the pathological investigations; and to the lady whose nursing skill and unwavering optimism contributed in no small measure to the patient's recovery.

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NOCTURNAL ENURESIS

BY

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The prevalence of nocturnal enuresis among children, especially of the poorer class, has been something of a revelation to those concerned with evacuation. Most mothers are very reticent about bed-wetting in their own children, and until the children were obliged to leave home the secret was so well kept that the high incidence of bed-wetters was not even guessed.

The causes of bed-wetting are various, and therefore it is essential to investigate each case individually and to deal with it in relation to the cause rather than to the effect. The general attitude to this unfortunate habit is one of horror and disgust on the part of strangers and shamefaced acceptance on the part of the mother. Hostesses of evacuated children are sorely tempted to treat the offending child with reproach and punishment coupled with sarcastic references to his mother and his upbringing.

Training in Cleanliness

One of the commonest causes of bed-wetting is the lack of training in cleanliness in infancy and early childhood. This is the fault of the mother, and may be due to sheer laziness or indifference or to an unconscious desire to keep the child dependent and a "baby." This latter motive is frequently unearthed when children are brought to child-guidance clinics and the cases fully investigated by experts. When a new baby arrives the mother's attitude changes and she now wants the older child to become independent as soon as possible so that she may be free to look after the infant. She is therefore apt to begin to scold and punish the bed-wetter, quite failing to realize that she alone is to blame. If this treat-

ment fails—and it usually does—the child may become the black sheep of the home, nagged and sneered at until his self-confidence is destroyed or until he feels that every man's hand is against him and that rebellion against life is his only means of escape. He is indeed fortunate if he comes to a clinic early, where his difficulties are understood and can be dealt with wisely. This lack of training is certainly the commonest cause and accounts for a large proportion of cases.

It is noteworthy that bed-wetting is much more prevalent among boys than among girls, and the reason for this has never been satisfactorily discovered. It is probable, however, that in many cases it is due to the greater indulgence which mothers show to their sons and their wish to keep them closely attached to themselves. In such a case the obvious treatment is to get the mother's confidence and co-operation and to enlist her help in patient training of the child to independence and self-reliance in every way. By holding up to the child the ideal of growing up as a privilege and a pleasure, and by giving him opportunities for exercising responsibility and for self-expression, he soon realizes that bed-wetting belongs to the "babyish" things which are unbecoming to his dignity and self-respect.

It may be laid down as an axiom that, whatever the cause of bed-wetting, scolding and punishment should never be employed: first, because it never cures the trouble; and, secondly, because it seriously damages the child's personality and often results in a further regression to babyishness and a timidity and fear of facing life, or in a sense of grievance and injustice that it is being blamed for a thing of which it is not even aware and that it knows to be entirely out of its control. These attitudes of mind, if allowed to continue, lead to an asocial or anti-social outlook which may persist and hamper both the individual and the community in which he lives.

Physical Causes

Among the commonest of the physical causes of bed-wetting are the following: (a) Extreme acidity or alkalinity of the urine, and concentration of the urine so that it becomes irritant. In this connexion the attempt to cure bed-wetting by restricting fluids should be mentioned. Usually it makes matters worse, because it tends to produce increased concentration of the urine and therefore to render it more irritant. This is certainly not a method to be used without medical advice and frequent testing of the urine. (b) Threadworms are also a fairly common cause. (c) In boys irritation of the prepuce by an accumulation of the greasy material normally found there is not unusual. The treatment is gently to draw back the prepuce with a moist cotton-wool swab and remove the smegma with olive oil. Zinc or some other bland ointment should be applied nightly. (d) In girls there is not infrequently a vaginitis that leads to redness and inflammation of the parts around the opening of the urinary passage. Zinc sulphocarbolate or a mild mercury ointment is helpful in relieving this condition. (e) Where there is frequent passing of water by day as well as by night a cystitis is to be suspected.

Psychological Causes

The causes which are primarily due to the child itself are all psychological, but they are nearly all unconscious and not in any sense the child's fault. These include:

Mental Defect.—A child whose mental development is retarded or permanently damaged by failure of the brain

to grow normally seldom learns to acquire habits of cleanliness at the normal age. In severe cases it may never be able to learn. Among the evacuated children there will be a number who are of retarded mental development, so that their mental age may be several months or even years behind their actual age. Control of the bladder involves a complicated system of regulation between the nerves of the bladder and the brain which exercises command over them. The small child has to learn that it cannot give way to a desire to pass water immediately the nerves of the bladder wish to do so. It has to train these nerves to wait until a suitable moment arrives. It takes a shorter or longer time for the brain and nerves to learn to co-ordinate according as the brain is of good quality and as the emotional attitude of the child is well or ill disposed towards trying to gain this control. It is important to find out whether we are dealing with a child of poor mentality or one of normal intelligence.

Emotional Attitudes.—This is one of the most important causes of bed-wetting, and again is nearly always unconscious and out of the child's direct control, but it can usually be modified satisfactorily by learning to understand the child's feelings and guiding it to a better emotional reaction. The commonest undesirable emotional attitudes are:

(i) Desire to remain a baby and to be protected by the mother or the nurse. This may be due to natural over-timidity or to the mother's unwise coddling.

(ii) Jealousy of a new baby and a desire to receive more of the mother's attention. In any case in which the child sees its security threatened there is a tendency to retreat to a more babyish level of development. Thus a clean child may revert to bed-wetting under any condition of change or loss of sense of security.

(iii) Evacuation to a strange home with strange people, especially separation from its mother. Here there is a great loss of the sense of security, and this will react unfavourably on children who are naturally timid, babyish, or who have been over-protected. Bed-wetting is therefore to be expected in a considerable proportion of this type of child. It is obvious that scolding and punishment are going to make the child much worse, as they will increase its fears and consequently its desire to regress to the security of babyhood. It is necessary to realize that unconscious motives make people act not in the way that is likely to be successful in the world of reality but in a way which would only bring the results they desire in a world of fantasy. Thus the unconscious desire to return to babyhood cannot be gratified in fact, but only makes things worse. It is important to try to help the child to realize this and encourage his interest and confidence in the world of reality so that he may be willing to give up his unconscious fantasy and learn to enjoy taking his part in life. The first approach to the bed-wetter should therefore always be that of a friend who wishes to help. If the child is very timid or very ashamed, or if he has been spoilt by his mother, he may resent the attempt to gain his confidence and feel that he is being "got at." The adult must not feel or show annoyance at such a rebuff, but should feel pity that the child has suffered so much that he has become suspicious even of his friends. Great patience and great sympathy are the only keys to unlock the barriers of reserve that the frightened child sets up as his defence against a terrifying world.

(iv) In a few cases the unconscious motive will be one of hostility and revenge towards the adults, whom the child regards as enemies. Fear in the case of a person of naturally aggressive temperament usually manifests itself in rebellion. Here again the proper treatment is to try to gain the child's confidence and to direct his aggression into socially useful and acceptable channels. Occasionally a child will be met with who is consciously rebelling and whose rebellion takes the form of nocturnal enuresis. Even here punishment will fail of its object, because the underlying motives are the same and

it is even more important to readjust the child's outlook to society, as it is of this type that delinquents are made.

Treatment of Nocturnal Enuresis not due to Gross Physical Causes

Plenty of fluid should be given in the early part of the day, but very little at the evening meal and none after it, unless the child complains of thirst, when it should be allowed to sip water. Tea is especially stimulating and therefore should be taken weak and avoided after four o'clock in the day. The child should sleep in a well-ventilated but not too cold room; the bedclothes should be light but warm. Night garments, especially pyjama trousers, should be so large as not to cause pressure or irritation. In many cases raising the foot of the bed a couple of inches will help by relaxing pressure and consequent irritation on the sensitive neck of the bladder.

A chamber pot of suitable size (this is very important) should be placed on a chair beside the child's bed so that he can see it. A dressing-gown and bedroom slippers, when these are available, should be beside the bed so that he does not get chilled from standing on the cold floor, or a small mat may be placed beside the bed. Sudden chilling will check the desire to pass water, and this may explain why some children fail to pass it when roused from sleep but pass it soon afterwards on returning to their warm beds. The child should pass water immediately before going to bed and should be roused again in three or four hours. He should be thoroughly awakened in spite of protests and required to remain on the pot or out of bed until he has passed water. It is not satisfactory to expect a child to go to a toilet: the pot should be close at hand.

It is good practice for all children to assist in making their beds, and this is particularly true of the nocturnal enuretic, as it gives him the practical evidence of the unpleasantness of handling wet and smelly bedclothes and shows him the extent of damage to mattresses and blankets. It is noteworthy that the physical discomfort of wearing wet garments does not seem to be a deterrent to either the nocturnal or the diurnal enuretic. The mattress should be protected by a mackintosh sheet which should be placed next to the mattress and underneath a thin blanket and the sheet. If this is done there is no danger of the child's catching cold, and this practice is universally followed in children's hospitals. It is noteworthy that one of the largest organizations dealing with resident convalescent children states that up to the age of 7 nocturnal enuresis once or twice a week is looked upon as almost normal. Theoretically the age at which a child should be clean at night varies from 18 months to 2 years. Occasional bed-wetting is not exceptional up to 5 years of age, but persistent bed-wetting after this is definitely abnormal.

Medicines most commonly used include bromide and belladonna, which in certain cases are helpful. Ergot, and more recently ephedrine, have also been tried with some success.

Diurnal Enuresis

Enuresis in the daytime after the age of 5 years must definitely be regarded as deliberate naughtiness and treated with firmness. Punishment should be of the constructive kind, and should take the form of withdrawal of privileges wherever possible—for example, withholding of a sweet or some special treat. This gives the child a positive motive for co-operation. Punishment should preferably take place on the spot and should not be delayed or prolonged;

it should always be associated with an attempt to understand the child's emotional reactions, which are the underlying cause of this form of maladjustment to society.

In a certain number of cases in which the child is obviously not adapting itself happily to the changed conditions of life away from home and is not settling down in its billet it would be of great value to remove it, at least for a time, to a special environment where it would be under the care of people who are accustomed to the handling of children and who could help to readjust it and train it in habits of cleanliness. Certain organizations are concerned themselves with the provision of such accommodation and with investigation of the nature and extent of the problem. These include the Mental Health Emergency Committee, which has been formed of representatives of the Central Association for Mental Welfare, the Child Guidance Council, the National Council for Mental Hygiene, the Association of Mental Health Workers, and the Association of Psychiatric Social Workers, and whose address is 24, Buckingham Palace Road, London, S.W.1; and the Invalid Children's Aid Association, 19, Kensington Gate, London, W.

Conclusion

It will be seen that the problem of enuresis is one of great complexity, and not a matter that can be dealt with by any rapid or rough-and-ready methods. This is unfortunate, because it is a very practical and real difficulty at the present time, and is causing great annoyance and damage and extra work to the hostesses of evacuated children. A magic is greatly needed, but, alas! no magic is available. On the contrary, each case must be treated on its merits, and demands both time and patience as well as insight and understanding.

The social worker and the teacher are the two people who can do most to help: the social worker because she is in touch with the child's new home and his hostess and her family, and the teacher because she is in touch with the child and is the only link with his past life. Many cases will respond to a friendly approach and to the opportunity to talk freely to a sympathetic listener. All child-guidance experts will recall cases in which a single interview has been sufficient to change the child's whole outlook to life and to work a seeming miracle, so much does it mean to a child to feel that he is understood. Others will take much time and patience, and yet others should be referred to special clinics for guidance. It is better to refer a child unnecessarily than omit to refer one who needs specialized treatment. It is obvious that in all receiving areas such clinics should be available and also that all social workers and teachers should have guidance by means of pamphlets or talks with discussion, or preferably both, in the handling of the children's and hostesses' difficulties. If this is done the evacuation may prove a blessing to many children and lead to far better opportunities of personality development than they would have had in their own homes; but if the children are mishandled now it will prove a national danger and will sow the seeds of temperamental instability, of asocial or anti-social behaviour, and thus lead to serious psychological damage to the coming generation.

Summary

The prevalence of nocturnal enuresis is discussed, particularly in connexion with war-time dispersal.

The importance of training in habits of cleanliness in infancy and early childhood is stressed.

A survey is made of the physical and psychological causes of bed-wetting.

The treatment of the condition is outlined.

TREATMENT OF MENTAL DISORDERS WITH MALE SEX HORMONE

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The record given below of patients treated with sex hormones contains, with one partial exception, no case in which there was any physical indication, such as hypogonadism, for hormone treatment. The paper includes the case histories of males treated with testoviron (testosterone propionate) and proviron (androsterone benzoate).

Case I

A man aged 53 had previously been a certified patient in another mental hospital, where he was acutely excitable and noisy. Before coming under my care he had also had prolonged psychotherapeutic treatment without any tangible result. It was clear from his history that his psychopathological reactions began as a young boy over forty years previously. The family history was bad. One parent was at least psychoneurotic, and the mother had been in a mental hospital.

The patient was admitted in a state of acute anxiety, with obsessional traits. Obsessional doubt was a paramount feature of his illness. He was markedly paranoid, and, despite repeated assurances that he was in the hospital for treatment, held that he was here as a punishment and because he had annoyed his relatives. His paranoid tendency was so pronounced as to make him inaccessible to psychological treatment, which was abandoned. His ideas of persecution were such that one night he made his way out of the window of his room, below which there was a drop sufficient to endanger his life. He was rescued from this predicament by an attendant at considerable risk to the latter. It was impossible to be certain whether this was an attempt at suicide or escape.

The patient's condition deteriorated, and a bad prognosis of paranoia was made. He was given testoviron (5 mg. daily) by intramuscular injection on twenty occasions. He showed mental and physical improvement towards the end of his course of injections. The improvement became more noticeable about a fortnight after these were discontinued. His paranoid tendency diminished quickly. His anxiety decreased, he became restful and quiescent, and his symptoms of obsessional doubt diminished considerably, so that he no longer spent hours pondering whether every helpful reassurance made to him implied its dreadful opposite. He was able to transact the business necessary to enable him to return to his profession, whereas when previously he was advised to send on an ordinary income tax form to his solicitor he remained for days in a state of indecision, anxiety, and increased psychomotor restlessness, refusing to part with the form, yet dreading its presence in his bedroom.

He gained 3 lb. during treatment, and was discharged six weeks after ending his course of injections. Hesitation in diagnosing a true "pure culture" paranoia is proverbial. I do not assert that the case came within this category. I am satisfied, however, that for some weeks his paranoid tendency was emphatically psychotic. I have never seen a paranoid tendency to such a degree, occurring in clear consciousness in a patient at any rate superficially rational, which cleared up so rapidly.

A very interesting feature in this case was that the first beneficial mental effects from the treatment embodied a rapid transition from a psychotic to a psychoneurotic state. One was able to note, in the course of a few days, delusions becoming obsessions—for example, the patient's positive false beliefs that different horrors were imminent changed rapidly to a preoccupation with the mere