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Psychosomatic Aspects of Pediatrics

Volume XX | Friday, October 22, 1948 | Number 4

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UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
CALENDAR OF EVENTS

Visitors Welcome
October 25 - 30, 1948

No. 219

Monday, October 25

9:00 - 9:50	Roentgenology-Medicine Conference; L. G. Rigler, C. J. Watson and Staff; Todd Amphitheater, U. H.
9:00 - 10:50	Obstetrics and Gynecology Conference; J. L. McKelvey and Staff; Interns' Quarters, U. H.
8:00 -	Fracture Rounds; A. A. Zierold and Staff; Ward A, Minneapolis General Hospital.
10:00 - 12:00	Neurology Ward Rounds; A. B. Baker and Staff; Station 50, U. H.
11:00 - 11:50	Roentgenology-Medicine Conference; Staff, Veterans' Hospital.
11:00 - 12:00	Cancer Clinic; K. Stenstrom and A. Kremen; Eustis Amphitheater, U. H.
11:00 - 11:50	Physical Medicine Seminar; E-101, U. H.
12:00 - 1:00	Physiology Seminar; The Influence of Adrenalin on the Lymphocyte Count and the Mechanism Involved; E. Gellhorn; 214 M. H.
12:15 - 1:20	Obstetrics and Gynecology Journal Club; M-435, U. H.
12:30 - 1:20	Pathology Seminar; Roentgen Demonstration of the Inferior Vaca; B. J. O'Loughlin; 104 I. A.
12:30 - 1:50	Surgery Grand Rounds; A. A. Zierold, Clarence Dennis and Staff; Minneapolis General Hospital.
1:30 - 2:30	Pediatric-Neurological Rounds; R. Jensen, A. B. Baker and Staff; U. H.
2:00 - 3:00	Surgery Problem Case Conference; C. Dennis and Staff; Small Class Room, General Hospital.
3:00 - 5:00	Kellogg Lecture; Hepatic Disease; Clinical Physiology; Frederick W. Hoffbauer; 229 Center for Continuation Study.
3:45 -	Pediatric Seminar; Muscle Physiology in Myotonia; Lloyd Nelson, 6th Floor, Child Psychiatry, U. H.
4:00 - 6:00	School of Public Health Seminar; 113 MeS.
5:00 - 6:00	Urology-Roentgenology Conference; D. Creevy and H. M. Stauffer and Staffs; M-109, U. H.
5:00 - 5:50	Clinical Medical Pathologic Conference; Todd Amphitheater, U. H.

Tuesday, October 26

8:30 - 10:20 Surgery Reading Conference; Lyle Hay; Small Conference Room, Bldg. I, Veterans' Hospital.

9:00 - 9:50 Roentgenology Pediatrics Conference; L. G. Rigler, I. McQuarrie and Staff; Todd Amphitheater, U. H.

10:30 - 11:50 Surgical Pathological Conference; Lyle Hay and Robert Hebbel; Veterans' Hospital.

12:30 - 1:20 Pathology Conference; Autopsies; Pathology Staff; 102 I. A.

2:00 - 2:50 Dermatology and Syphilology Conference; H. E. Michelson and Staff; Bldg. III, Veterans' Hospital.

2:00 - 4:00 Kellogg Lecture; Amino Acids; Paul R. Cannon, Chairman, Department of Pathology, University of Chicago; Eustis Amphitheater, U. H.

3:15 - 4:20 Gynecology Chart Conference; J. L. McKelvey and Staff; Station 54, U. H.

3:30 - 4:20 Clinical Pathological Conference; Staff; Veterans' Hospital.

4:00 - 5:30 Surgery-Physiology Conference; O. H. Wangensteen and M. B. Visscher; Eustis Amphitheater, U. H.

4:00 - 5:00 Pediatric Rounds on Wards; I. McQuarrie and Staff; U. H.

5:00 - 5:30 Urology Pathological Conference; C. D. Creevy and Staff; Todd Amphitheater, U. H.

5:00 - 6:00 X-ray Conference; Dr. Rigler and Staff; Powell Hall Amphitheater.

Wednesday, October 27

8:00 - 8:50 Surgery Journal Club; O. H. Wangensteen and Staff; M-515, U. H.

8:30 - 10:00 Orthopedic-Roentgenologic Conference; Edward T. Evans; Room 1AW, Veterans' Hospital.

8:30 - 12:00 Neurology Rehabilitation and Case Conference; A. B. Baker and Joe R. Brown; Veterans' Hospital.

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

12:00 - 12:50 Radio Isotope Seminar; Basic Definitions Useful in Nuclear Physics; Charles Nice; Rm. 216, Hospital Court, Temporary Bldg.

4:00 - 5:00 Infectious Disease Rounds; Minneapolis General Hospital.

Thursday, October 28

8:15 - 9:00 Roentgenology-Surgical-Pathology Conference; Walter Walker and H. M. Stauffer; M-109, U. H.

8:30 - 10:20 Surgery Grand Rounds; Lyle Hay and Staff; Veterans' Hospital.

9:00 - 9:50 Medicine Case Presentation; C. J. Watson and Staff; M-109, U. H.

10:00 - 11:50 Medicine Ward Rounds; C. J. Watson and Staff; E-221, U. H.

10:30 - 11:50 Surgery-Radiology Conference; Daniel Fink and Lyle Hay; Veterans' Hospital.

11:00 - 12:00 Cancer Clinic; K. Stenstrom and A. Kremen; Todd Amphitheater, U. H.

11:30 - 12:30 Clinical Pathology Conference; Steven Barron, C. Dennis, George Fahr, A. V. Stoesser and Staffs; Large Class Room, Minneapolis General Hospital.

12:00 - 1:00 Physiological Chemistry Seminar; Malic Dehydrogenase and Cytochrome Oxidase of Lutein and Other Ovarian Tissues during Pregnancy and Lactation; Don Clausen; 214 M. H.

1:00 - 1:50 Fracture Conference; A. A. Zierold and Staff; Minneapolis General Hospital.

4:00 - 5:00 Bacteriology and Immunology Seminar; Histochemical Observations on Certain Bacteria; Robert Siem; 214 M. H

4:30 - 5:20 Ophthalmology Ward Rounds; Erling W. Hansen and Staff; E-534, U. H.

8:00 - Rigler Lectureship; The Roentgen Diagnosis of Heart Disease and Cardiac Catheterization; Merrill C. Sosman, Professor of Radiology, Harvard University Medical School; Museum of Natural History.

Friday, October 29

8:30 - 10:00 Neurology Grand Rounds; A. B. Baker and Staff; Station 50, U. H.

9:00 - 9:50 Medicine Grand Rounds; C. J. Watson and Staff; Todd Amphitheater, U. H.

10:00 - 11:50 Medicine Ward Rounds; C. J. Watson and Staff; E-221, U. H.

10:30 - 11:20 Medicine Grand Rounds; Staff; Veterans' Hospital.

10:30 - 11:50 Otolaryngology Case Studies; L. R. Boies and Staff; Out-Patient Department, U. H.

11:00 - 12:00 Surgery-Pediatric Conference; C. Dennis, A. V. Stoesser, and Staffs; Minneapolis General Hospital.

11:30 - 12:50 University of Minnesota Hospitals General Staff Meeting; Surgical Treatment of Tetrology of Falot; R. L. Varco; Powell Hall Amphitheater.

12:00 - 1:00 Surgery Clinical Pathological Conference; Clarence Dennis and Staff; Minneapolis General Hospital; Small Classroom.

1:00 - 1:50 Dermatology and Syphilology; Presentation of Selected Cases of the Week; H. E. Michelson and Staff; W-312, U. H.

1:00 - 2:50 Neurosurgery-Roentgenology Conference; W. T. Peyton, Harold O. Peterson and Staff; Todd Amphitheater, U. H.

3:00 - 5:00 Kellogg Lecture; Roentgenologic Contribution to the Diagnosis of Abnormalities of the Large and Small Intestines; Harry M. Weber, Mayo Foundation; 229 Center for Continuation Study.

Saturday, October 30

7:45 - 8:50 Orthopedics Conference; Wallace H. Cole and Staff; Station 21, U. H.

8:00 - 9:00 Pediatric Psychiatric Rounds; Reynold Jensen; 6th Floor, West Wing, U. H.

8:00 - 9:00 Surgery Literature Conference; Clarence Dennis and Staff; Minneapolis Gen ral Hospital, Small Classroom.

9:00 - 10:30 Pediatric Grand Rounds; I. McQuarrie and Staff; Eustis Amphitheater, U. H.

9:00 - 9:50 Surgery-Roentgenology Conference; O. H. Wangensteen, L. G. Rigler, H. M. Stauffer, and Staff; Todd Amphitheater, U. H.

9:00 - 9:50 Medicine Case Presentation; C. J. Watson and Staff; E-101, U, H.

9:00 - 12:00 Child Psychiatry Conference; Powell Hall Amphitheater.

10:00 - 11:50 Medicine Ward Rounds; C. J. Watson and Staff; E-221, U. H.

10:00 - 12:50 Obstetrics and Gynecology Grand Rounds; J. L. McKelvey and Staff; Station 44, U. H.

11:00 - 11:50 Urology Seminar; E-101, U. H.

11:00 - 12:00 Anatomy Seminar; Fat and Carotene Absorption from the Gastro-intestinal Tract; David W. Molander; 226 I. A.

II. PSYCHOSOMATIC ASPECTS OF PEDIATRICS

Joseph Carpentieri
Reynold A. Jensen

That emotional factors have a significant role in illness has long been known. As long ago as 500 years B.C. Socrates, returning from military service, commented upon the wisdom and understanding of the physicians of Thrace who recognized and analyzed the principle that bodily symptoms could not be relieved without first curing the mind.

It is only of recent years, however, that there has been a significant acceptance of psychogenic and social factors in relation to disease and the disease processes. The recent publication of many books and articles attest to the growing interest in this phase of medicine.[1] Likewise extensive research is being done. For the most part attention has been directed largely to the field of adult medicine. However, there is a growing appreciation of the importance of psychogenic factors in the field of pediatrics. This has been particularly true here at our hospital.

Our purpose today is to briefly review our findings in six cases which we have had an opportunity to study and work with. Each child was referred to the hospital with complaints suggestive of a physical disorder. Nearly all had been so treated prior to acceptance by the hospital for further study and treatment. Nearly every phase of medical practice is represented, - medicine, ophthalmology, dermatology, psychiatry, orthopedics and surgery.

All came to the hospital with complaints suggestive of physical disease. However, when studied psychiatrically, important social and emotional problems were found. Once these problems were defined along with others, it was possible to offer additional help which resulted in the patient's improvement and in some cases, recovery.

Ages of these children vary from $4\frac{1}{2}$ years to 16 years. The fact that five of the six cases are girls is purely accidental and in no way represents sex distribution. These children, except for the majority being girls, are typical and representative of the many "psychosomatic" problems we encounter regularly.

Case 1

, a girl age 12, was admitted to pediatrics service of University Hospitals with a history of "spells" of two years' duration, characterized by nervousness, fatigue, dizziness, tachycardia, and mild dyspnea, occasional vomiting, crying spells and inability to stand noise.

Past medical history was not particularly significant.

The family consisted of the father and mother, 3 younger boys and one older girl.

Physical examination was essentially negative except for rapid heart rate. The electrocardiogram was reported as "probably normal". A 6-foot x-ray film of the heart showed slight left auricular and ventricular hypertrophy though fluoroscopic examination was negative.

A tentative diagnosis of ventricular paroxysmal tachycardia was made but not substantiated. Since the physical and laboratory findings did not completely account for the patient's symptomatology, she was seen by one of the child psychiatry staff regularly for a period of two weeks. The girl did not seem reluctant to discuss her problems with the doctor and during the interviews the following important information was obtained.

(a) When the patient was 6 years old her father lost his ministerial position in a small town with attendant loss of social prestige and financial security. She suggested the father's misfortune was in part due to the behavior of the older sister and her choice of companions.

(b) There was much quarreling between the older sister and the mother who disapproved of her actions.

(c) The patient had much ill feeling toward her sister because of the family's

plight for which she was held partly responsible and because the patient had to take care of the younger children.

(d) Loss of the father's position necessitated moving to a different town. Here the patient felt alone and friendless which was extreme because of her shyness and inability to make new friends.

(e) Concurrently a new baby was born into the family which meant another sibling to care for. Because of the precarious financial standing of the family it was necessary for the mother to work outside the home.

(f) The patient resented being deprived of the attention of her mother and father who were too busy to have time for her.

(g) The girl had very little privacy and her siblings intruded on what little privacy she had.

(h) For all of these reasons the patient developed a great deal of resentment toward the mother and her whole family, especially her older sister. This troubled the patient because she thought it was wrong and sinful.

(i) In addition, since the girl was rather large and precocious in her development, she was the only girl in her classroom whose menses had begun. This increased her feeling of discomfort because she thought she was "different from the other girls".

Talking with her doctor resulted in increased relaxation and alleviation of her tremendous anxiety. Normal sex physiology was discussed and explained to the patient. Full, free discussion of her angry, resentful feelings permitted the physician to explain that anger and resentment were commonly prevalent in families and not peculiar to her alone. She finally seemed able to understand that one could have such strong feelings about her family and still fundamentally like them.

During her stay in the hospital her older sister had married and established her own home. The socio-economic condition of the family had improved permitting the mother to remain at home. At the time of hospital discharge the patient was encouraged to discuss her problems with her mother instead of keeping them all to herself, which she agreed to do. When some of the patient's difficulties were outlined to the parents they seemed to comprehend them and agreed to help the patient re-establish herself in the home.

No known attacks of tachycardia occurred during her hospital stay.

Six weeks later we received reports that the girl was doing well, her symptoms were practically gone and she was actively participating in most of the school activities.

Case 2.

, a girl age $4\frac{1}{2}$, was referred for study and treatment with a diagnosis of dermatitis factitia, of nearly two years duration. The patient had been seen by several physicians. Various therapies prescribed had brought no improvement. The patient was in excellent physical health with the exception of an open lesion which extended from the zygomatic eminence to the angle of the mandible. It was reported that she irritated the lesion only during the night hours.

One visit with the youngster while in the hospital revealed a pleasant, attractive child who was well developed and well nourished. She had a large bandage on her face covering the wound. She was shy during the visit and tended to be somewhat suspicious of the physician. The nurses, however, reported that she was a very good patient, easy to manage. She got along well with the other patients and responded nicely to attention. No sleep disturbance was noted.

Four interviews were held with the parents. The following information was obtained:

(a) The family was in poor economic circumstances with much concern about finances, etc. This concern was exaggerated by the necessity of medical at-

tention for the daughter.

(b) The initial lesion on the patient's face occurred as a slight infected area in the region of the zygoma, ostensibly from a sliver of spun glass with which she had been playing.

(c) From the moment of the initial lesion, both parents had focused their entire attention on it. The mother explained that the exaggerated concern about this lesion arose from a morbid fear of facial cancer which had caused the death of one of her near relatives. The persistence of the lesion and its subsequent progression had increased the anxiety of the family. The interest and curiosity regarding the lesion had become a problem of community concern. The milkman, the delivery boy, the grocer, all made the daily inquiry: "How's L's face today?" The first question asked by the father upon return from work in the evening was, "How's your face today?"

Somewhere in the course of events it seemed the parents as well as others had forgotten the patient in their interest in the patient's face!

In the final interview with the mother and father this simple fact was suddenly realized and the following plan evolved with them.

(a) From this point on, their attention was directed toward the patient rather than the lesion.

(b) A period of two or three weeks' stay with relatives was arranged for the patient.

(c) In the interim, the family found other living quarters in a new community. From all reports the lesion gradually healed spontaneously and has not recurred.

Case 3.

, age 7 years, had been suffering from "spells" for several years. Repeated thorough physical studies by the family pediatrician and several consultants had revealed nothing of particular significance with the exception of an EEG which had been reported "abnormal suggestive of petit mal epilepsy". Medical history was noncontributory. None of the various anti-convulsant regimes prescribed were successful. Despite these the patient's spells became progressively more frequent and of longer duration. However, no major seizures had ever been observed.

At the time of referral the patient was having approximately 50 spells per day. Because previous medical regimes had been unsuccessful and because of considerable reluctance on the part of the parents to try again, it was decided to postpone medical treatment for a time. Subsequent developments in the case obviated the need.

After the initial interview with the mother, during which she was continuously in tears, parents and child were seen on a weekly basis for a period of several months, after which they were seen every two weeks. Intensive psychological testing was done on the child who was found to be an extremely bright youngster with many unusual capacities and interests. The case was active for a period of seven months.

The family was of modest economic circumstances, living in a small home in the suburbs. Both parents were middle-aged. The father was a mild-mannered, conscientious, hard worker. The mother was a highly nervous, apprehensive woman who prior to her marriage had been professionally trained and had held a very responsible position. Our patient was the only living child in the family. At the time we began our study she was not in school. She was at home under constant surveillance.

Interviews with the parents individually and jointly revealed the following pertinent data:

(a) Considerable tension existed in the home. Both parents were discouraged.

(b) Financial circumstances were trying. This had been accentuated by additional medical expense incurred since onset of the daughter's illness.

(c) An attitude of utter hopelessness prevailed regarding the possibility of the daughter's recovery.

(d) The mother was anxious to return to work but was unable to do so because of her husband's resistance to such a plan and the necessity of caring for her daughter.

(e) The patient was becoming increasingly difficult to manage due to the many restrictions placed on her.

(f) Both parents had been severely traumatized years before when they had witnessed the accidental death of their first child, a boy. Our patient had been conceived in the hope of replacing this youngster in the family.

Interviews with the patient revealed her to be disappointed in "not being like other kids", in not going to school and not being permitted to do many things like riding a bicycle or leaving her own yard to play. She was overly rebellious over the manner in which she was being managed.

Thru the medium of the interviews, the parents were helped to deal with their own problems and feelings more constructively. They were encouraged to permit the patient to attend school. Many of the restrictions regarding play, etc. were gradually reduced and greater participation in family responsibilities was urged. The parents were further encouraged to participate in community affairs to the point where they were absent from the home an occasional evening.

The child gradually shared her feelings of resentment and hostility with the psychiatrist. Ways and means of directing her many unusual abilities were developed with her and her mother. Several interviews were held jointly with child and mother during which each came to a better understanding of how to share more intimately their respective differences.

From the first month on, the child showed steady improvement not only in her spells but in her behavior generally. The last noted spell occurred just prior to the time she was permitted to ride her bike to school like the other kids.

The patient has been followed for three years during which time she has had no spells. This past summer she and her mother spent a profitable time together in a girls' camp.

Case 4.

, a girl of 6 years, was referred to the University Hospitals because of complete blindness of one month's duration. Onset of the illness occurred suddenly during a mild attack of the measles from which she had an otherwise uneventful recovery. Previous medical and health histories were negative. Physical examinations, including several thorough ophthalmological examinations, were negative. One physician advanced the presumptive diagnosis of "retrobulbar optic neuritis" and fitted her with glasses. No improvement followed.

Thorough study in the University Hospitals revealed no significant findings to account for her blindness. She adjusted nicely on the pediatric wards and was soon observed to get about very easily and comfortably. Several days after admission she began improving and within a week thereafter she had recovered fully from her complaint.

The family consisted of mother and father, 5 older brothers and our patient, the youngest and only girl.

A few months prior to the patient's illness, the family had moved from a rather spacious house to a smaller home which crowded everyone. Our patient, who had previously had her own room, was compelled to sleep on a day-bed in the dining room which had interfered considerably with her rest.

A chance remark by the parents provided the first clue. Both parents were very active in an organization for the blind and spent many evenings away from home in supporting this organization's program. For the year prior to the onset of the illness of our patient, both parents had been leaving her at home "in care of the boys because she was getting older and could take care of herself." Gradually the following significant data

were pieced together:

(a) The family was in better than average economic circumstances.

(b) The patient, the only girl in the family, had been "spoiled" during her early childhood.

(c) The parents, interested in several organizations, had been leaving the patient alone many evenings with the older brothers.

(d) On occasions, however, our patient had rebelled at staying home and had insisted on accompanying the parents, which had been permitted.

(e) On these occasions, our patient had met and had become very much attached to an unusually fine elderly woman who was blind. She once remarked that if she ever became blind, she hoped she could be such a fine lady as her friend was.

(f) Prior to her measles, the mother had noted that the patient was becoming increasingly restless and irritable and that tension between the patient and her brothers was noticeably greater.

(g) It was also noted that she was prone to be more demanding of both parents, acting many times like a child much younger than 6 years.

(h) At the onset of the illness, she seemed quite content and happy, accepting the attentions of everyone in the family but more particularly the mother.

As this data was gathered, the parents began to appreciate how critical the tension between our patient and her older brothers had been. Also it became clear the brothers had been at times, quite rough and hostile toward the patient, resenting the necessity of caring for her so frequently during the parents' absence in the evenings. The parents likewise began to understand their own thoughtlessness in not appreciating how threatening all this might have been to the patient.

Meantime, while the patient was in the hospital, she was considered entirely well and a letter later from the parents indicated everything in the household was moving along more smoothly with our patient doing nicely.

Case 5.

, a girl age 14, was first seen in the pediatrics out-patient service with complaints of lumbar pain of two months' duration. The onset of this pain occurred during a tumbling class in school. It became aggravated and persistent after another fall three weeks later. She also complained of headaches which were relieved by glasses; cough and substernal pain which was relieved by rest and warmth; and muscle aches and pains in both legs but more especially in the right.

Because of a deviated nasal septum, she was admitted to University Hospitals five months later. Physical examination and laboratory studies were not particularly significant except for a spina bifida occulta of S-1 on x-ray examination. Several consultations were requested on this patient. One of these suggested that the back pain was definitely organic in origin and that the prognosis would be unfavorable without surgical care. However, because of the possibility of a severe emotional disturbance in her case, the girl was first studied psychiatrically with surprising improvement.

The patient was studied intensively for a period of three weeks. During interview she talked freely about her troubles which centered primarily in her feelings about her home. Several significant factors were defined.

The family consists of mother and father, 5 boys and 7 girls. They are very poorly housed.

(a) The father was described as a passive, inadequate individual unable to cope with family circumstances and situations. He receives old age assistance.

(b) The mother evidently is a dull, nagging yet complacent, ill-kept woman who has had to assume most of the parental responsibilities.

(c) The socio-economic status is very unsatisfactory. In addition to the father's old age pension of $25 per month the mother receives $165 on an A.D.C. grant, making a total of $190 per month with which to maintain her large family.

(d) Home conditions are very crowded. Ten people live in a 5-room house.

(e) The patient herself expressed a great deal of ill feeling and resentment, especially toward the mother. According to her story the mother nagged so continuously that she wanted to run away every day.

(f) She also harbored a great deal of resentment toward the other children saying "I hate children".

(g) According to the mother the girl was using her pain for two reasons, - to avoid housework and to absent herself from school, which was apparently difficult for her.

(h) The patient felt imposed upon and resentful because she had to assume a great deal of responsibility for housework. (It was not certain whether the girl was actually doing too much at home or whether she merely felt that such was the case.)

It was found that the girl had repeated two grades in school. Psychological testing revealed that she was of dull-normal intelligence with an I.Q. of 81.

After the patient had discussed some of her difficulties and had expressed a great deal of her anger and resentment she seemed much relieved though not entirely so.

Since her discharge from the hospital it has been reported that she no longer complains of back pain but cries a great deal.

While the patient was in the hospital, it was suggested to the mother that she be placed with relatives. Altho the mother seemed to be receptive to this suggestion, it became apparent that she would not follow thru. Therefore, it would seem that further progress is not to be expected. The family has not contacted the clinic recently so the present condition of the patient is unknown.

Case 6.

, a boy age 15, was seen first in the pediatric out-patient department with the initial complaints of hypertrophy of the breast, frontal headaches and associated blank-out spells of about two years duration. He was not so much concerned about his headaches or spells as he was about the breast hypertrophy. He demanded that "my breasts be taken off". Because the boy seemed unusually disturbed he was admitted to the hospital.

Physical examination was essentially negative except for a mild enlargement of both breasts commonly found in adolescent males. Laboratory studies were not significant except for EEG which suggested a diffuse cerebral disrhythmia, maximal on the right.

Preliminary discussion with him revealed failing grades, severe nightmares and somnambulism since a car accident 7 years previously. For these reasons and because of his unusual concern about his breast condition, it was felt that psychiatric help might benefit him.

Exploration into his background revealed the following pertinent data:

(a) The family consisted of father and mother, 3 boys and 2 girls. The patient was the second oldest sibling. He seemed to get along fairly well with his siblings except for a younger brother, age 14, who he felt was the favorite in the family.

(b) The boy appeared depressed. This depression seemed to be related to hypertrophy of the breasts, but actually his mood response seemed to underlie other conflicts.

(c) Lacking the knowledge that breast hypertrophy occurs in normal adolescent boys, he felt he was different.

(d) He was fearful and anxious about what his classmates might say concerning his condition when school began.

(e) He reported a great deal of sibling rivalry and jealousy. His younger brother was crowding him in school achievement which was very embarrassing to our patient. He felt his brother was considered to be the "baby" of the family in spite of the fact that there were two younger children. This brother was a persistent tease to the point where it was obnoxious to the rest of the family.

(f) During the patient's life time his family had moved 7 times. This meant continuous new adjustments which he found difficult. His school work suffered as he was seldom able to complete a full year in any one school.

(g) For two years the boy lived with a large, domineering, abusive grandmother. He considered placement with his grandmother as punishment for his quarreling with his younger brother.

(h) At the age of 7 years he was in a car accident for which he was hospitalized for a period of 8 months.

(i) Two years previous to our contact he had been struck in one breast by a dart thrown by his brother, toward whom he had a great deal of ill feeling.

Although the father appeared to be a stable person he spends little time with his family. The mother, a very nervous, anxious individual, had been a patient in adult psychiatry. As far as is known the father and mother apparently get along well together.

During his hospital stay the patient showed gratifying improvement. Initially his only concern was to have his breasts treated surgically. However, he was informed that there would be no surgical interference until other problems were worked out with him. It was explained that breast hypertrophy occurs commonly during normal adolescence, and why. Early in treatment it was difficult for him to talk about anything except his breast condition. When it was suggested that much of his trouble might be related to his general state of unhappiness he became much more responsive and began talking over the problems previously outlined. As time went on he talked more and more freely about himself. This led to a better understanding not only of his breast condition but also his other troubles and he became less and less interested in surgery.

The parents were also seen. It was suggested to them that the patient and his younger brother be allowed to make their own decisions as much as possible and that perhaps it would be wiser to permit the children to express some of their ill feeling toward each other rather than repress it as had been done. This the parents agreed to try. They also decided that because the grandmother was a very difficult person, they would not place their children with her any more.

Since his discharge from the hospital, the patient has been seen on out-patient basis on several occasions. He continues to be relieved of his symptoms and is getting along well in school.

Comment on Cases

These six cases have several common features. In each the patient was under severe emotional tension. These severe tension states had previously been overlooked. When once defined and help given, changes occurred which led to a more satisfactory life adjustment with either a diminution in severity of the complaint or complete recovery. Those patients who attained complete recovery have sustained their gains for a period of several years.

These cases, along with the many others which are seen from month to month, strongly suggest the relative importance of emotional tension in the complaints offered by children. No data is available as to the extent to which this is true. In all probability, however, it could be safely estimated that at least fifty per cent of all children coming to the physician have disturbing tension states complicating their complaints. If this be true, it behooves every physician, regardless of his specialty inter-

est, to include a careful evaluation of the emotional factors in every child brought to his attention.

Discussion

Gillespie[2] has suggested that severe emotional tension may operate in one of several ways in illness.

1. It may be a causative factor as in psychiatric illness. Case 4 in our series illustrates this mode of action.

2. It may be a sustaining factor. Case 2 illustrates this particularly well.

3. It may be a precipitating factor. Case 3 illustrates this mode of action for whenever tension was increased in the family and likewise in our patient, her spells were more severe and frequent.

Whenever severe tension states occur in children, it is usually because the basic needs of the child are inadequately met. Jordan[3] refers to these basic needs of children as:

1. The need for security.

2. The need for understanding and affection.

3. The need for recognition and achievement.

Whenever these basic needs are not satisfied in a reasonable way or the child is too seriously frustrated without adequate help, trouble may be anticipated. In general the chief difficulty centers in the adverse feelings the child has about himself and others.

These adverse feeling states may manifect themselves in various ways. The child may become a behavior problem, be destructive, asocial, negativistic or generally provocative. He may become severely inhibited to the point suggesting mental retardation. He may either express his disturbed emotional states through the medium of symptoms of illness or he may become ill.

The sources of excessive disturbed emotional states are many and varied. We have found the following of significant proportions and always seek to delineate as far as possible their potential contribution to the problem at hand.

1. Consitutional or acquired deficiencies.
2. Traumatic physical experiences
3. The presence of excessive demands on the child
4. Lack of information or knowledge
5. Adverse parental attitudes
6. Sibling jealousies or rivalries
7. Adverse socio-economic circumstances
8. School difficulties
9. Health and adjustment of the parents
10. Marital difficulties
11. Sibling favoritism
12. The inability to compete successfully with contemporaries
13. Real or imagined lack of parental affection
14. Interference from relatives, etc.

Others could be mentioned.

Careful explanation in these several areas with both the parents and the child often yield surprising information.

While it is often difficult to evaluate the relative importance of severe tension states, we offer a few suggestions which have proved helpful to us.

1. The orientation of the physician is of paramount importance. The willingness to accept the possibility that disturbed tension states may influence the child's problem is primary.

2. The willingness to listen is likewise essential and to these should be added the willingness to observe what is happening to the patient's behavior during each contact.

3. A willingness to spend a little time alone with the child to obtain, if possible, the child's own story. In our experience we are impressed with the helpfulness of this procedure. The child may require time and patience before yielding the desired information but these are often re-

warded if granted him.

4. Securing data regarding social or emotional tension requires that each one be willing to develop his skill to secure this information. The manner in which the patient and/or his family is interviewed is important. One cannot often secure such confidential information by direct questioning.

5. A willingness of the physician to try at least to see the world from the child's point of view. Nothing has been so helpful to us for it provides a way of evaluating the child's own feelings.

We have adopted a set of simple criteria which has proved useful and helpful in many cases. These are:

1. The nature of the complaint. Often single to begin with, it soon multiplies, if the parent is given a chance to elaborate. Multiplicity of the complaint factor provides an initial lead.

2. The absence of or presence of minimum physical findings. It should be stressed that each child be given a thorough basic physical examination.

3. The manner in which the child and parent react toward one another. It is not difficult to sense soon how parent and child feel toward one another, if one observes carefully.

4. Evaluation of the child's total behavior during the physical examination may also be very helpful and revealing. Ideally this should be done without the parents' presence.

In conclusion we should like to suggest that social, psychological, emotional or intellectual factors are important in children's complaints suggesting physical illness. This importance should receive consideration by every physician in the case of every child seen. By so doing not only will many errors of omission be avoided but also means for the child's rehabilitation which should help him in his total adjustment to living, will be provided.

References

1. The following are very useful:

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   c. Berderlands of Psychiatry
   S. Cobb
   Howard University Press, Cambridge, Mass., '43.

   d. Psychosomatic Prognosis
   Dunbar, F.
   Paul B. Hoeber, Inc., '43.

   e. Jr. Psychosomatic Medicine
   The American Society for Research in Psychosomatic Problems, Inc., N.Y.

2. Psychological Effects of War on Citizen and Soldier.
   Gillespie, R. D.
   W.W. Norton & Co. Inc., N.Y., '42.

3. The Role of the Pediatrician in Mental Hygiene
   Jordan, P. H.
   J.Peds. 15:121-129, '39.

III. MEDICAL SCHOOL NEWS

Medical Foundation Dinner and Litzenberg Lecture

On Friday evening, October 22, at 8:15 p.m., Dr. Everett D. Plass, Professor of Obstetrics and Gynecology of the University of Iowa Medical School will deliver the Jennings C. Litzenberg Lecture. Dr. Plass has chosen as his subject "Advances in Maternal Welfare."

A graduate of Johns Hopkins Medical School, Dr. Plass was formerly Chief of Obstetrics at Ford General Hospital. During the past 20 years, he has served as head of the Department of Obstetrics at the University of Iowa. A devoted friend and colleague of Dr. Litzenberg's, he has been extremely active in the field of maternal welfare. Since Dr. Litzenberg contributed so much to the reduction of maternal and infant mortality during his life-time, it is especially fitting that Dr. Plass should deliver this lecture and choose this particular subject.

A dinner will be held at the Campus Club at 6:00 p.m., Friday, October 22, preceding the Litzenberg Lecture. All members of the Foundation are urged to attend both the dinner and the evening lecture. The lecture is open to the public.

A committee of the Minnesota Obstetrical Society is formulating plans for cooperation by the local and national obstetrical societies with the Minnesota Medical Foundation. Below are excerpts from letters received from Doctors C. J. Ehrenberg and Robert D. Mussey, former presidents of the Society:

"The proposal of the Minnesota Foundation to create a memorial fund for Dr. Jennings C. Litzenberg is not only timely but very appropriate. At the time of his death, his wife, Dr. Olga Hanson Litzenberg, asked that no flowers be sent. She expressed the wish that if anything was to be made as an offering that it be in the form of a contribution to some memorial fund in the Minnesota Medical Foundation. Dr. Litzenberg was interested and close to the Foundation at the time of its inception, and she felt that nothing would please him more.

"It probably is not necessary to point out what a distinguished career Dr. Litzenberg had in the University, but it might be well to recall a few things. He entered the University as a student in 1890 and thus made a connection which was not severed until 1938 when he retired from the chair of Professor and Chief of the Department of Obstetrics and Gynecology in the Medical School. During this time, he rose to a position of eminence in his field, not only locally but in a national way. At various times in his career, he filled the highest office in every national society, having to do with obstetrics and gynecology. Few men in the history of this field, in this country, have been so signally honored by their contemporaries. Also his unlimited capacity for friendship, his force as a teacher, and his consideration as a consultant kept him in high regard in his immediate community.

"I sincerely hope that the Foundation is successful in building this fund and that it will in some way then be used for the advancement of obstetrics and gynecology to which he contributed so much and in which he was so vitally interested until the very end."

--C. J. Ehrenberg, M.D.

"That the memorial fund should be dedicated to the advancement of maternal welfare is most fitting. During his many years of service as Professor of Obstetrics and Gynecology of the Medical School of the University of Minnesota, the progressive conservatism which characterized Dr. Litzenberg's professional work, his teaching, and his publications played a large part in the

improvement of obstetric care and maternal welfare throughout the country, and especially in Minnesota and its bordering states.

"I was privileged to know 'Litz' for many years, and I cherish the thought that I was numbered among his numerous friends. I deem it a privilege to be among the many who will heartily endorse this memorial which is planned by the Minnesota Medical Foundation in honor of Dr. Litzenberg."

-- Robert D. Mussey, M.D.

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Annual Leo G. Rigler Lectureship

The annual Dr. Leo G. Rigler Lecture in Radiology will be given by Dr. Merrill C. Sosman, Professor of Radiology, Harvard University, on Thursday evening, October 28, at 8:00 p.m., in the Auditorium of the Museum of Natural History, University of Minnesota. Dr. Sosman will speak on the subject "The Roentgen Diagnosis of Heart Disease and Cardiac Catheterization." The Rigler Lectureship was established in 1944 by colleagues, former students, and friends of Dr. Rigler in recognition of his contributions in teaching and research in radiology. He has been Professor of Radiology and Chairman of the Department of Radiology of the University of Minnesota since 1926.

Dr. Sosman's lecture will be given in connection with a Continuation Study Course in Cardiovascular Roentgenology, October 25 to 30, at the Continuation Study Center of the University. The participating faculty will be: Dr. Richard Bing, Baltimore, Maryland; Dr. Fred Jenner Hodges, Ann Arbor, Michigan; Dr. Marcy Sussman, New York City; and Dr. Sosman. In addition, the graduate faculty of the Mayo Foundation and the University of Minnesota will participate.

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Dean Diehl Appointed to Board

Dean Harold S. Diehl has recently been appointed to the Medical Advisory Board of the United Mine Workers Welfare and Retirement Fund. This Board will recommend plans and policies of the medical program of the Miners Welfare and Retirement Fund.

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Homecoming Activities

Medical School graduates will be welcome at the Medical School and University Hospitals on Homecoming Day, October 30. Any interested physicians are invited to attend the Saturday morning session of the course in Cardiovascular Radiology. Other conferences and clinics regularly held on Saturday morning will also be open to any physician alumni.

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Kellogg Foundation Lectures

Dr. Frederick W. Hoffbauer	Evaluation of Liver Function	Mon., Oct. 25, 3:00 p.m., 229 Center for Continuation Study
Dr. Paul R. Cannon	Amino Acids	Tues., Oct. 26, 2:00 p.m., Eustis Amphitheater, U. H.
Dr. Harry M. Weber	Roentgenologic Contribution to the Diagnosis of Abnormalities of the Large and Small Intestines	Friday, Oct. 29, 3:00 p.m., 229 Center for Continuation Study