Staff Meeting Bulletin
Hospitals of the » » »
University of Minnesota

Ulcerative Colitis in Children

Volume XVI | Friday, February 2, 1945 | Number 14

STAFF MEETING BULLETIN
HOSPITALS OF THE . . .
UNIVERSITY OF MINNESOTA

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INDEX

Published for the General Staff Meeting each week during the school year, October to May.

Financed by the Citizens Aid Society, Alumni and Friends.

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I.

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
CALENDAR OF EVENTS
No. 57 February 5 - 10, 1945

Monday, February 5

9:00 - 10:00 Roentgenology-Medicine Conference; L. G. Rigler; C. J. Watson and Staff; Todd Amphitheater, U. H.

9:00 - 11:00 Obstetrics and Gynecology Conference; J. L. McKelvey and Staff; Interns Quarters, U. H.

12:30 - 1:30 Pathology Seminar; Congenital Sacrococcygeal Tumors; Kano Ikeda, 104 I.A.

4:00 - 5:00 Public Health Seminars; Aerial Sanitation; Mr. Bond and Whittaker, 6th Floor Student Health Service.

Tuesday, February 6

9:00 - 10:00 Roentgenology-Pediatrics Conference; L. G. Rigler, I. McQuarrie and Staff; Eustis Amphitheater, U. H.

11:00 - 12:00 Urology Conference; C. D. Creevy and Staff; Main 515, U. H.

12:30 - 1:30 Pathology Conference; Autopsies; Pathology Staff; 104 I.A.

12:30 - 1:30 Physiology-Pharmacology Seminar; The Metabolism of Alcohol; John T. Litchfield, Jr., 214 M. H.

4:00 - 5:00 Physiological Pathology of Surgical Diseases; Physiology and Surgery Staffs; Todd Amphitheater, U. H.

4:30 - 5:30 Obstetrics and Gynecology Conference; J. L. McKelvey and Staff; Station 54, U. H.

4:00 - 5:00 Pediatrics Grand Rounds; I. McQuarrie and Staff; W-205 U. H.

4:30 - 5:30 Ophthalmology Ward Rounds; Erling Hansen and Staff; E-534, U. H.

5:00 - 6:00 Roentgen Diagnosis Conference; T. B. Merner, Solveig Bergh, 515 U. H.

Wednesday, February 7

9:00 - 11:00 Neuropsychiatry Seminar; J. C. McKinley and Staff; Station 60 Lounge, U. H.

11:00 - 12:00 Pathology-Medicine-Surgery Conference; Monocytic Leukemia; E. T. Bell, C. J. Watson, O. H. Wangensteen and Staff; Todd Amphitheater, U. H.

12:30 - 1:30 Pediatrics Seminar; Pathological Conference (Pediatric Cases); Forrest Adams; W-205 U. H.

12:30 - 1:30 Physiological Chemistry Literature Review; Staff; 116 M. H.

4:30 - 5:30 Neurophysiology Seminar; The Influence of Age on Cortical Organization; Jean Swain; 214 M. H.

Thursday, February 8

9:00 - 10:00 Medicine Case Presentation; C. J. Watson and Staff; Todd Amphitheater, U. H.

4:00 - 5:00 Pediatric Journal Club; Review of Current Literature; Staff, W-205 U. H.

4:30 - 5:30 Ophthalmology Ward Rounds; Erling Hansen and Staff; E-534, U. H.

5:00 - 6:00 Roentgenology Seminar; Some Roentgen Observations of Urinary Tract Lesions; Harold Peterson; M-515 U. H.

4:30 - 5:30 Bacteriology Seminar; Site of Formation of Antibodies; W. P. Larson, 214 M. H.

Friday, February 9

9:00 - 10:00 Medicine Grand Rounds; C. J. Watson and Staff; Todd Amphitheater, U.H.

10:00 - 12:00 Medicine Ward Rounds; C. J. Watson and Staff; E-214 U. H.

10:30 - 12:30 Otolaryngology Case Studies; L. R. Boies and Staff; Out-Patient Otolaryngology Department, U. H.

11:45 - 1:15 University of Minnesota Hospitals General Staff Meeting; Personality Aspects of Skin Disease; Olive Lundgren; Powell Hall Recreation Room.

1:30 - 2:30 Medicine Case Presentation; C. J. Watson and Staff; Eustis Amphitheater.

1:00 - 2:30 Dermatology and Syphilology; Presentation of Selected Cases of the Week; Henry E. Michelson and Staff; W-206 U. H.

1:30 - 3:00 Roentgenology-Neurosurgery Conference; H. O. Peterson, W. T. Peyton and Staff; Todd Amphitheater, U. H.

Saturday, February 10

8:00 - 9:00 Surgery Journal Club, O. H. Wangensteen and Staff, M-515 U. H.

9:00 - 10:00 Pediatrics Grand Rounds; I. McQuarrie and Staff, Eustis Amphitheater, U. H.

9:15 - 10:30 Surgery-Roentgenology Conference; O. H. Wangensteen, L. G. Rigler and Staff, Todd Amphitheater, U. H.

9:00 - 10:00 Medicine Case Presentation; C. J. Watson and Staff; M-515 U. H.

11:30 - 12:30 Anatomy Seminar; Problems of Human Heredity; C. P. Oliver; 226 I.A.

II. ULCERATIVE COLITIS IN CHILDREN: A PSYCHIATRIC EVALUATION

Reynold A. Jensen
Olive Lundgren

Chronic ulcerative colitis continues to be a stubborn medical problem. That this refractory condition occurs in children as well as in adults has not always been appreciated. Allchin[1] (1909) noted none of the adult characteristic findings of ulcerative colitis in children. In a review of 14,000 cases of recurrent abdominal pain, Morse[2] (1934) fails to mention chronic ulcerative colitis. Helmholz[3] is credited with reporting the first five cases occurring in children in 1923. Since then reports have been made from time to time emphasizing its occurrence and importance in patients of podiatric age.

Fortunately, chronic ulcerative colitis, while it does occur, is not a common childhood disease. Jackman, Bargen and Helmholz[4] reported 95 cases from the Mayo Clinic in 1925 to 1931. This represents 10.9% of the total number (871 cases) of ulcerative colitis patients who attended that clinic and one of every 274 patients studied in the Section on Pediatrics. Elitzak and Widerman[5] found 23 patients had been admitted to Mount Sinai Hospital, New York, during the fifteen years 1927 to 1941. From 1939 to 1945 11 pediatric patients have been diagnosed as ulcerative colitis at the University Hospitals. Although this condition occurs infrequently, its chronicity, its resistance to the best of therapeutic efforts, its tendency to be rapidly fatal at times, and its remissions and exacerbations continue to challenge those who are called upon to deal with it.

Ulcerative colitis is a definite clinical entity characterized by persistent or recurring diarrhea. The stools contain mucous, pus and blood. Its onset may be acute or insidious. It may be either severe or mild in type. Pathology, which consists mainly of swollen, inflamed mucous membranes with follicular ulcers, is usually found in the sigmoid colon, but may involve the entire colon and extend into the terminal ileum. An irreversible change, in chronic cases of long standing is the excessive scar tissue formation in the large bowel.

Patients characteristically have a poor appetite, are listless and fail to grow normally. A low grade fever is often noted. Abdominal pain is frequently encountered as is rectal tenesmus if the diarrhea is severe. Diagnosis is established on the basis of history, symptoms of persistent diarrhea with mucous, pus and blood in the stool, the proctological and x-ray examinations, and careful bacteriological study of the feces. A diagnosis of ideopathic ulcerative colitis is justified if no specific microorganisms are found in the stool. In children tuberculous peritonitis and celiac disease need consideration in the differential diagnosis.

The etiology of chronic ulcerative colitis continues to remain obscure. Although many theories, including that of infection, allergy, avitaminosis and the injudicious use of purgatives, have been advanced to explain it, none has been found entirely satisfactory. A neurogenic[6] as well as psychogenic[6] factor has also been suggested to be important in this condition.

Psychiatric Literature

The few psychiatric studies on patients with ulcerative colitis have been made on adults. Murray[7] is credited with the first report in 1930 on 12 patients--7 men and 5 women. Preliminary study of the patients' personality patterns suggested strongly the presence of deeper emotional problems than seemed apparent originally. To that end he carefully scrutinized the patients' life histories with particular emphasis on the development of their symptoms. Several pertinent findings noted were: (1) There was a well-marked time relationship between the outbreak of an emotional disturbance and the onset of the symptoms; e.g., a boy 18 years old with a past history of diarrhea associated with fear reaction, noted blood in his stools several days after one of his fellow workers had threatened to murder him. (2) The patients were characterized by fearfulness and emotional immaturity; and

(3) the majority of the patients had not achieved full emancipation from their respective parents. He concluded, "the evidence is very suggestive that the more severe colitis with bloody diarrhoa and ulceration have a psychologic factor in their etiology of a kind similar to that which has long been recognized as existing in some simple diarrhoa and in mucous colitis."

Following psychiatric study of 6 adult cases, Sullivan and Chandler[8] concluded that "psychogenic factors seemed to have played a major role in the onset and course of the disease." In a later report, Sullivan[9] emphasized again emotional tention as characterizing 15 patients studied.

The conclusions of Brown[10] and his associates generally agreed with the above findings. In addition they noted "there was not a single successful marriage or complete emancipation from parental ties" among a group of approximately 30 adult patients with ulcerative colitis. Daniels[11] conclusions following observation of 25 unselected patients and intensive study of 14 of them are likewise in agreement with the others. Weiss and English[12] stress the evidence of psychopathology in their case.

One of the most systematic studies on the importance of personality factors in patients suffering from ulcerative colitis has been reported by Wittkower[13] from the Out-Patient Department, St. Bartholomew's Hospital, London. Forty unselected patients (14 males and 26 females) varying in age from 12 to 65 comprise the group observed. Careful biographical data obtained from the patient were checked against an objective anamesis obtained from relatives. Following analysis of this data he concluded: (1) "In the majority of the patients studied, psychological abnormalities and disorders far beyond the range of individual differences in the average population were found to antedate the initial onset of the colitis." (2) "Disturbing events in the patient's life had preceded the onset, return, and increase of symptoms more often than can be due to chance." (3) While "the patients did not fall into any one psychological group," the patients as children arranged themselves into three well-defined groups with common characteristics--the obsessive-compulsive group, the hysterical group, the depressive-schizoid group--and another miscellaneous group of five who did not fit into any of the others. (4) These childhood characteristics carried over into adult life with a tendency to show "an accentuation of the differentiating characteristics." (5) Although the precipitating complex situation was "fairly uniform within the various groups, no universally common similarities were noted." In conclusion he believes "evidence has been given to demonstrate that ulcerative colitis is a disease of the mentally ill or maladjusted."

Daniels[14] has reported improvement of a patient 32 years of age with a history of three previous attacks of ulcerative colitis associated with depression, in which he found deep unconscious hostile trends and suicidal tendency, when treated psychotherapeutically. Murray[15] and Sullivan[9] likewise report improvement of patients under psychiatric management.

Review of the literature reveals only five brief references to the probable importance of disturbed emotional and psychogenic states in ulcerative colitis in children. Holt and McIntosh[16] believe "...often there is a strong psychopathological component" and indicate "a close study of the patient's life may suggest pertinent measures direct at the removal of courses of worry and tension." Ladd and Cross[6] write "contact with a group of these individuals clearly indicates that a large number of them have complicated sociologic backgrounds or a psychogenic disorder. Behavior problems, familial maladjustments, or other complex psychologic disturbances can apparently manifest themselves by physiologic and later organic changes in some part of the alimentary tract, particularly the colon. Whether or not mental aberrations can initiate chronic ulcerative colitis is a question, but they certainly can aggravate the condition when it has once begun." Daniels[11] and Wittkower[13] include a brief case report of a child in their

papers and Murray[9] mentions a child in one of his contributions.

We have had the opportunity to study and in several instances to attempt psychotherapeutic measures concomitant with other medical therapies in the eleven pediatric patients seen here at the University Hospitals from 1939 to 1945.

In view of our abysmal ignorance of the etiologic factors in this condition, we reviewed our findings in these cases with the hope of stimulating interest to consider more critically the possible emotional and personality factors in this stubborn refractory condition.

Our method has been to carefully study the more detailed psychiatric records in addition to the regular medical record. Interest has necessarily centered on the patient as a person, his personality integration, his life adjustment and his home background. We also include an evaluation of our efforts at psychiatric treatment.

Chart 1 gives pertinent data on the medical history and findings on the respective patients. Of the eleven, seven were boys, four were girls. Although our series is small, sex incidence is in agreement with that noted generally. Age at the time of referral to the University Hospitals varied from 6 to 15 years with the majority being 13 years or over. The duration of the illness varied from a little over one year to 11 years; the average was four years. With the exception of Patient No. 4, who died in hospital, there were no fatalities.

As far as is known no psychiatric explorations were made prior to referral to the University Hospital. This is mentioned specifically because difficulties encountered in psychiatric study and treatment of any condition are immeasurably increased when not undertaken early.

Onset

With but two exceptions, the onset of illness in our series occurred before adolescence. In six instances the onset was acute, in four it was insidious. Due to factors beyond our control, we could not determine the nature of the onset in the remaining case.

Circumstances Surrounding Onset

It is our impression that tension-producing circumstances were present in nine patients in our series on whom we have information. We have no definite data on the remaining two.

Of the six patients whose onset was acute, three developed their disease while away from home. Patient No. 11 remembered that just before leaving for a vacation in the north woods "they (the parents) had a big fight." This patient comes from a home broken by divorce. Another patient developed her initial real attack while away from home for the first time with the school band. She could scarcely wait to get home. In the third case onset occurred during a weekend in the country. Nothing could be secured from either the patient or his mother regarding any unusual event except that no other member of the group developed the disease. This patient had had his colitis for nine years. Patient No. 1 developed his diarrhea one week after moving from a farm owned by an old man who hated children and who had made the boy very fearful. Our patient was playing with his older brother when his first attack occurred. He later told the father that he feared his brother, and that the brother had hit him in the stomach. Patient No. 2 had two attacks one year apart. Each occurred toward the end of the school year. It is known that great pressure was exerted on him by his parents, particularly his father, and that he greatly feared the consequences of failure to achieve goals set for him. We have no definitive information on the sixth patient whose diarrhea was acute in onset.

Each of the four whose onset was insidious present evidence of unusual stress and strain for a period varying from a few months to several years prior to the development of frank symptoms.

CHART I

Patient No.	Sex	Age seen in Peds.	Dur. of Disease	Character of Onset	No. of attacks	Dur. of last attack	Hgb. in gms.	WBC	Max. pulse	Max. Temp.	Blood agglutinins	Bacteriology Stool	Proctological Examination	X-Ray
1.	M	5	2	Ac.	Chr.	Chr.	11+	10,000	110	101°	Neg.	Neg.	Typ.ulc.col.	Colon redundant & atonic.
2.	M	10	1	Ac.	2	2mos.	13	9,500	160	103°	Neg.	--	Not done	Severe ulcer col.
3.	F	11	1	Ins.	Chr.	6-9ms.	9.45	10,700	140	99.8°	Neg.	Neg.	Typ. ulc. process to sigmoid	Ulc. col. with marked narrowing and rigidity of bowel
4.	M	13	1½	Ins.	Chr.	Chr.	10.8	10,000	160	104°	Neg.	Neg.	Typ.ulc.col.	Ext.ulc.col. involving entire colon.
5.	M	6½	1½	?	Chr.	Chr.	10.3	7,650	130	100°	--	Neg.	Anal stenosis with anal abrasions & small bleeding pts. in rectal mucosa.	1937-Ba enema neg. 1943-ulc.col.
6.	M	13	8	Ac.	Chr.	Chr.	11.2	5,300	160	103°	Neg.	Neg.	Typical stricture ½ cm. diam. 2 cm. above rectum.	Marked ulc. col. with shortening of entire colon.

Patient No.	Sex	Age seen in Peds.	Dur. of Disease	Character of Onset	No. of Attacks	Dur. of last Attack	Hgb. in gms.	WBC	Max. Pulse	Max. Temp.	Blood agglutinins	Bacteriology Stool	Proctological Examination	X-Ray
7.	F	15	2	Ac.	3-4 attacks	1 wk.	9.08	11,000	160	104°	Neg.	Neg.	Typical sentinel pile vulva thick bleed easily polyps.	Chr.ulc.col. infl. polyps. Invol. of ileum.
8.	F	15	12	Ac.	Chr.	Chr. since onset	3.9	9,200	148	102°	Neg.	Neg.	Chr.ulc.col.	Chr.ulc.col. term. ileitis
9.	F	15	9	Ins.	Large no.	Since 1937	12.25	6,050	96	99°	--	Neg.	Typ.ulc.col.	Ulc.col. polyps of Trans colon ? term.ileum involv.
10.	M	14	2	Ins.	Chr.	4wks. 1941	10.08	11,000	120	102.4°	Neg.	Neg.	Typical fulminating ulc. col. polyps edge of valve.	Chr.ulc.col. involvement of ileum.
11.	M	15	9	Ac.	Var. & Chr.	Chr.	12.25	6,050	96	99°	Neg.	--	Typ.ulc.col.	Ulc.col., polyps-Trans. colon,Termin. ileum involv.

In the case of Patient No. 3 the record indicates: "Every year since she started school patient has had a brief illness at the beginning of the term when she was put in bed two or three days or a week with vomiting and diarrhea. The parents were not particularly concerned about these illnesses as they thought 'the change from being outdoors all the time to being inside' was the cause. After two or three days in bed 'she seemed to be all right.' She has never complained about going to school, although both parents report that school has been hard for her, especially reading." Her illness began during the middle of the fifth year of school when the work got too hard. School achievement tests place her in the fourth grade in reading.

Patient No. 4 developed his initial symptoms after a series of threatening events. The story has been reconstructed as follows: Father and son were left alone while Mother was on a trip out west. (We do not know the circumstances of her leaving.) During her absence the boy was left to shift for himself a good deal as the father's working hours were irregular. During this interim he was apprehended three times by the police for misdemeanors. On one occasion he was caught stealing from a garage with a group of youngsters; on another he was rummaging cars and on a third he was caught in masturbatory activities with other youngsters. Mother and Father never did get along and the lad was obviously rejected. "Although he has confided to neighbors his envy of other boys' parental affection, he retains a loyalty to his parents that will not let him admit they have been unkind. He was really agitated, however, when he said his home was 'all right.' The problem is apparently one of rejection, particularly by the Mother."

About the time Patient No. 9 developed her colitis at age 6, several things happened which seem significant. Her parents were not getting along well. She developed abdominal complaints which persisted for some time. Finally she was operated on. She greatly feared the operation: "I was just scared." It was shortly after this operation that her colitis developed.

Patient No. 10 was likewise subjected to a long period of emotional as well as physical stress and strain. He entered our hospital initially at the age of 15, acutely ill. Several days following admission he asked to come to talk to one of us (RAJ). During this first interview he related some of his previous experiences and feelings. From the age of 11 he had been required to do the equivalent of a man's work on the farm. He felt definitely discriminated against by his father who compelled him to work in the fields long hours, often when he was not feeling well, and who severely criticized and often punished our patient when work laid out was not completed. School attendance was irregular due to the demands made on him. It was impossible to enjoy an occasional day off for play or sports; hunting, fishing or trapping were out of the question. When the family occasionally went to town or to visit he was required to remain at home to watch the place. As he poured out his story he broke down and wept bitterly. He expressed regret at his weeping but added, "I've been holding things back so long I have to get them out of my system."

Analysis of Patients' Status.

An effort has been made to describe these patients in terms of their intelligence, school adjustment, emotional status, social relationships and personality integration. Chart II gives the results of psychological tests when used.

Nine of our patients, on the basis of standardized psychological tests, were found to have intelligence quotients within the average range or better. Seven fell within the high average or superior group. The criteria of school performance would place the remaining two, not tested, well within the normal range.

It is noteworthy that, despite the favorable intelligence factor in our patients, the majority of them were

CHART II

Patient	1	2	3	4	5	6	7	8	9	10	11
Score	108	127	100	-	83 99 85 - - -	107	140	109	-	116	117

worried about school performance and were upset because achievement had fallen below the standard set for them either by themselves or by others. It is true that several of them, having been penalized by non-attendance due to illness, worried about making up their work. Apart from this factor, however, the group generally tended to worry about school performance.

The attitude of the patient toward his illness is also revealing. In general those acutely ill tended to be extremely irritable, whining and demanding. They were easily upset and tended to complain incessantly. Without exception, they could recite verbatim their many symptoms, knew to the minutest detail the varied medications administered, and upon admission to hospital were prone to resist any change in management.

Those not acutely ill displayed a superficial attitude of indifference and resignation toward their affliction. They were reluctant to discuss their illness with anyone.

Unusual circumstances were reflected in an increase in the number and character of their stools. In illustration of this, Patient No. 7 was doing nicely in hospital when suddenly she showed a marked temporary exacerbation in her diarrhea. Exploration revealed that she had received word from home that several of her favorite pets were ill. The foster mother of Patient No. 1 "noticed that the number of bowel movements increases if E. is upset; e.g., when his father was here they increased to six or seven per day. Two days after father left they were again under control." The same experience was noted in Patient No. 3 when her father visited her.

The social relationships of this group tended toward (1) an attitude of isolationism from others; (2) having one or at the most two companions at a time; (3) desperate attempts, despite new surroundings, to maintain contact with the old friends; or (4) functioning at a social level inferior to developmental status. In illustration, Patient No. 5 never seemed to form any close relationships with any of his contemporaries. "Parents state that the boy (Patient No. 4) has very few friends, is more of a solitary person, lives within himself a good deal. Father says, 'distant is what I say.'" Patient No. 10 never has but one friend at a time. Patient No. 11 went back repeatedly to his old community "to see old friends." Patient No. 8 was reluctant to move with the family because it meant leaving friends and her older brother. Patient No. 1 either played alone or was content to play with his younger brother.

The outstanding common characteristics were fear and anxiety--fear of parents, fear of failure and fear of being hurt. In every instance it can be said that these patients were unusually sensitive. They were easily hurt and tended to harbor their hurts for days and even weeks.

Without exception as individuals they were inclined to be meticulous and fastidious about their body and person. A few comments selected at random from the records will illustrate. Patient No. 1, age 6, "is very fastidious about his person and belongings. He always wants his clothes clean and pressed and frequent bathings. As related to his present difficulty, he is very careful in handling himself at night; only wakes his mother to have her look at his bed to see if it is clean." Patient No. 5, age 12, "is clean about his person. He is inclined to be somewhat of a 'dude' in his anxiety to look nice and

will spend much time before the mirror combing his hair. When he has new clothes he wants to wear them every day." Patient No. 8 "seems to be very meticulous, almost to the point of being fastidious."

Although the majority of the individuals in the group tended to be quiet, shy and withdrawn, they were inordinately stubborn, resistive, and insistent upon having their demands met on their own terms. One patient "once went to a picnic and because the eating hour was postponed would not stay." In another instance, "if father got up to give E. his milk during the night, E. absolutely refused to take it, no matter how much he was coaxed or what other methods were used to persuade him. If mother got up, E. took his milk without question. He was very much the same about his toilet habits. Father comments that E. is dependent upon his mother in this way only for the things that most very young children are, such as feeding and elimination. He simply will not do these things for anyone else." We can substantiate this from our own experience. When admitted to our hospital he informed his mother he would never speak to anyone, nurses and doctors alike, as long as he was away from home. He carried out his threat. The only time he spoke was to say goodbye following his last visit, and this he did under persuasion!

The Rorschach test was done on three patients. The findings were surprisingly uniform. Excerpts from reports of the examiners are quoted.

Patient No. 3: "The Rorschach record was atypical for a girl of this age from several points of view. Responses seemed to indicate an attempt at refinement beyond that to be expected in a girl of her age and mental ability. In addition, there were responses indicating anxiety and inner conflict and poor reaction to external emotion-provoking stimuli. From her behavior it was my impression that she felt considerably challenged in spite of all I could do to reassure her, telling her there were no right or wrong answers, everyone saw different things in the blots, etc. My conclusions would be that there is anxiety far beyond that usually evoked by this situation. If the anxiety and inhibition which characterized her so strikingly in these test situations is generally true of her in her home and school situations, it would seem there would be little opportunity for the overt channelization of aggression and spontaneity."

Patient No. 7: "In comparison with the Binet test rating of superior intelligence (I.Q. 140), her responses on the Rorschach might indicate intellectual inefficiency. The record as a whole is similar to that found in many hysterics. There is no evidence for manifest anxiety. The basic personality structure is that of introversion. There is evidence for a good deal of negativism, for introspection and self-consciousness. Aggression and relations with the external world are very poorly handled." On the Thematic Apperception Test, which this patient also had, "she showed a great deal of facility and versatility in constructing plots for the stories. However, the plots, while not stereotyped, were comparatively commonplace for a girl of her intellectual level. The stories on the whole might be said to be evasive and there seemed to be a minimal identification with the characters in the stories."

Patient No. 2: "T's Rorschach responses seem to indicate a rather high degree of emotional constriction in the direction of depression with feelings of inadequacy, insecurity and anxiety in the form of evasiveness rather than active aggression. In general, his attitude of approach portrayed uncertainty although there were no long time intervals of silence. In fact, he gave up the cards quickly, as though he wanted to get through with them--an attitude in direct contradistinction to his good and prolonged attention in the Stanford-Binet (score 127). In summary, this protocol shows many indications of a depressed little boy. He displays little evidence of imaginative spontaneous functioning; he shies away from his own ideas and impulses. Although it appears that he is interested in and has a natural inclination toward contacts 'with the outside world,' he represses his responses

to human contacts. It seems pretty clear, too, that T. is functioning considerably below his capacity and drives--imaginatively, emotionally and intellectually."

The Home Situation

A stable, well-integrated home is now recognized to be of paramoung importance to the growing child. Any real or imaginary threat to the child's security causes undue emotional tension to develop and prepares him for illness.

The atmosphere was considered poor in nine of the eleven homes from which our patients came. Poor or strained economic circumstances, illness, alcoholism and personality problems in one or both parents contributed to the tensions. Two of our patients came from broken homes--one by divorce and one by desertion of the father. Marked parental discord was recognized in five other instances. Three fathers were confirmed alcoholics. In one home both parents were alcoholic. It is of interest that their only child had made two unsuccessful attempts to run away prior to the onset of his illness. His death was the only one of our series. Two other patients had made feeble abortive attempts to leave home but unsuccessful.

The family of Patient No. 3 is interesting and enlightening. It consisted of the parents and five siblings; our patient was the youngest. They lived on a 239-acre farm which the father was attempting to buy from Rural Credit. They had previously been on relief. In the spring of 1942, at the age of 54, the father developed bronchial asthma "when much of his crop was spoiled by the rain and the lack of help." The mother, 53, described herself as being in poor health, having suffered from severe migraine headaches periodically for 30 years. In addition, she offered numerous gastrointestinal complaints. Two of our patient's siblings had asthma. One of them also had severe headaches.

Obvious emotional tension, apart from the concern expressed over the patient, was noted in one or both parents in five of the families represented. Gastrointestinal complaints were encountered in four parents.

Position of the Patient in the Family

Chart III indicates the position of the patient in the family, and ages when known.

CHART III

Patient No.	Sibling Order*					Patient's Position in Family
1.	B(9)	S(8)	Pt.(6)	B(4)		Third
2.	Pt.(11)	S(9)				Oldest
3.	B(17)	S(16)	B(14)	B(12)	Pt.(11)	Youngest
4.	Pt.(13)					Only child
5.	?(dec.)	?(dec.)	?(dec.)	S(17)	Pt.(13)	Youngest
6.	S(21)	Pt.(14)	B(12)			Second
7.	Pt.(15)					Only child
8.	B( )	Pt.(15)				Youngest
9.	S(24)	B(18)	Pt.(15)			Youngest
10.	Pt.(15)	?	?	?		Oldest
11.	B(30)	S(25)	B(22)	Pt.(15)		Youngest

*B-brother, S-sister, Pt. -patient, ( )-age of each.

As is noted, two of our patients were only children, two were the oldest, two were in an intermediary position, and five were the youngest.

Parent-Child Relationships

In eight of the eleven patients, we were impressed by the strong emotional attachment to the mother. This attachment in our opinion seemed pathological. In illustration we refer to Patient No. 6 who, at the age of 14, was still sleeping with his mother. Furthermore, the mother steadfastly refused to permit him to come to the University Hospitals alone though he lived in the city and would need to transfer only once if he came by streetcar. Patient No. 7 deferred to her mother's wishes in practically every decision she made. While in hospital she wrote long letters to her mother each morning and afternoon despite the fact that she was confined to bed and segregated.

Patient No. 4 seemed more closely identified with the father than with the mother. Patient No. 10 felt and expressed repeatedly a sense of utter rejection on the part of both parents. Patient No. 5, having come from a broken home, had spent most of his days in boarding homes and had not had an opportunity to feel a real sense of home ties with anyone.

Sibling Relationships

Sibling relationships impressed us as important in three cases. Patient No. 1 had a marked fear of his brother and avoided him. During one of his father's visits, while he was living in a Minneapolis boarding home, the patient started to say, "It was all R's fault." When encouraged to talk, he indicated fear of the older brother who hit him in the stomach. Patient No. 10, in addition to feeling a real sense of rejection by his parents, intensely hated his younger brother who he felt was the father's favorite. Patient No. 8 had an unusually strong attachment for her older brother and was upset when the family moved to a new community, leaving her brother behind.

The significant role of the family in illness has recently been emphasized by Richardson[17]. He says, "The idea of disease as an entity which is limited to one person, and can be transmitted or spread from one individual to another, fades into the background, and disease becomes an integral part of the continuous process of living. The family is the unit of illness, because it is the unit of living."

Evaluation of Psychotherapy

In evaluating the results of our efforts at psychotherapy, several real differences between treating children and adults must be kept in mind. The child is usually brought to the physician--the adult comes of his own accord. Psychiatric management of children usually involves not only the child but also the parents. Therefore attention to parental attitudes and feeling states are fully as important as encouraging the child's free expression of his feeling and attitudes. Full cooperation on the part of all is vital. Necessarily accessibility is essential.

Failure to initiate psychotherapy concomitant with other treatment makes it less effective when finally attempted. In this connection we point out again that in no case was psychotherapy begun until a year or more after the onset of illness.

An effort was made to work intensively with every patient situation. After preliminary investigation we decided psychotherapy would be ineffective in two cases. Three families were uninterested in our efforts. Of the remaining six, one of the patients placed in a foster home showed steady improvement during her stay there. She had a prompt recurrence of her symptoms upon returning to her own home. They cleared quickly upon admission to hospital, only to recur when she again went back to her family. We believe we have influenced favorably the course of the five remaining cases.

Summary

1. Psychiatric literature on ulcerative colitis has been briefly reviewed.

2. Medical and psychiatric data on eleven unselected pediatric patients

with ulcerative colitis has been presented.

3. Psychological and personality factors as well as home backgrounds appear to be important in ulcerative colitis in children.

4. Psychiatric study and treatment concomitant with medical study and treatment offers promise but should be undertaken early in every case of unexplained diarrhea.

5. Cooperative effort of the pediatrician, internist, surgeon and psychiatrist offers a useful method of attack in the study and management of patients with chronic illness such as ulcerative colitis.

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III. GOSSIP

Nearly 80 physicians are in attendance at the course in Cancer Diagnosis and Treatment at the Center for Continuation Study. North Dakota with nearly half the registrations illustrates social interest in medical practice of a high order. Cancer is now a reportable disease in North Dakota and simple forms are used to expedite the process. In order to help physicians to better understand the cancer problem, key physicians from North Dakota are here this week. They will return to their practices and report to their medical societies on what they have learned. They are the guests of the North Dakota State Department of Health and the North Dakota branch of the American Cancer Society. A similar group of physicians from Minnesota are taking the course as guests of the Minnesota Cancer Society. Cancer is not a reportable disease in Minnesota. Most of the activity in this state is centered in the cancer committee of the Minnesota State Medical Association and the Minnesota Cancer Society. The latter is a group of professional and lay persons who maintain an organization for educational purposes. Special study outlines are prepared for high schools. Great interest is manifested at the present time in cancer "detection" clinics. Some states have already started them and the Readers Digest has stirred up interest in the other states. There are two plans in operation. In one, women report every six months for a pelvic, breast, skin, and mouth inspection. Inquiry as to the condition of the health of the individual is made and any suspicious sign or symptom is the basis for referral to the family physician. In the other type of detection clinic, opportunities are provided for anyone to consult the clinic for examination and advice. As a result of the Readers Digest article over $50,000 in funds have been sent to the American Cancer Society as voluntary offerings. This year, a national campaign for funds will be made during April. It is being handled by a national advertising agency as their contribution to the cause. Eric Johnson who has become famous through his Chamber of Commerce activities has agreed to act as general chairman. The American Cancer Society, formerly the American Society for the Control of Cancer is over 30 years old, It has never occupied the prominent place in philanthropy that similar organizations have enjoyed. It may be that the large number of cancers which have developed in our aging population has stimulated public concern. It is interesting to note that 40% of all funds which will be collected will go to research. The United States government has gone into the cancer program in a good program (research). There is a tendency to coordinate research in cancer. Cancer results from extrinsic and intrinsic factors playing upon the cells. Multiple factors are present in every instance. The number of factors involved and their values can be learned only after extensive study. At the University of Minnesota we have a good example of the prevailing type of research program. Dr. John Bittner working on mice, and Dr. Peter Oliver, working on genetic factors in humans are both making progress. The beginning history of cancer is lost in the distant past. It apparently does not have any beginning, for signs of malignant disease are found in fossils thought to be many millions of years old. Modern cancer concepts go back to 1740 when the first cancer hospital was established in France. The disease was thought to be contagious so the hospital was located out of town. The first cancer control society was organized in 1802. It consisted of a committee of physicians who asked certain questions concerning cancer. Although the society lasted only four years, many of their questions remain unanswered. The invention of the compound microscope in 1824, and the discovery of the cell as a unit of living matter in 1838, created new fields in cancer diagnosis and research. Conheim's theory of embryonic rests accounts for some new growths but not all. Present day type of investigator first appeared around the turn of the century. Loeb, Jensen, and their associates studied animal transplants and tissue cultures. It appeared as if some of these investigators had simplified the story of the development of cancer to the point where agreement would soon be possible, but the problem has become complex again, and apparently no one is going to hit the jackpot with a single discovery which will revolutionize the whole field.....