmness is greatest. The degree of abnormality in family relationships is often so striking that many view school refusal as a "family" problem and treat it accordingly.

Management

The first requirement is to recognize the condition. It should be distinguished from truancy, which is possible in most cases but more difficult when there is an overlap in the pattern of non-attendance and associated behaviour. More important, perhaps, is the early recognition of the underlying pschological factors in those patients presenting with somatic symptoms. When this is suspected, investigations should be an essential few or omitted if possible, so as to avoid unnecessary time at home or attendance at hospital. If convalescence from a minor illness is more protracted than appropriate under the circumstances and there is a past history of repeated absences from school with minor illness, the possibility of incipient school refusal must be considered. An over-anxious mother who seeks to convince the doctor that a few days longer at home will make all the difference is an additional indication that difficulty in returning may be expected.

The study of each case should begin with a careful inquiry into whatever complaints about school the child may have. These often turn out to be significant but not sufficient causes for school refusal, in that the unpleasant experience has been a precipitating factor which summates with predisposing neurotic elements in the patient and the family. Efforts should be made to correct such factors as inappropriate placement in school or class, educational backwardness, unnecessary exposure to games and physical education when a child is patently hopeless at these.

RETURN TO SCHOOL

Early return to school is an essential aim of all treatments whatever their nature; otherwise too long an absence sets in train secondary factors which make treatment more difficult. Once the condition has been diagnosed parents can be encouraged to take a firm stand instead of the customary bargaining. Tension and anxiety in the family can be contained with the support of the family doctor, who can make the decisive intervention and decision to return the child to school at a time when parents and child are waiting for someone else to do so. Such intervention is more effective with younger children once a gentle interview with a child has revealed fears about work, physical training, or mother's safety.

When parents are being reassured about the absence of physical disease in spite of symptoms an explanation of how underlying anxieties can express themselves in physical ways can be immensely helpful. Direct advice to parents on how to handle the issue of going back to school by fixing a day, acting firmly and consistently, and not engaging in unnecessary exhortation or justification can achieve much. Getting a father involved whenever possible is a support for the mother, who all too often is left to struggle alone.

TRANQUILLIZERS

The minor tranquillizers such as chlordiazepoxide and diazepam are useful in reducing anxiety in the child sufficiently to start out for school. A morning dose alone may be sufficient, or they can be prescribed morning and evening if the child is also anxious the night before school. Such measures are an important adjunct to advice and counselling (given to the family) but should never be used as the only treatment. The effects will be temporary if the basic problem of anxiety is not dealt with in discussion; indeed, the prescription of medication alone may negate in the child and parents the reassurance, given earlier, that no physical illness is present. In older children and adolescents when there is clinical evidence of persistent depressed mood, loss of appetite and interest, and sleep disturbance one of the tricyclic antidepressants such as amitriptyline can be of help provided the safeguards mentioned above are observed.

REFERRAL TO CHILD PSYCHIATRIC SERVICE

If and when school refusal does not respond to the above measures, referral to a child psychiatric service should be initiated. In these instances the behaviour in relation to school is usually a symptom of a more severe phobic disorder, or depressive reaction in the child or adolescent, or a manifestation of severe family disturbance or abnormality of parent-child relationship. For the treatment of these cases the resources of the child and adolescent psychiatric team are necessary, and in some admission to an inpatient unit may be required. Overall, the results of treatment are fair, in that about two-thirds of children return to school, with best results in those under the age of 11 years. Those who are unable to return are usually older adolescents nearing school leaving age. In some, school refusal is a precursor of more serious psychiatric disorder requiring further treatment in adult life. This is particularly so when it has been an aspect of a neurotic or personality disorder which has interfered with the development of independence and normal social relationships.

To sum up: a child presenting with recurrent somatic symptoms or persistently negative attitudes to school attendance, or both, needs careful consideration, not only of the overt phenomena but of underlying personal, family, and social pathology.