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A study of the background of twenty-five enuretic children in residence at the Governor Bacon Health Center Delaware City, Delaware

Wilhemina Thompson
Atlanta University

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A STUDY OF THE BACKGROUND OF TWENTY-FIVE ENURETIC CHILDREN
IN RESIDENCE AT THE GOVERNOR BACON HEALTH CENTER
DELTAARE CITY, DELAWARE

A THESIS
SUBMITTED TO THE FACULTY OF THE ATLANTA UNIVERSITY SCHOOL OF
SOCIAL WORK IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF MASTER OF SOCIAL WORK

BY

WILHELMINA THOMPSON

ATLANTA, GEORGIA
JUNE 1952
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CHAPTER I

INTRODUCTION

Significance of the Study

Enuresis is one of the most common behavior problems in children with which parents, social workers, analysts and pediatricians are confronted, as well as one of the most baffling and unsatisfactory conditions to treat. The term "enuresis" is commonly used to describe lack of control of micturition in a child over three years of age. It may take place during the day or during the night, or be both nocturnal and diurnal in occurrence. This failure to control the bladder is not a disease or a clinical entity, but a symptom of a variety of physical, emotional and environmental disorders and states. Although it is generally recognized that enuresis is psychological in origin, a few claim an organic basis. The term "urinary incontinence" is employed in relation to the involuntary voiding of urine attributable to organic disease or defect, therefore, "enuresis" will be used to describe those cases whether voluntary or involuntary without organic etiology.

The disadvantages of the symptom to both parent and child need hardly be mentioned. From the parents' point of view the habit is inconvenient, unhygienic, labor-making, costly and a reflection of parental upbringing. The child has to contend not only with the indignity of the symptom, but the restrictions it creates. Holidays, visits to friends or relatives, camp activities, education at a boarding school, are either precluded or

1Muriel Barton Hall, Psychiatric Examination of the School Child (Baltimore, 1947), p. 163.
undertaken with the risk of mishap, discovery or reproach. The disorder is met with not only among the poor section of the community but also at all levels of society and among primitive as well as civilized races.

Interest in this study of enuretic children originated from a six months' block field experience at the Governor Bacon Health Center, Delaware City, Delaware. Formerly Fort Du Pont, the Health Center was transformed from an implement of war into a modern special hospital in November of 1948 - a place for complete or partial rehabilitation of handicapped children and adults of the State of Delaware. The main focus of this residential psychiatric treatment center is on childhood, the philosophy being preventive and curative psychiatry. It was the writer's observation that although the children studied were referred to the Center for numerous other reasons, enuresis was frequently found to exist.

At Governor Bacon Health Center admissions, treatment and discharges are the mutual responsibility of the clinical team which is composed of psychiatrists, psychologists, pediatricians and social workers. These team members are also responsible for periodic evaluation of the children in residence to determine their present status.

The cottage plan is employed at the Center in an effort to provide a twenty-four hour therapeutic service resembling as nearly as possible that of a normal home environment. Efforts to further facilitate a normal setting are provided in education, recreation and religious services.

Dr. R. Reed, acting medical director, referred to the Center's psychiatric treatment program as:

\[1\text{Ibid, p. 164.}\]
A retreat to which may retire children who in their ego weakness and inadequacy are being overwhelmed by too much traumatic excitation, from within themselves and from a hostile environment without. Here (GBHC) is attempted to be supplied a warm, permissive, understanding and accepting atmosphere, home-like in its conception and its structure and peopled with steadfast, stable persons who have prepared themselves in the art and the science of guiding the personalities of children back along the accepted path of development.1

If persons working with children are to be assured that they are doing all they can to meet the needs, they must utilize all opportunities to expedite treatment for needy children.

Purposes of the Study

The purposes of this study were to disclose the backgrounds of twenty-five enuretic children to discover what factors were similar as well as different in their histories, to indicate how these factors may have influenced their present patterns of behavior.

Another purpose of this study was to determine whether enuresis is a symptom associated with some other particular symptom such as, delinquent behavior, habit disorders, neurotic traits, personality disturbances or educational retardation.

Method of Procedure

The twenty-five enuretic patients in this study were all known to the Governor Bacon Health Center during the years January 1, 1950 to January 1, 1952. Particular consideration was given to other behavior problems presented by the children studied. Data were systematically extracted from the case record of each child by means of a schedule

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1 Interview with Dr. Roy Reed (Governor Bacon Health Center, Delaware City, Delaware, November 30, 1951).
constructed to include family histories, personal histories, presenting problems or symptoms, physical, psychological and psychiatric examinations, current cottage and school adjustment, as well as adjustment to the total environment and therapeutic situation. Following examination of case materials, the case study method was employed and supplemented by numerical data. Pertinent literature was relied upon to serve as a frame of reference for the study.

Scope and Limitations

This study was confined to twenty-five children possessing the symptom of enuresis. Each child had to meet with the following qualifications: (1) admittance to the Center during the years January 1, 1950 and January 1, 1952, (this period was chosen because of the newness of the agency prior to this time and the lack of sufficient information in the case records), (2) possession of the symptom of enuresis, with or without accompanying symptoms, and (3) absence of somatic defect or disease, deformity or organic findings. Out of thirty cases which could have been studied, five were discarded, one due to organic findings, one to deformity and three to somatic defects, leaving a total of twenty-five children to be studied. No discrimination was made as to age, sex or race of subjects.

Because of the limited number of children studied, broad generalizations cannot be applied to cases other than those in this study.
CHAPTER II

FACTORS CONTRIBUTING TO THE ONSET AND DURATION OF ENURESIS

The general atmosphere of the family, or the emotional climate of the home, is to the growing child what weather and climate are to the growing plant. Because of it the child grows and prospers socially and emotionally, or he is stunned and warped. Some homes, unfortunately for the children in them, create an atmosphere of antagonism, suspicion, distrust, selfishness and mutual competition. In such homes, the children suffer from lack of sound affectional security, steady discipline and an inspiring pattern for personal behavior. In an atmosphere of competition, selfishness prospers. In situations where exists mutual personal distrust, the child learns to suspect all people of ulterior motives, and to lie and evade situations in order to get things for himself. Open frankness, honor and confidence in love cannot be found in such homes. Only when the family atmosphere is one of genuine love, unselfish living, pursuit of honor and mutual welfare can children develop adequate confidence in themselves and in family life in general. In family life, one of the most important factors influencing the growth and development of the child, especially his emotional development, is a satisfying parent-child relationship. This relationship is the one which grows out of the child's inner needs for love,

2Ibid.
3Ibid.
4Ibid., p. 380
discipline and growth at his own rate.

It is important for the reader to have some perspective into the past of these enuretic children who were in residence at the Center, and some of the important experiences which loom behind their behavioral productions.

The Adults in Their Lives

If prevailing criteria for what constitutes an adequate child-adult relationship pattern are used as a basis for reaching conclusions, we can see very little in the case history profiles of the children studied that would satisfy even the most naive clinician or educator that they had had anything even approaching an "even break." Only in a few instances would one be able to gather any evidence that there had been a continuity of relationship with original parent figures. Homes broken through separation, divorce and desertion, and numerous foster home placements and institutional confinement, were outstanding events in their lives as shown in Table 1.

Of the twenty-five children studied, only four lived with both parents. In this group, five children lived with the mother only, and seven with only the father in the home. Two children lived with their mother and stepfather, as compared with one child living with the mother and the mother's paramour. There were eight cases in which neither parent was in the home; three children lived with a guardian, usually a relative; five children had lived in one or more foster homes; while one child had previously been in an institution.

Aside from lack of continuity, the quality of the tie between child and adult world was marred by rejection ranging from open brutality, cruelty and

\[\text{Fritz Redl and David Wineman, Children Who Hate (Glencoe, Illinois, 1951), p. 50.}\]
neglect to "affect barrenness" on the part of some parents whose narcissistic absorption in their own interests exiled the child emotionally from them.

TABLE 1

PARENTS IN THE HOME

<table>
<thead>
<tr>
<th>Parents</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>25</td>
</tr>
<tr>
<td>Both parents in home</td>
<td>4</td>
</tr>
<tr>
<td>Mother only</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
</tr>
<tr>
<td>Deserted</td>
<td>1</td>
</tr>
<tr>
<td>Father only</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
</tr>
<tr>
<td>Deserted</td>
<td>1</td>
</tr>
<tr>
<td>Mother and stepfather</td>
<td>2</td>
</tr>
<tr>
<td>Father and stepmother</td>
<td>-</td>
</tr>
<tr>
<td>Mother and paramour</td>
<td>1</td>
</tr>
<tr>
<td>Father and paramour</td>
<td>-</td>
</tr>
<tr>
<td>Neither parent in home</td>
<td></td>
</tr>
<tr>
<td>Guardian</td>
<td>2</td>
</tr>
<tr>
<td>Foster home</td>
<td>5</td>
</tr>
<tr>
<td>Institution</td>
<td>1</td>
</tr>
</tbody>
</table>

Of the twenty-five children studied, none experienced wholesome parental attitudes. Twelve of the mothers were unconsciously rejecting of their children as indicated by a rejecting attitude, as compared with seventeen rejecting fathers. Two children were overtly rejected by the mother as demonstrated by brutality and cruelty, as well as two cases of overt rejection by

¹Ibid.
the father. An over-protective attitude of the mother was experienced by
two of the children studied, as compared with one over-protective father.
Four mothers were regarded as being inconsistent in their attitudes towards
their children, while two fathers were considered inconsistent. In this
group, five children had ambivalent mothers, while three had ambivalent
fathers.

**TABLE 2**

**PARENTAL ATTITUDES TOWARD CHILD**

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Total</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>50</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Wholesome</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Overt rejection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Attitude</td>
<td>29</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>Over-protective</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Inconsistent</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>8</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

Certainly, there were also operative heavy mixtures of both styles of
rejection, overt and unconscious. A typical example of this is cited in
the following case.

**Case 1**

Lucy was an eleven-year-old girl of average intelligence who
experienced what was probably the trauma of her mother going to the
hospital to bear a baby out of wedlock. The mother later gave
birth to another child by her common-law husband whom Lucy resented.
Lucy's parents separated when she and her twin brother were two
years old, and there was never a close parent-child relationship due
to the mother's lack of warmth. The mother's paramour resented the
protective attitude she had towards Lucy, and demonstrated it by
refusing to allow Lucy to accompany him when he took his two child-
ren visiting. The mother attributed his rejecting attitude to Lucy's
gross untidiness, and in her weak way tried to defend Lucy against the rebuffs of this man. However, the mother herself became extremely irritated at the child's slovenly appearance since she had always been overly meticulous, leaving her own home at the age of fourteen because of her mother's dirty, ill-kept house. Lucy reacted to this rejection and inconsistency with extremely aggressive behavior such as, stealing from the mother and severe negativistic behavior, both in the home and at school. She ate constantly, sucked her two middle fingers and was enuretic. The mother, in desperation, asked for the child's removal from the home after Lucy was apprehended by the law when found asleep in a truck.

Apparently, Lucy's mother was so preoccupied with her own conflicts centering around financial dependence upon her paramour, her inadequacies as a parent and subsequent guilt feelings, that she was unable to give any affection to the child. She over-compensated for her suspected deficiencies by loading Lucy with material possessions and catering to her every want. It appeared that a good deal of Lucy's behavior was motivated by emotional conflicts and insecurity; that she was reacting to a basic feeling of maternal rejection, sibling rivalry, and anxiety and confusion around the father-figure. Her stealing and oral preoccupation appeared indicative of the love and affection she craved from her mother. Her hostility and aggression in fights with her peers appeared an acceptable medium to free herself from guilt in wanting to hurt her mother. In general, the child's defenses consisted of a sullen, negativistic, uncommunicative attitude. She showed regressive features (sucking fingers, enuresis; temper tantrums) in an effort to compensate for the neglect and rejection that she felt, and which apparently had been exaggerated by the advent of the new arrivals of babies into the home.

This phenomenon of casual surrender of one's own child marks Lucy's mother off decisively from the parents of the typical neurotic child who has had to go into institutional placement. The parents of the neurotic child who cannot live with him also begin to feel in his absence that they
cannot live without him either. He is somehow necessary to their neurotic design as in the case of Henry.

Case 2

Henry, an eleven-year-old boy of high average intelligence, was referred to the Center by a neighbor upon recommendations of the Mental Hygiene Clinic. Henry's problem centered around a compulsion to steal his mother's money. At first the stealing involved small amounts, gradually becoming larger, and extending over into the community. He would spend the entire amount on other children, sometimes returning only when all the money was gone. The mother handled this by spanking him, by talking with him, punishing him and trying to remove all funds from his reach. Henry showed no remorse or guilt around his actions. In the initial separation from his mother, Henry was observed to be rather aloof, turning his back on her. However, the next day or so he developed tremendous homesickness, sobbing inconsolably, begging to return home. He told of his fears and dreams in which his mother was being injured. The mother visited regularly, telling Henry of her terrifying dreams concerning his well-being. Henry became excessively enuretic, the habit having persisted since birth.

The patient was a rather complicated boy who had both a physical problem, in reference to his conspicuously protruding teeth, and a severe emotional problem. It appeared as if he had highly ambivalent feelings toward his mother; on the one hand, strong positive feelings derived from the fact that he was in an abnormal situation with a mother always available on whom he could depend but no father-figure around. On the other hand, Henry probably felt that his mother was responsible for his father's desertion. Hostility towards the mother was revealed further by Henry's fantasies and fears in which the mother was being injured in his absence. From all indications the Oedipal situation was never completely resolved, thus the sex aim remained directed toward the mother for which Henry felt guilty. 

English and Pearson stated:

1 Ibid., p. 51.
If as a result of traumatic experiences which interfere with the even course of a child's psycho-sexual development, he is forced to suppress his ambivalence to his father too suddenly, then he will find that he remains ambivalent toward all future libidinous objects. He cannot love completely for when he loves he also hates, and vice versa.  

Stealing from the mother seemed to represent an effort to compensate for the lack of real love and affection received from her. Punishment, especially spanking, from the mother may have given Henry some sexual gratification as well as relief from any guilt he may have had for stealing. It is felt that Henry and his mother were entangled with each other in a way which was not particularly healthy. The mother was probably acting out her own problems in relation to love and affection unconsciously through the boy since she admitted loss of interest in her husband and men in general. It was significant that Henry was called "Buster" supposedly by his father, however, "Buster" was also the nickname of the mother's father. It was interesting that the mother's teeth also conspicuously protruded, perhaps a further source of parent-child identification and another basis for the mother's over-protective attitude. However, unconscious rejection of the child was indicated by the mother's comparison of him with his father, whom she despised. Although Henry had high average native ability, emotional conflicts in the home caused him to function on a lower level of intelligence, as revealed by the psychological examination at the Center.

The above case illustration and that of Lucy, previously discussed, show the difference in the parental style of involvement with one's own child, and is of basic etiological significance in determining the children's contrasting as well as similar symptom structures. It was really the

difference between little or no relationship at all, and an ambivalent but strong love-hate ridden relationship. Further, the writer could gather no impression, either from case histories or subsequent material productions by the children once in treatment, that they had known even one adult with whom they had built up a warm relationship on an occasional friendly visit basis to which they look back and glow. No relatives seemed to take any interest in them which was enough to provide significant gratifications. This whole vacuum in adult relationship potentialities cannot possibly be over-estimated in terms of how impoverished these children felt or how much hatred and suspicion they had toward the adult world.

A considerable number of the children studied came from untidy, ill-kept homes and from parents who "let themselves go" in many ways.

**TABLE 3**

CLASSIFICATION OF PROBLEMS PRESENT IN FAMILY

<table>
<thead>
<tr>
<th>Classification</th>
<th>Total</th>
<th>Problems Presented</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Father</td>
<td>Mother</td>
<td>Siblings</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>25</td>
<td>25</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Alcoholism</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Emotional instability</td>
<td>16</td>
<td>6</td>
<td>10</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Social maladjustment</td>
<td>9</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Mental illness</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Limited intelligence</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Suicide</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Criminal records</td>
<td>5</td>
<td>3</td>
<td>-</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Sex delinquencies</td>
<td>11</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

1Fritz Redl and David Wineman, op. cit., p. 50.
Out of a total of fifty-six family members tabulated, twenty-three presented amoral behavior, such as alcoholism, sex delinquences and arrests. Another twenty-three were either emotionally unstable or socially maladjusted. One mother was mentally ill, while five parents were of limited intelligence. Two fathers committed suicide.

Under these circumstances, one certainly does not have to think of some mysterious form of heredity via the bladder or the kidney. With such type of inadequate background, we are apt to deal with human material which does not adjust as easily as children of healthy and stable parentage. It is easily seen that in such homes toilet training with regular meal times and retiring hours and attention to cleanliness can hardly be expected to be carried out consistently and intelligently as the parents have not revealed the ability to train or control themselves. To many of them, the wetting appeared a relatively small problem or no problem at all in comparison with the major difficulties in the life of the family. As a matter of fact, the enuresis was not offered as a complaint at all and was brought out only incidentally in the course of the examination, the child's admission or by observation. It sometimes took a sore throat or poor school work to bring the child to the Center where the occurrence of the wetting was discovered. The parents simply considered the matter too unimportant, or attributed it to a "weak bladder" or "weak kidney," and did not wish to be bothered. This attitude frequently motivates parental references to the effect that the child had wet himself every day or every night "until two weeks ago" or "until a month ago," or that it happens "very seldom."

In addition to the problems that characterized parental relationships,

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special traumatic experiences affected some of the children. All children encounter experiences which have some degree of traumatic impact but seldom do we see children who have been so grossly and continuously exposed to traumatization on so many different levels as those studied. While trauma was common with them, benign experiences were rare. From their histories, it was this that emerged as the most predominant theme in their prior experience. The traumatic events appearing in the following Table are only a few of the many varieties experienced by these children.

**TABLE 4**

**TRAUMATIC LIFE EVENTS**

<table>
<thead>
<tr>
<th>Events</th>
<th>Number of Traumatic Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>33</td>
</tr>
<tr>
<td>Death of parents</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>1</td>
</tr>
<tr>
<td>Father</td>
<td>2</td>
</tr>
<tr>
<td>Both</td>
<td>-</td>
</tr>
<tr>
<td>Separated or divorced parents</td>
<td>6</td>
</tr>
<tr>
<td>Foster homes</td>
<td>5</td>
</tr>
<tr>
<td>Significant illnesses</td>
<td>2</td>
</tr>
<tr>
<td>New sibling arrivals</td>
<td>17</td>
</tr>
</tbody>
</table>

The majority of the children studied, seventeen, revealed that the advent of new siblings in the family was the major traumatic experience. Three children experienced the death of a parent. Parents were either separated or divorced in six of the cases studied. Five of the children had been in one or more foster homes. Significant illnesses were experienced by two children.

1Fritz Redl and David Wineman, *op. cit.*, p. 54.
An example of a special traumatic experience is illustrated in the case of Fred, a ten-year-old boy.

Case 3

Fred's father deserted shortly after his birth and was never seen again by the family. His mother, an unstable person, deserted shortly afterwards, having no contact with the family until recently when she returned after an absence of seven years. Fred, who had always considered his grandmother to be his mother, was considerably confused by the arrival of the mother, who remained in the home for only a short while before disappearing again. This time probably never to return again. The maternal grandmother, upon whom Fred was extremely dependent, requested placement for him and his older brother due to financial difficulties. Fred, who had always wet himself and frequently soiled his clothes, was otherwise a conforming, inhibited child.

The injuriousness to ego growth of such casual, inconsistent, and emotionally cold contact with adults can be taken for granted, for psychological trauma is not only a function of destructive things that are done to the child but can likewise be a product of what is not done. In the case of Fred, we can see an obvious mixture of both. At the Center, Fred's enuresis diminished but he continued his intractable habit of soiling himself during the day which was obviously a spite mechanism, deliberately done, for he would draw his housemother's attention to it. This continued, however carefully he was taken to the bathroom. Fred became strong-willed and somewhat negativistic. On the whole his conduct was considered regressive and seriously maladjusted. Increased excitability was noticed after home visits.

These frequent disruptions in the family unit and subsequent confusion contributed to Fred's maladjustment. In other instances, the degree to which some of the children had been physically abused, in addition to having been exposed to inadequate, emotionally cold adult handling, was also prevalent. Their basic significance was the degree to which the children
encountered the extent and intensity of trauma. Clinically, there is no reason for doubting that these events were destructive to ego development in themselves, although the exact dimensions of the effects they exerted and how they are blended with other factors in the traumatic area must be left to later research.

Their Siblings

Sometimes the specific type of association with the brothers and sisters may contribute its share to the development of personality problems and behavior disorders. The majority of the children studied had siblings. In many cases there was open sibling rivalry and tension, quarrelsomeness and bickering. Many of the siblings were no better adjusted than the child who came into placement, however, it was usually the case that the placed child had a scapegoat position with respect to parental attitudes in the sibling preference range. He was always accused of being the "worst one." Upon closer scrutiny there was usually some psychological factor which predisposed the parent to hold this discriminatory position toward a particular child. Resentment and friction had, in a number of the children, been created by the parents' attitude of preferring one child to another or of contrasting them openly. Occasionally, both the child praised and the one blamed may be harmed; in the former, conceit and an unjustified feeling of superiority may be the result; the latter may react with lack of self-confidence and of self-assertion, spite, or with jealousy of the rival. Such

1 Ibid., p. 56.
2 Leo Kanner, op. cit., p. 98.
3 Ibid.
was the case of Henry, discussed previously.

Case 4

Henry's arrival into the family caused his parents great concern. He was rejected by his father at birth, for the mother had had this second child against his will. The father was an only child while the mother came from a large family. The father idolized the older child, a girl, and was completely disinterested in Henry. Henry was the target for most of the family quarrels. He closely resembled his mother because both had unattractive protruding teeth, which apparently caused the mother to closely identify with him and his problem, for he was constantly teased by his sister and playmates, yet his likeness toward his father, whom the mother disliked, caused her great distress. The father, who was never much of a family man, deserted the family when the patient was four years old. Henry reacted to this rejection, unfavorable comparison and family disharmony by becoming excessively enuretic, extremely jealous of his sibling and stealing from the mother. The sibling suffered a nervous breakdown.

Such careless, neglectful, overtly rejective behavior by the parents not only victimize any individual child but predispose the siblings to open brutality toward each other on the basis of general insecurity. Not a few instances of hatred between siblings in later life dates back to unequal treatment during the period of childhood. In some cases severe sibling rivalry and tension were related to the step parent in the home when such a parent rejected the child in favor of her own children - just as the typical story-book step-mothers do. Such was the case of Joyce.

Case 5

During Joyce's early childhood there was marital friction, partially attributed to by the interference of the paternal grandmother. The father was never able to earn a living and the mother worked irregularly. When Joyce was three years old, her parents separated, later divorced. Following this separation, Joyce lived with her father and his paramour. Three children were born from this union. Joyce was physically neglected and mentally abused in the household by both the mother-figure and siblings. Her father,
being a passive man, seldom voiced any opinion in her favor. When it was known that Joyce did not get adequate supervision and care, her own mother requested foster home placement. Since that time Joyce has been in three temporary and two "permanent" homes. Her enuresis and wilful behavior became so acute that it was necessary for the foster parents to ask for her removal.

As in the above case, certain traits are definitely connected with the child's wetting. This is especially true if the incidence of enuresis is a spite or jealously reaction. The onset of the symptom was apparently associated with the arrival of new siblings, and subsequent displacement and rejection. Joyce, who had been an only child until then, showed her resentment also in many other ways.

The child who is given charge of the younger siblings and who is expected to devote much of her time to them, may in one case form a strong attachment, but in another, feel that she is done an injustice by curtailing her time of recreation and play. If for any reason the younger child is more competent, the struggle is even more difficult, and may create a giving-up attitude, sometimes regression to an infantile type of behavior, either as an attention-getting mechanism or as a method of rebelling against the enforced heavy program mapped out for them. An example of this is seen in the case of Judy.

Case 6

Judy was a thirteen-year-old girl whose family was known to social agencies for years because of neglect of their children. The father was believed to be alcoholic while the mother was considered inadequate, thus the responsibility for the care of five siblings rested upon Judy, the oldest child. She developed a strong familial attachments in spite of her physical and emotions deprivation. At the Center she gave one the impression of being

\[1^1\] Leo Kanner, op. cit., p. 98.
\[2^2\] O. Spurgeon English and Gerald H. J. Pearson, op. cit., p. 43.
hungry for attention. Her deprivation and neglect were revealed in her wishes for a home, food and clothing. In the cottage, she was profane, belligerent, and given to enuresis and complaints about other children. In school, she was unable to learn.

Judy was a girl of low average native capacity of intelligence with a poorly integrated personality. She was functioning on an inferior level in all of the personality spheres. She was also definitely retarded in all school work. She lacked emotional warmth, appeared suspicious and otherwise showed the effects of her emotional deprivation and disturbance. Judy’s hostility toward her parents and siblings was successfully suppressed while in the home, displacing it onto her peer group.

The second child is confronted with the problem of keeping up with his older sibling, while the middle child must strive to keep up with his older sibling and yet at the same time keep a step ahead of the younger. The only child is apt to be more exposed to parental and sibling over-solicitude and overindulgence than others. The only child, "exposed to the undiluted force of parental attitudes," has to react to these attitudes without the benefit of projection onto siblings.

The child’s place in the family, in order of birth, may at times be of significance in the evaluation of the psychiatric problem for which examination or treatment is requested. A certain amount of "scrapping" among brothers and sisters is a common occurrence. There are, however, children, who, because of their dullness, or sensitiveness, or because of some specific peculiarities, are selected by the rest for continuous "testing," with sometimes very unpleasant accompaniments and results. Goodenough and Leahy, in conclusion of an interesting study, stated that "there is

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1 Ibid.
2 Leo Kanner, op. cit., p. 99.
probably no position in the family circle which does not involve, as a consequence of its own peculiar nature, certain special problems of adjustment."

**TABLE 5**

**ORDINAL POSITION IN THE FAMILY AND SIBLING RELATIONSHIPS**

<table>
<thead>
<tr>
<th>Position</th>
<th>Total</th>
<th>Harmonious</th>
<th>Rivalry</th>
<th>Extreme Rivalry</th>
<th>No Siblings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>25</td>
<td>4</td>
<td>12</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Oldest of two</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Oldest of three or more</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Middle</td>
<td>10</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Youngest of two</td>
<td>3</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Youngest of three or more</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Only child</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

In general, sibling relationships were somewhat more harmonious than parent-child relations but, even at that, only four children experienced pleasant relationships with their siblings, while the remaining twenty-one were rivalrous toward one another. All of the children studied had siblings except four. Seven held the oldest child's position, ten were in the middle of the sibling range, and four children were the youngest of siblings.

**Life in the School and Community**

Invariably, the children who came to the Center's attention because of

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enuresis, had made extremely poor adjustments in the communities and schools from which they came. In the school, both on a behavioral and scholastic basis, some showed severe disabilities to the extent of having to be in special classes or of being excluded from school altogether. Truancy, disobedience, aggressiveness, lying, stealing, swearing—all of these were familiar complaints. The child's humiliation in the home, school and community because of the unpleasantness of the symptom served to make him much unhappier than he had often already been. Preoccupation with the problem interfered with the quality of his school achievements. Lawson Lowrey stated, "lacking other avenues of success which might help to balance the feelings of inadequacy and insecurity, the intellectually inferior resort to various types of delinquent behavior in an effort to acquire status in the group." The table below illustrates the relationship between school adjustment and achievement.

**TABLE 6**

**SCHOOL ADJUSTMENT AND ACHIEVEMENT PRIOR TO REFERRAL**

<table>
<thead>
<tr>
<th>Adjustment</th>
<th>Total</th>
<th>Satisfactory</th>
<th>Poor</th>
<th>Retarded</th>
<th>No Formal Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>25</td>
<td>8</td>
<td>9</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Satisfactory</td>
<td>8</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Poor</td>
<td>10</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Disciplinary problem</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>No formal education</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

The majority of these children, sixteen, fell within the categories of poor school adjustment or disciplinary problems, with subsequent poor academic work and failures. In some cases the degree of disturbance in the school situation made it necessary for the authorities to ask for the child's removal, as in the case of Trudie.

Case 7

Trudie, an eight-year-old girl of average intelligence, was placed in a foster home at the age of three after her father's desertion and the mother's neglect. She had always wet the bed and several times had bowel movements on the floor of her bedroom. In school, as well as in the home, she stole many small items. In this as in all things she was most cunning. On one occasion she stole money from the teacher's desk and wrapped it in her sandwiches. She denied to the teacher that she had taken the money. Trudie was sadistic in her treatment of other children. She pinched them and tried to hurt them in every possible way. Her attitude was poor and she became a disciplinary problem. She was never interested in learning and distracted the other children with her wild and uncontrollable behavior.

The behavior exhibited by Trudie indicated her eagerness for attention. Her infantile manner and insatiable demands for love and admiration otherwise showed evidence of her insecurity.

Some children who were not severe behavior problems in the school situation still had built up intense fear and anxiety about school because of emotional barriers to learning which involved them in continued failure. While this is not a usual complaint of the school, as it does not present the problems of overt aggression and defiance against rules and routines, it often existed, sometimes as an isolated symptom, frequently in combination with other school-related disturbances as in the case of Johnnie.

Case 8

Johnnie, aged eleven, was referred to the Center by the school

Fritz Redl and David Wineman, op. cit.
upon recommendations of the visiting teacher. He was in the first grade for three years. School work made him "nervous." When he became nervous, he would sit isolatedly and there was noticed a tremor of his hands and arms. Johnnie also complained of pains in his stomach and often had headaches. He did not gain weight properly and recently weighed only forty-eight pounds. His younger brother was in the same grade as he and this caused him to develop feelings of inferiority. Johnnie began to realize and admit that he could not do the same work as other children of his age.

Johnnie was born to a very neurotic and insecure mother and an alcoholic father. The home environment was inadequate. He lacked the developmental stabilizing factors which are conducive to feelings of security and adequacy. To this deprivation, he reacted by a failure in the learning processes, so that he appeared to be functioning at a defective level. He was characterized by excessive timidity, fearfulness, anxiety and withdrawal. He was unsocial and given to moodiness. He was enuretic, hypochondrical, given to nail biting and persisted in the habit of taking a doll to bed with him. There is a history of some difficulty during the mother's pregnancy. Johnnie was born prematurely and physical development had always lagged. He had been subject to an endless series of chronic infections since birth, which apparently had a significant influence on his personality. His maladjustment was indicated by numerous neurotic traits.

In their communities, some of the children either ran with the other delinquent children or engaged in "lone wolf" activities of a delinquent or impulsive nature. A typical example is the case of Charlie.

Case 9

Charlie was a ten-year-old boy of average intelligence but who was functioning far below his level. His retardation in first grade reading was to the extent that a kindergarten class was recommended to afford him more individual attention. He also had a speech handicap. Charlie wasted a great deal of time in the classroom; refused to pay attention, many times sitting and staring into space, seldom appearing to hear anyone who was
talking to him. He would attend school in the morning but not in the afternoon. Instead of going home for lunch as was expected, he would roam the streets until late at night. He stole many articles from the five and ten cents stores which he always gave or threw away, never keeping any for himself.

Charlie associated with a gang of neighborhood boys three and four years older than himself, and who his mother believed also stole. It was almost impossible to keep Charlie at home. He was described by his mother as doing many odd things, such as removing some of his clothing and going out into the streets. He had a violent temper, and once when angry, threw a pen knife at some older boys. Charlie had been enuretic since birth and the mother stated that he was not the least bit ashamed of it, although he sometimes lied about it, saying he split water on himself. It was only lately that Charlie began lying.

The number of Charlie's problems was in direct proportion to the intensity of his disturbance. In both the school and community areas, Charlie's maladjustment was felt. It seemed significant that Charlie's father always carried a pen knife, once cutting the mother's arm. Thus, a similar behavior pattern existed in the home.

Some children suffered from loss of continuity and stability in their school and community relationships. Because many of them were shifted about so much, they never became acquainted with or rooted in any one community milieu. Such was the case of Wally.

Case 10

Wally, who had been in several different foster home placements for five or six years prior to his admission at the Center, had become such a disciplinary problem that the foster parents asked for his removal. He made threats against the foster father, disobeyed the foster mother and was hostile towards both his own as well as his foster sibling. In addition, he was described as destructive, untruthful and enuretic nightly. He over stuffed himself when eating and vomited frequently. Wally had been in many schools, both rural and urban. He chronically tried to avoid school by pretending illness and when forced to go, would sometimes truant.

Ibid., p. 53.
Thus, from the point of view of his many shifts in placement as well as his truancy pattern per se, Wally practically had no community life during this period. His psychosomatic disorders, hypochondriacal symptoms and disinterest in school seemed reflectors of the lack of secure attachments in his world. He probably took the numerous changes of placement as rejections and was constantly in competition with his siblings for the affection of his last foster mother.

The cases illustrated were those of children whose intelligence ranged from dull normal to high average potential but who were functioning below their levels of performance. A number of studies of the distribution of behavior problems in school populations have been made which uniformly show that there is marked increase in behavior problems as the intelligence levels depart from the average in both directions.

Throughout, in the home, in the school and in the community, it was noted that different children reacted differently to similar situations, as well as the fact that different situations affected different children similarly. However, some of the common denominators in the lives of these children were: traumata relative to parental discord; unwholesome parent-child relations; sibling rivalry; maladjustment and poor achievement in school, and in four cases, no community ties.

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1 Lawson Lowrey, op. cit.
CHAPTER III

CONCOMITANT SYMPTOMS

From the earliest infancy until death people are reacting to others - their behavior, their attitudes, expressed or surmised, their approval or disapproval, their love or hate, their dominance or submission. External situations are of great importance in inciting behavior, both internal and external, and social. They act as conditioning or modifying factors for reactions to later situations, since previous experiences are retained. As a result of the combination of present stimulus and past experience, a reaction is initiated and either carried through or inhibited. The resulting behavior reaction may be external (social), in which case it is directly observable as it affects the individual himself and as it affects the person or group to which it is exhibited. The reaction may be only internal (personal), with no manifestations that can be perceived by others. Finally, the reactions may be both internal and external. In this case there is not necessarily any similarity between the two sets of reactions; in general, we interpret the internal reaction (feelings and thoughts) by the external behavior. This is usually a delicate task, especially if there is partial or complete voluntary suppression or distortion of external reactions, even in situations where emotions are acute. Thus, from this viewpoint any and all changes in the dynamic equilibrium of the individual are to be called behavior.

2 Ibid., p. 253.
3 Ibid.
Since the children in this study developed symptoms in keeping with their fundamental disorders, a Table according to the official psychiatric statistical classification in this country was devised. According to Lowrey, primary behavior disorders in children are classified in three groups: habit disturbance, conduct disturbance and neurotic traits. The writer included personality disturbances and educational retardation in the classification, as these disorders were also used in her agency. Children referred as social problems will be discussed later.

It is perhaps unfortunate that no better classification can be offered. As it happens, there is very little to be gained by attempting to apply diagnostic labels to children who present behavior problems without adequate consideration of the individuality of the behavior and the subsequent inaccuracies of stringent classification. However, these problems may be defined as behavior manifestations which are socially unacceptable at home, in school, or to the community. Some represent the continuance of behavior, once useful, past the time when it should normally be replaced by physiologically and psychologically better integrated behavior. In other instances, there is regression to an earlier type of behavior which had been "outgrown." Other problems occur as manifestations of aggression or its suppression.

The symptoms do not appear as unitary revelations but a great number of them are exaggerated forms of behavior common to all children at some time or other. It is possible to recognize neurotic symptoms (as usually defined) in many of the cases, and, in others, neurotic conflicts may be discerned which have produced symptomatic behavior rather than symptoms of 1

1 Ibid., p. 260.
illness. Conduct disorders which bring youngsters into conflict with the law, are considered as delinquency. It should be noted that much delinquent or illegal behavior does not result in police or court action; the individuals showing such behavior may not be delinquent in a technical sense, but their actions are delinquent. As an example, only three children studied were actually apprehended by the law for committing delinquent acts, such as stealing and running away, however, nine other children presented similar behavior which remained undetected or unreported to court authorities.

The behavior problems which were found in association with enuresis are classified below as shown in Table 7. Of the thirty-six symptoms tabulated, each child, ranging in age from six to thirteen years, presented from one to five symptoms.

TABLE 7
CLASSIFICATION OF SYMPTOMS ACCORDING TO SEX

<table>
<thead>
<tr>
<th>Classification</th>
<th>Total</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>125</td>
<td>35</td>
<td>90</td>
</tr>
<tr>
<td>Habit disturbances</td>
<td>22</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Conduct disturbances</td>
<td>58</td>
<td>17</td>
<td>41</td>
</tr>
<tr>
<td>Neurotic traits</td>
<td>15</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Personality disturbances</td>
<td>17</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Educational retardation</td>
<td>7</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Social problems</td>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

Out of a variety of one hundred twenty-five symptoms presented by both sexes, fifty-eight were classified as conduct disturbances, or as Dr. Lowrey has said, children who, if apprehended by legal authorities, would be

\[\text{Ibid., p. 263.}\]

\[\text{Ibid.}\]
labeled delinquents. These disturbances ranged from negativism as shown by belligerency, destructiveness and the like, to vagrancy. A total of twenty-two habit disturbances were reported, such as nail biting, masturbation and temper tantrums. There were fifteen neurotic traits presented, among them were speech defects, overactivity and hypochondriasis. The seventeen personality disturbances included seclusive states, sleep disturbances and feelings of inadequacy. Educational retardation occurred in seven cases, ranging from superior intelligence to borderline or dull normal intelligence, although all the children studied were functioning at levels lower than their potential capacities. Six children were admitted to the Center as social problems such as, neglected or dependent children or children whose parents were no longer able to provide for them due to financial strain, marital discord, death or other social reasons.

The most common behavior problems presented by the boys in this study were: disobedience, stealing and enuresis. Aggression, untruthfulness, vagrancy, seclusive states and school failures followed in equal frequency. There were significant differences in the problems presented by the girls. The most frequent problem was that of disobedience followed by temper tantrums, sensitiveness, "nervousness," negativism, untruthfulness, sex activity, enuresis and school failures. It was seen then, that boys tend to react to their conflicts with external aggression, while girls often show internal evidence of symptom formation, which may be a cultural factor.

This aggressive pattern of boys was intimately linked up with stealing, as well as other forms of evasion and dishonesty such as, lying and truancy; both represent rebellion and an attempt to escape unpleasant situations. It

1Ibid., p. 263.
was not surprising, therefore, to find that lying was far and away the most frequent associated symptom in those who stole. All of these aggressive acts may have been motivated by a desire for revenge or centering the attention of others (usually the mother) on the individual. They certainly represent overt reaction to a disturbance in interpersonal relationships, in which there were both ego and libidinal frustrations.

In cases presenting negativistic behavior as an outstanding mode of reaction to situations, fears and fantasy formation, as occurred in a few instances, may be present to an extreme degree, but masked both by verbal reticence and by the overt behavior. The latter usually expresses the exact opposite of fears and fantasies. If fantasies are expressed, they seem to be especially daring, pompous conceptions. On the other hand, fears and fantasies are integral parts of neurotic pictures, and the negativistic children do not present many symptoms of a neurotic nature. That is, their response is direct in that they tend to react to their conflicts with external aggression without revealing internal evidence of symptom formation.

Habit disturbances are characterized by children becoming "conditioned" to a certain type of response to a number of similar situations. The response becomes a habit, an emotional reaction. The period of domestication is coincident with a mode of behavior which may be said to be almost universal and which is commonly referred to as resistiveness, or negativism, or spitefulness.

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1 Ibid., p. 309.
2 Ibid.
3 Leo Kanner, op. cit., p. 67.
4 Ibid.
Maladjustment in the school setting and school failures may create in the child envy of those who are more fortunate in this respect, and cause him to truant or look for satisfaction in daydreaming or in the development of hypochondrical complaints. These are complaints in which the patient's personality is very obviously and conspicuously in the foreground.

Perhaps the most significant data demonstrated over and over again during the past twenty-five years have to do with the enormous influence of an individual's relations with people in the development of personality and behavior patterns, especially those of one's own family and during the first few years of life. It is in the details of the relationship with one's family and with other people rather than in mere factual statements or diagnostic categories that the fundamental points of his personality and behavior patterns are to be found.

Considering the wide variety of symptoms presented by the children in this study, enuresis almost never existed alone but was accompanied by other symptoms. This list of associated difficulties as shown in Table 7, demonstrated better than anything else the futility of treating "enuresis" rather than the child in toto with all his problems and peculiarities and traits. In doing so, a knowledge of the environmental factors influencing his conduct would be indispensable.

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1 Lawson G. Lowrey, op. cit., p. 257.
CHAPTER IV

SUMMARY AND CONCLUSIONS

This case study supported the theoretical concepts of some authors that enuresis is a symptom of many abnormal states, and is only one symptom of social and emotional maladjustment.

The cause of this symptom in the individual case can only be determined by considering the child and his environment as a whole. The case material of the children isolated for study offered a great variety of physical, emotional and psychological factors that may have precipitated the behavior. Some of these were: poor living conditions, traumatic experiences relative to the adults in their lives, sibling relationships and the communities and schools from which they came.

A low economic status existed in the homes of most of the children studied. Although this factor is by no means of prime importance, it does throw some light upon the conditions under which the children lived. Children in this category either belonged to the social problem group and were reared in an atmosphere of squalor, overcrowding, poverty and dirt, with lack of toilet facilities and absence of training; or they were by nature phlegmatic, apathetic, pale, lanquid or indifferent.

In five of the cases, children possessing the symptom of enuresis were sensitive, timid, dependent and emotionally unstable in the sense that they were readily moved to tears if reproved or disappointed. These children were usually of average intelligence but functioning on a lower level, especially in the personality sphere. They were infantile in facial expression and outlook and were given to anxiety, worrying, and allied nervous habits such as stammering, as well as psychosomatic disorders. They were
usually children who were over-protected or whose parents presented similar neurotic traits.

In cases involving the more traumatizing experiences, mental conflict was associated with the enuresis in seven of the cases. The child who was unhappy over some particular circumstance such as that of being unloved, unwanted or insecure in his home life, or stress in his school life as a result of emotional disturbances in the home, began to wet the bed. In these cases the child had previously gained normal control of the bladder. In cases of broken homes, the enuresis, if not already begun, may have been attributable to separation anxiety. Under these circumstances the symptom could be regarded as a call for help and protection, indicating a regression to infantile dependence. In other cases where the symptom was probably due to mental conflict, evidences of anxiety, such as irritability of temper and sleep disturbances were present, appearing in three of the cases.

In ten of the cases, wetting was a symptom of a behavior disorder. The act was not considered unconscious but deliberate and purposive - a conscious desire to hurt, inconvenience or attract attention or interest, or to achieve power by upsetting the household. Although the wetting appeared a wilful act, it apparently represented overt reactions to a disturbance in interpersonal relationships in which there were both ego and libidinal frustrations.

Several psychological components were present in the children studied. They were: the desire for attention; the desire for love and physical gratification; the hostility and revenge against the parent who did not give the desired gratification and also against the other parent who may be held
responsible for the thwarting; the memory of the real or phantasied danger by which the revenge is gratified; and the need for punishment for such "horrible" and reprehensible desires - found expression in the enuresis, and the child, suppressing them all into the one symptom could continue to live blandly unconscious of the presence of his real feelings.

It will be seen from what has been said that the enuresis was only an indication of a severe intrapsychic conflict - the child was very neurotic. This concept is borne out by the fact that adult neurotics frequently give a history of this type of enuresis in childhood and that their adult difficulties of adjustment revolve around similar problems that they attempted to solve in childhood by their enuresis.

On the basis of the foregoing findings, the writer drew the following conclusions:

1. The overt factors influencing the behavior of the children in this study differed in every case. However, emotional and physical deprivation, and thwarted desires and satisfactions were in evidence throughout.

2. Disturbed intrafamilial relationships constituted the most influential factors in the development of the behavior disorders shown by these children.

3. Parental rejection was the most outstanding single factor influencing these children's behavior.

4. Children with emotional disturbances, as observed in this study and substantiated by similar studies, tend toward low educational achievement and poor school adjustment.

5. Enuresis cannot be attributed to one factor alone but to multiple causes expressed in numerous ways, in addition to the enuresis. The enuresis
is one of several manifestations of a general habit disorder. Poor endowment, poor upbringing and poor example may all contribute their share to the undesirable conduct.
SCHEDULE USED FOR OBTAINING DATA

I. Identifying Information

Name ____________________________
Age ________
Sex ________
Race ________
Date of Admission ____________________

II. Family History

Marital Status of Parents (underscore one)
(single, married, widowed, separated, divorced, common-law)
Age of Parents: Father ________ Mother ________
Occupational Status of Parents: (name – describe if necessary)
Father __________________________________________
Mother __________________________________________
Relationship of Parents to Each Other (describe)

Number of Siblings __________________________
Ordinal Position of Patient __________________________
Other Relatives in the Home (name relationship) __________________________

Economic Status (underscore one)
(indigent, marginal, adequate, comfortable)

III. Personal History

Mother's Health During Pregnancy (describe briefly)

Attitude Toward Birth of Child (describe)

Nature of Delivery (check one)
Full term, normal birth __________________________
Premature __________________________
Instruments used __________________________
Caesarean __________________________

Delivery (age of each)
Weaning __________________________
Walking __________________________
Talking __________________________
Toilet training __________________________ Problems incurred (describe)

Serious illnesses (describe briefly)

Social Adjustment (describe briefly)
Relationship to siblings __________________________
Relationship to parents __________________________
Relationship to others __________________________
School Adjustment Prior to Center

37
Grade achieved
Scholastic ability as reported by informant (describe briefly)
Adjustment (describe briefly)

IV. Referral

Referring Agency
Reason for Referral (describe briefly)

Presenting Problems or Symptoms (describe in detail)

V. Physical Examination (Performed by resident pediatrician)

Essentially Negative ______ (check)
Physical Abnormalities ____________________________ (name)
Significant Illnesses (name and describe)

VI. Psychological Studies

Tests Given ____________________________ (name)
Tests Results (summarise)

VII. Diagnostic and Evaluation Formulations

Current Cottage and School Adjustment and Therapeutic Results (describe)
Significant Findings (summarise)

Psychiatric Evaluation (summarise)

Diagnosis

Recommendations (name)
BIBLIOGRAPHY

Books


Articles


Unpublished Material

Reed, Roy. "Governor Bacon Health Center's Treatment Program," Interview at Governor Bacon Health Center, Delaware City, Delaware, November 30, 1951.