1958

Maternal attitudes in female enuresis

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Boston University

http://hdl.handle.net/2144/22510

Boston University
BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

Thesis

MATERNAL ATTITUDES IN FEMALE ENURESIS

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In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service
1958
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CHAPTER I
INTRODUCTION

This is a study of the attitudes of the mothers of thirteen enuretic girls, as indicated primarily during the diagnostic process. Enuresis is a symptom frequently observed in children referred to child guidance clinics for help, and it is considered one of the most common disorders of childhood. Although there is wide divergence of opinion as to the cause of enuresis and consequently numerous theories expounded to explain its etiology and proper treatment, there is general agreement that it is a serious and baffling childhood problem.

In the literature concerning childhood enuresis as a symptom of emotional disturbance comparatively little attention has been devoted to a discussion of the mothers of these children. However, the mother-child relationship is of basic importance in the child's development, and in treating an emotionally disturbed child the mother is always included in the treatment plan.

Very few writers have differentiated between the psychodynamics and parent-child relationships operating in male and female enuretics. More often than not, sex differentiation is not taken into account in studies on enuresis, or emphasis is placed on the male enuretic.

In the present study, the case records of thirteen mothers of enuretic girls were examined by means of a schedule.
The schedule covered the mothers' attitudes in the following areas: relationship with the enuretic child; attitudes toward and handling of the problem of enuresis; relationship with the husbands; father-daughter relationship; relationship with their own families; acceptance or rejection of child guidance treatment. Also included in the schedule were identifying background characteristics of the children and mothers.

The setting of the study is the Psychiatry Department of the Children's Hospital, a part of the Children's Medical Center, in Boston. The Psychiatry Department provides consultation service to the clinics and wards of the hospital and offers diagnostic and treatment services within the Department on an out-patient basis.
CHAPTER II
THEORETICAL CONSIDERATIONS

Introduction

This chapter is divided into three main sections. The first is a general discussion of literature on the problem of enuresis, including a definition of enuresis, incidence of the problem, and general psychological viewpoints about enuretics and their parents. Although a large portion of the literature on the subject involves discussion of the physical aspects of the problem, this study is concerned with the emotional factors and therefore this review is limited to a discussion of emotional factors in relation to the problem of enuresis.

The second section deals specifically with a discussion of the literature about female enuretics and their parents, and includes a brief review of the girl's psychosexual development, with emphasis on the Oedipal period.

The third section is a brief theoretical discussion of mother-child relationships, specifically in instances where the child had emotional problems.

Literature About Enuresis

Definition of Enuresis

There are varying definitions of enuresis set forth in the literature. Some writers include urinary incontinence on an organic basis, although most include only those cases in which no physical cause for the wetting can be found; some in-
clude only nocturnal wetting, while the others include diurnal wetting also; some state that wetting can be considered enuresis after two years of age, while most insist that bladder control should not be expected to exist until after the third year. Most definitions include the fact that enuresis can be either persistent, where the child was never trained, or regressive, where the onset occurred some time after training was established. The following excerpts represent the elements which recur in many definitions, and are brought together as a definition of enuresis used in this study:

Enuresis is a condition in which the child who has been toilet trained, or has passed the age when toilet training should be completed (three and one-half), wets himself during the day or in bed at night.¹

Only regular accidents are included but not rare or occasional accidents associated with unusual stresses.²

...a more or less direct causal relation to known, anatomical, inflammatory or neurological disorders cannot be obtained by physical examination.³

Incidence of Enuresis

Enuresis is an extremely common childhood disorder "being second in frequency only to feeding problems."⁴

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³ L. Kanner, Child Psychiatry, p. 231.
⁴ O. S. English and G. H. Pearson, Common Neuroses of Children and Adults, p. 118.
Kanner\textsuperscript{5} notes that twenty-six percent of all the patients referred to his clinic for psychiatric consultation had enuresis. Bawkin\textsuperscript{6} reports that in a Bellevue Hospital study of one-thousand randomly chosen clinic patients, twenty-six percent were found to have enuresis. In a very small number of these was the enuresis organic in etiology. The literature contains many other evidences of the large number of children suffering from this symptom.

There is a divergence of opinion as to the frequency of the symptom in boys and girls. According to Bawkin\textsuperscript{7}, "Enuresis is said to be more common in male than female children, although the opposite has also been reported." English and Pearson\textsuperscript{8} report that it is more common among boys than girls, and Kanner\textsuperscript{9} states that in his clinic sixty-two percent of the enuretic children were boys and thirty-eight percent were girls. Kanner further reports that according to Thom enuresis is found in both sexes with about the same frequency, and adds,

\textsuperscript{5} Kanner, \textit{op. cit.}, p. 231.
\textsuperscript{7} \textit{Ibid.}
\textsuperscript{8} O. S. English and G. H. Pearson, \textit{Common Neuroses of Children and Adults}, p. 118.
\textsuperscript{9} Kanner, \textit{op. cit.}, p. 231.
interestingly enough, that Thursfield reports a preponderance in girls. Anderson\textsuperscript{10} comments that "In general the opinion wavers between that of approximately equal incidence of the sexes and a moderate preponderance among males." A large majority of the enuretics referred to the Psychiatry Department of the Children's Hospital in Boston are boys. It is noted that a study of referrals to this department\textsuperscript{11} found that there are about twice as many boys than girls referred.

\textbf{Psychological Viewpoints About Enuretics and Their Parents.}

Many writers who discuss the psychological factors operating in enuretic children note that the symptom is rarely an isolated one, and that there is variety in the types of symptoms and emotional disturbance which accompany it. Some symptoms of emotional disturbance which are said to accompany enuresis are nailbiting, eating problems, masturbation, fears, temper tantrums and stuttering. In discussing the case of a female enuretic, Pearson states that:

> The fact that she suffered from enuresis no more indicates the structure of her symptom complex than if the presenting symptom had been fever. Enuresis, like fever, can be the presenting symptom of a number of syndromes whose structure and psychopathology are very dissimilar.\textsuperscript{12}


\textsuperscript{11} Louise Ritter, "Child Patients in a Hospital Psychiatric Clinic," p. 11.

\textsuperscript{12} G. H. Pearson, Emotional Disorders of Children, p. 42.
Gerard\textsuperscript{13} stresses the fact that enuresis is not a clinical entity to which a single cause can be ascribed. Pearson\textsuperscript{14} classifies five "symptom complexes" of which enuresis can be the presenting symptom: 1. Enuresis as a result of environmental or cultural errors. An example of this is lack of proper toilet-training; 2. Enuresis as a chronic aggressive pattern, in which the child is expressing hostility toward the parents through wetting; 3. Enuresis in anxiety hysteria, as a reaction to anxiety; 4. Enuresis in conversion hysteria, in which the child converts the emotional reaction into the symptom; 5. Enuresis in character neurosis, in which the symptom of enuresis is one of many symptoms. English and Pearson\textsuperscript{15} feel that there are five psychological concepts which find expression in regressive enuresis: 1. The desire for attention; 2. The desire for love and physical gratification; 3. Hostility and revenge against the parent who does not give the desired gratification, and also against the other parent who is held responsible for the thwarting; 4. The memory of the real or phantasied danger by which the revenge is gratified; 5. The need for punishment for such reprehensible desires.


\textsuperscript{14} Pearson, op. cit., p. 46.

\textsuperscript{15} O. S. English and G. H. Pearson, Common Neuroses of Children and Adults, p. 128.
Kanner\textsuperscript{16} discusses the various descriptions of enuretics reported. The descriptions of these children range from their being shy and inhibited, to spiteful and vengeful, to delinquent and anti-social. They range also from the children being hyper-active, excitable and precocious to their being lazy, drowsy and of retarded intelligence. He concludes that he prefers to not generalize at all about the personality type of enuretic children, but to deal only with individuals, and goes only so far as to say that in most cases there is exhibited a "general immaturity which expresses itself in a variety of combinations of personality differences."

Some writers feel that sibling rivalry plays a part in the causation of enuresis. Gerard\textsuperscript{17} found that in several of her cases the onset of enuresis coincided with the birth of siblings, or that the symptom appeared several months after the siblings' birth.

Many authors note the aspect of revenge toward the parents as a cause of enuresis. English and Pearson note that:

When one considers the annoyance, extra work, washing, shame and embarrassment caused the parents by a child with enuresis, it is evident that motive in enuresis may be revenge and a desire to annoy them.\textsuperscript{18}

\textsuperscript{16} Kanner, \textit{op. cit.}, p. 243.
\textsuperscript{17} Gerard, \textit{op. cit.}, p. 51.
\textsuperscript{18} O. S. English and G. H. Pearson, \textit{Common Neuroses of Children and Adults}, p. 127.
Consistent with this theory of a "revenge" motive in enuresis, Gerard discusses eight cases of persistent enuresis in which she noted that the children evidenced stubbornness and aggressive behavior. All were verbally antagonistic toward one or both parents and antagonistic toward their siblings. She feels that the basis of this stubborn form of wetting is the attitudes of the parents, and states:

Five mothers openly rejected the children. Three stated that the children had been unwanted in the first place, and the others, that caring for them had been an irritation and a nuisance. These mothers were all dominating, nagging, perfectionistic and unusually punitive and hostile in their disciplinary measures. In the three other cases of this category the mothers' attitudes were moderately good, but the fathers were cruelly punitive. 19

Gerard found these parents to be extremely neurotic, and that understanding the cause of their child's behavior had no effect in changing their attitudes toward the child. She differentiates between this type of enuresis, being a reaction to a traumatic situation, and the enuresis found in forty-six other cases, which she felt indicated a deep-seated neurosis in the children. In the group of eight cases presented above, Gerard did not differentiate as to sex of the child.

Smith comments that he feels that the children who seem to be inflicting punishment on their parents may in reality not be wetting with revenge as a primary motive. He states that

"An annoyed parent is all too ready to interpret the child's lapse as an act of reprisal, and in time the child may come to accept the interpretation." In further discussion of parental attitudes in enuresis, Smith indicates that parents are very rejecting of the enuretic child:

It is the spirit that exists in the household that has most to do with producing wet or dry beds.... Bed-wetters are more likely than others to be in parental disfavor. This is due not so much to the disagreeableness of their habit as to the character of their parents. Wet or dry, there would be little love lost on many of these children, as far as their parents are concerned."

However, Bostock feels that the mothers of enuretics are usually the better mothers, who only need reeducation in order that they may give up their too rigid method of toilet training.

English and Pearson stress the importance of investigating the parental attitudes toward enuresis and toward the child in general, feeling that if these attitudes are unfavorable, they must be corrected if the enuretic condition is to be corrected.


21 Ibid., p. 12-13.


23 O. S. English and G. H. Pearson, Common Neuroses of Children and Adults, p. 123.
In her study of a mixed sex group of enuretics, Bouknight\textsuperscript{24} found that all the mothers displayed varying degrees of rejection toward the children. Their marital adjustment was uniformly poor and the fathers were generally passive.

Female Enuretics and Their Parents.

In reviewing the literature on the subject of enuresis one is struck by the general lack of emphasis placed on the difference in the personalities and parent-child relationships operating in or with male and female enuretics. Often it is only the male enuretic that is considered. However, it is felt that sex differentiation might be an important consideration in the development of this symptom and in maternal attitudes toward the children. The small amount of literature which has dealt with the sex difference points up its significance. In his study of male enuretics, Lord felt that his findings of the feminine identification in these boys "stimulate many exciting speculations regarding girl enuretics."\textsuperscript{25} He suggests the importance of examining the parents of enuretic male children so as to determine what relationship there might be between their attitudes and behavior and their sons' "feminine identification, fear of women, vacillation between masculinity and femininity."\textsuperscript{26}

\textsuperscript{24} P. Bouknight, "Enuretic Children Referred for Treatment,"

\textsuperscript{25} Joseph Lord, "Psychological Correlates of Nocturnal Enuresis in Male Children," p. 168.

\textsuperscript{26} \textit{Ibid.}, p. 172.
It is noted from Lord's statements that the boys appear to have a definite problem in sexual identification, and that their problems are intricately bound up with the type of mothers they have.

The Girl's Relationship with her Parents.

During the oral and anal stages of development, the girl differs little from the boy in relation to the mother. The girl, as well as the boy, turns to the mother as the love object -- the person who gratifies her and meets her dependency needs. According to psychoanalytic theory, with the onset of the Oedipal period problems are produced for the little girl which are different from those of the boy. While the boy's primary love object remains the same -- his mother -- the girl normally begins to turn to the father as a love object and to view her mother with hostility, as a rival for the father's affection. This creates a great conflict in the little girl, between the desire to do away with the mother and so have the father to herself, and the fear of losing the mother, whom she still needs as a source of security. The girl fears the loss of love by the mother in retaliation for her hostile wishes, and the ambivalence in her feelings toward the mother is very strong.

A further problem for the girl during this period of development is her awareness of her anatomical difference from the male, her consequent envy of the male's penis, and the
desire to have one for herself. During this period the girl may fantasy she has a penis, attempt to urinate standing up like a boy, and act the part of a "tomboy". She develops the belief that she once had a penis, which her mother took away from her. This is referred to as the "castration complex", and is another reason for the hostility toward and disappointment in the mother, and the turn to the father for love. However, if the girl resolves the Oedipal conflict successfully, she will give up her masculine strivings, which were exemplified by her wish to have a penis. In healthy circumstances, the resolution of the Oedipal conflict is made by identifying with the mother and the realization of the little girl that since she cannot have her father as her mother does, nor can she have a penis, she can attempt to become like her mother, and eventually grow up to marry a man like her father. Thus, she renounces the father as a sexual love object. If the mother is generous and accepting of her daughter and the father is a strong, understanding person, the girl is in a good situation in which to resolve her conflict successfully. However, many factors may stand in the way of a successful resolution of the Oedipal conflict, particularly in terms of the problems the parents themselves may have. If the parents are immature, have unresolved Oedipal problems themselves, a poor marital relationship, or are unable to properly fulfill the role of mother or father to the girl, this period will be a particular-
ly stressful one for the child, and severe psychological problems may develop. For example, if a father is dissatisfied with his marital situation he may turn to his daughter to meet his needs, and thus create an extremely threatening situation for the little girl, who feels herself in danger of having her fantasies towards her father realized and losing the mother's love. She may then retreat from the father and begin to hate and fear men. This might lead her to identify and compete with men, giving up any feminine strivings. An overly punitive father may create the same effect. If the mother is rejecting toward the girl, problems for the child during this period are complicated and intensified. English and Pearson note that "The manner in which the child handles the Oedipal conflict crystallizes the personality and behavior patterns for all life situations." 27

Helene Deutsch stresses the continuing importance of the mother in the girl's life. She feels that the change in the girl's love object from the mother to father is never completely achieved, as the need for and attachment to the mother retains a primary place in the girl's concerns:

In all phases of woman's development and experience, the great part played in her psychologic life by her attachment to her mother can be clearly observed.

27 G. S. English and G. H. Pearson, Common Neuroses of Children and Adults, p. 40.
Many events in that life are manifestations of attempts to detach herself...28.

The Personality of the Enuretic Girl.

Kanner29 states that according to psychoanalytic theory enuresis serves girls and women as an expression of the castration complex, since urine symbolizes semen and the wetting is therefore an unconscious outlet for the unconscious wish to be a man. Consistent with this theory, English and Pearson30 feel that there is a clear association between sexual life and enuresis, as determined from the analysis of dreams of the enuretic. They state that the enuretic child often wets his bed after dreaming that he (or she) is urinating in the manner of a person of the opposite sex. The girl may dream that she has a penis and/or is urinating standing up like a boy. The same authors report that in a case of a regressive enuretic girl the cause of her symptom was a feeling of deprivation by her father. The mother had recently become pregnant, and the girl resented the father's giving mother a baby, feeling this meant withdrawal of affection toward herself. The authors state there was jealousy and resentment toward the mother, but the primary cause of the

29 Kanner, op. cit., p. 238.
30 O. S. English and G. H. Pearson, Common Neuroses of Children and Adults, p. 120.
enuresis was a feeling of neglect by the father.

In another book, English and Pearson describe what they consider to be the personality of the enuretic girl. The girl is pictured as having many fears, especially of men, is very ambitious and must equal or surpass any boy. She does not show "the natural passivity" of a girl, but attempts to be active, as a boy. "In short, her whole life will be conducted on the principle that she is not a girl, that she will try in every way to be a boy." The authors conclude that the basis of this idea is the girl's fear of having a feminine relationship with a man because she is afraid of her father as a sexual person. They state that the girl may have been over-stimulated sexually by her father or witnessed his sexual behavior toward other women. As a result of her fear she refuses to allow herself to feel the natural feminine feelings toward her father, and must therefore give up altogether the idea of being a girl. Thus, she urinates in her sleep as an attempt to become a boy, with a penis. They further state that all her life, even after having given up the symptom, she will deny her femininity, will tend to avoid men or dominate them completely.

Gerard similarly stresses the girl enuretic's identification with men. Of the girls she saw in the group which she

felt presented neuroses, as opposed to the type of enuresis which is a reaction to a traumatic environmental situation, she noted that they presented consistent manifest attitudes, and that these attitudes differed markedly from those of the boys in the group. The following is her description of the enuretic girl:

The girls appeared much more normal than the boys in their manifest behavior. All were active children, the majority leaders among other girls, and they were independent and proficient in performing tasks. In school, their achievement correlated with their intelligence quotient rating and they were attentive, ambitious and well behaved. In play, they evidenced a strongly competitive attitude toward boys, associated with a verbal deprecation of males in general...they were honest and frank in their relations with other individuals....the girls behaved as if they were equal or superior to other girls....Each girl...presented an excessive amount of material which expressed clearly a fear of man as a destructive aggressor who could injure her in his activities. She...avoided the difficulty by denying men their abilities, eliminating them from her existence in fantasy, and yet identifying with the active male rather than the passive female.32

The above descriptions of a masculine identification in girls with enuresis are indications of a faulty resolution of the Oedipal Complex.

The Parents of the Enuretic Girl.

English and Pearson33 comment that in cases of per-

32 Gerard, op. cit., p. 32.

33 O. S. English and G. H. Pearson, Common Neuroses of Children and Adults, p. 121.
sistent enuresis there is often a rejecting parent of the same sex, against whom the child cannot express aggression.

The only other author found who makes specific mention of the attitudes of the parents of enuretic girls is Gerard. Her description of the parents follows:

In the cases of the girls no consistent maternal attitude was disclosed. In some cases the mothers were affectionate, kindly persons, fond of the daughter and tolerant toward her. In other cases they were irritable, semi-rejecting mothers, but none were as excessively rejecting and punitive as were those found in the cases of the stubborn negativistic form of wetting. A few of the mothers disclosed jealousy toward their daughters, because of the obvious affection of the father for the girl. The fathers in these cases, however, presented an exceptionally similar picture. They were fond of their daughters, affectionate toward them and, in most cases, obviously favored them above the siblings. In eleven cases, they were punitive as well...four fathers had been physically seductive...34

It is noted from the above discussions that the relationship of the enuretic girl to her father and the father's attitude toward her is felt to be of special significance in the formation of the symptom. In the cases examined for the present study, only two fathers were seen, and therefore their attitudes could not be studied directly from the record. However, the mothers commented on their own perception of their husbands, and some aspects of the father's relationship to the child. These aspects of the father's relationships will be included as part of this study.

34 Gerard, op. cit., p. 55.
Mothers of Children with Problems.

To a large extent, human personality is a response of the child to parental attitudes. Symonds states that "...of greatest importance to the child's development is his relationship to his mother -- a fact now axiomatic." Hamilton notes that "for any modification of the child's behavior the parent must be treated." In current child guidance practice the above "axioms" are recognized, and the mother is always included in the treatment plan. In order to help the child, the mother must be helped to understand and modify her behavior and attitudes. In attempting to help a mother it is not enough to give advice or educate her as to what is "right" or "wrong" in her attitudes and child-rearing practices. Rather, the mother must understand and work out some of her own feelings toward the child through the medium of a relationship with an understanding, accepting, objective person; in child guidance work usually a social worker. In order to treat the mother successfully, it is important for the worker to understand the background, past relationships and problems of the mother. Wickman notes that:

the parent's relationship with the child represents one in a constellation, namely, grandparents, siblings, spouse, child....Conflicts in feelings in

early relationships are later reflected in the parents' relationship with the child...Patterns in the behavior with the child...bear a relation to those which figured conspicuously in the parents' own home earlier.37

Using this knowledge the worker can attempt to help the mother recognize her own involvement in the child's problems. Hamilton points out that parents who come to a child guidance clinic are currently acting out and reliving former emotional experiences and therefore "the past is active in the immediate present in a special way."38

Various types of problems manifested in children may stem from particular types of mother-child relationships, and the mothers may have certain characteristics in common, in terms of early relationships, marital relationships, socio-economic factors, etc. With knowledge of the characteristic patterns of the group, treatment may be undertaken with more foresight and understanding as to how best these mothers may be helped.


CHAPTER III
METHODOLOGY

Setting of the Study

The setting of the present study is the Psychiatry Department of the Children's Hospital in Boston, which offers consultation services to the clinics and wards of the hospital and diagnostic and treatment services within the department.

A child may be referred to the Department of Psychiatry for diagnostic study from other departments within the hospital by a psychiatric consultant or medical doctor in the particular department where the child is first seen. Even if the original referral for psychiatric help is from an outside medical doctor, every child is examined physically in one of the clinics before being seen in the Psychiatry Department.

The Psychiatry Department's diagnostic service involves two or more interviews with the mother by a social worker. Whenever possible, the father is also interviewed. The child is seen by a therapist and undergoes psychological testing, both projective and intelligence, in addition. A diagnostic conference is then held to determine the disposition of the case in the light of the information gathered during the study. The recommendation is often psychiatric treatment in the department; however, another type of disposition may be made: for example, referral to another, more appropriate agency.

An important part of the diagnostic process is the
series of interviews with the mother by the social worker. During these interviews it is the social worker's function to gather information both about the child's development and about the mother herself and to make a preliminary psycho-social formulation. An attempt is made to explore and evaluate the mother's attitudes toward and relationship with her child, her own background, and the marital relationship, as well as other factors which might have a bearing on the child's problems. At times, because of the mother's resistance, certain important areas cannot be explored during these initial interviews. However, in general, the diagnostic interviews with the mother are most revealing of the interplay between mother and child and the forces existing within the family which might contribute to the problem.

Treatment in the Psychiatry Department usually involves weekly interviews with the child by a psychiatrist or psychologist and with the mother by a social worker.

Criteria of Sample Selection

The purpose of this study was to examine the attitudes of the mothers of thirteen enuretic girls who were seen in the setting described above. Since the study was concerned with social and emotional factors operating in cases of female enuresis, the medical records or referral slips of the cases of children considered for inclusion in the sample were checked in order to insure that organic etiology had been ruled out.
Another criterion used for the sample was that the children had normal intelligence. This was felt to be important in terms of the mothers' attitudes toward the children; for if a mother saw her child as "stupid" or incapable intellectually, or if the child had a learning problem, this could be then considered a function of emotional involvement rather than of objective reality. In order to insure the fact that the children in the present sample had normal intellectual capacities or potential, the psychological test results were checked.

Since this was a study of maternal attitudes, a third criterion for sample selection was the fact that the children were living with their natural mothers.

**Method of Sample Selection**

The Psychiatry Department card file was investigated as a means of gathering the sample. This file contains a card for every child seen in the Department. There was no limitation as to dates of the referrals in the selection of cases. The cards often indicate the referral problem. In this file eleven cases of girls with the referral problem of enuresis were found, all of which fit the criteria, and were therefore included in the sample. From discussion with staff members, three more cases of female enuretics currently in treatment were discovered. One of the girls had been adopted when she was five years old and therefore the case was not included in the sample. The other two cases fit the
the criteria and were included. The total sample consisted of seven cases which had had or were currently in treatment and six which were seen only for the period of the diagnostic study. Of the latter six cases, five were offered treatment, which they refused, and one was referred elsewhere.

Method of Data Collection

A schedule was applied to the case records in collecting the data. For the cases which had been in treatment, data was collected primarily from the diagnostic interviews, but treatment interviews were also consulted for additional information. However, in collecting the data in the treatment cases, an attempt was made to limit the material to attitudes which existed prior to changes which might have taken place through the treatment process.

Areas of Study

The areas which this study investigates are as follows:

1. The nature of the mothers' primary family relationships.
2. The mothers' description of their husbands.
3. The father-daughter relationship.
4. Factors to which the mothers attribute causation of the enuresis, and their methods of handling the problem.
5. The mothers' attitudes toward their daughters.
6. The mothers' reaction to the offer of psychiatric treatment.

Included in the schedule for gathering information on the cases were the following items: identifying data for
the children, including age at referral, problems at referral, number of siblings, ordinal position in the family; identifying data for the parents, including age, occupation, education, religion, for purposes of describing the total sample; description of the mothers' own families; description of the fathers' or workers' impression of the father in cases where he was seen; father-child relationship as described by the mothers; mothers' general attitudes toward their daughters as noted through comments of the mothers and impressions of the workers; mothers' and daughters' attitudes toward the childrens' siblings; mothers' acceptance or rejection of clinic treatment.
# CHAPTER IV

## DATA PRESENTATION

### The Children

#### TABLE 1

**AGES OF CHILDREN AT TIME OF DIAGNOSTIC**

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 - 6</td>
<td>2</td>
</tr>
<tr>
<td>7 - 11</td>
<td>8</td>
</tr>
<tr>
<td>12 - 14</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
</tr>
</tbody>
</table>

#### TABLE 2

**ORDINAL POSITION OF CHILDREN**

<table>
<thead>
<tr>
<th>Position</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only Child</td>
<td>0</td>
</tr>
<tr>
<td>Oldest:</td>
<td></td>
</tr>
<tr>
<td>of two</td>
<td>4</td>
</tr>
<tr>
<td>of three</td>
<td>2</td>
</tr>
<tr>
<td>Middle:</td>
<td></td>
</tr>
<tr>
<td>2nd of three</td>
<td>1</td>
</tr>
<tr>
<td>2nd of four</td>
<td>1</td>
</tr>
<tr>
<td>4th of five</td>
<td>1</td>
</tr>
<tr>
<td>Youngest:</td>
<td></td>
</tr>
<tr>
<td>of two</td>
<td>2</td>
</tr>
<tr>
<td>of three</td>
<td>1</td>
</tr>
<tr>
<td>of four</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
</tr>
</tbody>
</table>

The age range of the thirteen children at the time of the diagnostic study was from five to fourteen years. The age groupings on Table 1 correspond to the Oedipal, latency and adolescent periods of development. The great majority of the sample fell into the latency-age grouping, which is the age range of the majority of children referred to the Psychiatry Department.
In no case was the patient 1 the only child in the family. In the majority of cases, the patient had either one or two siblings. Therefore, most of the families were two- or three-child families, while none were unusually large.

In six of the cases the referred girl was the oldest child, while in four she was the youngest. Thus, we see that almost one-half of the sample are first-born children, and in the great majority of cases the girls were either the oldest or youngest in the family.

There were in total thirteen brothers and eleven sisters of the referred children. The ordinal position with regard to the sex of the siblings did not appear to follow any significant pattern.

In the three cases of regressive enuresis, the onset was not chronologically related to the birth of siblings. This factor was investigated to examine the possible influence of sibling rivalry in enuresis, since in the literature the condition has been seen as an aggressive or hostile act toward the mother, or as jealousy toward siblings. Symonds 2 states that "sibling rivalry will be acute in proportion to the extent of parental rejection." The mothers' comparative attitudes to-

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1 The referred girl will alternately be called the "patient".

2 Symonds, op. cit., p. 29.
wards the referred girl and their other children, will be discussed below.

TABLE 3
PROBLEMS OF THE CHILDREN

<table>
<thead>
<tr>
<th>Problems</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enuresis</td>
<td>13</td>
</tr>
<tr>
<td>School Failure</td>
<td>4</td>
</tr>
<tr>
<td>Behavior Problem at Home (demandingness, over-aggressiveness, defiance)</td>
<td>5</td>
</tr>
<tr>
<td>Phobias</td>
<td>2</td>
</tr>
<tr>
<td>Immaturity, Shyness, No Friends</td>
<td>8</td>
</tr>
<tr>
<td>Early and/or Current Feeding Problem</td>
<td>4</td>
</tr>
<tr>
<td>Tics</td>
<td>1</td>
</tr>
<tr>
<td>Masturbation</td>
<td>1</td>
</tr>
<tr>
<td>Soiling</td>
<td>1</td>
</tr>
</tbody>
</table>

In Table 3, problems were included which were mentioned by the mother during the diagnostic interviews as well as those problems for which the child was originally referred.

It is noted that nine girls exhibited shyness, immaturity, or had no friends and/or were doing poor school work. This finding is in contrast to the picture of the enuretic girl pre-
sented in the literature, which describes the enuretic girl as a leader among other girls, as well as independent, ambitious and proficient in school.

Ten out of the thirteen children had persistent enuresis while three had regressive enuresis. Nine of the girls wet only at night, while three wet both night and day. One girl wet only during the day. This girl was also referred for persistent soiling, however, her enuresis was regressive.

Onset of the three cases of regressive enuresis occurred at age four and one-half in a ten year old, age six in an eleven year old, and age twelve in a thirteen year old girl. The mother of the ten year old associated the onset to the death of the girl's father. The mother of the eleven year old associated the onset to the fact that she began to work long hours and was out of the home a great deal during that period. Interestingly enough, in the case of the thirteen year old, the mother mentioned no association to the onset of the enuresis, and hardly discussed this problem, though one might think it would be of great concern in a girl of that age.

The Parents

Age. The age of the mothers at the time of referral ranged from twenty-seven through forty-seven. Since the children ranged in age from five to fourteen years, this wide range in the mothers' ages was not felt to be unusual.
Marital Status. In eleven of the thirteen cases the mother and father were married and both living with the patient. In one case the parents were separated six months before referral, and when treatment was offered several months later it was refused, mother reporting that father was back in the home and things were improved. In one case the father died when the patient was four and one-half, just prior to the onset of her regressive enuresis. From the above data it is noted that the enuretic girls are not from broken homes. This finding is in contrast to Ealahan's study of eight enuretic boys, in which two of the mothers were unmarried and two were divorced.

Religion. Four of the families are Catholic, six are Jewish, and one is Protestant. In the twelfth family the father is Catholic, mother is Protestant, and there has been conflict as to the religious upbringing of the child. The religion of the thirteenth family is not known.

Mother's Occupation. Only one mother, of a nine year old girl, was employed full-time, as a factory worker. Because of her own deprived background, this mother resented her daughter's having any advantages that she did not have, and had a great deal of difficulty giving to the child. Since her husband was employed full-time, it would seem that besides

3 G. Ealahan, "Certain Factors in the Relationship of the Mother to her Enuretic Son," p. 29-30.
being of help financially, this mother's employment also served the purpose of denying her responsibility as a mother.

Two mothers worked part-time. One was a bookkeeper, the other a nurse's aide, whose husband was an alcoholic factory worker. In a case of regressive enuresis, mother's association to the onset is that she was out of the home working long hours at the time to help her husband, and feels that her daughter showed her anger at this through the wetting.

**Father's Occupation.**

**TABLE 4.**

**OCCUPATIONS OF THE FATHERS**

<table>
<thead>
<tr>
<th>OCCUPATION</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unskilled Labor</td>
<td>2</td>
</tr>
<tr>
<td>Skilled Labor (bricklayer, etc.)</td>
<td>3</td>
</tr>
<tr>
<td>White Collar (salesman, busdriver, etc.)</td>
<td>4</td>
</tr>
<tr>
<td>Managerial (restaurant)</td>
<td>2</td>
</tr>
<tr>
<td>Own Business</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>
As noted from Table 4, page 31, the majority of fathers were skilled laborers or white collar employees. It is noted that one father, a restaurant manager, had many business failures in the past and another, who had his own business, was in financial difficulties and depressed over his inability to support his family adequately. A third father, a bricklayer, was often unemployed, and a fourth was alcoholic and irregularly employed.

**Education.**

**TABLE 5**

<table>
<thead>
<tr>
<th>Grade Completed</th>
<th>Mothers</th>
<th>Fathers</th>
</tr>
</thead>
<tbody>
<tr>
<td>College</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Some College</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>High School</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Some High School</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Grammar School</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Unknown</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

It is interesting that two of the mothers who completed grammar school expressed frustration and anger at not having been able to go on to high school because they had to work to help support their families. Two mothers who
completed high school also had to work part-time to help support their families. Of these four, one mother is dissatisfied when her daughter receives a mark lower than "A" in school, and two have daughters with school learning problems.

In all but one case, the occupations of the fathers, where this information is known, seem to reflect the amount of education received. However, in one case, the father, an alcoholic, had graduated from high school but was employed as a factory worker.

Mother's Family Constellation.

| TABLE 6 |

<table>
<thead>
<tr>
<th>FAMILY CONSTELLATIONS OF THE MOTHERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Mother's Siblings.</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>3-4</td>
</tr>
<tr>
<td>6-9</td>
</tr>
<tr>
<td>14</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

In the majority of cases the mothers had six or more siblings, these mothers coming from unusually large families. In only four of the cases where the constellation is known did the mothers have four or fewer siblings. These facts are in
contrast to the size of the mothers' present families.

The Mothers' Primary Family Relationships.

Four mothers expressed extreme hatred and fear of their abusive fathers, three of whom were alcoholic. Three of these mothers also felt unloved or unjustifiably treated by their mothers. One of these mothers stated that maternal grandmother was "nervous and overly strict," another maternal grandmother often made mother stay home from school to take care of siblings, and the third maternal grandmother was seen as a weak person who "could not love her children."

Three of the mothers described an extremely close and dependent relationship with their fathers. In two of these cases the maternal grandmothers died when the mothers were eleven and thirteen years old respectively. It is interesting that in spite of their closeness to maternal grandfather, they express unhappiness as children, especially in relation to women. One stated that she felt very unhappy and lonely as a child, especially in relation to her poised, popular younger sister, her only sibling. This mother was considered "the competent one" and given early responsibilities. Her father remarried a woman with whom she could not get along. In the case in which maternal grandmother died when mother was thirteen, mother was the youngest of eight sisters. Some of these sisters took on the maternal role, and mother felt dominated and overcontrolled by them, feeling that she could never express her desires over their's or go against them in any way.
The third mother who felt close to and dependent on her father described maternal grandmother as very controlling, telling mother what to do at every turn.

Two more mothers described very poor relationships with females. One felt that of the four girls in the family she was the least favored by maternal grandmother, who had wanted boys, and is described as being frustrated and angry at having had only daughters. After the birth of her fourth girl she is said to have inflicted abortions on herself so that she would have no more children. The second of these two mothers was the oldest of seven children, and feels that she always got all the punishment and "had to do all the dirty work." She resented maternal grandmother a great deal, feeling that she was given too much responsibility. Maternal grandmother was "always sick" and mother had to nurse her in addition to having to leave school at the age of fourteen to help support the family.

Another maternal grandmother died when mother was thirteen years old. This mother states that she was "never close to her family." She, too, had to care for siblings and work as a teen-ager. In addition, there is a mother who stated that she is afraid of her family and has always felt rejected by them, though she did not specifically discuss the members of her family.

There are two cases in which the mothers spoke positive-
ly about their mothers. One described her as "quiet and sweet" and felt that maternal grandmother loved her more than her nine siblings. In the second case, mother has always been extremely dependent on maternal grandmother, sees her every day even currently, and "tells her everything". It was the workers' impressions in the two preceding cases that these mothers had "hostile-dependent" relationships with their own mothers.

In summary, eight mothers described poor childhood relationships with female figures. They felt either unloved, overly controlled, or given too much responsibility and punishment by early female figures. Two of these women lost their mothers before they were adults. In only two instances the mothers described a close relationship with maternal grandmother, and in these cases it was felt by the workers that the relationships were of a hostile-dependent nature.

Two mothers spoke only generally about their families, describing deprivation and unhappiness as children. One of these lost her mother as a teen-ager.

In relation to maternal grandfathers, four mothers expressed resentment toward their abusive fathers. Three mothers describe close, dependent relationships with their fathers.

In total, eleven mothers described poor childhood relationships with at least one parent, or siblings in cases
where maternal grandmother died, or describe feelings of re-
jection or unhappiness as children. The twelfth mother de-
cribes dependence on maternal grandmother even currently, and
in the thirteenth case the nature of mother's relationship to
her own family is not known.

The Mothers' Description of their husbands.

Six mothers described their husbands condescendingly, in a
manner which indicates that they saw them as weak, passive,
inadequate men. These mothers appeared to have no respect
for their husbands. One stated that her husband has few
opinions of his own, and she can "talk him into everything." Two mothers complained that their husbands were weak and un-
able to offer them a satisfactory sexual life. Another ex-
pressed anger and resentment at her husband because he is "too
good" and lets people "step all over him". Two mothers com-
plained that their husbands were unable to support them adequ-
ately. The wife of an alcoholic described him as being totally
dependent on her, saying "he's my most difficult problem child."
Five of these mothers stated that their husbands left all res-
ponsibility to them, let mother run the family, and four spec-
ifically complained that the husbands did not take part in
disciplining the children.

Although these mothers obviously saw their husbands as
inadequate, it is interesting that they all stayed with them.
One said that she feels she must put up with her husband and
"bear my lot in life." One might speculate that even though these mothers felt consciously dissatisfied with their husbands they have a need to remain in this kind of masochistic union and to dominate men.

Two mothers described their husbands negatively for reasons other than those stated above. The mother who separated from her husband stated that he had a violent temper and was always physically abusive to her. The mother whose husband had died described him as stubborn, demanding and unwilling to talk with mother, preferring to keep things to himself.

Three mothers described their husbands positively. One felt her husband is a good, kind person, has good judgement, and is able to help her. Another states she depends on her husband's help in making decisions, he takes her out when he feels she needs the recreation and talks things over with her. The third mother expressed satisfaction about the good sexual relationship she and her husband have, and stated that they talk everything over.

In one case the mother and father were seen together during the diagnostic interviews, and it was the worker's impression that there was a "positive, warm feeling" between them.

In summary, eight mothers described their husbands negatively, six of whom saw their husbands as passive and tended to belittle them, and two of whom felt antagonistic for other reasons. Of the latter two husbands one was separated from
his wife and the other deceased. In four cases there appeared to be a good, sharing relationship between husband and wife, and in one case no information about husband is available.

**Father-Daughter Relationship.** The information about the father-daughter relationship was gathered in ten cases from the mother's report. In the case of a fourteen year old girl, the parents were seen together, and the information was gathered from the reports of both the parents and the patient. In one case no information is available about the father-daughter relationship. Speculations made by the therapists who saw the girls were also taken into account.

In five cases the father's relationship with his daughter is described as close and affectionate. One mother feels that father and daughter conspire to keep secrets from mother about patient's misbehaviors, and another describes father as very affectionate toward the child, thinking patient is "wonderful". In a third case, in which the father died when patient was four and one half years old, mother states father and daughter were very close, and the child spent a great deal of time with father rather than playing with other children, especially when he was very sick. The fourth mother states that of his three children, father loves only the patient and expresses his affection effusively. In the fifth case father was seen and he expressed pride in the fact that his daughter turns to him for help and confides in him. Daughter in this
case stated that he hits her and will not allow her to go out with boys, however, she feels close to him and feels he is more understanding than mother, preferring him to mother.

In two of the above five cases mother complained that father takes no part in disciplining the child. In two additional cases, the mothers made the same complaint, but did not go into the nature of the father-daughter relationship any further. Thus, four mothers complained that their husbands did not discipline the children. It is noted that these four mothers also complained of their husbands' passivity.

In two cases the mothers stated that father prefers another child to the patient. In one case there is an interesting reason given for this; the father feels hurt because his daughter does not respond to his affectionate advances as does her younger sister. The second father, an alcoholic, is said to prefer his younger son. However, the doctor who saw the child speculated that this father might have been sexually abusive toward her. This girl is thirteen, and her regressive enuresis had its onset when she was twelve years of age.

In one instance, the mother stated that father "plays rough" with patient, through wrestling a great deal, and the patient enjoys teasing father and making him angry. This form of play was felt by the doctor to be sexually seductive. In another case, the girl is described as not being close to
father, but having no fear of him, though she fears mother.
Only one mother reported that the patient is afraid of her
father and avoids him, but did not discuss the father's attitude
toward the girl.

In summary, seven fathers were described as being either
close and affectionate toward their daughters, or did not dis­
cipline them. In two cases, where it was stated that father
preferred another child to the patient, one father was suspected
of being sexually abusive toward the patient, and another felt
hurt because his daughter did not respond to his affectionate
advances. Another father is felt to relate seductively to
his daughter, and in still another case the patient is said to
fear mother but not father. Only one mother reported that the
patient is afraid of and avoids her father, but did not discuss
the father's attitude. In one case there is no report of the
father-daughter relationship.

In general, the above findings conform to the picture
of the father of the enuretic girl presented in the literature.
These men were said to be affectionate toward their daughters
and in most cases favoring the patient above the siblings. Some
of the fathers were punitive as well, and some had been physic­
ally seductive. On the other hand, the picture of a girl who
is afraid of men which is presented in the literature does not
emerge from the mothers' descriptions, and only in one case did
the mother mention the girl's fear of her father.
Mothers' Attitudes Toward the Children

Attitudes Toward Enuresis.

TABLE 7

MOTHER'S ATTITUDE TOWARD CAUSATION OF ENURESIS

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostility or Defiance</td>
<td>7</td>
</tr>
<tr>
<td>Emotional</td>
<td>3</td>
</tr>
<tr>
<td>Physical</td>
<td>1</td>
</tr>
<tr>
<td>Don't Know</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
</tr>
</tbody>
</table>

The criteria used for the categories on Table 7 are as follows:

Hostility or Defiance - Cases in which mother states directly that she feels the patient wets to aggravate, spite, punish, defy or show anger, to mother. Also, cases where mother states she feels patient wets deliberately, or wets out of stubbornness.

Emotional - Cases in which mother notes that patient wets more in periods of stress or nervousness, or associates causation or onset (in regressive enuresis) to emotional factors other than the factors in the above category.

Physical - Cases in which mother does not express or accept any other view of causation.
Seven mothers saw their daughters' enuresis as a form of hostility or defiance toward them. In three cases the mothers noted that the girls wet more when nervous or upset, and one mother saw the problem as organic. In two cases the mothers' attitudes are not known. Thus, it is noted that the majority of mothers in this group see their daughters' wetting as directly connected with themselves, as an expression of hostility toward them on the part of the child.

Of the seven cases in which the mothers thought their daughters were wetting out of hostility, the mothers expressed varying degrees of anger in handling the problem. Four of them were overtly punitive, using methods such as beating and placing patient's face in the wet sheet. The remaining three were angry and scolding when the patient wet. Five of these mothers complained about the odor, and two felt the wetting to be embarrassing and shameful. One mother felt that her daughter had a body that was "too lazy to function." It is interesting that in these seven cases the enuresis seemed to represent a battleground on which the mothers were angry and frustrated at their inability to control the child. To these mothers the enuresis symbolized their daughters' hostile feelings, and they retaliated by being angry back. One wonders whether perhaps the children were reacting to the mothers' angry feelings to begin with. Two of these mothers verbalized that they noticed the patient wets after a scolding about some other
issue. Hamilton states that "In all family difficulties the question of who provokes whom is basic; with disturbed children the parents must usually first have been the ones to provoke." \(^4\)

Of the three mothers who stated that they felt their daughters wet for emotional reasons other than hostility towards them, two were cases of regressive enuresis. One associated the onset to the death of the patient's father, and the second mother of a thirteen year old girl noted only that she wets more in periods of stress and did not appear very concerned about the problem. In the third case of this group, mother stated vaguely that she thought the patient wets out of nervousness.

The mother who felt that the enuresis was completely physical in etiology saw all her daughter's problems as physical. This mother herself has numerous somatic complaints and "shops around" for doctors to operate on her daughter and herself. She was considered to be a borderline-psychotic personality, the most seriously disturbed mother of the thirteen. It might have been expected that in a hospital setting more mothers would be prone to attribute the causation of their daughters' enuresis to organic factors, and it is interesting that only one mother expressed this.

Most of the mothers attempted various methods of handle-

\(^4\) Hamilton, op. cit., p. 281.
ing the problem in addition to beating and scolding. Eight
wake up the patient at least once a night, several restrict
the girls from drinking water in the afternoon, one has tried a
mechanical gadget unsuccessfully.

It is interesting that two of the mothers of ten and
thirteen year old girls noted that they washed the sheets
themselves. These were the only two mothers in the total group
who were felt to be overprotective and will be discussed in
more detail below.

Attitudes Toward the Girls.

Rejection. Symonds states that:

It may not be an exaggeration to say that every parent
who brings a child to a child guidance clinic is to
some extent rejecting the child. The very fact that
the child does not satisfy and is a problem shows the
direction of the parent's feeling.\(^5\)

Other writers have made similar statements, and other studies
in child guidance settings tend to confirm this. However, re-
jection is a very complicated concept, and manifests itself
in numerous ways -- ranging from overindulgence and overprotection
to severe overt neglect by the parents. Statements by
parents indicating excessive affection toward a child may be
seen as disguised hostility for which the parent is overcompen-
sating, and overt hostile statements about the child are also

\(^5\) Symonds, op. cit., p. 21-22.
felt to indicate rejection.

In all of the thirteen cases under study, there were statements by the mothers or attitudes noted by the workers which are considered to indicate some rejection of the child. For example, some of the mothers say of their daughters, "she drives me crazy", "no one likes her", "she's strong-willed, cruel and arrogant", "she was never loveable", "she was not wanted from the beginning". Only one mother made a positive statement about her daughter, saying she is proud when the child "puts her best foot forward". It is interesting to note in this connection that ten of the mothers favored a sibling over the referred child. Of the three remaining cases one mother felt closest to the referred girl but compared her unfavorably with her brothers in that they were no problem to her and she felt more easily irritated at her daughter. The other two mothers did not discuss the siblings, but there are other indications of rejection on their part. The preference for a sibling is felt to indicate a rejecting attitude, and the overwhelming majority of mothers who manifested this preference is a strong proof of their lack of acceptance of their daughters, and perhaps indicates a greater than average active dislike of them, even within the usual child guidance caseload, although this cannot be documented as there is no control group in this study.
Control. A significant area of discussion in these cases was in terms of the mothers' attitudes about control over the child. The manner in which the mothers handled discipline, the extent to which they pressured, dominated, or were dominated by the child, and their comfort or discomfort about these factors appeared crucial in revealing the type of mother-daughter relationship operating in the cases. The manner in which a mother handles discipline or is able to control a child is always an important factor in the relationship established with her child, and an indication of her own adjustment as a mother. In these cases, where enuresis is one of the child's problems, and where so many mothers see it as a form of hostility toward themselves, the element of control of hostile and aggressive impulses, both of the mother and child is of particular significance. Therefore, the mothers' attitudes toward their daughters will be examined through the dimension of attitudes toward control. The following descriptive categories were set up:

1. Overprotective: These mothers express guilt and fear of limiting or punishing their daughters, and feel they must give in to their demands. They foster dependency in the children by doing everything for them, greatly restricting the children's independent activities. They see their daughters as inadequate to function on their own, have difficulty in separating from them. There are some expressions of hostility toward the children.
The following is an example of an overprotective mother:

Jane X., age thirteen, was referred for persistent nocturnal enuresis and school failure. Mrs. X. states that she "spoiled" her daughter as she always did everything for her. She was always afraid to allow Jane to go anywhere or do anything on her own and expresses amazement whenever Jane is able to accomplish even the smallest task, for example, bake a cake. Mrs. X. was depressed for the first three years of Jane's life. She says during this period she never talked to Jane, but feels that they were always very close and able to communicate non-verbally. Mrs. X. does not hit her daughter as she is afraid that because of her anger she might harm the child. Although she feels closer to Jane than to her three older sons, she feels that she becomes more easily and intensely angry at Jane, however, has more difficulty in limiting her.

2. Lax, but Ambivalent-Anxious: These mothers have similar characteristics to the mothers of the above category, but the element of operprotectiveness is not evident. These mothers express irritation, impatience and exasperation at their daughters' demands and/or aggressiveness. There are expressions of hostility toward and rejection of the children. They are guilty, however, and though they may pressure the children in certain areas, in general, they are unable to set limits comfortably. They are concerned about lack of control over their daughters, and appear to be dominated by them.

The following is an example of a Lax, but Ambivalent-Anxious mother:

Ann, age 5, was referred for persistent nocturnal and diurnal enuresis and behavior problems at home. Mrs. Y. describes Ann as overactive, defiant and willful, a child who wears her down because of her tantrums and demandingness, and whom she is unable to control. Mrs. Y. says
that she is easy on Ann, for "you have to give in to her or lick her." She expresses decided preference for her year-old son, who is good-natured, well behaved, and "so cute you could eat him up." She discusses the fact that she never felt her daughter was a loveable child, had difficulty in showing her affection, and feels guilty about and responsible for her child's behavior.

3. **Strict-Controlling**: These mothers tend to be overtly rejecting and hostile toward their daughters. They are demanding and perfectionistic in their attitudes toward their daughters, frequently pressuring for achievement socially or academically. They are dominating and may be quite punitive or withholding toward their daughters, tending to resent them and exhibiting little understanding of emotional needs.

The following is an example of a Strict-Controlling mother:

Mary Z., nine years of age, was referred for persistent enuresis, school failure and abdominal pains. Mrs. Z. complains that Mary refuses to play with other children, which she tries to force her to do. Although she was concerned about Mary's school failure and pressured her to obtain better grades, Mrs. Z. expressed a great deal of resentment that her daughter had the opportunity to attend school regularly as she herself had not been able to do as a child. She also resented Mary's having material things which Mrs. Z. lacked as a child, and is able to give things to her daughter only grudgingly. Until she was seven years old, Mary was a very active tomboy and when she misbehaved Mrs. Z. would lock the screaming child in her room. At the time of referral Mary was a docile, quiet child. Mrs. Z. expressed preference for her seven year old daughter, who "toilet-trained herself", and also desired a son.

4. **Democratic-Accepting**: Mothers who are consistent and appropriately firm in the area of discipline, without evidence of guilt. They allow their children freedom of expression and are able to tolerate some aggressiveness. They express
positive feelings toward their children, including warmth, pride, and affection. They are understanding of and able to meet the child’s emotional and physical needs with a minimum of hostility and anxiety.

TABLE 8

MOTHER'S ATTITUDE TOWARD CONTROL

<table>
<thead>
<tr>
<th>ATTITUDE</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overprotective</td>
<td>2</td>
</tr>
<tr>
<td>Lax, but Ambivalent-Axious</td>
<td>7</td>
</tr>
<tr>
<td>Strict-Controlling</td>
<td>4</td>
</tr>
<tr>
<td>Democratic-Accepting</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

Two mothers exerted control over their enuretic daughters through overprotecting them. Both these girls had symptoms of vomiting and difficulty in separating from their mothers. As mentioned above, these were the only two mothers who stated that they washed their daughters' soiled sheets themselves. One associated the onset of the enuresis to father's death and the other felt the child wet to aggravate mother.

Seven mothers appeared to be "lax, but ambivalent-anxious" in terms of controlling their daughters. None of these mothers stated that they beat their children because of the
enuresis, but tended to become angry and scold, although one guiltily told that she once placed her daughter's face in the wet sheet.

Four mothers were "strict and controlling." All four of the daughters were shy and submissive. One of these mothers hardly mentioned the enuresis, although it was a referral problem, and information is unavailable as to how she handled the problem. The other three mothers saw the enuresis as defiance, hostility or stubbornness toward themselves and beat their children because of it.

Reactions to Offer of Child Guidance Treatment.

Twelve mothers were offered child guidance treatment for their daughters, while one was referred to another clinic, in a hospital where she herself was receiving psychiatric help. Of the twelve mothers, seven accepted and entered treatment, and five did not. Acceptance or rejection of treatment was correlated with maternal attitudes toward control in order to find if there was any significant relationship between the two factors. Both mothers who overprotected their daughters accepted the offer of clinic help. However, the "lax, but ambivalent-anxious" mothers and the "strict-controlling" mothers were divided exactly evenly as to acceptance or rejection of treatment. Three of the former group rejected treatment while three accepted, and two of the latter group rejected treatment while two accepted. Therefore, in this study there is no correlation
between the attitudes toward control and the acceptance or rejection of treatment.

Interestingly enough, however, six of the seven mothers who accepted treatment were Jewish, while only one was Catholic. Included in this group was the total population of Jewish families in the sample. Three Catholic mothers and two Protestant mothers rejected treatment.
CHAPTER V
SUMMARY AND CONCLUSIONS

This study examined the attitudes of thirteen mothers of enuretic girls who were seen at the Children's Hospital Psychiatry Department in Boston.

The literature on enuresis indicated that little attention has been devoted specifically to a discussion of female enuretics and their parents. The literature on female enuresis stressed the importance of the father-daughter relationship in girls with enuresis. Therefore, the mothers' perceptions of the fathers' relationships with their daughters were included as part of the study.

A schedule was applied to the cases. Data was collected primarily from the diagnostic interviews.

Ten of the girls had persistent enuresis, while three had regressive enuresis. Some of the literature differentiated between the dynamics operating in cases of persistent and regressive enuresis, however, in this study the two types were not contrasted. Comparison of parental attitudes in regressive and persistent enuresis is suggested as an area for further study.

The enuretic children ranged in age from five to fourteen. Ten of the girls had one or two siblings. The small size of the families was found to be in contrast to the unusually large original families of the mothers. None of the girls
were only children, six were oldest and four were youngest children.

In the majority of cases the mothers reported jealousy or fighting between the enuretic girl and her siblings.

The girls presented a variety of emotional problems other than enuresis. In contrast to the description in the literature of enuretic girls as independent, proficient in school and leaders among other girls, the majority of the girls in this study exhibited shyness, friendlessness, or school failure.

Eleven mothers were married, with father living in the home. One father was deceased and one mother was separated for a short time from her husband. This was found to be in contrast to a study of enuretic boys, in which one-half of the fathers were not in the home.

Four of the families were Catholic, six were Jewish and one was Protestant. In one family the mother was Protestant and the father was Catholic.

Only one mother worked full-time and two worked part-time. The majority of the fathers were skilled laborers or white-collar workers.

The following areas were investigated:
1. The Nature of the Mothers’ Primary Family Relationships.

In general the mothers described difficult childhoods. Over one-half of these were given early responsibilities such as having to care for siblings, leave school to work to help support the family, or work part-time while attending school, and appeared to resent these responsibilities. The majority described poor relationships with female figures, either mothers or siblings, by whom they felt unloved or overly-controlled. In two instances in which the mothers described a close relationship with maternal grandmother, it was felt that the nature of the relationship was a hostile-dependent one.

Only seven mothers described their fathers. Of these, four expressed resentment and hatred of their abusive fathers, while three described extremely close relationships with their fathers.

2. The Mothers’ Descriptions of their Husbands.

Twelve mothers discussed their husbands. One-half of these described their husbands condescendingly, as passive, inadequate men. Two mothers described a poor marital relationship for other reasons, and in four cases there appeared to be a good marital relationship.

3. The Father-Daughter Relationship.

Five fathers were described as being close and affectionate toward their daughters. In addition, one father was
suspected of having been sexually abusive toward his daughter, another complained that the daughter did not respond to his affectionate advances, and another was felt to relate seductively toward his daughter. In general, the description of the fathers conformed to that of the literature, in which the fathers are pictured as affectionate and in some cases seductive or punitive toward their daughters. However, the literature described the girl enuretic as afraid of her father, whereas in only one of the present cases the mother mentioned the girl's fear of her father.

The majority of mothers in this study felt that their daughters wet out of defiance, stubbornness and hostility toward them. In these cases the mothers expressed varying degrees of anger toward their daughters because of the wetting and handled the problem either by verbally scolding or beating the child. In addition, almost all the mothers attempted various methods, such as waking the child at night and restricting their daughters from drinking liquids after a certain hour. One might expect that, within a hospital setting, the mothers might tend to attribute a physical causation to the problem, however, only one mother in this study felt the problem was completely physical.
To the mothers, the problem of enuresis seemed to represent a battleground on which they were unable to control the child, and they expressed anger and frustration because of this. It is interesting that so many mothers viewed their daughters' enuresis as hostility or defiance, as in the literature there are many speculations of the enuretic's "revenge" motive in wetting. It is often felt that these children are attempting to gain revenge or express hostility toward a rejecting parent.

5. The Mothers' Attitudes Toward Their Daughters.

All of the mothers expressed some hostility toward their daughters, and were felt to be to some degree rejecting of them. Almost all the mothers favored a sibling over the daughter. An area for further study is suggested in determining whether the degree of rejection might be greater in a group of mothers of enuretic girls than in a control group of mothers of girls seen in Child Guidance for other problems.

Problems in the mothers' relationships with their daughters were evidenced by their attitudes toward control. None of the mothers had a "democratic-accepting" attitude toward their daughters. The majority of mothers had difficulty in the area of control. They were fearful of setting limits and punishing the children, but expressed irritation and impatience with their daughters, and pressured the girls in some areas. Their problems in controlling the girls appeared
to stem from guilt over their own aggressive and hostile impulses. These mothers were called "lax, but ambivalent-anxious". Two mothers were considered "overprotective". They fostered dependency in their daughters, seeing the girls as inadequate to function on their own. These mothers expressed somewhat similar problems in limiting their daughters as did those in the above group. The remaining mothers were "strict-controlling" toward their daughters. They were demanding and perfectionistic, and at times punitive.

Gerard's study of enuretic girls showed that there was no consistent maternal attitude toward the children. The mothers' attitudes in her study ranged from semi-rejecting to affectionate and tolerant. The mothers in the present study did not conform to this picture, as all were felt to be somewhat rejecting and hostile. Gerard's picture of the mother whose child is expressing revenge through enuresis is of an openly rejecting, dominating, punitive, woman. Since the majority of the mothers in the present study appeared to be dominated by rather than dominating of their daughters, they cannot be said to fit this description either.

6. The Mothers' Reactions to Offer of Psychiatric Treatment.

Of the twelve mothers who were offered child guidance treatment, seven accepted and entered treatment, while five did not. Acceptance or rejection of treatment showed no significant correlation with the maternal attitudes toward the
children. All six of the Jewish mothers in the sample accepted treatment. An interesting area for further study would be the acceptance or rejection of clinic treatment according to socio-economic-religious factors.

Accepted 6/153

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