Personality Disorders Accompanied by Vegetative (Somatic) Symptoms in Childhood

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I. Clinical Symptoms

The clinical symptoms or complaints related by the patient or his parents constitute an important part of the initial activity of the paediatrician. It is the appearance of certain "symptoms" which are taken for the disease itself by the patients and their relations, and nearly in every instance when the parents call on the paediatrician it is for some organic pathologic symptom in their children. Although it is known by the physician that this "symptom" is only a sign of a certain general organic or functional disturbance, and the essence of the disease is not the "symptom" in question, he nevertheless starts to examine the patient on the basis of this "symptom" or "symptoms". The investigation follows the "symptom" and the physician attempts to discover the essence of the disease in the meantime. The paediatrician using up-to-date concepts and methods, seeking the direct and indirect cause or causes of the disease while considering the "symptom" or "symptoms" and applying methodical investigation, explores the actual morphogical and functional quality of the child's organism. Within this activity he attempts to establish the actual degree of the organism's development and the previous course of that development. These investigations and examinations concern the entire organism of the child in question as a unit and include all organs and organ systems constituting the organism's entity. When by means of classical and at the same time up-to-date examination methods the paediatrician endeavours to establish the actual organic structure of the individual child at a given moment from both the morphological and functional points of view, he cannot neglect to explore the quality of the actual personality of the child. When establishing the quality of the "actual personality", the investigation must consider the factors of the personality, which have played a part in the development of the actual personality structure, further the factors and processes which have influenced its development in a positive or negative manner. It is the knowledge of all these factors which enables the physician to form a notion concerning the quality of the "personality structure" from both the static and dynamic points of view.

The close interrelation of the vegetative, somatic character of the organism and that of the personality mirrors itself in every manifestation of the child's life. The younger the child in its "actual personality" manifestations, the more decisive the vegetative dynamism of the organism. It is only in the later years of individual development that the dynamic preponderance shifts to the emotional sphere, and it takes some more years before it shifts towards an intellectual character of the personality. In childhood, under physiological conditions as well as in disease, the manifestations of the individual's life appear for the paediatrician in the form of closely connected events, phenomena and symptoms of the "personality" and "non-personality" (primitive vegetative) traits.

With due consideration to the above, at our Department the following examination methods are employed in order to explore the underlying cause of the disease simultaneously with investigating the symptom or symptoms in a given case. It would be incorrect to assume that that method of investigation is applied uniformly, mechanistically, in a schematic way, in exploring or interpreting the cause of the "symptom" in every case. It is the quality of the individual case which determines which of these methods should be applied in a detailed form. When planning the course of investigation, the consideration of the related symptoms and the first impression of the condition and quality of the child as well as their evaluation decide which of the above methods should be employed in due detail. This complex examination method or diagnostic technique has been developed, corrected and simplified for over 25 years, in the course of its application to the large patient material accumulated during these 25 years. Our diagnostic and therapeutic method has been summarized clearly and has become so simple that it can be applied not only by ourselves but also be recommended for the use of others.

The parent takes the sick child usually to the general paediatric outpatient clinic of the Department. It is there that the complaints are heard for the first time and the paediatricians start to deal with the symptoms. Next, the following methods of examination are applied to explore the cause or causes of the symptom or symptoms, and to clarify the previous course of the pathological process. The order to be given below is at the same time the usually applied order of the examinations.

(i) First of all, the patient is examined by classical paediatric methods, calling in if necessary our different special clinics (surgery, oto-rhino-laryngology, orthopaedics, neurology, ophthalmology, urology, X-ray, general laboratories, ECG, EEG, etc.). If, however, at the first examination at the clinic the condition of the child is considered as necessitating admission, the classical paediatric investigations are carried out in the ward. The purpose of these examinations is to define the morphological and functional, so-called vegetative (somatic),

condition of the organs, in other words the whole organism of the child. The vegetative (somatic) status is established by these means.

(ii) If in the course of these examinations the need for a psychological examination arises, this is carried out at our child guidance centre by well-trained psychologists experienced also in paediatrics, in collaboration with paediatricians. In the course of the psychological examination all kinds of up-to-date methods are applied, supplemented with some tests developed by us. In this way is established the psychological status.

(iii) Should the results of the above mentioned two investigations call for a study of the child's environment, this is carried out by special social case workers. In this way is established the "environmental status". In certain cases this study consists of two parts.

(A) Study of the child's family, which again has to be carried out according to different points of view, viz. *(a)* investigation of the living conditions of the family, *i. e.* its economic situation, living conditions, education of the parents, hygiene and education of the child, including its nutrition, clothing, sleeping place, washing possibilities, exercise and playing possibilities, books, television, wireless; *(b)* evaluation of the subjective features of the family, i. e. the peculiar emotional atmosphere, the emotional structure of the family, the emotional relations between the child and its father, mother, siblings, eventually grandparents and other relatives living in the family; the emotional and "power" position of the child, and its situation in the emotional structure of the family; *(c)* an important problem is to find out who is the leading person in the life of the family, the decisive "power" factor, who the emotional and intellectual centre; the personality of this member and the relationship of the rest of the family and the child to this person and what characterizes his or her relationship to the rest of the family and to the child; *(d)* it is also most important to explore the quality of the social position, "respect", "authority" of father and mother.

(B) The other part of the environment is that in the broader sense of the word, the community outside the family where the child spends part of his life and which therefore exerts a forming, educational effect upon him. According to the age of the child, this is either the nursery, the kindergarten or the school, *i. e.* the community of the day-nursery, the pioneers, etc. When examining the communal environment, it is necessary to study the attitude of the responsible adults directing the child and therefore exerting a most serious influence upon the child and its personality, and, in addition, the relationship of the child in question to the other children of the community. Further items of the study are the equipment of the environment, the daily working system, the life habits and the occupations of the child.

The data of the three kinds of status are compared and summarized; the

essential features of the complaint are defined by these means, the diagnosis is established and the plan of therapy is set according to the results obtained.

In the following, some cases will be discussed in which the complaints consisted of pathological symptoms pointing to organic changes and in which only the above summarized examination method has made it possible to recognize and understand the complex quality and essence of the trouble, the grave personality disorder. Had in these cases the usual methods described by paediatric textbooks been applied, it would have been impossible to cure the complaints of these children.

II. Clinical Observations

Case 1. F. M., a male child 9 years of age.

Complaint. Nocturnal enuresis since five years.

Results of classical paediatric investigation.

Admitted, September 24, discharged, October 7, 1960. (Registration No. 2308/1960) —

History. First child. In the third month of pregnancy the father died in a motor accident and the following months of pregnancy were emotionally difficult for the mother. Her state was complicated by nephritis treated at home. Delivery was protracted, and injections were administered repeatedly to further it. The newborn weighed 3200 g; he cried immediately after birth, but during the following 3 days he was somnolent, could hardly be waken up; jaundice was moderate and lasted 5 days. The infant was nursed by the mother for 5 months. Weaning was started in the 6th month and completed at the age of one year. Dentition, development of locomotion started normally; at the age of one year the infant walked, spoke, and was sphincter trained, signalling the urge to void. Obligatory vaccinations were administered. From among the infectious diseases he only had measles. Concerning the present complaint of nocturnal enuresis, the mother related that 5 years ago, at the age of 4 years, the child had jumped from a chair, broke his leg and since that time, initially every night, later on periodically, he has voided in bed.

(i) *Vegetative (somatic) status*

Height, 137 cm; weight, 36.7 kg; hence developed according to age, well nourished. General paediatric, neurologic and urologic investigations showed no organic change. Ophthalmological examination showed normal visus, eye function and fundus. Wassermann, Meinicke flocculation and Sachs-Witebsk tests were negative, neither could pathological changes be observed in the separately collected portions of urine tested several times. During hospitalization the patient's temperature was normal; blood pressure was 100/70 mm Hg, normal in that age. ECG and EEG records showed no changes. X-rays of the sacral region showed occult spina bifida on the first sacral vertebra. It should be emphasized that during the 14 days of hospitalization no nocturnal enuresis was observed, but it has to be mentioned that dinner time was regulated and twice during the night (at 12 p. m. and 3 a. m.) the patient was awakened to urinate.

Summarizing the classical paediatric vegetative (somatic) status, the detailed clinical investigation of the organs including the urinary tract revealed no organic change other than an occult spina bifica; the somatic trauma (fracture of the leg), at the age of 4 years has also to be mentioned.

(ii) *Findings of the psychological investigation.*

a) *Biological factors.* The father of the patient had died in a motor accident in the third month of the mother's pregnancy, a fact which affected the mother seriously. During pregnancy not only psychic excitement but also an episode of nephritis had occurred. Delivery was protracted, and after birth the infant slept more deeply than normal. An uncle of the mother on her mother's side was paranoic. The marriage was a love match, the parents wanted to have a child.

b) *Psychological status of the child.* Intelligence level according to age. Character of intelligence primarily reproductive, memory of medium quality; observing, concentrating capacity low, divided; the patient is an average pupil. Emotional state: anxiety of a high degree. In the course of conversation he admits this fact, and the tests show the same. His relation to his mother is extremely close; he often feels anxiety at night and in such instances he sleeps in his mother's bed; he is uncertain and dependent; in his general behaviour very quiet, giving the impression of a reserved, lonely, unnerved child, scarcely having any friends and these few he never meets outside school.

Summarizing the psychological status, the child's intelligence level corresponds to his age, he is gravely affected by anxiety, closely attached to his mother, uncertain, dependent, spoiled, lonely.

(iii) *Environmental status.*

a) *Living conditions.* The child lives with his mother and his paternal grandfather in a flat in a provincial house, under suitable living conditions.

b) *Subjective conditions of the environment.* The death of the husband greatly affected the mother, she became lonely, did not marry for a second time, lives with her father in law, is emotionally too closely attached to her son. A paranoic uncle lives in another flat of the same house. The boy is very much afraid of the insane uncle who apart from being mentally deranged, sometimes is so drunk that he runs about in the common court threatening the family with a knife, an axe or a scythe. This happens about every 8 to 10 days. In such instances he is insufficiently clothed, shouting for someone "whom he could kill". Mother and grandfather are not afraid of the paranoic uncle, believing that his murderous mood is only idle talk. Their opinion has been confirmed by the district physician whom we have asked for a written opinion concerning the uncle. The reactions of the child, however, are different. He very much fears the insane uncle, with his threatening behaviour, gesticulations with a knife, an axe or a scythe.

Summarizing the environmental status, although the living and economic conditions of the family are suitable, from the emotional point of view neither the absence of a father nor the close emotional bond between child and mother and the behaviour of the paranoic uncle can be considered appropriate. On the contrary, these conditions have to be considered extremely unfavourable.

On the basis of a comparison of the three kinds of status, (*i. e.* those of the paediatric vegetative (somatic), the psychological, and the environmental one), the cause of the nocturnal enuresis is to be sought in the child's biological locus minoris resistentiae (the psychic and organic disturbances of the mother during pregnancy, difficult delivery, occult spina bifida). The complaint of vegetative character has developed on the basis of personality disorders as a consequence of an environmental psychic damage, the immediate cause having been the somatic trauma (fracture of the leg). In the disturbance of personality development the dominating factor is the disorder of the patient's emotional life. In establishing the diagnosis, a false course could easily have been taken. The results of the classical paediatric investigations seemed to suffice for interpreting the cause of nocturnal enuresis. The presence of certain biological factors, further that of the spina bifida and the actual somatic trauma (leg fracture) could have been regarded as an acceptable cause and on this basis could have been planned the therapy. Accepting, however, these facts as the genuine cause, no therapeutic result could have been achieved, as no results had been achieved in different institutes with usual therapeutical methods. The apparent aetiology did not, however, seem satisfactory and it was by applying complex examination methods that the grave personality disorder could be determined. In this way it was possible to explore the entire complex trouble of the child and accordingly the patient was treated with good results.

Therapy on the basis of the above data was as follows.

1. The time of dinner and the quantity of fluid taken in the evening was prescribed. Three hours after falling asleep the patient had to be awakened to urinate. To the prescribed diet adequate vitamins were added.

2. The mother was instructed as to the fact that the behaviour and presence of the paranoic uncle are frightening for the boy even if by the experience of the adult members of the family the threats of the uncle are mere clownery. She was told to enhance a gradual loosening of the very close emotional mother-child relationship and that it would be favourable to encourage the boy to be more independent. Meeting friends outside school, a deepening of friendships, and common play were advised. The mother was told gradually and tactfully to give up the habit of sleeping with her son in the same bed. She was instructed that temporarily, as long as the emotional disturbance of the patient lasted and until his capacity of concentration and attention had increased, she should not demand excellent school results in every subject.

3. During one year, on the average every fortnight, when he visited us for a talk and some play, we have discussed his problems with the boy. It has been endeavoured to assist him in understanding and properly evaluating his own life and the objective

elements of his environment, on the level corresponding to his age. The problems were manifold, due to the lack of the father and the presence of the paranoic uncle. Discussing the uncle's disease, so frightening for the boy, we have pointed out the qualities of the healthy human life and the peculiarities of insane persons. While talking of these problems, we have endeavoured to show the boy that it is the paranoic, old and sick uncle who is in reality at the mercy of his environment and not the environment at his mercy and that he (the boy) should try not to react with such extreme fear.

4. Temporarily, a total change of environment was brought about for the boy. Since, according to the opinion of the local physician, the paranoiac was not dangerous and since he lived in provincial surroundings under adequate home care and so he could not be placed in an institute, there was no possibility for establishing such conditions in the present environment which would free the boy from the constant damaging psychical experiences. Thus it was recommended to take the boy for a time to the distant farm of the grandfather. This proposition was accepted by the mother and the boy went to stay in an entirely new environment for 2½ months, went there to school and could follow his studies.

This complex therapeutic process was continued for a year. In the meantime the condition of the patient improved gradually, the enuretic episodes became rarer and then ceased altogether. At present, after 5 months, the child seems to be completely cured.

Summing-up of the case. A 9-year old boy had suffered from nocturnal enuresis for 5 years. The trouble could be traced back to a personality disorder developed in consequence of environmental psychic damage started by a direct somatic trauma on the basis of a certain biological locus minoris resistentiae. Essentially, the personality disturbance was the disturbance of the patient's emotional life. On adequate complex therapy nocturnal enuresis ceased altogether. Therapy consisted of the following. Regulation of the child's life and nourishment; the mother's instruction and education for an appropriate behaviour towards her child; the forming of a proper mother-child relationship; bringing about a temporary environmental change; discussing with the patient his own problems and in the meantime leading him to a proper understanding and evaluation of his own situation and the environmental factors. The complex use of these therapeutic means resulted in complete healing in a year.

Case 2. J. T., a male child 9 years of age.

Complaint. Encopresis during the day since 2 months. According to the patient, he does not feel the urge to defecate only after the faeces have been voided. He often complains of abdominal pains. 4 days before admission he had once wetted his trousers at school.

Results of the classical paediatric investigations. The patient was admitted Novem-

ber 28, and discharged December 7, 1958. (Registration No. 4033/1958).

History. The grandparents of the father were cousins; the siblings of the father's mother were "nervous" persons, their hands and head were shaking. The patient is a first child. Pregnancy was uneventful; he was born at time; delivery was normal; birth weight, 3000 g. The newborn-period was normal; dentition, growth, development, development of motility (sitting, standing, walking), speech, sphincter training, were normal. Obligatory vaccinations were administered. He had measles, chickenpox, whooping cough, epidemic parotitis, dysentery. His appetite is good. No vomitings. Before the present disturbance no disease of longer duration had occurred.

(i) *Vegetative (somatic) status.*

Height, 141 cm; weight, 31.5 kg, somatic development normal for his age. Paediatric test showed no organic change; the result of neurological examination was negative. Ophthalmological examination showed normal visus and fundus. Wassermann, Meinicke flocculation and Sachs-Witebsk tests were negative. Owing to BCG vaccination, the intradermal tuberculin test was positive. Blood tests, sedimentation rate were normal. Repeated urinary analysis revealed nothing pathological. Blood pressure was at the upper limit of the age group, 120/75 mm Hg. X-rays revealed no changes. During the 11 days of hospitalization no episodes of encopresis or enuresis occurred.

The classical paediatric vegetative (somatic) status can be summarized as follows. The organs of the patient, including the rectum, its surroundings and the genitals, showed no organic change.

(ii) *Findings of the psychological examination.*

Biological factors. As already mentioned, the grandparents of the father were cousins, the siblings of the father's mother, "nervous" persons.

Psychological status of the child. Intelligence level according to age, combinative intelligence is excellent; average pupil. Emotional state: anxious. He is emotionally uncertain, rather worried, in a prepubescent emotional state, afraid of the school-mistress.

The psychological status can be summarized as follows. Intelligence according to age; anxious, worried, in the stage of prepuberty, emotionally uncertain, shy.

(iii) *Environmental status.*

a) *Living conditions.* These are adequate. The family lives in a 3-room flat of a house owned by the father's parents; the house is occupied by 7 persons, the family of 5 members, the widowed mother of the mother and the widowed father of the father. The flat is clean, well furnished and kept.

b) *Subjective living conditions.* The marriage of the parents presented many problems; it is the second marriage of the father who had divorced his first wife. His son from the first marriage who resembled the patient, died 2 years ago. The father's first wife married for a second time, lives in the country in the same village where the dead boy is buried. The grave of the husband's first son is visited by the parents of the patient once a year. According to the mother of the patient, her marriage was good initially, though now she has suspicions whether it was a love match only on her side. She seems to be jealous of the first wife and believes that they are gradually drifting apart with her

husband. The professional and social functions of the husband take up much of his time. He comes home late in the night on the pretext of having been occupied with his work. The wife, however, has found out that his cause for being late is often secret entertainment. According to her, this is one of the causes why the marriage has gone wrong. From the emotional point of view she takes it as an offense that the husband is concealing his entertainments ever since their children were small. She has lost her confidence and has become estranged from him. The husband occupies a leading position in his profession as well as socially, and often travels abroad. On the basis of the environmental study, the mother seems to be an emotionally poor, frigid and rigid personality. The paternal grandfather, although living with the family, is entirely separated and even eats by himself. He does not like the patient and treats the two smaller children with partiality. The grandmother is also living with the family. Practically directing its life, she is overburdened by this work. She is a grumbling personality who often hits the children with a wooden spoon. The father spoils the patient because of his resemblance to his dead son, a fact very badly tolerated by the mother thus increasing her ambivalent feelings towards her husband.

Data of the broader environment, the school. It has been revealed that the encopresis had begun 3 months previously when the teacher of whom the patient is very much afraid had hit him several times on the fingers with a ruler. The child's anxiety was increased by finding out that it was a habit of the teacher to hit the other children in the same way. The unsuitable environmental situation in school and so the problem itself has been made worse by the fact that if the boy was afraid of something he had diarrhoea and the teacher forbids the pupils to use the toilet during classes, her principle of "training for order" being that they can only use it in the second interval. The personality of the teacher is energetic, of good will, but her paedagogic training is inadequate. In the course of conversation she complained of not being able to keep her pupils under discipline; she does not remember hitting them on the fingers, but does not deny to use this method of disciplining. In her class there are many children who are difficult to handle and she is hardly able to control them. As regards the patient, she admits that every time she calls him to repetition, the boy is scared and cannot answer. This happens also with the other children in the class and in such instances she tries to reassure the pupils.

The environmental status can be summarized as follows. The living conditions of the patient, as also the economic situation of the family are satisfactory. The emotional atmosphere, however, is inadequate, excited. Neither the emotional relationship of the mother to the father, nor that of the grandfather to the patient, are appropriate; the emotional father-child relationship is spoiling, that of the

mother-child much too rigid, emotionally poor. The environment of the school evokes fear in the child and he lives in a constant state of anxiety concerning the teacher.

On the basis of the three statuses (somatic, psychologic, environmental) the cause of the encopresis has been traced back to a personality disorder evoked by complex psychic environmental damages. The direct cause is the disciplinary system of the school and the child's vegetative lability, on the basis of which the sensation of fear induces diarrhoea. The patient is a personality in a state of anxiety, emotionally uncertain, in prepubertal age. The personality disturbance can be traced back to the unsuitable family atmosphere, the inadequate emotional structure, the unfavourable marriage of the parents, the inadequate father-child, mother-child emotional relationships and the inappropriate child-teacher relation.

According to these, the following *treatment* was instituted.

A) The tasks were discussed with the teacher. We have persuaded her to stop thrashing the children and to allow the use of the toilet when the child wants to defecate. She was told that the boy had been left-handed and was forcibly trained to right-handedness so that it is undesirable to forbid the use of the left hand, as this would have an unfavourable effect.

B) We discussed with the mother the effect on the boy of the emotional family problems. We persuaded her not to project on the child her anger and dissatisfaction towards the husband, not even unconsciously. She was advised to take a temporary tutor, until the anxiety of the boy has ceased and his school results have improved.

C) The emotional situation of the family was discussed also with the father. He was advised not to spoil the boy, calling his attention to the fact that such treatment upsets the relationship between the children and makes his wife suspicious, as she is convinced he is spoiling the patient because he reminds him of his dead son. He was further told that his staying-out at night has a most unfavourable effect upon his wife and the emotional atmosphere of the family.

D) We had several talks with the patient at our child guidance centre discussing his emotional problems, disturbing thoughts, feelings arising from the excited, worried state of prepuberty. It was endeavoured to explain and evaluate all these problems at the child's level and to help him to accept these interpretations.

E) In group conversations with the patient and his siblings we discussed their relationship, the desirable quality of the behaviour of younger and elder children.

Encopresis as well as enuresis ceased. The child was re-examined four months later with the result that the complaints had disappeared.

The success of treatment is demonstrated by the fact that although it was impossible to solve the family's problems in their deep layers and connections, on eliminating the more coarse damaging effect of the school and family environment the com-

plaints of vegetative character, *i. e.* the projection of the personality disorders manifesting themselves with encopresis and enuresis, could be stopped in a lasting manner.

Case 3. *D. K., a female child 10 years of age.*

Complaint. Severe obstipation, defecates once every 10 to 14 days. Since one year she had often had headaches, often waking-up with one; had been sent home from school several times because of episodes of vertigo.

Results of the classical paediatric investigation. She was admitted December 5, and discharged December 21, 1961. (Registration No. 3466/1961).

History. The patient, the second child of the mother, has an elder brother and a younger sister. Pregnancy had been uneventful, delivery normal; birth weight, 3200 g. She cried immediately after birth. The newborn period had been normal; she had been nursed until the age of 11 months. Somatic and intellectual development had been normal. Obligatory vaccinations had been administered. At the age of 18 months she had had pulmonary tuberculosis which had healed after one year of sanatorium treatment. She had had measles. In the family no chronic nervous disease or metabolic disturbances occurred. The mother had been left-handed in her childhood, the patient is also left-handed, but was trained to right-handedness. Menstruation had not yet begun. Since about one year she has been severely constipated, defecating once every 10 to 14 days, with much pain. She urinates only every second day. Since a few days both breasts are somewhat swollen, sensitive on palpation.

(i) *Vegetative (somatic) status.* Moderately developed and nourished child. Classical paediatric investigation showed no organic changes. The results of neurological, urological and ophthalmological examinations, the urine, faeces and blood analyses were negative. X-rays revealed an occult spina bifida on the first sacral vertebra. Blood pressure repeatedly measured during several days, showed fluctuating values: 120/70, 130/70, 135/60, 150/90, 115/65, and 120/70 mm Hg. In the ward the patient had no fever. The pulse rate was unstable, values in the lying position varied between 80 and 116. Wassermann, Meinecke flocculation and Sachs-Witebsk tests were negative, the EEG was normal; X-rays of the internal organs, the skull and sinuses showed no pathological change. On the first 2 days of hospitalization the patient did not defecate. After having told the nurse in the presence of the child to give an enema, spontaneous defecation occurred. From this time on she defecated daily and no difficulties whatsoever arose with urination either. During her stay in hospital, the child was lively, had a good appetite.

The classical paediatric vegetative (somatic) status can be summarized as follows. Severe obstipation and urination disturbances were mentioned in the history. These complaints disappeared without drug treatment. Clinical investigations demonstrated only an occult spina bifida and vegetative lability.

(ii) *Findings of the psychological investigation.*

a) *Biological factors.* The mother of the patient used to be left-handed in childhood. The patient herself is left-handed, trained to right-handedness.

b) *Psychological state of the patient.* Basically ofaverage intellectual capacities; according to the results at our child guidance centre, she is capable of normal accomplishments. She is an average pupil of the fifth grade of primary school. In consequence of emotional causes to be discussed below, the patient is unable to use her intellectual capacities, therefore her intellectual accomplishments are not in accordance with her intellectual level. Her emotional state is gravely depressive, sad, lonely, solitary. Although her relation to the mother is a good one, she does not dare to tell her the cause of her sadness, which is that she misses the father to whom she

used to be very closely attached emotionally and who left the country in 1956, and who now does not even answer her letters. She considers school discipline much too hard.

The psychological status can be summarized as follows. Although the patient's intellectual capacities are normal for her age, owing to grave emotional disorders she is incapable of intellectual accomplishments according to the due level. She is depressive, sad and lonely, feeling deserted.

(iii) *Environmental status.*

a) *Living conditions.* The father had left the country in 1956. Since then, the living conditions of the family have become essentially worse. Although they have a proper, 2-room flat in perfect order, they live, according to the environmental study, under most modest conditions, together with the grandmother, on the mother's and grandmother's salary.

b) *Subjective living conditions.* The marriage of the parents, which had been a love match, deteriorated gradually, the husband having been aggressive, rude, even rough, as also most ambitious, a megalomaniac who was pestering the life of his wife, first of all because of the educational difference between them. One of the causes of the deterioration of the couple's emotional relation was that the wife was forced by the husband to continue her studies against her will. The woman, however, could and did not do so because of her 3 children. The husband had graduated at the Technical University. After leaving the country in 1956, he finished his studies in England and became an engineer. As already mentioned, he wanted to take his wife along but the woman did not consent to leave Hungary nor to abandon her mother whose only child she is. That is why the husband had left alone, at first asking his wife in his letters to follow him. Then he wrote gradually less and less, and at present, although not divorced by law, he does not even answer the letters written to him. The emotional problems of the woman concerning her husband and her marriage are still unsolved. She has become a most sad person, basically straightforward, honest, intelligent, of good will, living only for her family, but not sufficiently educated. All her efforts are directed towards the education of her children. The grandmother living with them is impatient. The patient is often scared by her brother.

In this emotional situation the patient has become a gravely depressive, sad and lonely child. It is only with difficulty that she can bear the changed situation, missing the father who does not answer her letters; she had been strongly attached to him.

The *environmental conditions outside the family*, in school, are good, the teachers and the other children are treating the patient with patience, love and tolerance.

Summarizing the environmental status, since the father had left, the patient lives in a split family. Family life is directed by the work and person of the mother and grandmother. The mother is sad, depressive. Her marriage problem being unsolved, she

· s emotionally hunted, excited. The grandmother is impatient, the brother's behaviour is unsuitable.

Comparing the data of the three st atuses (somatic, psychologic, enviro nmental), it is clear that the severe ob stipation and micturition disturbances of the patient were caused not by some organic change but by environmental damages of psychic character.

The aim of *treatment* was the education of the mother, the child, the grandmother and the siblings. The task was first of all to build-up the emotional relation of mother and child and to advise her to improve the family's grave emotional situation. The voiding troubles of the patient stopped without drug treatment on the second day of hospitalization, solely under the changed environmental and psychic influences. The condition of the patient was systematically followed up in the past 3 months. Talks with her and her family were continued. The vegetative complaints, *i. e.* the disturbances of voiding have not returned.

Case 4. M. J., a female child 10 years of age.

Complaint. Since four days the patient cannot swallow (aphagia). She has a feeling of something pressing her throat from the inside, as if she had a lump in it. She is very restless, has often headaches.

Results of the classical paediatric investigations. The patient was admitted August 16, discharged August 22, 1961. (Registration No. 2371/1961).

History. The mother had had 2 spontaneous abortions. During pregnancy with the present child she had been weak and had received injections of tonic. Otherwise the pregnancy had been uneventful. Delivery was protracted; birth weight, 3600 g. The child cried immediately after birth. The newborn period had been normal. The baby had been nursed for 7 months. Somatic and intellectual development had been normal. Obligatory vaccinations had been administered. She had had measles, scarlet fever, whooping cough and chickenpox. At the age of 7 years, tonsillectomy had been performed.

The present complaints began quite suddenly 4 days ago. She had a feeling of something pressing her throat, as if having a lump in it, could not swallow, was choking. Next day she was free of complaints, but 2 days ago the swallowing disturbance returned. The district physician had sent the patient to a hospital from where she had been discharged with the diagnosis of being nervous. The complaints reappeared the night after her returning home from the hospital. According to the mother, the patient used to be a quiet child, easy to treat, but in the last 4 days she was very restless. On the day of admission she vomited 4 times in the morning. About 3 months ago she fell from a height of about ½ m, did not hit her head but became pale, cyanosed, and could not speak.

(i) *Vegetative (somatic) status.* Development normal for her age, well nourished. The general paediatric, neurological and ophthalmological investigations revealed no organic change. X-rays of the skull and sinuses were negative. Laboratory tests showed no pathological changes in blood and urine. Wassermann, Meinicke's flocculation and the Sachs-Witebsk tests were negative. Blood pressure was 75/50 mm Hg. The pulse rate during rest in bed varied between 82 and 120. In hospital she had no elevated temperature. She received no drugs, we only used to talk with her several times daily. From the 3rd day of hospitalization, the complaints ceased altogether, her behaviour was calm, interested, her appetite good.

The results of the classical paediatric investigations and the vegetative (somatic) status can be summarized as follows. No organic changes could be revealed apart from a lability of vasomotor function, temporary hypotony and fluctuation of the heart frequency.

(ii) *Findings of the psychological investigation.*

a) *Biological factors.* The mother had felt weak during pregnancy. Delivery had been protracted. The vasomotor functions of the child are labile.

b) *Psychological status of the child.* Intellectual capacities according to age, of average quality, so-called "good-pupil" personality. In her former school she had been a mark five pupil, in the present school only a mark three one, owing to causes to be discussed below. Her emotional state is extremely excited, worried, intensely anxious. She would like to escape from her present environment, preferably back to her old place with the grandmother whom she loves, or any other place. She does not dare to speak to the mother of her situation and her worries.

(iii) *Environmental status.*

a) *Living conditions* are suitable, the environment is adequate.

b) *Subjective living conditions.* The relation of the parents is good, they are honest, simple working people of good will. Their general education, especially concerning cultural and paedagogic aspects, is primitive. Their emotional relationship to the child is good. There are, however, some environmental troubles. The family lived formerly in another village where the little girl was brought-up mostly by the maternal grandmother whom she loved. In her previous school the patient was taught by a school-mistress, she was a mark 5 pupil, and had many friends. About 2 years ago, at the age of 8 years, the family moved to a new place where the patient's younger brother came to live with them. At this new place the environment of the school, which is coeducational, does not suit her. The master is rough and impulsive, who, if the children do not behave, beats them with a ruler or hits them in the face or on the head, or birches them while they have to stand bending forward and holding both ankles. The patient is beaten also by the younger brother as well as by the boys at school. It is, however, the 12 year old hunchback son of their landlady who beats her most frequently with a strap or birches her. This same boy is her class-mate and it was he who instigated the other boys to beat her. He also intimidates her by threatening with the strap should she tell anything to her mother. The same boy also forces her to sexual plays (fellation). Her swallowing complaints have started following this incident.

The environmental status is summarized as follows. Although the living conditions, the emotional relationship between the parents and the patient and her parents are adequate, the environmental influence of the present school, the patient's relation to her younger brother and to the 12 year-old son of the landlady is most unfavourable.

The data of the three kinds of statuses (paediatric, psychologic and environmental) showed no organic changes, but a personality disorder devel oped on the basis of grave environmental psychic trauma.

Therapy was instituted according to this finding. The parents were told with due emphasis about the situation and an urgent change of environment was recommended.

As a result, the family moved to a new place and the brother ceased to beat the patient. The parents discussed the problem with the teacher and the parents of the hunchback. As a result, the teacher stopped his unsuitable treatment of the patient and the boy ceased to beat her. In spite of the change, the girl went to the same school, met the teacher, the hunchback and all the class-mates who used to beat her and of whom she was frightened.

3 months later the patient seemed relaxed, her emotional situation improved but her problems have not been solved entirely. Therefore, the parents were advised to provide for a complete change of environment, to send the patient back to her grandmother where she could go to the old school. In this old environment, going to her old school, her complaints, her emotional excitement have completely disappeared. The father has decided to change his working place and to move back to their old place with the whole family where they will live under the original conditions and reestablish the environment adequate for the patient.

In the present case the complaint of swallowing inability was due not to some emotional disturbance between child andparents, of father and mother, but to other environmental factors *i. e.* the behaviour of the brother, the boy class-mates, the teacher. Therapy consisted of stopping the environmental traumatization. When this problem had been solved the complaints of the patient ceased without any drug treatment.

Case 5. P. M., a female patient 16 years of age.

Complaint. Since 6 months occasional respiratory disturbances occur with consequent suffocation.

Results of the classical paediatric investigations. The patient was treated at the out-patient department in November, 1961.

History. The patient is the first child of her mother and has a 10 years old sister. Pregnancy, although under very hard conditions during the postwar period, had been normal. Uneventful delivery, birth weight 3000 g. The newborn period had been normal. She had been weaned at 6 weeks, the mother having no milk. Somatic and intellectual development of infancy and early childhood had been normal. Obligatory vaccinations had been administered. She had had measles, chickenpox and tonsillitis several times. Tonsillectomy had been performed. The father has mild diabetes since 3 years, the mother is very nervous.

In March 1961, the patient after having repeatedly had tonsillitis, had headaches and later respiratory disturbances. These disturbances changed in some instances into attacks of suffocation. The patient describes these episodes as follows. On inspiration the wings of the nose close themselves and simultaneously a spasm-like state occurs in the cervical muscles, inhibiting or completely blocking inspiration. In such instances after 4 to 6 attempts at inspiration a sensation of suffocation appears, with a general state of anxiety. Such complaints initially were only rare, but have became gradually more frequent. They are independent of exercise or rest and are very exhausting. In June, 1961, she had been admitted to one of the large provincial hospitals, where a thorough examination had been carried out. No organic change was demonstrated except tonsillar hypertrophy. Tonsillectomy had been recommended. The intervention had, however, not been carried out as she was planning to go to a summer camp in the Soviet Union in August, 1961. She was repeatedly examined and again no organic change could be

found. She was allowed to leave for the Soviet Union hoping that an environmental change would probably do some good. This, however, was an idle hope, as in the Soviet Union the attacks of suffocation occurred again. She was examined in one of the Moscow hospitals. According to the patient, they again found no change other than a hypertrophy of her tonsils. Treatment with chlorpromazine and imipramine did not help. Tonsillectomy had also been recommended in the Moscow hospital. Shortly after she had come home, tonsillectomy and adenotomy were performed, but no change ensued in her state. Then the hospital sent her to a specialist in Budapest who tried hypnotherapy without success. A short time afterwards the attacks of suffocation became more frequent and her state worse. She was taken to a Budapest hospital from where she was referred to our Department with the note that her disease was considered as being of psychic origin.

(i) *Vegetative (somatic) status.* Somatic development is normal for her age. General paediatric examinations did not reveal any organic change, neither did our special allergy clinic find genuine asthma. Urine and blood tests (Wassermann, flocculation and citochol tests, Ca, P, phosphatase, blood counts) were negative as also the results of X-ray examinations, including those of the skull and the sinuses; no changes were revealed by ECG and phonocardiography.

(ii) *Findings of the psychological examination.*

a) *Biological factors.* The mother is highly nervous. She had been pregnant under the most difficult circumstances, during the immediate post-war period. The father is an intelligent and gifted person; he has diabetes. The patient had been weaned at 6 weeks.

b) *Psychological status of the child.* High intellectual capacities, intelligent, gifted, educated and cultured. Emotional state, extremely worried, emotionally labile, crying readily. She forms emotional attachment only with great difficulty, is reserved, hardly speaks of her own problems, takes moral norms most seriously. The tests at the child guidance centre point to the presence of a serious conflict.

(iii) *Environmental status.*

a) *Living conditions.* The living conditions of the family, their housing and economic situation are excellent. The general educational level of father and mother is high, their paedagogic culture, however, is insufficient.

b) *Subjective living conditions.* The marriage of the parents, their emotional relationship has been completely destroyed. On the basis of repeated talks with the parents, we gained the impression that the marriage had never been a good one. This impression was supported by the fact that the mother was not working and the family lived under favourable conditions in the country, but since the age of 1 ½ years the child was brought-up by the maternal grandmother, education of the little girl "having been too tiresome" for the mother.

According to the mother, her marriage and the emotional relation between her and her husband started to deteriorate when in the period following the birth of the patient the husband had contracted syphilis. The woman has not been able to overcome this disappointment. According to her, the husband is an aggressive, rude, tyrannical individual who, however, felt guilt following the syphilitic infection. In this period, loud quarrels, tantrums were daily occurrences. In the course of these scenes the father was seriously humiliated by the wife in the presence of their children.

The situation became worse when after a certain time she had become interested in another man and started an affair with him. On the urging of the jealous husband she admitted to have committed adultery and the husband again became aggressive, rude and rough. Managing of every kinds of household dealings, problems and questions concerning the children, direction of economic, material matters, were taken over by him from the mother with the consequence that the loud quarrels often ended with fights. These quarrels and fights were witnessed by the children insome in stances and even friends and relatives took part in them.

The serious marriage problems of the parents exerted an increasing influence on the patient, as in the course of time the mother had completely lost her hold. Although not quite frankly, she discussed her problems with the child, asking for the moral support of her daughter treating her as a friend. In the course of these discussions, the mother threw a false light on the father's personality. Concealing her adultery, she presented the father as someone who is insulting her "without any real cause". She persuaded the child to think of the father as someone who behaves in this way because he is a tyrannical, unreasonably evil, aggressive, rude individual without any feelings. Since the mother in the ultimate deterioration of the marriage, concealing her own deeds and role, spoke in this manner of the family's problems, the patient was not in the position to realize the whole truth. She was feeling emotionally with her mother and was therefore forced to accept the unfavourable picture of her father, but could still not take an unanimously negative emotional attitude to him since the picture drawn by the mother was not in accordance with the perceptible every-day reality, the way how the father treated her and her younger sister. He was patient with them, cared for, and occupied himself with the children, but was not willing to discuss his marriage problems and his wife's adultery with them.

The environment outside the family, the school. The patient goes to a co-educational school. In her class she has made friends with one of the boys and a sentimental friendship has developed between them. The boy accompanies her home after school and visits the family quite often. In the meantime their friendship meant a serious emotional support for the patient in the grave emotional situation. The mother, however, who, according to the patient, has driven away all her girl friends sometimes even by threatening with suicide, spoilt the present friendship by accusing her daughter to the teacher. The teacher then humiliated the girl and the boy and their friendship in a tactless manner in front of the whole class. This humiliation has gradually spoilt the relation between the patient and her class-mates. The class-mates, being at the age of puberty, adopted the sarcastic, mocking attitude of the teacher. The gossip about the "affair" has made the patient's position in school prac-

tically unbearable in spite of her being an excellent pupil. She did not dare to tell all this to her father owing to her solidarity with the mother, since she feared that if she tells him about the mother's behaviour and its consequences he will again start to be rude. This difficult situation started around April, 1961. The complaints of suffocation started at the same time. Because of the complaints she had left the school and since her discharge from the hospital she learns at home. Summer camping in the Soviet Union, in spite of the environmental change, did not facilitate her situation. In camp she was with children much younger than herself and could therefore not discuss her problems with anybody; she felt lost, having neither a solution for her situation nor hopes for the future.

The environmental status can be summarized as follows. Suitable living conditions and economic situation. The family's emotional atmosphere as well as the patient's relation to her mother and father, as also her situation at school are most unfavourable and psychically damaging.

On the basis of the compared data of the three kinds of statuses (somatic, psychologic, environmental) the attacks of suffocation were caused by a personality disorder due to environmental traumata of psychic character, in other words a severe acute conflict.

Treatment is in progress. In its planning the prognostic opinion that treatment will have to extend over a long period before achieving complete result, has been duly considered. The main points of treatment are as follows.

A) Talks with the father and mother at short intervals, in the beginning separately, later on simultaneously. Forming of a good relationship with them has been endeavoured so that our advices should be accepted and the fact clearly understood by both of them that their behaviour presents a grave danger for the patient. By this way of approach it has been achieved that the most damaging effects were stopped, no quarrels and fights happen any more in the presence of the children and both parties are doing their best to follow the paedagogic principles recommended by us.

B) The patient was invited to discuss her problems systematically, endeavouring to gain her confidence. The aim of these conversations was to make her face her problems at a level corresponding to her age; to demonstrate the reality of these problems; to evaluate them, initially with our help, and later by herself alone. In the meantime, it has been endeavoured to clear her relationship to her boyfriend on her own childish level. The direct aim of these conversations was to enable her to evaluate the occurrences in her environment appropriately and to help her to detach herself emotionally from the complicated matrimonial emotional problems of her parents, to form an emotional attitude by means of which to consider the parents' matrimonial conflict without emotional partiality, without taking one or the other side. It was further made clear to her that

connecting the serious emotional injury suffered in school to the grave emotional problems of the parents, is not a proper attitude to take. The moral problems of the patient, who has strict moral standards, were difficult to solve.

At present, after treatment lasting nearly 3 months, the attitude, behaviour and consideration required for the acceptance of her problems has been basically formed in the patient and accepted by her.

C) It was a separate task to adjust the school situation of the patient. A change to a parallel class was recommended and this has been accepted by the parents. Preparations for such a change are in progress.

D) It is also necessary that the patient resume her connections with her old friends. The present disadvantageous situation in her relation to school-mates and friends has to be corrected. Some steps have already been taken in this respect, she has contacted one of her old friends.

As a result of the treatment, the condition of the patient has significantly improved. She is cheerful. Frequency and severity of the suffocation episodes have decreased. Treatment will, however, be necessary for a long time.

Case 6. F. Z., a boy 13 years of age.

Complaint. Since 6 months the patient has vertigo, headaches and nausea, sometimes vomits suddenly.

Results of the classical paediatric investigation. The patient was admitted July 3, and discharged July 19, 1959. (Registration No. 2248/1959).

History. Pregnancy had been uneventful, delivery normal, birth weight 4600 g. He had cried immediately after birth. The newborn period had been uneventful. Since the mother had no milk, artificial feeding had been instituted from the beginning. Somatic and mental development during infancy and early childhood had been normal. He had received all the obligatory vaccinations. He had had measles, chickenpox, whooping cough, scarlet fever. Tonsillectomy and appendectomy had been performed a few years ago.

The present complaints, vertigo, headaches and vomiting started about 6 months ago, and he had been admitted for 20 days to one of the large, well directed neurological departments of Budapest in June, 1959, where he had been thoroughly examined from every point of view. Organic changes had not been revealed and the patient had been discharged free from complaints. Two days later he again complained of vertigo, headaches and nausea. In the morning of the day of admission to our department, he vomited. He has no appetite, but no defecation complaints.

(i) *Vegetative (somatic) status.* Height, 147 cm, normal for his age; weight 31 kg; the nutritional state is not adequate, the weight being about 10 kg less than would be normal in his age. At admission the patient was dehydrated and acidotic, due to the inadequate nourishment and vomiting. The state was rapidly relieved by administering 1000 ml of Ringer's solution and 5 per cent dextrose 1 : 2 in an intravenous drip infusion in 12 hours. Repeated paediatric and neurological investigations demonstrated no organic change. Cerebrospinal fluid, urine and blood tests gave normal values. The sedimentation rate was normal. The blood sugar value was normal. Wassermann, Meinicke and citochol tests were negative, as also the intradermal tuberculin test. No deviations could be found by X-ray examinations. The temperature was normal throughout. Blood pressure varied between 80/40 and 100/70 mm Hg, and the heart rate, recorded on different days and at different times of the same day with the child lying in bed, between 68 and 90.

In the first 6 days of hospitalization when the above investigations were carried out, especially those causing pain, the patient became excited, headaches started again and during one of the examinations he suddenly vomited in a jet. In these days no changes could be observed in the digestive tract or other organs, neither such dehydration and acidosis as on the day of admission. After 7 days the com-

plaints disappeared. The boy was lively, gay and most happy among the other children. For another 10 days he was kept in the ward. The complaints did not reappear.

The classical paediatric vegetative (somatic) status can be summarized as follows. In the child apart from a lability of the vasomotor system and a tendency for acidosis, no organic changes could be found neither at our Department nor 1½ months previously in a neurologic department.

(ii) *Findings of the psychological examination.*

Biological factors. The father is an alcoholic. The mother had been operated upon 6 times because of different diseases. The child's constitution is characterized by vegetative lability.

b) *Psychological status of the patient.* Intellectual and volitional capacities are normal for his age. His combinative capacity is low, as also the intensity of spontaneous intellectual activity. Average pupil, has finished 7 classes. Attention capacity and tolerance are low; he is easily tired, his reaction time to stimulation is pathologically protracted and uneven. The patient's emotional world is bleak, he is emotionally poor, having nearly no positive emotional relations to people.

The psychological status can be summarized as follows. Although of an intelligence level normal for his age, his tolerance to stimulation is limited, the combinative intelligence is weak, spontaneous intellectual activity is almost non-existent, his attention is weak, his emotional life poor, has no emotional relations to people.

(iii) *Environmental status.*

a) *Living conditions.* The family lives in a hardly suitable 1-room-kitchen flat, the patient sharing a bed with his younger brother.

b) *Subjective living conditions.* The father is alcoholic, aggressive, uneducated, who beats the boy often. The mother had had 6 operations, she is impatient, nervous. Quarrels, loud ugly scenes, even fights, occur frequently between the parents in the presence of the children. At school, according to the boy, the master treats him unfairly, with partiality, a fact also badly tolerated by the patient.

The environmental status can be summarized as follows. Neither the objective nor the subjective conditions of the family, or those at school, are adequate; the emotional environment of the family is unfavourable, damaging.

On hand of the data of the three statuses (paediatric, psychological, environmental) the cause of vertigo, headaches, sudden vomiting, cannot be traced back to some organic change in the intracranial space or any other organ. The complaints are considered as a symptom of personality disorder developed in a constitution of vegetative, but especially vasomotor functional lability. In our opinion, the personality disorder was due to the inadequate emotional relation between the parents, further the inadequate father-child, mother-child emotional relationships, causing the unfavourable psychic effect of the irritated emotional atmosphere in the family. The above diagnosis has been con-

firmed by the complaints of the patient having disappeared after some days of stay at the neurological department as well as at our department. These environmental changes and the relatively favourable emotional environments sufficed to stop the severe complaints in a few days.

In the knowledge of the above data, the following *treatment* was prescribed.

A) Because of the tendency for vegetative lability and acidosis, a diet completed by adequate vitamins and systematic meal-times were prescribed.

B) The problems were repeatedly discussed with the father and mother. We tried to explain the bad effect of beating a boy of 13 years. They were informed as to the unfavourable influence upon the child of quarrels and fights between the couple. It was endeavoured to make them to apply proper educational methods. The unfavourable effect on the family's life of the father's noisy drunkenness, rudeness, as also the impatient, irritated behaviour of the mother to her husband and children was pointed out. They were instructed to speak to the teacher of his unsuitable relationto the boy.

C) For 3 months, every 3 weeks, we discussed with the child his main emotional problems. During these confidential conversations it has been endeavoured to place in the proper light the family's situation, the relationship of father and mother, the reality of the troubles due to it, to make the child to realize that his father wishes to make a good pupil of him, who brings home praises instead of admonitions. The conversations were directed to make the boy understand the real problems, especially those of emotional character and to help him to evaluate them.

By this complex method the result of the hospital treatment has been stabilized, and since his discharge from our department no vertigo, headaches or vomiting has occurred, the child is gay, playing with his pals, feeling well. 2 years have now passed since his discharge in the course of which the boy has periodically visited our child's guidance clinic for continuous treatment.

Case 7. F. I., a girl 13 years of age.

Complaints. She has often strong palpitations, pain over the heart accompanied by breathing difficulties. These complaints sometimes are felt so strongly that she faints.

Results of the classical paediatric investigations. The patient was admitted May 18, and discharged June 12, 1949. (Registration No. 1540/1949).

History. The patient is the first child of the mother; she has an oligophrenic brother of 5 years, who does not speak. Normal pregnancy, uneventful delivery, birth weight 3360 g. She had cried immediately after birth. The newborn period had been uneventful. She had been weaned gradually after 4 months. Somatic and intellectual development in infancy and early childhood had been normal. Obligatory vaccinations had been administered. She had had measles and chickenpox, at the age of 3 years pleuritis, at the age of 10 years arthritis. Menstruation had started at the age of 10 years.

The present complaints are pain over the heart, strong palpitations, sometimes fainting, breathing difficulties; these episodes are accompanied by nausea. Since the death of the father the complaints have been complicated by headaches. Because of the characteristic heart complaints, she was admitted toour department of cardiology.

(i) *Vegetative (somatic) status.* Height, 150 cm, weight, 40 kg, *i.e.* somatic development according to age. The cardiac area,

the site of the apical beat, the heart dullness are normal. Apically, and leading from there to the sternum, and parasternally on the left side, a systolic murmur of blowing character was heard. X-rays showed a normal heart shadow. No deviation from normal was observed on the ECG except somewhat lower and thickened R waves in lead III. Stimulus formation, conduction, S-T intervals and T-waves, normal. The heart examination was equally normal a half year later. Blood pressure, measured on different days showed variations between 85/45 and 100/70 mm Hg. The pulse rate with the child lying in bed measured on different days and at different times of the day varied between 80 and 100. The results of detailed clinical examinations of the other organs were absolutely normal. The sedimentation rate investigated 4 times was normal in every instance, with values of 5 mm, 4 mm, 5 mm and 8 mm, respectively, per 1 hour. During the 26 days of hospitalization the patient had no elevated temperature. Wassermann, Meinicke and Sachs-Witebsk tests were negative. Owing to BCG vaccination, the intradermal tuberculin test was positive. Blood counts were normal. Liver function tests, serum bilirubin value, sugar tolerance test, blood sugar values gave normal results; values of gastric acidity on fractionated test meal were negative; bacteriology of duodenal juice was sterile. No changes of the locomotor organs were observed.

The classical paediatric vegetative (somatic) status can be summarized as follows. The complaints were a pain over the heart, palpitations, fainting and nausea. 3 years previously arthritis had occurred. As to the organs, the following changes were found. With completely compensated circulatory and functional conditions and a normal ECG, mitral insufficiency due to previous disease was present, with no hypoxic signs in the myocardium. On the basis of the blood counts, sedimentation rate, the lack of fever and the fact that circulatory conditions were entirely balanced, it could be stated that no recurrence of the previous rheumatic fever or pleuritis was present.

(ii) *Findings of the psychological examination.*

a) *Biological factors.* Mixed marriage; the mother a gipsy, the father not of gipsy origin. A brother suffers from Down's disease. The patient menstruates since the age of 10 years. Moderate lability of vasomotor function.

b) *Psychological status of the patient.* Intellectual capacities are excellent, she is well informed, surpassing her age in practical questions of life; she is, however, uneducated for her age. Although she used to be a good pupil, she was forced to leave school about 1½ years ago because of family difficulties. She has to take care of her mother and look after the oligophrenic brother. Emotional state: anxiety of high degree, she is an emotionally solitary, lonely child, having practically no emotional life of her own. Although menstruation had started at the age of 10 years and she has reached the age of puberty, sexual problems do not interest her.

The psychological status can be summarized as follows. The intelligence level of the patient is normal for her age, even above it. Her educational level is, however, very low due to the worries of the whole family being her concern. Emotionally she is a lonely but a sentimental personality in a grave anxiety state.

(ii) *Environmental status.*

a) *Living conditions* are extremely bad. The mother, the patient, the oligophrenic brother and 2, 3, 4, sometimes 5 temporary lodgers are living

in a one-room-kitchen flat; the family needs the small rent. The flat is dirty and untidy; if there is no money for fuel, the rooms are cold and the whole family stays in bed till noon. The patient's duty is to look after the oligophrenic brother, the flat and the lodgers, to take care of the mother, to tidy-up and to wash. Nourishment is often insufficient, they live almost entirely on bread and potatoes.

b) *Subjective living conditions.* The marriage of the parents — of a gipsy girl and non-gipsy man — had been a love match. In the course of time many a trouble has arisen between the couple, chiefly because of educational differences. During World War II, the father had been a soldier, become a prisoner of war and had returned in a state of limited responsibility, with a nervous breakdown. He did not go back to stay with his family, lived apart, although he still cared for them and, if possible, gave them money. He peddled with books without having a licence for such an occupation. On one occasion he had some business difference with a bookseller who called on him and they had a row, allegedly because the man had denounced the father of not having a licence for peddling. The father in his sudden anger killed the man with an axe. Because of martial law being in force at that time, the father was sentenced to death because of murder, and executed. The patient, who was very much attached to her father, knows the whole tragic story. As already mentioned, it is the 13 years old girl who carries all the responsibility for a family under the most deranged living conditions, she has to take care of the sick mother, look after the oligophrenic brother, do the washing, cleaning, and provide for the lodgers.

The environmental status can be summarized as follows. Neither the living conditions, nor the emotional atmosphere of the family environment are suitable, and they exert a most damaging effect upon the patient.

On the basis of the three statuses (somatic, psychological, environmental), the cause of the heart complaints is not to be sought for in the mitral insufficiency due to previous rheumatic fever, since the organic change of the heart is in an entirely compensated state; the symptoms are consequences of a personality disturbance. The disturbance has been evoked by grave environmental damages of psychic character and the essence of the trouble is rooted in the patient's emotional life.

The diagnosis was later supported by the course of the disease. During the 26 days of hospitalization the pain over the heart, the palpitations, the faintings have ceased without drug treatment, on instituting an adequate diet and a due vitamin supply.

The patient has been followed-up since 1949 for 12 years now. The following interventions have been applied to eliminate the environmental damage causing her personality disorders. Meals and aid were obtained from the Council for the mother. The patient's schooling was organized enlisting her in a so-called "double-class", obtaining a learning partner

and a temporary tutor. Admission to the Institute for Defective Children of the oligophrenic brother, meaning the greatest burden for the patient, was endeavoured but the mother did not consent.

In 1950, the patient came again to the child guidance centre. Pain over the heart, palpitation, fainting, nausea did not recur, but she complained of headaches. Ophthalmological, neurological and cardiological examinations, apart from the above mentioned systolic murmur, were again negative. According to our opinion, the cause of the headaches was that, although the patient now went to school more or less regularly, her situation in the family became worse, the oligophrenic brother having in the meantime grown much stronger, more aggressive and caused more and more trouble.

The patient finished school in 1952 and our social case worker found an employment for her in a foodstuff factory. There she worked most efficiently, was free of complaints, her colleagues liked and helped her in every respect.

In the following years, although she was passed child age, her relation to the child guidance centre has been maintained, she comes to talk, to seek help in some of her practical problems. So, for instance, a summer camping was arranged for her, etc. Pain over the heart, palpitations, fainting did not reappear.

In 1955, she came again with the complaint of severe headaches. This, however, could not be traced back to the effect of a primary psychological environmental damage, but to sinusitis. She was admitted to and cured in a municipal hospital.

The situation of the patient has finally been solved when at last in 1956 the mother consented to give the oligophrenic brother into a suitable institution, the boy having become unbearably aggressive. This was arranged by the child guidance centre, eliminating the last environmental damage.

The patient, who has grown into an independent adult, is still followed-up from time to time. She works at a suitable place. Ever since the environmental traumata had ceased, not only her organic symptoms have disappeared but also the personality disturbances have been solved. It is, however, clear that an adult person having in her "world of memory" such a childhood, stays in the need of serious support from society. Help is needed if some problems or troubles arise in her individual life.

The diagnostic difficulty and interest of the present case is that on the basis of classical paediatric investigations we would have easily been mislead, since the 13 years old patient with complaints of palpitation and pain over the heart, had had rheumatic fever 3 years previously, and at admission a mitral insufficiency could be demonstrated. By not taking utmost care when establishing the diagnosis, the complaints could have been taken for symptoms of the past rheumatic carditis. Fortunately, on the basis of our large experience with

rheumatic carditis we could not accept the diagnosis, the complaints of the patient could not be placed into the picture of completely subsided and compensated mitral insufficiency. It was for this reason that we carried out further investigations, which have then revealed the essential trouble, the complex quality of the disease. Thus, treatment was centered not upon the heart, but on the organisation of the family, their environmental, social situation, and elimination of the personality and emotional disturbances. This complex therapy has lead to complete success.

Case 8. G. R., a male child 11 years of age.

Complaint. Since one and a half months every 4 to 14 days he has episodes of "weakness" and if there is no help at hand, falls dawn. During these fits he does not answer questions, has a "fixed look" and after the episodes he starts to cry (a picture reminding of petit-mal epilepsy).

Results of the classical paediatric investigation. The boy was admitted on September 8, and discharged, September 21, 1954. (Registration No. 3586/1954.)

History. The patient had been born of first pregnancy; he has two younger siblings. The father is an alcoholic; in the father's family there have been other alcoholics. Pregnancy had been normal, although the mother had cried often, had been nervous, not having been yet married to the father of her child. Delivery had been uneventful, in time; birth weight, 3800 g. The patient had cried immediately after birth. Jaundice had been somewhat protracted, lasting one week. The baby had been nursed by the mother till the age of 8 months, and had been weaned ac 16 months. Somatic and intellectual development in infancy and early childhood had been normal. Obligatory vaccinations had been administered. He had had chicken pox and whooping cough, then 3 years ago serum sickness; a year ago tonsillectomy had been performed. 8 months ago he had had pneumonia.

The present complaints started about 1½ months ago with fits occurring every 4 to 14 days. In these instances the patient suddenly grows "weak" and pale, and if there is no one near he falls. During these episodes which last a short time he does not answer questions, has a "fixed look" consciousness is not lost. He is able to stand up sometimes in a few seconds and starts to cry. Falling down, he does not hurt himself, does not bite his tongue. The consulted physician prescribed an iron-containing tonic with no result.

(i) *Vegetative (somatic) status.* Prior to admission to our department, the patient had been under observation in one of the large provincial hospitals where no organic change had been found. The complaints had been regarded as of psychic origin and the patient had been referred to us.

At admission, the height was 150 cm, above the average; wight, 31 kg, normal state of nourishment. General paediatric, neurological, ophthalmological examinations revealed no organic change. Wassermann, Meinicke and Sachs-Witebsk tests were negative. Owing to BCG vaccination, the intracutaneous tuberculin test was positive. Results of X-ray and EEG examinations, blood sugar, serum Ca, P and phosphatase, blood count, sedimentation rate, serum bilirubin values and liver function tests were negative. Blood pressure was 110/55 mm Hg. The pulse rate varied between 72 and 96. During the 14 days of hospitalization the patient had no elevated temperature, neither have occurred the described fits. In case of excitement due to examinations, a circumscribed redness of the skin appeared.

According to the classical paediatric status, except a certain vegetative functional lability, there was no organic change.

(ii) *Findings of the psychological examination.*

a) *Biological factors.* The mother has cried much and had been worried during pregnancy, being at the time still unmarried. Neonatal jaundice had been somewhat protracted. The father and some members of the father's family are alcoholics. One of the

patient's siblings is left-handed. The patient had been nursed by the mother for 16 months. The marriage of the parents had been a love match.

b) *Psychological status of the child.* His intelligence level is high; he has swift, excellent constructive intelligence. His intellectual development surpasses his age by approximately 3 years, he is a premature, oldish youngster. In school he was always an excellent pupil, learning easily and having a broad range of interest. As regards his emotional state, the patient is in the stage of prepuberty, worried, extremely anxious, extremely impulsive, in a state of grave and complicated emotional conflict.

The psychological status can be summarized as follows. A personality of intellectual capacities definitely surpassing his age, emotionally worried, impulsive and anxious.

(iii) *Environmental status.*

a) *Living conditions* are good. They live in a suitable two-room flat. The father earns enough money and if he would give his salary home, they could live easily. This, however, is not the case and the family lives from the salary of the mother and the support of the grandmother.

b) *Subjective living conditions.* The father is an alcoholic. Although the marriage was initially a love match, because of the frequent drunkenness of the father troubles have arisen. The mother loves her husband and tries to maintain her marriage and bring up the children with all her energy. When sober, the father cares for his wife, but does not like the patient and treats the two younger siblings with partiality. Much help is lent to the family by the mother's mother, both emotionally and materially. The father is essentially a gifted man, definitely above the average level. He has a university degree and used to work in a ministry. Being an alcoholic, he was transferred to a provincial department, initially in a leading position; due to increasing alcoholism, however, he was first put into a lower administrative position then, not being suitable for such work either, he lost his job. Since then, he is employed as a workman, earning well but spending his whole money on alcohol. When drunk, he is rude, brutal. At such instances he quarrels, loud scenes and scandals are every-day events in the presence of the children. When drunk, the father scolds the patient, but he also insults his wife and his mother-in-law. When sober, he is ashamed of his behaviour, grows contrite towards his wife, but not even at such instances does he show any emotional approach towards the patient. The mother is an intelligent person, of good will, attached to her husband, her family and especially to the eldest son. The mother-child relationship on the mother's side is much too close and emotionally overburdening for the child. In consequence of the family situation the mother has also become nervous and worried.

The damaging effect of the family environment and the emotional conflict of the patient were told by him most intelligently at the child guidance centre. He judges clearly and is

aware of the unbearable behaviour of the alcoholic father and his dislike towards him. This dislike arose when the mother sent him to fetch the father on pay-day and to try to make him come home instead of going to the pub. The son was willing to do so, but the father, instead of coming home, took the boy to the pub where he and his friends forced the child to drink, and finally both father and son came home drunk. This happened several times. After some months, the boy came to like being drunk, realizing that in the nebulous state his emotional problems are dimmed. At this period he already wished to drink, and found that this was the only platform for improving his relationship with the father.

Having recognized the patient's high intellectual capacities, it was not astonishing when he told us that he came to seek help having considered his situation and having come to the conclusion that he has to liberate himself from it and has to stop drinking.

The environmental status can be summarized as follows. The living conditions are suitable. So would be the economic situation of the family, but because of the father's alcoholism, the situation and the relationship of the patient to the father have caused grave personality disturbances.

On the basis of the data of the three statuses (somatic, psychologic, environmental), the complaints reminding of "petit-mal" could not be traced back to organic changes but to a personality disturbance due to environmental damage of psychic character.

In accordance with the above, the course of *treatment* was as follows.

A) The patient was admitted to the general medical ward. The other patients of the wardwere not informed of the real cause of his trouble. Withholding alcohol in the ward was uneventful, causing no conflict. During the 14 days of hospitalization conversations were instituted daily with the boy. Hospitalization meant essentially taking him out of the damaging environment.

B) During our conversations, it was endeavoured to make him understand the structures of his emotional problems, the realities of the family situation; to help him to settle these and diminish the intensity of his emotional conflict.

C) We had several conversations with the mother of the patient, exposing the damaging influence of the family situation. The mother was understanding, of good will, and although it meant emotional difficulties because of her attachment to the boy, she consented that after discharge from our department the patient should move to the grandmother, creating thus a possibility for avoiding the father's unfavourable influence.

The patient after discharge reported for treatment at the child guidance centre every 3 weeks. For 6 years now we have worked systematically with him and followed-up the course of his life. The fits simulating "petit-mal" stopped altogether without any drug treatment. He finished school with excellent results. He is a gifted youth of broad interests and good standards.

No recurrence of alcoholism occurred, since the hospital treatment he never drank again. His emotional relationship to the mother continued to be close, but not exceeding a normal mother-son—son-mother relationship; his emotional relation is understanding, polite, somewhat detached. He is still living with his grandmother. During his visits home, no conflicts arise with the father who now treats the gifted son as an equal adult, somehow even respecting him. The alcoholism of the father, although to a lesser degree, is still present.

It has to be pointed out that the grave personality disturbance of his childhood did not entirely disappear in the patient. His lability manifests itself with gastric pains whenever some excitement arises, especially at school. These pains at the age of 15 years were of such intensity that he was again thoroughly examined for gastric ulcer in one of the provincial hospitals. The results of all the tests were entirely negative, pointing to the necessity of further assistance on the part of society, and from the child guidance centre, until his personality had reached a degree of stability which will enable his function of forgetting to assist the function of intellect and will, to maintain an equilibrium in the patient's personality.

Case 9. R. É., a girl 14 years of age.

Complaints. Since some time the patient has become restless, nervous; at the social insurance clinic high blood pressure has been found (150 mm Hg).

Results of the classical paediatric investigations. The patient was admitted February 16, and discharged February 24, 1959. (Registration No. 673/1959).

History. The mother in the last phase of pregnancy had had hypertension. Normal delivery, birth weight 3000 g; the mother had no milk and the infant had been feed artificially. Somatic and intellectual development during infancy and early childhood had been normal. Obligatory vaccinations had been administered. She had had measles, chickenpox, whooping cough, german measles. According to the mother, the present complaints are restlessness, nervosity, insomnia, learning difficulties. The mother told us that one morning about a week ago, going to work she has forgotten her purse and returning home found the doors of the flat ajar, the girl missing. She was scared and searched the flat, the more so as previously some objects were missing and on such occasions loud quarrels occurred with the other family living in a house situated in the garden. The mother ran into the garden and found her daughter crying behind the house, half naked, only in panties, although all this happened in cold weather at the end of November. The patient told her that she only went to the family in the other house and when they saw the mother coming into the garden, they threw her out. The mother was alarmed, interrogated the girl, but she just cried and could not be persuaded to say anything more. The mother asked for the district physician who gave the patient a sedative and 2 days later at the social insurance clinic a high blood pressure (150 mm Hg) and irregular heart sounds were found. She was referred to us for detailed examination.

(i) *Vegetative (somatic) status.* Height, 154 cm, weight, 44.5 kg, a well nourished, well developed girl. On general examination the only deviation from normal observed was a soft systolic murmur apically. Ophthalmological, neurological and gynaecological investigations were negative. Wassermann, Meinicke, and Sachs-Witebsk tests were negative. Blood counts, sedimentation rate, urine analysis, faecal tests, ECG- and X-ray examinations, including that of the skull, yielded normal results. The temperature was normal. The pulse rate on different days varied between 98 and 116. Blood pressure during hospitalization was initially 135/75 mm Hg, then decreased gradually to 115/70 mm Hg. From the 3rd day of hospitalization the patient was free of complaints.

The classical paediatric status can be summarized as follows. Mitral insufficiency, completely compensated circulation, at admission hypertension and vegetative lability were established.

(ii) *Findings of the psychological examination.*

a) *Biological factors.* The mother is left-handed, has hypertension, especially since the last phase of pregnancy. She has often headaches. The patient was also left-handed, but was trained to right-handedness. The marriage of the parents had been a love match, they longed for a child.

a) *Psychological status of the patient.* The intelligence level is good, with a short reaction time. In the present state, however, intellectual attention and capacity have decreased and the results in school have lately deterioreted. The patient is in a state of anxiety, cries easily, she is restless, overexcited, worried, reserved, emotionally attached only with difficulty. She has grave problems of conscience and feelings of guilt towards the parents which worry her deeply. According to the test results, the patient is seriously endangered.

The psychological status can be summarized as follows. Intelligence level excellent, but in consequence of emotional disturbances, attention and intellectual capacity have decreased. She is in a state of anxiety, worried, overexcited, labile.

(iii) *Environmental status.*

a) *Living conditions.* The family lives in a suburb of Budapest, in a two-room, comfortable flat in their own house with a garden. Living standards, economical situation are good.

b) *Subjective living conditions.* The marriage of the parents is good. They work in the city and the patient remains alone at home. In the garden there is a small separate house which has been inhabited by a gipsy couple since about 2 years. This couple is childless. The man is a drunkard and does not work. The woman, about 45 years of age, is a peddlar. The couple has neither regular work nor a regular income. Quarrels between the two families had started soon. The patient had a dog which the family liked very much. The new tenants, however, maltreated the dog, kicking and throwing stones at it, so that the animal had to be kept in the flat. Then the tenants poisoned the dog. The patient was sorry about the loss of the dog, and also afraid as now she had to remain in the house quite alone.

Taking advantage of the parents, absence during the day, the tenants, especially the woman, started to win over the little girl. She came during the absence of the parents, in spite of having been prohibited of doing so, into the house to see the child, cajoling her, telling her stories and even cooking for her. The patient did not tell about this her mother, who once became aware that their fat, meet and sausages were missing. When asking the little girl, her answer was that she eats very much. Later, however, she has told us that their larder was regularly looted by the tenant woman and other objects were also taken by her;

she also asked the girl to show where her mother keeps the money.

After we had gained her confidence we asked the patient why she lied and even stole from her mother. Then only she related the following events. She was lured into this impossible situation gradually. First the woman only cajoled her, then she told all sorts of interesting stories of her own life and later began to speak of sexual questions and about details of sexual life. The girl in her state of puberty was excited by these questions, they aroused her imagination and curiosity. Gradually, a state developed when she demanded these stories, the woman, however, was only willing to tell her any if the girl allowed her more and more; finally she so-to-say blackmailed her. The situation became gradually worse and the child used to go and see the woman in her flat where she was shown pornographic pictures. Sexual plays were also started (mutual masturbation, cunnilinguus).

The patient drifted into a state of permanent excitement, being completely at the mercy of the older woman. At the same time she naturally developed a grave emotional conflict with her parents and saw no possible way out of this situation. Her results in school became bad, she could not sleep, was constantly afraid and in a state of anxiety. On the day mentioned in the history, she was also with the woman who, seeing the mother in the garden, throw her out dressed only in panties.

There is no need of further proofs to show why the grave environmental trauma had produced a disease in the patient.

On the basis of the three statuses (somatic, psychological, environmental), the cause of the hypertension and the extreme restlessness could not be traced back to any organic change but to a grave environmental trauma of psychic origin in the patient in puberty with a certain biological locus minoris resistentiae.

Plan and course of treatment were as follows.

a) The patient had to be removed immediately from the traumatizing environment and was therefore admitted to our department.

b) We discussed with the mother everything that had to be done. After discharge the patient went to live with relatives in the country. The parents were helped by us in their effort to dislodge their tenants. With due help, this was achieved in 6 months. Returning from the country, the patient was looked after by an elderly woman taken to the house for the time the parents are away working.

c) The patient was treated first every day, then at short periods, helping her at these talks to sort the events of the past and the emotions produced by them, her own behaviour and situation, as also to see the connections clearly. It was endeavoured to diminish the tension of the emotional conflict. In the course of these conversations she shared this tension with us and became able to bear it. Her emotional insecurity and uncertain behaviour was also eased by the fact that in a certain

sense the responsibility of her life and affairs had been taken over by us. She was again able to find a way out of her troubles, feeling support and protection surrounding her.

The patient has now been treated at our child guidance centre for 2 years. Some transient episodes of restlessness, unusual nervosity still occur, but her emotional state has been cleared and her actual personality, although still under the burden of the past events, develops promisingly and in the desired direction. The vegetative symptoms have disappeared.

Case 10. Sz. A., a female child 9 and a half years of age.

Complaint. She eats and drinks too much, putting on much weight, 2 kg in the last fortnight (obesity).

Results of the classical paediatric investigations. Admitted, February 2, discharged, February 10, 1959. (Registration No. 620/1959).

History. Siblings of the maternal grandmother and grand-grandmother were diabetics. The grandparents and both parents suffer from hypertension. The mother has gastric ulcer and on psychic excitement "gastric haemorrhage" presents itself. Such episodes have occurred five times.

The patient is an only child, born in the 15th year of marriage. Pregnancy had been tolerated badly by the mother; she had often vomited; because of a narrow pelvis, caesarean section had to be performed. After delivery nephropathy had been diagnosed in the mother. The baby's birth weight had been 3750 g; she had been fed artificially, the mother having no milk. Somatic and intellectual development in infancy and early childhood had been normal. Obligatory vaccinations had been administered. She had had chickenpox, scarlet fever, parotitis, several episodes of tonsillitis, enteritis and otitis. Tonsillectomy and appendectomy had been performed.

As to the complaints, the patient during a long trip in a cart in glaring sun in August 1958, had probably suffered a sun stroke; in the night she had a temperature of 40° C and was delirious. The disease was accompanied by vomiting and headaches. According to the mother, after the incident she began to eat very much, "she has decidedly grown voracious". Three weeks ago she felt sick in school, had vertigo, nausea, headaches, everything went dark before her eyes. At the social insurance district clinic they found a blood sugar of 352 mg per 100 ml on January 14, and 102 mg two days later. According to the mother the body weight of the patient increased by 2 kg in the last 2 weeks. She eats and drinks very much. Recently her sight has deteriorated; as a small child she had worn spectacles for a year, but lately they have been discarded.

(i) *Vegetative (somatic) status.* Height, 135 cm; weight, 40 kg. The height is normal for her age, the weight surpassed the average by 10 kg. No changes were found in the respiratory or other organs; over the heart, a soft systolic murmur in the height of the third rib parasternally on the left side and an accentuated second pulmonary sound were found. Neurological and ophthalmological examinations revealed normal conditions, except her visus requiring mild correction. Blood pressure measured on different days varied between 115/85 and 125/85 mm Hg. Wassermann, Meinicke flocculation and Sachs-Witebsk tests, intracutaneous tuberculin tests, as well as blood counts, sedimentation rate, urine tests, were negative. Daily fluid intake and excretion were in equilibrium. Serum total protein, protein fractions, Ca, P, phosphatase, cholesterol, nonprotein nitrogen, chlorine, bilirubin, were normal; liver function tests were negative. Results of X-ray examinations of the organs and the skull were normal. Dimensions of the sella were at the upper limit of normal. Carpal bone development corresponded to the age of 7 years. Basal metabolic rate, tested twice in an interval of one week, was between +10 and —10 per cent. In view of the diabetes in the ancestors and obesity in the patient, as well as the fact that at the social insurance clinic a high fasting blood sugar value was found at the first examination, a double tolerance test was carried out twice with 40 g dextrose solution. Blood sugar values in one of these tests were as seen in the Table.

The double dextrose tolerance test showed no signs pointing to diabetes, on the contrary, the increase of the sugar curve was somewhat low.

It has to be emphasized that during the 9 days of hospitalization, in spite of the performance of a number of investiga-

Fasting blood sugar mg per 100 ml	After drinking 40 g dextrose solution				After drinking a second 40 g dextrose solution		
	minutes						
	20	40	60	90	20	40	60
	blood sugar, mg per 100 ml						
80	96	136	130	112	108	124	112

tions, the patient did not feel sick, had no headache, vertigo or nausea, she felt well.

(ii) *Findings of the psychological examination.*

a) *Biological factors.* Several ancestors on the mother's side suffered from diabetes. Both parents and grandparents were hypertonic, the mother has gastric ulcer with "haemorrhages" on psychic excitement. The patient is a late child, conceived in the 15th year of marriage, born with caesarean section. During pregnancy the mother had often vomited. The patient had been fed artificially. The marriage of the parents was a love match, they longed for a child.

b) *Psychological status of the patient.* Intelligence level in accordance with age, excellent combinative intelligence. She visits the fourth grade of primary school, is a mark 4 pupil. In the stage of prepuberty, she is closely attached to the mother, her emotional relationship to the father is not unequivocal. Since the sudden death of her grandmother she is often afraid, even at home. Her need of support is most intensive and at the moment not entirely satisfied, so that a feeling of solitude had developed. She has a disposition for an extremely impulsive attitude. In the preformed situation of a high degree of emotional, impulsive tension, her capacity of cortical control is decreased in consequence of her dynamic personality structure.

The psychological status can be summarized as follows. Intelligence level corresponding to age, good pupil, emotionally unbalanced, feeling solitary, in a state of anxiety, in too close emotional relationship with the mother.

(iii) *Environmental status.*

a) *Living conditions.* She lives with her parents in a suitable two-room flat under good economic conditions.

b) *Subjective living conditions.* The emotional relationship of the parents is good, there is, however, some kind of trouble due to ideological differences. The mother is religious and tries to bring up the patient in this sense; the father is a materialist and would like to form his daughter according to materialistic ideology. In this opposed attitude, mother and child take a common stand against the father.

From the point of view of the child, the following subjective and unfavourable environmental effects have to be pointed out. The mother is hypertonic, has a gastric ulcer, she is extremely disciplined, nevertheless a suppressed nervous personality with a tendency for depression who had "gastric haemorrhages" five times following situations of psychic strain. In the previous years the patient herself had to suffer many real worries. So, for instance, during the events of the 1956 counter-revolution, she often

accompanied her mother under dangerous circumstances. In March, 1957, the grandmother living with the family and looking after the child had suddenly died. Since then the child is afraid even at home. During the life of the grandmother, the patient had been a "poor eater". In the following year, in August, 1958, she suffered a sun stroke during a cart trip lasting for hours. According to the mother, this event had started the "period of voraciousness". It has to be pointed out that the patient, who is a mark 4 pupil, is overburdened by studies after school, such as dance, piano, foreign languages, religion, etc.

The environmental status can be summarized as follows. Living and economic conditions of the family are adequate. The subjective atmosphere of the family is not so unfavourable as to cause serious disturbances. The too close emotional relationship with the mother, the not unequivocal relation to the father, the religious attitude of mother and child opposing the materialistic ideology of the father however, had, together with the excitements of the 1956 events and a year later the tragic death of the grandmother, exerted upon the child influences damaging the normal development of her personality. This is further depressed by the too many after-school tasks. The personality disturbance manifested itself in that the formerly "poor eater" child became a "definitely voracious" personality. The manifestation of the symptom had been evoked by a sun stroke.

On the basis of the three statuses (somatic, psychologic, environmental) the excessive eating and the obesity could not be traced back to some organic change, but was considered as the manifestation of a personality disturbance developed on the basis of environmental damage of psychic character.

The diagnosis was supported by the observation that during the 9 days of hospitalization, *i. e.* outside the family environment, the patient was free of complaints, the usual hospital diet was found satisfactory by the child. After discharge she made up for the 6 weeks loss in school in one single week, but in consequence of being again overstrained, headaches started anew.

During *treatment*, the mother was instructed as to the suitable diet for a gradual loss of weight and to stop overstraining the child. For setting the ideological problems between herself and her husband, they were invited for talks to the child guidance centre. The family, however, did not report any more.

In the present case we cannot speak of such a convincing final therapeutical result as in the other cases, since the parents did not follow all our advices. This fact does not yet detract of the correctness of our statements as to the cause and essential connections of the complaint of overeating and obesity of the patient.

Case 11. Sz. I., a female child 12 years of age.

Complaint. The patient has lost her appetite a long time ago and has eaten

less and less, so that by now her fasting may have dangerous consequences. She only drinks 2 glasses of milk daily, no water at all, has lost much weight (anorexia, cachexia).

Results of the classical paediatric examination. The patient was admitted January 27, and discharged March 27, 1956. (Registration No. 511/1956).

History. The mother had died of Graves' disease following a delivery; earlier she had been treated twice in a mental hospital. A cousin of the maternal grandmother had died in a mental hospital. The patient had been born after a normal pregnancy. Delivery had been uneventful, birth weight, 3000 g. She had no mother's milk. Somatic and intellectual development had been normal. Obligatory vaccinations had been administered. She had had measles and whooping cough. The patient is brought-up by foster parents.

As to the present complaints, about one year ago she had pneumonia. She recovered rapidly on penicillin treatment, so that a week later she already went to school. Fever had reappeared, she had developed pleuritis which again healed in a week on salicyl treatment. Following this event, she had lost her appetite, her state had deteriorated, so that at present her food consists of 2 cups of milk daily. If eating is forced, she vomits; she drinks no water. Two months previously she had been thoroughly examined in the paediatric department of one of the country universities. Chronic gastritis, hyperacidity had been diagnosed, an adequate diet had been prescribed and the patient been sent for treatment to a sanatorium where she had spent 2 weeks without any improvement. The lack of appetite became worse, she lost more weight, in one year 8 to 9 kg. She now complains of gastric pains; defecates once to twice weekly, urinates once or twice daily. She had received vitamins C and B, further injections of liver extract, without any result. She never feels tired, learns well.

(i) *Vegetative (somatic) status.* Height, 125 cm, normal for her age. Chest circumference, 59 cm; weight, 27.5 kg, *i. e.* 13.5 kg less than the average for her age. Wasting has reached a degree when the patient makes the impression of having Simmond's disease. The classical paediatric and neurologic investigations revealed no organic change; ophthalmological examination showed normal conditions; X-rays of the skull, the respiratory organs, heart, gastrointestinal tract, were negative. Carpal bone development was normal for the patient's age. The EEG was normal. The ECG showed, apart from a deviation to the right of the QRS complex, no pathological sign. A test meal disclosed gastric hyperacidity, in accordance with the above mentioned finding in another hospital. Blood counts, sedimentation rate, serum protein and its fractions, nonprotein nitrogen, serum chlorine, cholesterol, blood sugar, alkali reserve were repeatedly normal. Wassermann, Meinicke flocculation, and citochol tests were negative.

For studying endocrine relations, the following tests were carried out at adequate intervals: oral double dextrose tolerance, water tolerance, insulin tolerance, epinephrine tolerance, Thorn tests, 17-ketosteroid excretion, diurnal variations of blood sugar (beginning at 6 a. m., testing blood sugar before and after every meal, further at 12 p. m. and 3. a. m.). The results pointed to a definite lability of the hormonal equilibrium. On certain days the values were indicative of insulin predominance while on others a lack of insulin effect was observed. On some days the investigations revealed a relative adrenocortical insufficiency while on others this function was normal. The absence of an increase of the blood sugar value in one of the oral double dextrose tolerance tests, due presumably to a disturbed absorption from the gastrointestinal tract, was also interpreted as a sign of lability. Blood pressure, on different days, varied between 75/40 and 90/50 mm Hg, the pulse rate between 47 and 90.

During the 60 days of hospitalization, all the methods of treatment usual in cases of grave wasting were employed. An adequate diet was prescribed, sugar, salt solutions, vitamins were administered intravenously, transfusions of blood, drugs compensating hyperacidity, adrenal cortical extract, insulin, as well as liver preparations, were administered. All these methods have failed to ensure success. On the 50th day of hospitalization the patient weighed only 24.5 kg, *i. e.* 3 kg less than at admission. From that date the psychic state somewhat improved and body weight started to increase a little, reaching, however, still only 25.2 kg.

The classical vegetative (somatic) status can be summarized as follows. The child weighed 13.5 kg less than the weight corresponding to her age and height. She was marasmic and

was not willing to eat. Clinical tests revealed no organic changes except gastric hyperacidity and endocrine lability.

(ii) *Findings of the psychological examination.*

a) *Biological factors.* The mother had been twice in a mental hospital; she had Graves' disease. A cousin of the mother's mother had died in a mental hospital. The patient had not been breast-fed. She has a vagotonic constitution (low blood pressure, marked bradycardia).

b) *Psychological status of the patient.* Intellectual capacities are surpassing the average, she learns very well. Emotional state: gravely depressive, does not form emotional connections, is most reserved. According to tests carried out at the child guidance centre, the predominating emotional character of her personality are depression, anxiety, worry, lability of mood and a generally decreased capacity of bearing emotional tension. She is at the same time extremely impulsive, aggressive, feeling at the same time some guilt because of her aggressivity. The emotional state is characterized by a constant ambivalence and insincerity. A great deal of emotional content referring to parting and escaping was produced in the tests. These gave the picture of an emotional state of compulsive and depressive character.

During her stay in hospital she was examined on different occasions and especially in the initial stage there were long periods during which she was entirely inaccessible for psychotherapy, partly because of extreme reservedness, partly because of deliberate dissimulation. On such days she did not play, talk or eat.

The psychological status can be summarized as follows. A personality of an intelligence level surpassing the average, prematurely old, emotionally depressive, aggressive, hardly accessible, reserved, almost antistic.

(iii) *Environmental status.*

a) *Living conditions.* When the patient lived with her parents and her mother was alive, they lived in the outskirts of a large provincial town in a ruinous vine-dresser's house under most unsuitable conditions. Since several years now she lives with foster parents in a large provincial town, under good conditions, in a comfortable 2-room flat.

b) *Subjective living conditions.* In the patient's early childhood subjective living conditions were presumably unsuitable. This is supported by the fact that at the age of 2½ years she had been sent to the grandfather living in a neighbouring country, but the parents accompanied the small child only to the frontier and it was only 2 weeks later that the child reached the grandfather's home with the help of strangers. Here she had been happy; she had playmates and the grandfather, to provide for a better family environment for the little girl, married again. Disturbing environmental effects in this period originated from the grandfather having been classed a kulak; he was often held under suspicion, imprisoned and gravely insulted. Apart from these

troubles, that phase of the patient's life seems to have been satisfactory.

New troubles arose when the patient's father who because of the grandfather's new marriage was afraid to lose his share of the inheritance, took his daughter back. The patient again travelled alone and no one was waiting for her at the station. Arriving home at the age of 6 years, a new sorrow awaited her. The mother was ill and shortly died following a strumectomy. After the mother's death, the patient together with her small siblings had to stay with distant relatives, acquaintances, neighbours, nobody really caring for them. The father soon remarried. The stepmother who is a rigid, severe, practical and cold person, did not like the patient and treated her badly. This kind of attitude was adopted also by the father. After so many grave emotional shocks the patient was taken to her present foster parents. The foster mother is the younger sister of her maternal grandmother, the foster father, an elderly crippled man, loves the patient very much, with a somewhat spoiling attitude. Allegedly, the patient likes her foster parents.

We have been told by the foster parents that when the patient came to them, she was already a poor eater. They tried to improve this state by sending her to a mountain resort in the summer, but without any result. During this holiday once after she had watched a football match in pouring rain for over 2 hours, she developed a fever and pneumonia. Following the pneumonia, her appetite deteriorated and she refused to eat. When the loss of weight became grave, she was brought to the above mentioned university paediatric department.

The environmental status can be summarized as follows. The patient had spent her early childhood under bad living conditions and had been exposed to different psychic excitement and traumata. Then her living conditions became suitable, but some further environmental traumata had occurred. The marriage of her parents was bad; the father, a rigid, irritable, somewhat brutal man was impatient with his wife; the patient's mother had Graves' disease, she was nervous, sensitive, of decreased vitality, then died. Shortly thereafter the father remarried, the stepmother did not like the patient and treated her badly.

On the basis of the three statuses (somatic, psychological, environmental), the cause of the grave anorexia and cachexia was not to be sought in organic changes, but in environmental effects damaging the vegetatively labile patient ever since her early childhood. An episode of pneumonia then started the grave marasmus.

Careful nursing for a long period with up-to-date paediatric therapy failed to improve the cachectic condition and the patient even lost further 3 kg in the first 50 days. The personality disorder did not improve, and the patient was practically inaccessible for psychotherapy. In several instances the possibility of schizophrenia was considered. During the

last 10 days in the hospital, some improvement could be observed, her weight increased somewhat and she became psychically accessible. She talked about literature, showed interest in poetry, in such instances her mood changed, she even smiled. Then she started to recite poems, talked about books she had read and some days later told us that she wanted to be a teacher of literature. She was discharged in a state promising improvement, with a better appetite, increasing weight, in a somewhat better mood.

With her foster parents who cared very much for her and whom she also liked, she was feeling well and her improvement continued. Contact with the foster parents was maintained regularly. In the first 3 months at home, she ate much and even drank water. She helped around the house and continued her school studies.

One month later, in July, 1956, her body weight reached 37 kg, having increased 11.8 kg since discharge. She passed her examinations excellently. According to the foster father, she has lately produced some "hysteric scenes", and lost somewhat her appetite, loosing 1 kg, but on the whole she is well.

A follow-up examination was carried out in July, 1956, when the above events were related again. Results were as follows. Height, 151 cm; weight, 35 kg; head circumference, 55 cm; chest circumference, 66 cm (an increase of 7 cm). In July, 1957, the patient was gay and eat well, in spite of her height being 155 cm; the weight, 38.5 kg, it increased by 3.5 kg. In September, 1958, the height is 164 cm, the weight, 52.5 kg. According to the foster parents, the patient eats much, her mood is rhapsodic, she is obstinate, sometimes nervous.

As to her personality in the summer of 1957 and 1958, the grave anorexia was replaced by a state of voraciousness. She is "ravenous", according to the foster parents. She eats mostly fatty dishes, bacon, but also meat, sausages, etc. She is an excellent pupil, reserved, has no friends, belittles the foster parents who love her very much and whom she also likes.

According to the tests carried out at the child guidance centre, the psychic state has improved, she has excellent intellectual capacities, a good mechanical memory. She learns with great ambition, but her emotional scale is narrow, she is highly egocentric. The much too spoiling environment of the foster parents had a favourable effect in this special case, and it was due to this protected environment that the slow healing process, which had begun during the last 10 days of hospitalization, continued. It has, however, to be pointed out that the personality disorder has not disappeared without traces. In the actual personality structure the dynamic significance of the emotional sphere manifests itself in a strong "forgetting" mechanism against the possibility of the manifestation of the grave emotional "memories". The actual personality does not "want" to remember emotions of the past. This "forgetting"

dynamism, however, is hindering the enrichment of the emotional world of the developing personality. In this way, the emotional part of the patient's personality structure will be poor.

The case illustrates that a personality disturbance due to environmental damaging effects of psychic character in early childhood may manifest itself with serious vegetative functional disturbances. Such a personality disturbance may reach a point when it already touches the limit of schizophrenia. The grave state has made it necessary to apply complex paediatric and psychotherapeutic measures. For the successful outcome, favourable environmental conditions are, however, still indispensable.

III

Conclusions

(i) From our patient material of over 10,000 cases accumulated during 25 years, the above presented cases have been selected in a manner that in the centre of every symptom and complaint, every organ, or organ system, should be represented by one case. Complaints referring to the urinary, digestive, respiratory, circulatory, and central nervous systems and basal metabolism, are to be found in the cases discussed. From among the different forms, one case each has been presented to prove that in childhood symptoms and complaints referring to any of the organs or organ systems may develop without a morphologic change of the said organ, primarily as a manifestation of personality disorder formed under the effect of environmental damage of psychic character.

(ii) The above discussed cases have clearly shown the serious effect of the environment upon personality formation and the child's development. The younger the individual, the more important the environmental influence of the family. The significance of the members forming the family environment varies according to the age of the child. The younger the child, the greater the significance of the mother. Only at a later phase, at the toddling or the kindergarten age, begins the significance of mother, father and the rest of the family be distributed. In the same way varies with the progress of the child's age the significance of the emotional relations between mother and child, father and child, mother and father, between the family's most powerful personality and the other members. The environment outside the family becomes significant in the later phases of childhood. It then increases during school age from year to year without diminishing thei mportance of the family environment. For the infant and the young child it is the mother, later the father and the entire family, who mean society in its environmental effect. At the kindergarten and school ages, this effect is completed by the adults surrounding and caring for the child, its schoolmates and contemporaries. The effect of the entire society in a broader sense of the word, as a

directly influencing factor, enters the child's life at a later stage of school age. At this stage, the effect of the environment is already a complex and complicated one, not to be discussed at present.

(iii) Our observations have also shown that for developing personality disorders under damaging environmental effects, certain preconditions of biological character are required in almost every case. According to our experience, the biological factors, the "historic environment" in the senior author's terminology, inherited from ancestors and parents, cause in the organism of certain individuals on the functional plane a potential locus minoris resistentiae. An unfavourable change in the biological factors, such as the family, ancestors, parents, pregnancy, delivery, birth, the congenital constitutional characteristic of the individual in question, could be demonstrated in practically every case. It has to be assumed that the biological factors inherited through ancestors, parents, exert such an effect upon the organism of the individual in question, that on the functional plane its "tolerance-capacity" becomes potentially narrowed towards inevitable difficulties, and traumata arising in the course of life. This also refers to difficulties and damaging influences of psychic character. Such individuals are not able to endure qualitative and quantitative environmental difficulties without developing functional disease and personality disturbances, which by others are tolerated withnot any trouble.

(iv) We believe that the discussed cases have convincingly proved that personality disorders in childhood can be traced back primarily to the disturbed development of emotional life. Such personality disorders may manifest themselves in the form of organic symptoms and are presented as such to the physician. To avoid misunderstandings, we do not mean that the cause of every kind of organic symptom or organic disease is, or can be traced back to, a personality disorder. In the large material of our department in the past 25 years only a small percentage of the patients suffered from symptoms of organic character which could be traced back to primary personality disorders. In addition, not every personality disorder materializes in organic symptoms. In many a case the personality disorder of the child manifests itself without any organic symptom, in anomalies of general behaviour. These will be discussed on another occasion, as also the fact that if in childhood a primary organic disease runs a protracted course, a personality disorder may develop as its consequence.

(v) On the hand of our observations it can be stated that in childhood personality disorders arising in consequence of primary environmental, psychic damages, may develop without deteriorating the intellectual function or capacity. Among the discussed patients there were some of exceptionally high intelligence. As already mentioned, in the mechanism of disturbances of personality development produced by the above described

troubles of emotional life, the pathological course of emotional development plays a decisive part. It has, however, been observed that if the personality disorder becomes protracted, an initially good, even excellent intellectual capacity and function may deteriorate secondarily.

(vi) The cited cases emphasize the difficulties of diagnosis. In the introduction, the methods used in our institute for exploring the disease for establishing the essential diagnosis have been summarized. In the material discussed, in other words in the cases presenting organic symptoms, the position of the physician is most difficult, since often the vegetative (somatic) complaints and signs, determined by means of classical paediatric clinical investigations, are in accordance with the complaints and symptoms of diseases observed in everyday paediatric practice. The diagnosis seems to be correct if an occult spina bifida is taken for the cause of nocturnal enuresis, or bronchial asthma for that of choking attacks, or a mitral insufficiency due to rheumatic fever for that of pain over the heart. This allegedly correct diagnosis is contradicted, however, if no result can be achieved by the usual therapeutical methods. This is the reason why in such cases the parents take the child from physician to physician, from out-patient departments to hospitals, etc. Our department is perhaps at an advantage in this connection as most of the patients presented to us had previously been studied and treated without success at several different hospitals. In such cases, taking into account the failure of classical therapeutical methods and in view of eventual suspicious signs, the complex examination method described in the introduction of this paper makes impossible to establish the proper diagnosis.

(vii) The above observations allow some conclusions of certain general validity concerning therapy.

a) The above discussed vegetative (somatic) complaints and symptoms will by no means respond to otherwise effective drug treatment or manual interventions. The complaints and symptoms will persist and the patient's condition may even deteriorate. It has, however, to be pointed out that classical paediatric drug treatment and interventions still have their place among the complex therapeutic procedure employed by us, as completing methods.

b) In the discussed cases, therapy was of a complex character. The manner in which to apply the different methods has been decided by the quality of the individual case. These methods are

A) classical paediatric drug treatment and manual interventions;

B) psychotherapy;

C) activity of social character.

c) It has to be pointed out that one of the preconditions of successful psychotherapy in childhood is that it be directed not solely to the child. First of all, contact with the mother is necessary, but one must usually deal with both parents, eventually with the grandparents or other members living with the family. If the patient

is of kindergarten or school age, the adults responsible for the child outside the family must also be contacted, for instance the leader of the kindergarten, the teacher, eventually the schoolmates. This kind of group-therapy, "family group therapy" in the junior author's terminology, often group sessions with several adults, with the whole family, is necessary for solving the problem.

d) The task of group sessions with the adult members of the family and of the environment outside the family is as follows.

1. We have to point out the actual mistakes committed in the emotional relationship to the child and in those concerning his occupation, bringing-up, education, tasks and the applied behaviour standards. In the course of these conversations it is absolutely necessary that the mother, the father, the members of the family or the persons who are connected with the child outside the family should fully accept our propositions for the elimination of these faults, and recognize their importance and correctness.

2. In the course of these conversations, the adults have to be instructed in the elementary knowledge of child education. This knowledge varies according to the different phases of childhood. Adults have to be instructed from different points of view, such as,

α. the importance of the continuity of the emotional relationship between adult and child, the quality and proper intensity of this relation. The adult has to be instructed to find out whether the emotional relation between the adult and the child is eventually too close, overburdening the child emotionally, causing "emotional nausea", or else much too poor, bleak, so that the child is perhaps in a state of "continuous emotional hunger", emotional "deprivations".

β. The parents have to be instructed to evaluate the capacities of the child under the given circumstances and to impose duties and tasks accordingly, without risking the development of a disturbance. It has to be repeated that our instructions must be given in such a manner that the parents accept them entirely. The question what kind of school results may be expected from the child and how far it can be charged with lessons and tasks outside the school, has to be discussed.

The adults must be able to ascertain how much motor drive-satisfaction, what kind of recreation, play, how much and what kind of joy, praise, encouragement, punishment, etc., are necessary; further, what kind of behaviour, conduct can be expected from the child in the given phase of his life.

e) It is clear that there are quite a number of cases in which the most adequate use of classical paediatric treatments and interventions and the above-described "group-therapy" remain unsuccessful, unless the objective unfavourable circumstances in the environment are not remedied simultaneously. The tasks in this respect are to provide for material aid, to ameliorate the living conditions, even-

tually by a temporary or lasting change of the family and/or school environment.

f) The psychotherapeutic method applied to the child is not psychoanalysis, but a method of "guided talk". Sessions are held daily during the patient's stay in hospital. After discharge, the child reports at the child guidance centre 2 to 3 times weekly. Later, if there is some improvement, he should appear once every 2 to 3 weeks, then once a month or every two months.

The psychotherapeutical conversations employed by us are not based on "persuasion". The child is not persuaded to fulfil tasks. The method means essentially that he is guided to accept and use of his own will what is desirable from the point of view of therapy. According to our experience, no child can be persuaded or forced by our adult will to change his disturbed emotional state, its fixed emotional "bad habits", its actual personality. The disorder, the specia lemotional form of life, the special personality, the child's undesirable and inadequate behaviour and attitude have been developed under certain biological conditions, under the influence of everyday, continuous, envir onmental effects, and been stabilized by continuous damaging influences. At this stage, the closed system of the pathological succession which is independent of our will and thus cannot be influenced and altered in a given time by our will, is already functioning in the emotional sphere of the child and its whole organism. It manifests itself in his actual personality, behaviour and attitude. The faulty functional system is the more rigid and fixed because the child, being a child, is helpless in the damaging environment and is at the mercy of the adult world. He has developed the faulty mechanism in order to adjust himself to the damaging environment. One of the factors underlying the personality disorder is the tendency to adaptation which becomes essentially incorrect and undesirable, but in reality is a misdirected adaptation to environmental demands.

The main point of the method of guided talk psychotherapy consists of the following phases.

A) Arousing the child's interest in our direction. This already begins in the first few minutes of acquaintance. The conversation is usually begun by the surprising question: "Were you told why you have been brought here?" From this frank sentence the child gets the impression that this relationship between adult and child differs entirely from his previous ones. This new relationship between the child and the newly acquainted adult starts on an equal level.

B) Arousing the child's confidence.

C) Forming a serious, lasting emotional relationship with the child.

What is the aim of a psychotherapy carried out in this manner? What is its main point? It can best be illustrated if the course of the therapy divided into different phases is followed step by step. The aim of the first phase is as follows.

1. We lead the child to the knowledge and acceptance of the fact that

he is important for us, that we care for him, that we can help and protect him from many things he is afraid of. Then the feeling is implanted and gradually stabilized that the bad, frightening situation of which he could not find a way out, can be solved, and put in order. In the meantime, an emotional relationship develops in the child towards the person dealing with him. In the psychologist, however, the emotional relationship is not centred upon the person of the child, even if the child must get that impression. It is part of the therapeutic work and the general emotional attitude towards children. The psychologist deals with the problems of the child without sentimentality, only by applying his psychological knowledge, strictly on an intellectual basis, without emotional participation concerning the individual child. Emotions formed in the child are used by the psychologist in the interest of treatment. It should be pointed out that the confidence of the child is not gained by promises, it is awakened and gradually strengthened by the behaviour and activity in the course of treatment.

In the course of these conversations our behaviour and attitude results in that the child will gradually look upon this adult as such a person as according his ideas and demands an adult should be, who in any problem, trouble or disturbance can be asked for advice and with whose help he will be able to solve the problem; the psychologist will help with advice, love, and adult knowledge.

2. Simultaneously, a precise image should be formed of the events in their detailed connections. Both the "external" events experienced by the child and the "internal" events which have occurred in his individual emotional, intellectual world, become clear and explain the entire actual situation of the patient. In exploring his "internal" events, it is important to know the child's reactions to the "external" events, how these have been evaluated, judged, how the child feels and thinks about them, how it considers its own actions. This kind of exploration is not always easy. It is a delicate task so to direct the conversation as to be able to find out what and how much is told by the child voluntarily, with what kind of emotional charge and, above all, in which phase of the conversation. If treatment is successful, the patient will in due course speak about things which are essential from the point of view of the disorder, which up to then were his guarded secrets. The child must be lead to share his concealed secret with us, to tell his opinion, judgement and feelings honestly, concerning all events, his parents, his teacher, and to reveal his attitude towards his own feelings, actions, the whole situation.

3. If the above aim has been reached, the now entirely confident child who is sharing his "secret" with us, will share with us also his constant emotional, impulsive tension. Then it will be possible to diminish his tension, his constant excitement and so to diminish his anxiety.

4. With the help of guided talk, the child will be able to put into words the

substance of his excitement without any effort. This would be impossible without our help. Smaller children dramatize with the toys at their disposal in the child guidance centre what they have to say, or they make a drawing of the family structure which they are unable to formulate into words. The younger the child, the more is he able to express himself in this manner. In these dramatizations and drawings there is much symbolic expression. The proper interpretation and understanding of the essential content expressed by the child in this manner needs much experience. The psychologist must be able to accomplish this, this task being a prerequisite of the further phase of treatment in which the child has to be helped to be able to formulate the problems alone.

What is the result of the formulation? As already mentioned in our earlier studies, formulating, putting into words, communication, relieves the tension of emotional and vegetative excitement, makes dynamic "memories" to be discharged. In this manner the internal stimulus source repeatedly eliciting the excitement, the "memory", loses its dynamic character, becomes relieved of its tension and changes into a "memory" of static character. In the meantime it becomes possible for the child to have a clear insight into his own unsettled problems connected to external events and to confide of his own will the management of his troubles to us, together with the previously unbearable sense of responsibility and fear, and so to accept therapy voluntarily.

If we have succeeded in reaching this point in psychotherapy, it often happens that in the course of a session the child begins to cry, even burst out sobbing. In other cases the outbreak of impulse is accompanied by incoordinated activity. This is the sign that, although with our help, but nevertheless spontaneously, impulsive tension maintained by an opposite emotional charge, has broken out unexpectedly, has "exploded". Parallel to this, with our aid emotional unanimity, emotional tranquillity is formed towards important exterior or interior stimuli. The equilibrium and tranquillity due to the emotionally unanimous behaviour is for some time labile. Its stability has to be strengthened gradually in the course of treatment.

5. To avoid misunderstandings and to make the above absolutely clear, the process in the sick child has to be described. Next to troubling exterior events, the continuous and unbearable repetition of inadequate exterior stimuli, the child is burdened by grave and disturbing emotional "memories" of dynamic character, by pathological, emotionally interwoven, sequences of events, developed at an earlier stage under the effect of inadequate interior stimuli. In order to establish the equilibrium of the child's personality, besides stopping the environmental pathological influence, it is necessary to put the undesired "memories", the unfavourable interior stimuli, to their proper place, comparing them intelligently with healthy emotions, reactions, actions consequences, issu-

ing from the present. The child in his present state, however, needs help to settle the past and the present, the connections of exterior and interior events; he is not even in the position to summarize the structure of the disturbed objective exterior situation. With the help of psychotherapy, the necessary assistance is provided for the child to summarize the connections of the present environment and his own memory-world, and to recognize, order and systematize its connections with the objective present. Now the child is able to put the disturbing environmental circumstances to their proper place, to evaluate them according to his own special ethics, and also the memories of its internal world, the interwoven pathological emotional sequences of events that had been established at an earlier stage. This capacity sometimes necessitates a long treatment to develop; its development is, however, indispensable. Only by a liquidation of demands that have been fixed in the child and have grown inacceptable for his actual personality is it possible to guarantee satisfying possibilities according to the child's age, and it becomes also possible to coordinate these with the new environment of the child. If this procedure is successful, it is possible to stabilize the child's environmental position, to organize his emotional situation both in the family and the community, and only then will the incertitude, the fear, the anxiety of the child cease, and his previously pathological personality, behaviour, be remodelled.

Individual psychotherapy applied in childhood is only successful if the tasks, designated earlier as environmental emotional and social tasks, are solved simultaneously and so the damaging repetition possibility of exterior pathological stimuli ceases as well as the practice of "bad habits", the possibility of repeated evocation and satisfaction of pathological excitement in response to pathological stimuli, inadequate emotional states, emotional and other sequences of events and accompanying inadequate demands.

If the two processes take a favourable course, the forgetting of the undesired "past" starts in the favourable "present" developed by making order in the child's environmental life. If "forgetting" is satisfactory, the newly formed present is no longer charged with "memories" having caused "past" pathological irritations, not even as spontaneously affecting "interior" sources of excitement, and in the actual present devoid of pathological influences the new, ordered life can start with healthy, qualitatively and quantitatively adequate, exterior and interior stimuli, and healthy excitements, demands and satisfactions.

6. We presume that this will suffice to explain the essential content and theory of "guided talk". By thi smethod of psychotherapy, not the ideation of some allegedly suppressed "unknown" is approached. On the contrary, things "much too well known", actual emotional conflicts formed essentially on the basis of real

environmental damaging effects, pathological emotional, closely linked undesirable sequences of events are formulated convincingly. Essentially, it is endeavoured to further in the child and with the child to order and systematize events of the past and present on an intellectual and emotional level according to his age, *i. e.* the "memories" and the "present", the connections of the exterior and interior environment. By means of this method the child is guided in the course of conversations to order with our assistance and to accept with his special possibilities the new, ordered situation with its entire personality. By ordering and systematizing the objective events of the exterior environment of the child and the events of his emotional and intellectual activity, new ways of reaction are created. This ordering means that according to the intellectual level of its age and his degree of development, the child realizes his own interior and exterior situation. On the basis of this realization are formulated in thought and word, as precisely as possible, the "exterior" and "interior" stimuli in accordance with reality and the excitation produced by these stimuli: previous actions, deeds, events, *i. e.* its own behaviour and attitude. This formulating in thought and word should go together with an evaluation experienced emotionally and the intelligent and genuine interpretation of the connections. As a most important point should again be emphasized that the evaluation and interpretation, *i. e.* the correct formulation, has to be "accepted", so-to-say "incorporated", by the entire personality of the child.

It has already been mentioned that in this kind of therapy as practised at our child guidance centre an emotional confidence between the treated child and the psychologist is essential. This emotional tie has to be deep and close so that the patient should entrust his fate, his concealed "unsettled affairs" with relief to the treating adult who by then has changed into a beloved person and has been chosen an ideal by the child. The character of the emotional relationship both in the child and the therapist has been discussed; here we only wish to add that the child-adult emotional relationship formed between the child patient and the adult therapist is a most complicated one. It is not endeavoured to create in the emotional and conscious world of the child the image of some exaggerated "idealized adult", but to build-in into the emotional and intellectual function of the child the image of the temporarily missing real mother, that of a "mother-substitute", the image of the "real adult". The task of this adult is to function in the emotional and intellectual world of the child as a really loving "mother-substitute". This adult person loves the child but also notices his faults, so that through the attitude of the adult the child realizes, understands its own faulty actions. The therapist could be called by the child also "a kind, correcting mirror". In it the child is able to see its entire self, its problems and connections.

7. It has to be stressed that in the treatment of the discussed forms of disease there does not exist a "cure-all", a miraculous method which would eliminate the troubles overnight. To achieve success, these procedures, eventually first only part of them, have to be employed most tactfully for months, sometimes for years.

8. From the prognostic point of view, it is always worth while to apply this therapeutic activity demanding much care, since in the majority of childhood cases excellent results can be achieved, especially as the organism of the child, in spite of being in the state of development, labile and easily injured, disposes of a high regenerating capacity. According to our experience, morphological and functional injuries hopelessly incurable in adults, may heal tracelessly in children. The organism, the personality of the child can most efficiently "forget", "grow-out" the damaging effects; and with appropriate help and successful "forgetting" of faulty connections, personality development may again take its normal course. The more so since human personality is a special individual life-manifestation in the course of general human life. By life, we mean the life of man lived in the society of a certain phase of history. Human personality in this sense is not a rigid, static, determined uniformity from infancy to old age. Personality, in the single phases of life is not the same, unaltering function-formation of constant character, even less a structure-form of static character. Human personality, in the course of individual life, as also the entire individual organism, develops, and is gradually formed. The dynamic and static structure of the actual personality characterizes only a certain phase of life. This developing trait of the personality makes it possible to alter by adequate interventions the disturbances, faulty "habits" built-in in childhood. In the progress of individual human life, the formation of personality is a developmental process, in the course of which a continuous change occurs. In this continuous change it is possible to alter the pathological course by means of adequate interventions and to direct the course of development in the desired direction.

9. The therapeutical procedure is considered successful and complete if the pathological symptoms, as well as the healthy rearrangement of the personality structure have taken place in a form corresponding to the age of the treated child. Then it will be possible to discuss the result with him, looking back, surveying the entire problem while the patient has distanced himself from it, considering it objectively as if it were something not pertaining to his very self. This shedding of the problem is made possible by its realization and formulation in the course of treatment. We believe that the subsidence of the inhibition according to Pavlov's concept, hindering the relief of the emotional tension which has originally caused the problem, is achieved in this manner. At this stage the personality of the child had already been so shaped that in a favour able atmosphere it is able methodi-

cally to consider and intellectually to formulate his own relationship with the environment, understanding it, recognizing what is "necessary", accepting and following it in the future course of his life. The personality has at this stage become so favourably organized that the course of events and their evaluation do not any more happen solely on the basis of the child's "emotional logic" but according to environmental, and his own emotional and intellectual, standards.

Finally, the newly shaped, re-established healthy family situation should be evaluated in a discussive manner with the adult members of the therapy group.

10. It has to be emphasized that paediatricians and persons dealing with children should do everyting in order to prevent the development of personality disorders. The living conditions, the patient's environment (family, dwelling place, community) are important factors. At the same time, if the other influences are inadequate, suitable living conditions do not suffice for preventing the development of personality disorders. Owing to the special character of personality in the different phases of childhood, adequate material conditions such as a suitable dwelling place, nourishment, clothing, studying possibilities, presents, money, etc. by themselves are not sufficient to ensure the proper development of the personality. In addition to those, the subjective conditions have to be equally adequate. It has to be pointed out that the younger the individual, the more decisive his relationship with the mother. In the subsequent phases of life, an important part is played by the relationship between mother and father, and the other members of the family, the quality of the family's emotional environment and its structure. At a later stage, the emphasis is on the emotional relation to the father. Still later, when the child starts to go to kindergarten, school, working place, the quality of its emotional relation to instructor, teacher, schoolmates, associates is the important factor. For the safe development of a normal personality it is imperative that in this every-day life of the child the stimuli, first of all those of emotional character, should not surpass in intensity, quality and quantity the child's actual "tolerance-capacity" and at the same time they should satisfy his healthy demands.

Accordingly, for the prevention of personality disturbances in childhood, not only the objective environmental influences in and outside the family must be suitable, but adequate emotional influences must also be guaranteed. This is the most important in the early phase of life, and later at periods when development is especially rapid, such as at school age, in prepuberty, puberty, etc. For the sake of a proper prevention, future parents must adequately be instructed so that the relevant knowledge should be acquired before the child is born. Such education should also be offered to parents with children, further for all those who are in professional contact with children. Such per-

sons must be in clear with the special tasks to be performed in the different phases of childhood.

The question may arise why, in spite of our favourable results, prevention is considered so important. The answer to this question has to begin with another question. Is it possible that an individual in whose memory events similar to those discussed above have accumulated in the course of childhood and whose "memory world" contains such a "past", should be able to forget, to make this past completely to disappear from his personality structure? Is it possible that in spite of the subsidence of the disturbance the personality of such a child in the later phases of life should be as "healthy" as the personality of those who have no such memories? That their "tolerance capacity" to unavoidable difficulties is the same as that of a healthy individual?

The answer of the poet to this question is perhaps somewhat exaggerated:

"Nothing can remedy the established fact" (Milan Füst: To a star)

And what is the answer of the paediatrician? — According to our experience, the healthy organism of the child built up on a good biological basis and a dynamically balanced personality may in the course of the years "forget" grave events, or at least diminish the tension of their emotional charge. In this manner, it is able to transform the "past" into an event "epically statical" in character. This is true, but it is also true that not every individual is built upon entirely suitable biological bases, not every individual's actual personality is maintained without effort. It has to be added that, unfortunately, our method of "forgetting" is undeveloped. In our culture, contrary to the continuous training of the memory-function, the function of "forgetting" is not practised and so a successful forgetting is generally entrusted to chance. A "forgetting-mechanism "of full capacity is not at our disposal. Neither is there a method at the disposal of physicians and psychologists by which the patient could be made to eliminate, wipe out, undesired "memories". If the trouble has already been formed and the personality disturbance has been established in the child, *i. e.* something has happened which is undesirable and involves danger, what can be achieved by the paediatrician by means of psychotherapy? The aim of psychotherapy is not to "remedy an established fact". It is not able to annihilate the established fact, it can only strive at, and help in, the recognition and evaluation of the present objective and subjective connections and simultaneously to help in the evaluation, consideration and organization of the past, with its memories, emotional pain, feelings of insecurity, the "established fact" causing anxiety and reappearing from time to time in the memory. By means of psychotherapy,nextto organizing the connections of the actual environment and the individual, the transformation into static ones of the undesirable dynamic memories caus-

ing actual excitement and representing a source of stimuli is also achieved. It helps to put the internal sources of stimulus to their proper place in time and space, to eliminate a potential source of irritation from the actual dynamism of the individual. By means of psychotherapy it is made possible for the child to realize and evaluate correctly its connections with the environment in accordance to its age, in spite of the established behavioural disturbance; to be able to learn the correct way of living in spite of the "established fact"; to learn the way of life by which no conflicts with the demands of the environment (society) arise and at the same time no undesired servile adjustment is formed which would hinder him to enjoy life, hinder the development and satisfaction of his healthy demands. It is endeavoured to help the child to recognize the characteristics of human social life, to find, instead of the previous false aims, new, correct ones which he is able to follow; fo find joy in learning, work, creation, and not only in momentary pleasures. If we arrive by means of psychotherapy to make the child to realize and accept all this, he will succeed to eliminate from his actual dynamic personality structure the undesired previous, eventually ancient, archaic, influences and they will persist only in the static structure, as a framework. If we have arrived to accomplish this, the child in its own environment will be able to find, in spite of the "established fact", the possibility to achieve his development, his position in society. Thus, we have succeeded in accomplishing everything what we are in the position to do for the time being. Still, the poet is right. "Nothing can remedy the established fact." This is why, in spite of the favourable results achieved by means of psychotherapy, the first task is to prevent the development of personality disorders in childhood and adolescence.

Summary

The paediatric concepts concerning the personality disorders accompanied by vegetative symptoms are discussed. A detailed review is given of the possibilities of diagnosis and therapy, supported by a report of 11 cases of personality disorder chosen from a patient material of more than 10,000 cases observed in 25 years. Each of the 11 patients exhibited vegetative (somatic) symptoms localized in different organs or organ-systems, such as nocturnal enuresis, encopresis, obstipation, aphagia, asphyxia, intracranial process, heart disease, petit-mal, hypertension, obesity-cachexia due to anorexia.

A detailed account is given of the biological, so-called "historic environmental" factors and those of the actual environment which have had a part in the causation of the personality disorder, discussing their significance and connections. It is stated that in childhood, especially in its early phases, vegetative (somatic) symptoms may arise under the influence of environmental effects. Such

symptoms are impossible to cure by means of usual paediatric drug treatment and manual interventions.

For the treatment of these cases a complex therapeutical procedure has been worked out. In establishing the diagnosis, the following points of view are essential. Precise observation and establishing *(i)* the vegetative (somatic) status, *(ii)* the psychological, and *(iii)* the environmental status. On the basis of the compared data of these three statuses are established the complete diagnosis and therapy. For the treatment of such patients a complex therapeutical procedure has to be applied, consisting of a classical paediatric and a special psychotherapeutic method to change the influence of the environmental factors. This is because the trouble of the child is based upon his incorrect relationship with its environment. Formation and fixation of the child's faulty personality structure is furthered by his striving to adjust himself to the damaging environmental conditions. A satisfying result can only be hoped for if treatment is directed not solely towards the child, but also towards his environment as the source of pathological stimuli. It is necessary to extend the treatment to themother, the family, and to all those who play a role in the life of, and are emotionally connected with, the child. On the basis of this concept has been developed the "family-group-therapy" method. One of the indispensable conditions of successful treatment is to eliminate eventual damaging objective factors of the environment; to remove the child from it temporarily, or finally. These latter procedures are of a social character.

The community relations of the child and their significance are discussed in detail.

The decisive factors in the relation between child and therapist are analysed, further the changes taking place in the child in the different phases of the therapeutical procedure.

The prognosis of these cases is considered favourable, provided adequate methods are applied.

Finally, it is pointed out that, in spite of the favourable results of psychotherapy, the main task is the prevention of personality disorders.

Prof. P. Gegesi Kiss
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