Interpretation of some Personality Disorders in Childhood

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(Received December 5, 1962)

The problem

On the basis several decades' experience, we are of the opinion* that when dealing with personality disorders in childhood it is necessary to establish a 'total diagnosis', comprising the entire problem of the individual. In our terminology, 'total diagnosis' means that on hand of detailed somatic, psychological and environmental examination, not only the 'symptomatic diagnosis' (revealing the basis of the actual complaint, explaining and including the cause of the most prominent symptom) has to be established, but also the actual quality of the organic and psychological personality structure of the patient. In other words, the 'total diagnosis' explains and includes manifestations of the interwoven dynamic symptoms and specific attitude of the organic and psychic personality structure, the effects of the pathological cause and connections of the effect of the primary factors exerting the pathological influence. A satisfactory plan of adequate treatment is only possible by revealing the direction and connections of stabilized events and the pathological factors, i.e. by explaining the dynamics, mechanism and genesis of the clinical pattern and the actual pathological situation and establishing their interrelations.

In spite of applying all the mentioned investigations, there occur some cases when it is impossible to arrive at a satisfactory 'total diagnosis'. The 'symptomatic diagnosis' is, however, correct also in such cases, assuming a mixed pathological pattern, in other words that a somatic disturbance and a personality disorder determined by a definite emotional developmental disturbance are present simultaneously. 'Total diagnosis', elucidating which of the troubles within the mixed pattern was the primary and which the secondary, is, however, impossible to establish in spite of the correct and precise 'symptomatic diagnosis'. Cause and effect within the mixed pattern cannot be clarified. Diagnosis, therefore,

* P. Gegesi Kiss and Lucy Liebermann: Personality Disoders Accompanied by Vegative (Somatic) Symptoms in Childhood. Acta paediat Acad. Sci. hung. **3**, 99 (1962); General Disorders of Attitude in Childhood. Acta paediat. Acad. Sci. hung. **3**, 297 (1963)

reveals only which of the organs or organ systems is affected by a certain vegetative lesion and the simultaneously present disorder of emotional development bringing about a personality disorder; it cannot, however, disclose their causal connection. The significance of this difficulty is not purely theoretical. It is our experience that successful therapy and prognosis are only possible in case of a 'total diagnosis', when in the mixed clinical picture the presence and degree of severity of the diseases, as well as their interrelations are elucidated. In the cases to be discussed it was not possible to obtain a definite diagnosis from clinical examinations lasting for weeks and even months. This can only be made on hand of the ensuing development, the success or partial success of therapy. The therapeutical plan, however, being itself a complex one, has to be outlined in spite of the diagnosis remaining open. The vegetative disease is treated by the usual paediatric methods and simultaneously we endeavour to achieve a favourable change of the personality disorder by applying the psychological and social methods of treatment discussed in previous papers. When planning therapy, it has to be taken into account that in diagnosing the condition a step has been missed and when evaluating the results of the therapeutical interventions, it must be endeavoured to eliminate this missing step and to obtain an answer to the core of the trouble, i.e. a 'total diagnosis' should be established. The precondition of this solution is to understand the specific problem and situation of the individual.

Cases of such mixed pathological origin are rare. In most instances, examinations carried out at a well-equipped department with a well-trained specialist staff, the part of the personality disorder in the pathological situation of a given organism and personality can precisely be defined. It can be revealed whether the direction of the pathological mechanism in the formation of the personality disorder is a psychosomatic, or a somato-psychic one. In the majority of cases, even in those of a mixed origin, it is possible to ascertain whether the trouble had been caused primarily by a vegetative disease and this was followed by the personality disorder, or vice versa.

The detailed description of some cases of a mixed pathological pattern has been considered necessary to call attention of both the paediatrician and the psychotherapist to the fact that there are cases when the direction of the pathomechanism cannot be clarified, in other words whether the trouble follows a psychosomatic, or else a somato-psychic line. This, however, does not alter the rule that these cases require complete treatment.

Clinical Observations

Case 1. F. I., a male patient 13 years of age.

Complaint. The patient has often vomited in the past year, sometimes

every day for several weeks. Vomiting is independent of the quality and quantity of the consumed food. He is never sick during the day, only after dinner when he has headaches, turns pale and vomits. Besides, 3 to 5 hours after going to sleep, he awakes with a pain in the chest. The patient is nervous, oversensitive, cries easily on the slightest excitement. He is a bad pupil, once he had to repeat a year and now again he seems to fail at the coming examination.

Somato-vegetative examination. Admitted, December 12, 1961, discharged December 29. (Registration No. 3518/1961). *History.* The patient is a twin child. Pregnancy was normal; delivery by Caesarian section. He immediately cried, in the newborn period there were no complaints. The mother had no milk, the patient was fed with the milk of another woman. Since the age of one week the boy was brought up by foster parents who adopted him, as the father committed suicide (he hanged himself). The foster mother is the sister of the dead father. Somatic and intellectual development of the child were nomal. He received every obligatory vaccination. He had chickenpox, measles, scarlet fever, epidemic parotitis and whooping cough. At the age of 5 years, appendectomy was performed; at the age of 13 years, tonsillectomy.

At admission. Height 148 cm, body weight 38.4 kg, development corresponding to age. The clinical findings were as follows. Examinations of blood, urine, and Wassermann, Meinicke and Sachs-Witebsk tests were negative. Gold sol, negative; thymol, 2 U; serum bilirubin, 0.88 mg per 100 ml; ESR 2 mm; intradermal tuberculin test 1 : 1000, 6 × 6 mm, corresponding to the previous BCG vaccination. Chest X-rays, dense hilus on both sides; X-rays of digestive tract, medium gastric tone, stomach reaching to the crista ilei, regular mucosal design; secretion of two finger's breadth; smooth gastric contours; normal peristalsis; free pylorus; duodenum filling well and showing smooth borders; the pain is extraventricular; after 2 hours little rest in stomach, after 24 hours the contrast material is distributed evenly in the colon. Fractionated test meal, 0—22, 0—12, 0—14, 6—15, 9—24, 28—42, 40—56, 36—52. Faeces, benzidine test negative; parasitology, Giardia lamblia.

The classical paediatric examinations revealed Giardia lamblia infestation; the parasite is known to attach itself to the duodenal wall causing thus abdominal complaints. Besides, regurgation vomiting was the essential complaint.

Psychological Investigations

Biological factors. The father of the child committed suicide and died. The child knows about his father's suicide. The mother in this (her first) marriage was restless, showed a tendency for truancy, she became, however, settled in her second marriage. The child was born of a twin birth, was not breast fed by the mother.

Pathophysiological factors. The patient was delivered by Caesarian section; had had five infectious diseases during early childhood; because of appendicitis, appendectomy had been performed and because of frequent tonsillitis, tonsillectomy.

Psychological status. Intelligence

Basically of good intelligence. However, because of the disturbed emo-

tional state, the patient is inhibited intellectually and hardly able to use his excellent capacities. So, for instance, his attention and intellectual achievements are varying, periodically impeded. He is a bad pupil, had to repeat a year in school and seems to fail this year, too. His associative capacity and the sphere of concepts are narrow, intellectual functions definitely 'oldish'. His intelligence is reproductive with repeated 'blank' periods. *Emotional state.* The child is anxious, at the same time aggressive, has extremely labile moods, is disturbed by sexual problems of puberty. His emotional life is fluctuating with depressions. He was gravely traumatized by this fathers suicidal death and although he tries not to think of it, this fact preoccupies him constantly. He is conspicuously tied to the mother in a way corresponding to the level of very early childhood.

Summarizing the psychological status, the patient, although of excellent intellectual capacities, can hardly make use of his capacities owing to the disturbed emotional state. Emotionally he is in a state of anxiety, depressed, traumatized, much too closely tied to the mother, dependent.

Environmental status. The patient is brought up by foster parents. Objective and economic situation of the family are adequate; the subjective environment is, however, inadequate because although he is fond of the foster mother, he very much misses his mother and the twin brother. At the same time he does not dare to speak about this to the foster mother, knowing that she dislikes the mother, making her responsible for the suicide of the father.

From the psychological and environmental status it was evident that the child suffered from a personality disturbance, caused by disorders of emotional development and grave emotional state.

In comparing the two diagnoses, giardiasis and the personality disorder, it is not possible to decide which of them was the primary and which the secondary one causing the abdominal complaints occurring in the evening, i.e. at the approach of night with the awakening on having a 'pain in the heart'. It had to be assumed that no causal connection existed between the two kinds of disease but their combination had narrowed down the child's tolerance so that symptoms were more severe than would have occurred under the effect of either of the two conditions. Therapy consisted in eliminating the infestation, by providing vitamins, adequate rest, a quiet way of life. Simultaneously, in order to eliminate the personality disorder with the aim of solving the depressive and emotional problems, the following psychological treatment was introduced. We discussed with the foster mother that although the boy is very fond of her, he nevertheless longs for his mother and twin brother, and, knowing that this would offend the foster mother, he did not dare to tell her about it. The foster mother, an intelligent woman, accepted our advice,

so that the boy now regularly visits his mother and twin brother living in the same street. The foster mother and the mother came to the agreement that the twin brother should go to the same school so that the twins can see each other more. By continuous guided talks with the child, we endeavoured to help him to work through his emotional suffering caused by the reality of the death of his father.

By the above complex treatment, the giardiasis was eliminated, the abdominal complaints and vomiting stopped. His emotional situation also improved; depression occurs less often with less intensity; the school results have also improved.

The conclusion is that there exist cases in which two kinds of disease, a somatic and a psychic condition are present simultaneously in the same person and if in such instances the patient is brought to a department where attention is solely concentrated upon paediatrics, the obvious 'symptomatic diagnosis' is considered sufficient. In the present case they would have eliminated the giardiasis and discharged the child without any further thought of a possible second, psychic condition. By such therapy, the complex disease is not solved and may subsequently lead to grave personality disorder. If, on the other hand, such a child is admitted to an institute which treats solely according to psychological aspects, attention will be focussed upon the grave environmental and emotional troubles and the diagnosis will be a personality disorder on the basis of environmental influences. From the child's point of view this diagnosis is also a 'symptomatic' one, and the best psychological methods will fail as long as the infestation giving rise to abdominal complaints has not been eliminated by suitable drugs.

Although once solved the case seems to be simple and clear, it demonstrates that for establishing a 'total diagnosis', for elucidating the pathological form, complex methods of examination are needed.

Case 2. S. Gy., a male child 14 years of age.

Complaint. Since two months he has pyrosis, vertigo and abdominal pain especially around the umbilicus, before meals. Somatic development is not satisfactory, the patient is easily tired and nervous.

Somato-vegetative examinations. The patient was admitted for observation and treatment on November 17, 1961, and discharged January 9, 1962. (Registration No. 3291/1961). *History.* The patient after uneventful pregnancy had been born at 8 months with 2100 g weight. He had cried immediately, had no complaints in the newborn period, had been breast fed for 3 months and weaned gradually. Somatic and intellectual development had been normal, dentition had begun at 6 months; he had been sitting at 8 months, standing at 10 months, spoken at the age of one year, walked at 18 months. Obligatory vaccinations had been administered. He had had scarlet fever three times, pneumonia three times, further dysentery, measles, chickenpox and several times otitis. He has two siblings. As to the present complaint, we were told that he had been repeatedly examined because

of pyrosis, had received drug treatment and although the state improved periodically, the complaints are essentially unchanged.

At admission. Height 143 cm, weight 27.9 kg, i.e. the height corresponds to that of a 12 year old, body weight to that of a 9 year old child.

Physical examinations revealed no abnormality. There was no abdominal tenderness; blood and urine tests were negative; bacteriological and parasitological examinations of the faeces and repeated benzidine test after adequate diet as well as the Wassermann, Meinicke and Sachs-Witebsk reactions were negative. The intracutaneous tuberculin test was positive owing to earlier BCG vaccination. The fractionated test meal showed hyperacidity, with following values:

Initial	HCl	Total acidity
—	22	8
10′	—	—
20′	0	3
30′	0	4
40′	20	28
50′	23	34
60′	44	56
70′	48	51
80′	50	56
90′	42	48

The first gastro-intestinal X-ray on November 23, 1961, showed the lower pole of the stomach to have normal folds and decreased tension, it hangs into the pelvis with intensive peristalsis. In the prepyloric part on the dorsal side a lentil-sized patch appears sometimes, to disappear within a few seconds; the contours are normal. During the examination, a secretion layer of 3 fingers breadth was formed. After 2 hours, most of the contrast material was evacuated, after 24 hours some remnants were still in the lower coecum. X-rays one week later again showed the lentil-sized adhering patch in the prepyloric part.

The child was under observation for 54 days. Symptoms of increased vegetative lability were not observed. The pulse rate of the lying patient was between 80 and 90/min; temperature, between 36.2°C and 36.8° C, blood pressure between 100/50 and 110/60 mm Hg.

According to the somatic findings, the 14 years old underdeveloped and undernourished patient had hyperacidity and gastric ptosis and a prepyloric ulcer.

Psychological Investigations

Biological factors. Father and grandfather of the patient are inveterate alcoholics; the father has gastric ulcer. The mother is nervous, her emotional problems were aggravated by the fact that her mother had suddenly died under tragic circumstances at the funeral of her mother, i.e. the great-grandmother of the patient; this event had caused a grave shock to the boy's mother.

Psychological status. Intelligence corresponds to age, and is of good reproductive character. Concentration and stress tolerance are normal. Associative capacity is quick and superficial. Thinking and interest are of a practical type and direction.

Emotionally the patient is in the period of violent puberty with many anxieties and intense aggressivity. He is ambivalent because of his aggressivity and the feeling of defenselessness. This difficult emitional state is characterized by a continuous tension although on the surface he seems to be on good terms with everybody. The emotional tension

inhibits his intellectual capacities and embodies the potential danger of an asocial 'short circuit' (manifestation of impulsiveness in direct uninhibited actions without intellectual control).

The psychological status can be summarized as follows. The patient has an inadequate biological and pathophysiological background, and adequate intelligence, in the period of puberty, in an unbalanced emotional state accompained by aggressivity and anxiety, causing the decrease of intellectual capacities. According to the psychological investigation, a definite personality disorder is present, determined by an emotional developmental disturbance.

Environmental Status

Environment. Objective conditions are inadequate. First, the family had lived in a treble co-tenancy, for some years they are living in a double cotenancy where they have 2 rooms. In one of them live the paternal grandparents, in the other the parents and the 3 children.

Subjective conditions. The mother in 1944 had to hide because of nazi persecution. She had met her husband during that period. The marriage had been opposed by the husband's parents. Nevertheless the young couple went to live with them. Quarrels, reproaches, were frequent and the mother had been badly treated by her mother-in-law. In the treble cotenancy till 1954 quarrels were not restricted to the family but were every-day occurrences between the parents and the co-tenants. The child at that time was one year old. The husband began to drink, a fact which further deteriorated the marriage. The boy, ever since he was able to do so, took an active part in the quarrels, taking always the side of the mother.

Summarizing the environmental status, neither the objective nor the subjective conditions of the environment are adequate. Quarrels between the parents, the parents and the cotenants, the inadequate personality of both parents, exerted a pathological, damaging series of stimulus on the boy and caused a serious personality disorder.

Direct precedents of the present complaints. The patient, before falling ill, had been employed as a waiter's apprentice and just before his troubles had started he had been accused of having stolen 100 Florins at his working place. Inquiries had been instituted, he was searched, but the money was not found. At the beginning of the clinical observation, the patient said at our Child Guidance Centre that he had not taken the money. In the course of examinations and further conversations, his attitude and especially the results of the association material of the TAT test made us assume that he had probably committed the theft. He told us that under no circumstances would he return to the same employment, not even to the same profession, but asked us to help him to realize his original plan to become a confectioner.

On the basis of the somatic, psychological and environmental status, the 14 years old boy suffers from hyperacidity, ventricular ptosis and gastric ulcer and simultaneously from a personality disorder. The investigations did not reveal which of the two troubles had been the initial one, the only thing we can state is that two kinds of disease are present, gastric ulcer and a personality disorder. Therapy was planned in accordance with this diagnosis. Constant rest, adequate diet and drugs were prescribed. The complaints persisted and body weight did not change until the 24th day of treatment. From then on, pain, pyrosis, nausea ceased and on the 40th day of treatment the patient had a good appetite and no complaints. On the 54th day he was discharged with a 2 kg increase in body weight, and was placed into a sanatorium for patients with gastric ulcer.

Besides the usual paediatric therapy, psychological and social treatment were considered necessary. In the course of individual psychotherapy during his stay in hospital the main emotional problems were discussed with the boy: the personality of the father, the conflict of the parents' marriage and his own participation in these. We tried to make him understand that it was not his task to settle the problems of his parents. At the same time he was placed into a group of children of alcoholic parents at the Child Guidance Centre. We were of the opinion that in this group of contemporaries with similar problems he has the possibility of making comparisons. By continuous treatment we helped to settle his emotional problems in his own emotional world and on the level of his own personality development. It has to be emphasized that keeping him in hospital for 54 days and then to place him in a sanatorium was necessary also from a social point of view, for a total change of environment. With the head of the sanatorium and the physician in charge of the boy the further psychic components of his treatment have been discussed.

In the present case when establishing the mixed pathological pattern, no difficulty had arisen in diagnosing two different troubles. The difficulty was to decide the causal connection of the two diseases. Under unfavourable circumstances, only one or the other disease would have been diagnosed. According to our opinion, neither of the pathological processes could have been successfully cured had only one been treated. However successful the treatment might have seemed in the cases it is necessary to start complex treatment in spite of the missing 'total diagnosis'. Follow-up examinations of such patients is of especial importance in view of the possibility of unexpected developments.

Case 3. P. K., a female child 6 years of age.

Complaint. Since 3 years, the patient has asthma-like attacks with dyspnoea and occasionally nocturnal enuresis.

Somato-vegetative examinations. The patient had been observed and treated at different times during the past years at our out-patient department. She was admitted on August 21, 1961, discharged on August 31, 1961. (Registration No. 2435/1961).

History. The patient had been born prematurely. The mother in the 6th month of pregnancy had a high blood pressure and developed extensive oedema (pregnancy oedema). She had been treated at home. The child had been born in the 8th month with 2400 g weight. Ever since birth the patient had been periodically dyspnoeic. Up to the age of 6 month she was breast-fed, then gradually weaned. Somatic and intellectual development had been normal; she had walked at one year, spoke at 18 months, been sphincter trained at 2 years, but still has sometimes enuresis. She had received the obligatory vaccinations and antirachitic treatment. Since early infancy, she was often ill. Because of purulent otitis, paracentesis had been performed repeatedly; she had had laryngitis, tonsillitis, influenza, pneumonia, enteritis, measles, and chickenpox. This accumulation of diseases is best characterized by the fact that the mother had to stay away from work 4 times in the first year of the child's life.

Asthma-like attacks with suffocation and dyspnoea had begun 3 years ago. Since then, the patient had been treated in different hospitals and climatical sanatoria 20 times. In 1959 she had spent 200 days in different institutes, four times also at our Department. The improvement achieved with the usual methods of treatment was always transitory.

As to the present complaint, every morning the patient develops an episode of dyspnoea lasting 2 hours. The day before admission, grave lasting dyspnoea occurred; epinephrine aerosal had not relieved the attack, the patient had become restless, cyanotic. During the past months, depending on the quality of respiration, she had received at home 1 to 2 tablets of prednisolone daily.

At admission, the patient was in a grave condition. The clinical picture was dominated by respiratory distress due to bronchial asthma, with characteristic anxious facial expression and cyanosis. The results of physical examination were, height, 119 cm; weight, 19 kg; somatic development according to age. The laryngeal structures were congested, the tonsils swollen. Diffuse wheeze, musical rales, a somewhat protracted rough expiration were observed. The heart, circulatory organs, abdomen, were normal, the Wassermann, Meinicke Sachs-Witebsk tests negative, and so was the tuberculin test, in spite of previous BCG vaccination; X-rays revealed a low position of the hardly moving diaphragm and a centrally situated heart smaller than usual at this age. Blood pressure during the patient's stay in hospital was between 85/50 and 90/65 mm Hg. Quantitative blood counts were normal, in the smears there were 6 per cent eosinophils. Ca and P values in blood were normal. Serial intracutaneous tests performed with different antigens revealed no specific antigen effect. Drug treatment brought complete relief of the process and the patient was discharged after 10 days in hospital.

According to the somatic status, the 6 years old girl had bronchial asthma since her 3rd year. The mother had an allergic disposition. The allergic origin of the disease has been suggested by the negative X-ray finding. There was no sign of tuberculosis nor of a previous pneumonia to account for the respiratory distress. No focal infection has been detected.

Psychological Investigation

Biological factors. The mother had sometimes hay fever. Both grand-

mothers had died of cancer. The mother had pregnancy toxemia and lived under difficult social and economic conditions. The child was born at 8 months. Preceding the present complaint of 3 years' standing, she had frequently been ill with repeated pneumonia, otitis, tonsillitis, etc. The course of these diseases pointed to a constitution being characterized by exudative diathesis.

Psychological status. Intelligence

The child is definitely intelligent, surpassing with one year the level of her age; she has a rich vocabulary. She makes the impression of being prematurely old; she does not go to school, although being of school age, but the mother makes her stay at home because of her illness.

Emotional state. She is restless, constantly excited, hypermotile, spoiled. Her attention is constantly centered upon her physical condition, she lives in anxiety because of the attacks. Being spoiled by the mother, she lives under a constant emotional burden. Her feelings of uncertainty and anxiety are partly caused by the attacks, partly by environmental causes to be described later.

The psychological status can be summarized as follows. The patient is an intellectually well developed, emotionally anxious child living under constant stress. On the basis of the emotional developmental disorder, a personality disturbance has developed.

Environmental status. Objective conditions. One-room flat, but in a neglected and not too clean state. The family lives under unsettled economic circumstances.

Subjective conditions. The mother is excited, dissatisfied, ambitious, with unfounded demands. In comparison to the family's financial circumstances, she dresses expensively, does not know the value of money, nor her own self; she is not satisfied with the work, nor with the income and professional success of her husband and criticizes him continuously and conspicuously. According to her, she wanted to be a physician, interrupted, however, her studies and went to work as a clerk in an outpatient department. She then gave up working to occupy herself with her child. Her statement that she was forced to stop studying and working because of the repeated illness of the child, is not true. Essentially, she refrains from every task under the pretext of the child's disease. This way of life suits her restless, unsatisfied, neurotic personality well. The father is overworked, nervous, neglected. He, too, is dissatisfied, unbalanced and neuropathic. In consequence of the wife's behaviour, his position within the family is unfavourable; the athmosphere of the marriage is tense. Discussions, quarrels and sharp remarks are frequent, mostly because of economic or other practical problems. These scenes take place before the child. The mother is rude not only with her family but also with strangers, so that they have no friends. She does not let the child play with other children or let her go to school.

Summarizing the environmental status, neither the objective nor the subjective conditions of the environment are suitable, the latter exerting a damaging effect upon the patient.

On the basis of the complex investigations we were of the opinion that a disease of mixed pattern had developed in the patient. The child partly suffers from bronchial asthma of allergic character, and partly from a personality disorder brought about by the emotional disturbance.

In the present case, too, it was impossible to establish a causal connection. It is well-known that respiratory distress simulating bronchial asthma often arises secondarily to psychic disturbances, as a manifestation of a personality disorder, but in the present case such a connection could not be proved. A secondary personality disorder resulting in consequence of a respiratory disorder is also a known pattern, but in the present case no such process was revealed. In spite of precise examinations and observation for many years, the relation of the two diseases in the pathomechanism and pathodynamism could not be assessed and thus no 'total diagnosis' could be made.

Treatment had thus be planned without a 'total diagnosis'. Relying on classical paediatric principles, it was endeavoured to ensure a mode of life for the patient which would decrease the incidence of respiratory distress episodes and stop the asthma-like attacks (adequate diet, climatic resort, drug therapy). We in fact succeeded in decreasing the frequency of the attacks.

To eliminate the personality disorder, repeated talks were started with the mother and father, first separately, later in the form of group-therapy to make them understand that for the satisfactory development of their child and in order to attain a cure, the atmosphere within the family has to be changed; the child should never be present when they are discussing their own problems. The parents, and especially the mother accepted that her spoiling the child has to be stopped, and also that she should be sent to school.

By means of conversations and plays we tried to help the patient to settle her own emotional world, her situation within the family, her relationship to the parents, and to start to forget the memories of the unfavourable past, the family quarrels.

The patient now is still under continuous control. She has been visiting school for several months, has found her place there without difficulty, is an excellent pupil and essentially free of complaints.

In the present case, without being in the position to establish a 'total diagnosis', without being able to trace back the complex disease to a single basic cause, a polycausal diagnosis could only be formulated and the pathomechanism could only be interpreted from several directions. The complex therapeutic method applied in several phases was, however, simultaneously directed against the

somatic, emotional and intellectual components. Treatment was successful, but this success is considered a result of "symptomatic treatment' and the case is held under continuous and thorough observation, because if no 'total diagnosis' can be established, surprising unwarranted events may always occur.

Case 4. D. M., a male patient 12 years of age.

Complaint. The patient since about 2 years has headaches and vertigo when walking. He is restless, recently he has run away from home several times. He is aggressive, with periodical fits of rage; unable to concentrate, a bad pupil, lies and steals without cause or reason.

Somato-vegetative examination. The patient was admitted for observation and treatment on December 13, 1959, and discharged, December 29. (Registration No. 3751/1959). *History.* He was brought by a stranger and the parents could not be found so that data as to pregnancy, delivery, infancy and early childhood are not at disposal. Detailed data were only available from the age of 8 years when the boy was placed in state care in a well equipped institute. It is from that institute that we received the information that since the age of 4 years, the patient had been in different institutes; after he had entered the present institute, he received the obligatory vaccinations. At the age of 9 years he had high fever for 8 days, but no precise diagnosis could be established. According to the institute's physician, he had an influenza. During his disease, he was treated with amynopyrine and valerian tablets and sometimes injections of barbiturate. His two siblings are also in state care at the institute; they are healthy, have no complaints.

At admission, height 147 cm; body weight, 39 kg, somatic development and state of nourishment corresponding to age. There was an extensive scar on the upper surface of the right leg; according to the boy this and a scar 1 cm long above the right eyebrow had been caused by some kind of caustic substance. At physical examination no organic change was found, neurological and ophthalmological examinations were negative. Blood pressure was 110/65 mm Hg; urine analysis negative. Wassermann, Meinicke, Sachs-Witebsk and tuberculin tests were negative. Blood counts, ESR, serum Ca, P, K and Na, as well as blood sugar values were normal. Chest X-rays showed normal conditions, X-rays of the skull revealed thickened cranial bones with increased ossification around the sutures; the sella turcica was normal. The EEG revealed a somewhat slower than normal, irregular activity, composed of 6/sec alpha frequency and modulation and 5—6/sec theta forms; above the right hemisphere, especially temporally, slow torsion with occasional spikes. Hyperventilation caused no change. A deep temporal epileptic focus on the right side could not be excluded with certainty.

On the basis of the above, the possibility of a circumscribed epileptic focus as a sequel of the suspected encephalitis at the age of 9 years could not be excluded, in spite of the fact that no organic change was demonstrated by the neurological investigation.

Psychological Investigations

Biological factors. The pertaining data are scarce. The father had been an alcoholic, often drunk, brutal, who had been convicted several times,

and finally sentenced to death for murder but escaped. The mother was often ill.

Psychological status. Mediocre intelligence corresponding to age, good combinative capacity within certain limits; irregular quick reaction time; reproductive character. Decreased tolerance to intellectual stress. *Emotional state.* In the state of puberty with much anxiety and a tendency for impulsive outbreaks. Decreased emotional tolerance, retarded emotional development at a much younger age level with an extreme demand for tenderness. In the course of conversations it became evident that since the age of 4 years the patient had been in different institutes. These institutes were unable to satisfy his emotional needs. He told us that he always wanted to go home, but the children were afraid of the drunk and brutal father: the mother was always ill so that the three children of whom he is the youngest, took regularly to truancy. These truancies were never planned in advance but, as he says, 'something gets over me and I have to go' or 'I have a feeling that I would like to go home'. Fear from brutality manifests itself in his entire attitude, that is the cause why he seeks the company of younger children who 'do not hurt you'. The fact that the patient is left-handed and was trained to right-handedness has also to be emphasized. On the basis of the tests, the possibility of a tenebrous state as a postencephalitic epileptic equivalent has to be considered.

The psychological status can be summarized as follows. The patient is intellectually well developed with decreased tolerance; his personality is characterized by an emotional developmental disorder, the essence of which is a feeling of solitude, with anxiety and a tendency for impulsive outbreaks.

Environmental status. The objective environmental conditions in early childhood were probably unfavourable. The skin scars left behind by some injury also point to this. Since the age of 8 years the patient has been living in one of the best state institutes, together with his two siblings. The mother lives with another man, the father with another woman. The father was convicted several times, then sentenced to death for murder, but escaped from gaol. The opinion of the institute concerning the patient was as follows. "The child had escaped at least 16 times from the institute, or hid in the park and could not be found. He stole all sorts of objects, even bycicles. Since 6 weeks we did not let him go to school but put him into the health centre to be sure of his whereabouts. His behaviour is insupportable even here. To place him into another institute would be inconvenient since his two sisters, both industrious, proper and excellent pupils, are also with us. He too could learn but does not want to, has no patience and cares only for adventures, truancy, etc."

From the somatic, psychological and environmental examinations it

has been concluded that the patient from early childhood had suffered grave environmental damages and a personality disorder has been present since the age of 4 years. At the age of 9 years he presumably had influenza with encephalitis and an epileptic focus remained in the central nervous system. In spite of the fact that since the age of 8 years he is in an institute providing for him quite adequate care, headaches, vertigo and personality disorder did not improve. The diagnosis of a mixed form of disease could be established, in which the disorder of personality developed on the basis of environmental factors and an epileptoid disease are simultaneously present. The simultaneous occurrence of these two conditions could be established, without, however, clarifying the causal connections of the two conditions. The personality disorder might have played a part in the development of the postencephalitic complication or else the encephalitic aftereffects were hindering the settling of the personality disorder during his stay in the present institute in spite of the favourable and adequate conditions. The former supposition is supported by the fact that his two sisters having experienced the same environmental damages in early childhood, are free of complaints at the same institution and are excellent pupils.

When trying to evaluate the present case, difficulties have arisen because neither was it possible to establish clearly the biological factors, nor the pathophysiological ones, nor to establish the mother-child relationship in early childhood. The interrelation of the two kinds of diseases could not be proved. When formulating the diagnosis it could only be ascertained that it is of a mixed polycausal form showing no definite direction, within the pathomechanism. The occurrence of a decreased tolerance and oversensitivity to environmental damage had to be assumed, since the two sisters living under similar conditions were free from personality disorder.

After evaluating the case, the institute was instructed as to paediatric care (diet, mode of life, drug therapy) and a member of our Child Guidance Centre was in constant connection with the pedagogues of the institute.

Case 5. K. E., a female child 16 years of age.

Complaint. She has often headaches, grows pale from time to time, complains of weakness and malaise, collapses. According to the mother, the patient is difficult to handle, reticent, depressed morose and the least excitement upsets her balance.

Somato-vegetative examination. The patient had first been treated at the outpatient department, then admitted for observation and treatment on January 9, 1962 and discharged January 14. (Registration No. 104/1962). — *History.* Pregnancy proceeded under very difficult circumstances and ended in the 8th month, with precipitated delivery. The birth weight is unknown. The newborn period was uneventful. Somatic and intellectual development were somewhat protracted;

she was sitting at the age of 9 months, could stand at one year, walk at 18 months; learned to speak at the age of 2 years and became sphincter trained at 3 years. In the lack of milk, she was breast fed for 2 weeks only and then fed artificially. Obligatory vaccinations were administered. She had twice scarlet fever, chickenpox. measles, whooping cough, pneumonia, repeatedly tonsillitis, influenza. Appendectomy was performed. Two years previously, she had been treated for 'vegetative neurosis'. One year ago, protein was found in the urine. Menstruation occurred first at the age of 11 years and is always accompanied by pain and strong bleedings. The present complaints had appeared a long time ago and did, in spite of adequate treatment, not improve.

TABLE 1

Blood sugar, mg per 100 ml

Initial	After oral administration of 50 g glucose				After oral administration of further 50 g glucose		
	20	40	60	90 min.	20	40	60 min.
102	114	110	106	116	108	118	114

At admission, height 167 cm, body weight 62 kg, both normal for age. Slightly acromegalic face, zygmotic process and jaw are markedly protruding. No pathological symptoms could be revealed in the course of physical investigation. Wassermann, Meinicke and Sachs-Witebsk reactions, as well as intracutaneous tuberculin test were negative. Blood counts, Ca, P, cholesterol, total serum protein, nonprotein nitrogen, serum chloride were normal. The oral sugar tolerance test with 50 + 50 g of glucose yielded a flat curve (Table 1), serum bilirubin normal, thymol and gold sol tests negative. Urine 17-ketosteroid 13.2 mg/24 hour. Blood pressure 115/75 mm Hg. Ophthalmological examinations showed normal fundus and visual field: visus needs correction. Neurological and urological investigations showed normal conditions. Gynecological examination revealed retroflexion of the uterus, juvenile metropathy. X-rays of the skull show the facial part, especially the mandibula, to be larger than normal, with normal thickness of cranial bones, a sella turcica with intact contours exceeding the normal by about 30 per cent. EEG revealed well modulated spontaneous wave activity of 11/sec with medium amplitudes. On the effect of hyperventilation and stroboscopic stimulation, steep alpha and occasional delta waves appear in the temporal leads bilaterally. On the basis of the findings, the suspicion of epilepsy cannot be excluded.

Summarizing the vegetative status, there was a somewhat acromegalic character with no endocrinological changes. The collapses and malaise may eventually be due to epilepsy.

PSYCHOLOGICAL INVESTIGATIONS

Biological factors. The father was a nervous, irritable, restless person who had committed suicide. The mother is very nervous. From among *pathophysiological factors* the fact that pregnancy had proceeded under very hard circumstances should be pointed out, as also that the child was born prematurely at 8 months and breast fed only for 2 weeks. The patient

had had several infectious and other diseases.

Psychological status of the child. Mediocre intelligence hardly reaching the level normal for the patient's age. School results are mediocre, in spite of hard learning and great efforts. Decreased intellectual tolerance. *Emotional state.* Puberty of hysteroid character; the emotional life of the patient is poor, her reaction time slow. Her relationship to the mother corresponds to that of a much younger child. She is attached to few persons, lacks independence and her emitional life is labile. Her attitude is characterized by contradictions; while she is tall, her large bones and acromegalic face making a boyish impression, her behaviour corresponds to that of a little girl, she is indecisive, uncertain and dresses like a little child. She speaks with difficulty, hardly ever on her own, if, however, she is induced to it, the flow of words cannot be stopped.

Summarizing the psychological status, the patient is of mediocre intelligence, backward in emotional development, dependent, restless, fighting puberty, she suffers from personality disorder developed on the basis of some emotional developmental disturbance.

Environmental status. Objective conditions are full of disturbing factors. The family lives under hard financial circumstances in a one-room-kitchen flat, the girl lives practically in the kitchen; from time to time she stays in the country with her maternal grandmother. *Subjective conditions.* The parents' marriage had been a love match, they wished to have a child; lived under hard conditions. The father, a nervous, labile person broke down under war conditions, and committed suicide. The patient at that time was one year old. The mother started life under difficult conditions, a fact which was aggravated by her own, nervous state. When the patient was 3 years old, the mother remarried a man 8 years her junior. According to the mother, this marriage is excellent but our investigations disclosed that although the relation of child and stepfather is good on the surface, it is in reality inadequate. The present family life exerts therefore a constant damaging effect on the patient; she is an obstacle in the marriage of the parents and she feels it.

According to the environmental status, neither the objective nor the subjective conditions are adequate and they exert a damaging effect on the patient's personality development.

On the basis of paediatric, psychological and environmental investigation, a 'total diagnosis' satisfactory from every aspect could not be established. On the one hand, it could be ascertained that the patient had suffered environmental damages which might have caused personality disorder. On the other hand, there were signs pointing to a neuroendocrine disorder; acromegalic features, a sugar tolerance test curve indicating insulin predominance, juvenile metropathy and EEG signs of eventual epilepsy. We did not succeed in

establishing the causal connection between the two kinds of disease, neither the pathomechanical direction within the pathomechanism. It could not be elucidated whether the personality disorder was due to an endocrine condition and whether the collapses, the epilepsy-like state are the primary disorder, or, else, the malaise with headaches is only a manifestation of a personality disorder developed on the basis of damaging psychic effects. Further clinical observations are required to establish a 'total diagnosis' satisfactory from every point of view. Therapeutic interventions until now were only symptomatic and our interventions of psychological character were just as unsuccessful. Both trials have failed; the headaches did not cease. On the other hand, no change could be brought about in the social situation of the patient and we had no possibility of dealing more than superficially with the essential emotional problems.

Case 6. H. E., a female child 6 years of age.

Complaint. Several episodes of indisposition with loss of consciousness since about a year. The patient starts to shiver, grows pale, especially around the nose, perspiration on the forehead appears, simultaneously she releases her faeces and urine and either during or immediately after this state she loses consciousness, collapses, her face becomes grey. The unconscious state lasts 2 to 3 minutes, with subsequent vomiting, then she is tired and sleeps for a long time. If she is kept awake, the attack reappears. Such episodes occur periodically, nearly daily for 2 to 3 weeks, then a period of 2 to 3 weeks free of complaints follows.

Somato-vegetative examination. The patient was admitted for observation and treatment on June 14, 1951 and discharged July 3. (Registration No. 1666/1961). The mother had repeated gall stone attacks during pregnancy and received injections of morphine. The child was born after 8 months of gestation with 2500 g birth weight, in livid asphyxia, had to be resuscitated. The mother had no milk and could not feed her child. Dentition started around the 6th to 7th month; she was sitting at 6 to 9 months; standing at 9 to 10 months; walked at the age of one year; could speak at the same time, but fluently only at 2 years. At present, at the age of 6 years, she is not entirely sphincter trained, enuresis and encopresis sometimes occur. In early infancy she had Leiner's erythroderma, later measles, chickenpox, whooping cough, twice pneumonia and several times lymphadenitis. The father, before the child was born had been treated for syphilis for two years; his Wassermann reaction at present is negative. The mother during pregnancy was not treated for syphilis. As to the present complaints, the headaches, enuresis and encopresis had been usual before the appearance of the attacks. During these episodes of headaches, she had also vertigo, no appetite and consumed only fluids. She often complaints of abdominal pain which, however, seems to be independent of the malaise. Sometimes she complains of pain in the cardiac area. Last year she had been treated in a paediatric hospital, but only frontal sinusitis had been diagnosed.

At admission, height 125 cm, body weight 24.8 kg, somatic development according to age. No organic lesion was revealed by physical examination. Wasser-

mann, Meinicke and Sachs-Witebsk tests were repeatedly negative. The intradermal tuberculin test was positive, owing to BCG vaccination. Blood counts were normal, save for 8 per cent eosinophils in the smears. Blood Ca, P, cholesterol, total protein and protein fractions, serum bilirubin, thymol test, gold sol, were negative. Neurological examination showed no organic lesion. Ophthalmological examination showed normal fundus and visual field, visus needing correction. Blood pressure varied between 90/45 and 100/60 mm Hg., the pulse rate between 90 and 100. Lumbar punction yielded a water-clear cerebro-spinal fluid with medium pressure and normal values for protein, cell count and sugar, a negative Wassermann test and normal colloid curves. X-ray of the skull revealed increased ossification in the vicinity of the coronary suture, with a normal sella turcica. EEG showed in the posterior leads a curve with dysrhythmic amplitudes and frequency, with moderate, 6 to 7/sec preponderance, and frequently mixed theta and alpha waves. Stimulation with light caused inhibition, hyperventilation and stroboscopic stimulation some slowing down of activity. Thus, the EEG revealed significant vasolability only.

Thus, the somatic examinations have made us to assume that the malaise and loss of conciousness were of centrencephalic origin. When establishing this tentative diagnosis, the fact was considered that the father had had syphilis, that the mother had not been treated for syphilis during pregnancy, and that the child had been born in livid asphyxia.

Psychological Investigations

Biological factors. The father had had syphilis 2 years before the child had been born. The mother is nervous; pregnancy proceeded under unfavourable conditions, the mother had had cholelithiasis and received injections of morphine. *Pathophysiological factors.* The child was born in livid asphyxia in the 8th months of gestation.

Psychological status of the child. Intelligence essentially according to age. Mediocre reproductive capacity, because of her emotional state, intellectual functions are somewhat inhibited. *Emotional state.* In the period of prepuberty, emotionally uncertain, seeking support, with a tendency to excesses, at the same time overdisciplined. She suffers from solitude.

According to the psychological status, the patient's emotional development is disturbed and due to her unsettled emotional state, the intellectual functions are also affected; a definite personality disorder is present.

Environmental status. Objective living conditions of the family are adequate. *Subjective conditions.* The parents are divorced. The mother remarried and the patient lives with her. The father was living recklessly attached himself to different women and contracted syphilis. The parents parted among loud quarrels. The stepfather is a peaceful person, living in ordered circumstances and his relationship to the little girl is good, even better than that of the mother, so that the patient has confidence in the stepfather, but not in her mother. From this second marriage a son was born, who now at the age of 3 and a half years is the mother's favourite. Mother—child relationship

and child—mother relationship are bad. The injuries suffered from her first husband are in a way being connected by the mother with her daughter, the man who had treated her badly is reflected in the child. She has often beaten the child, especially because of the enuresis and encopresis. The little girl therefore lives under most unfavourable emotional circumstances.

According to the environmental status, in spite of adequate objective conditions, the patient has suffered much under their effect.

On the basis of all the above, we were of the opinion that the patient suffers from a mixed form of disease. The parents had had syphilis, the mother had not been treated during pregnancy neither the child in infancy which we would have deemed necessary in spite of the negative Wassermann test. The child was born prematurely in livid asphyxia. She had suffered from different diseases since early childhood. The attacks with loss of consciousness were interpreted as due to an organic central nervous lesion. At the same time, the patient has been exposed since early childhood to damaging environmental influences and on this basis a personality disorder had been formed. A causal connection between the two kinds of diseases could not be proved. It is assumed that both had formed a favourable basis for the development of each of the pathological processes.

Drug therapy was introduced; at school we discussed with the head mistress the course of education and teaching of the patient. With the mother we could only achieve that she stopped beating the child, but she strictly refused to discuss their relationship. In the course of family group therapy, a situation arose in which the stepfather, being on good terms with the child, took her side and so it can be hoped that he will succeed in creating a family atmosphere which would diminish the damaging influence.

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Conclusions

In the cases presented neither the detailed paediatric, nor the psychological and environmental examinations have been sufficient for establishing a 'total diagnosis', satisfactory from every aspect. We wished to draw attention to the fact that there exist instances in which the theoretically correct aim of establishing the diagnosis is not possible to achieve, especially in the first weeks or months of observation. The therapeutical results, however, point to the fact that neither the paediatrician nor the psychotherapist should lose all hope if a satisfactory 'total diagnosis' cannot be established. Symptomatic diagnosis of such mixed patterns, when a somato-vegetative trouble and a psychological personality disorder are present simultaneously, can nevertheless be precise and this is the aim which has to be attained. In planning the treatment, two kinds of

methods are applied simultaneously. The vegetative disease is treated by classical paediatric interventions, while adequate psychological and environmental therapy is introduced for curing the personality disorder. If these methods lead to success and the state of the patient improves his situation takes a favourable course, in spite of the fact that the causal connection of the two kinds of disease had not been elucidated.

Why is it that in spite of some apparent successes we do not consider our results to have been satisfactory? It is to be feared that if the causal connection of the pathological factors, the dynamism of the disorder within the organism's function and the personality structure are not clarified, treatment remains essentially symptomatic. It remains symptomatic even if both diseases, i.e. the vegetative and the psychic one, are treated separately and with success. But as the interrelations of the two kinds of trouble being present simultaneously in the personality have not been defined, the danger exists that in spite of the apparent cure and the apparently eliminated personality disorder the occurrence of some unexpected complication cannot be foreseen, nor prevented. If, however, pathodynamism and pathomechanism have been elucidated, not only will it be possible to cure the actual trouble, but also to develop a new healthy ordering of the organism and personality and by excluding the damaging effects of the environment, the occurrence of unwarranted disorders issuing from stimuli within the memory of the patient and damaging for the personality structure can be prevented.

We believe that it was necessary to call attention to such cases as have been discussed in this paper to illustrate the fact that there occur situations in both paediatric practice and psychotherapy where the theoretically correct diagnostic demands cannot be fulfilled. At the same time, we wish to emphasize that this does not mean that theory is incorrect and the clinician should always endeavour to do his most in the given situation, to achieve the best result. It has, however, to be remembered that in such cases the problem is not entirely solved by the actual therapeutical result and must be followed up closely for prolonged periods.

Summary

Some clinical cases in which organic or somatic complaints imposing as organic ones were associated with more or less grave disorders of the personality structure have been discussed. A total diagnosis, establishment of which would be most important in every instance, is not always possible in these cases. Although it is possible to elucidate the somatic factors as also to detect psychic and environmental ones, their specific connections and their role in the structure of the pathomechanism is impossible to clarify.

The problem in such cases is the connection of the factors elicited.

Six cases have been discussed in detail from both the somatic and the psychological aspects.

The conclusion has been drawn that the formulation of a total diagnosis should be endeavoured in every instance.

In cases in which this cannot be established, the damaging factors have to be clarified as far as possible, and both somatic and psychiatric treatment introduced on the basis of the results.

It is emphasized that, owing to the unclarified pathomechanism, prognosis in the cases is uncertain and unreliable.

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