Section of Pædiatrics

President—D. W. WINNICOTT, M.A., F.R.C.P., M.R.C.S.

[*February* 27, 1953]

Symptom Tolerance in Pædiatrics

PRESIDENT'S ADDRESS

By D. W. WINNICOTT, M.A., F.R.C.P., M.R.C.S.

MY theme, which is foreshadowed in the title, might lead along two distinct paths. I mention one of these only because I may have been expected to follow it. I refer to the fact that the natural bodily processes tending towards health and towards a resolution of illness have become more than a little obscured by the recent flood of advances in chemotherapy. It is indeed difficult for a House Physician at the present time to find out by experience what a child does with pneumonia with no more help than the good nursing which, thirty years ago, was the only treatment. To-day, and we all agree about this, even a boil must not be allowed to take care of itself. I feel that in the best of the medical schools the teaching does include a reminder that children lived through illnesses before penicillin and that even to-day it is the child and the living tissues that ultimately bring about a restoration to health, not the antibiotic.

I have not followed this important trail because this theme has been developed with great competence in various addresses to medical students by physicians who remember the bad old times, and who see that from the teaching point of view the bad old times could claim some points in their favour. My theme follows another path which in the end will, I think, prove to be a related one, since again it concerns the natural tendency towards health and the use that we can make of this tendency as doctors. In the psychological field the principle that there is a natural tendency towards health or developmental maturity is one which has a particular significance. It could be said that much of physical disease is due to an invasion from the environment or to an environmental deficiency, and is not a purely developmental disorder. By contrast, psychological disorder can always be described in terms of emotional development either delayed or distorted or in some other way prevented from reaching the maturity that is due at the age which the child has reached. There is an even closer link therefore in psychological medicine between the normal and the abnormal than there is between physiology and the pathological processes of tissues and functions. In fact when there is only a disturbance of physiology then the illness is usually psychogenic.

When I was thinking over the relationship between pædiatrics and child psychiatry it occurred to me that this relationship involves not only a difference between the fields but also a difference of emotional attitude between those who adopt the one or the other approach to a case. The pædiatrician feels the symptom as a challenge to his therapeutic armoury. It is hoped that this will always be true. If a child has a pain, then the sooner it is diagnosed and the cause removed the better. By contrast, the child-psychiatrist sees in the symptom an organization of extreme complexity, one that is produced and maintained because of its value. The child needs the symptom because of some hitch in emotional development.

(For the purposes of clear argument it is helpful to assume that our physically ill child is psychiatrically healthy, and that our psychiatrically ill child has a well body. Although this is very often not true it is a justifiable simplification for us to make just now.)

THE CHILD NEEDS THE SYMPTOM

The psychiatrist is therefore not a symptom-curer; he recognizes the symptom as an S O S call that justifies a full investigation of the history of the child's emotional development, personal, and relative to the personal environment and to the culture. Treatment is directed towards relieving the child of the need to send out the S O S.

There is, as I have already indicated, a degree of artificiality in this statement of contrasts. The best body-doctors do also seek causes and, when possible, employ as their chief therapeutic the natural tendency of the body to be healthy. But even body-doctors who are suitably tolerant of symptoms that are physically determined and who seek first causes when faced with physical disease, tend to become symptom-allergic before a syndrome of psychological ætiology. They develop an urge to cure the moment they are confronted with an hysterical conversion symptom, or a phobia that has no apparent sense in it, or a sensitivity to noise that seems quite mad, or an obsessional ritual, a regression in behaviour, a mood disorder, an antisocial tendency, or a restlessness that connotes a hopeless confusional state at the core of the child's personality.

I am convinced that symptom intolerance appears simply because the body-pædiatrician does not know anything much about the science called dynamic psychology (psycho-analysis for me), and yet by this science alone can sense be made out of symptoms. Seeing that this fifty-year-old science is at least as large as physiology, and includes the whole study of the developing human personality in its setting, it is not to be wondered at if the weary postgraduate, having reached the heights of a pædiatric registrarship, boggles at yet another discipline, and eschews the new training that alone qualifies for psycho-therapeutic practice.

This problem of the double training must be left to solve itself in the course of time; meanwhile we must expect and welcome the two types of approach, the physical and the psychological, and we must try to assimilate the contribution that each can make to pædiatrics.

Unfortunately I must now narrow down my subject, which could be almost infinite in width and breadth. I have chosen to discuss enuresis, although I confess I find it difficult to leave aside so very much that would interest both myself and any pædiatric audience.

Enuresis: An Example

There are enuresis clinics run by pædiatricians, and usually the avowed aim in such clinics is the cure of the symptom. Mothers and children are grateful. There is nothing to be said against such clinics except that they sidetrack the whole issue of ætiology, of enuresis as a symptom that means something, as a persisting infantile relationship that has value in the economy of the child. In most cases cure of the symptom does no harm, and when a cure *could* do harm the child usually manages, through unconscious processes, either to resist cure or to adopt an alternative S O S sign, one that produces transfer to another type of clinic.

While these pædiatric clinics are coming and going, child psychiatrists are all the time meeting with the symptom enuresis, and often the symptom is easily seen to be quite a subsidiary phenomenon, a little bit of the huge problem of a human being engaged in trying to develop to maturity in spite of handicaps.

I shall give only one case out of the many hundreds to hand; by this one case description I shall hope to show how enuresis appeared in the course of a psychiatric illness.

I choose that of a boy for whom psycho-analysis was not available, yet whose cure (if I may call it a cure) depended, in part, on two psycho-therapeutic sessions.

At these two sessions the boy was drawing all the time, and I was able to take notes except at the most critical moments when feeling was so tense that the taking of notes would have done harm.

The case, not an unusual one, is the more suitable for presentation, because the child's treatment was mainly carried out by the parents, who were able to mend their home that had been broken by the war; I hope that you will be able to see in this part of the description, where the parents did the work, a type of illness and recovery that you have watched yourselves in those of your own child patients who have been able to use a period of physical illness as an opportunity for making delayed growth in personality. This boy was lucky; he was able to get what he needed without the otherwise helpful physical illness.

The Case. "Philip"

Philip, aged 9, was one of 3 children in a good family. The father had been away over a long period during the war, and at the end of the war he retired from the Army and settled down to rebuild his home, starting to be a farmer in a small way. The two boys were at a well-known prep school. The headmaster of the school wrote (October 1947) to the parents to say that he must advise them to take Philip away because, although he had never thought of the boy as in any way abnormal, he had found him to be the cause of an epidemic of stealing. He said "I can easily deal with the epidemic if Philip is removed"; and he wisely saw that Philip was ill and would not be able to respond in a simple way to corrective treatment. As a result of this letter, which came as a great shock to the parents, they consulted their general practitioner and he, on the recommendation of a psychiatrist, referred the case to me.

Consideration of these details shows how precarious is this matter of the referral of a psychiatrically ill child before damage is done. It was almost by chance that I was in a good position to give help at the very beginning and before a moral attitude towards the boy's delinquency had had time to become organized, and before symptom intolerance had developed to the extent of producing panic therapy.

I arranged first of all to see the mother and in a long interview I was able to take the following detailed history. This history turned out to be substantially correct, although in one important detail the exact truth did not emerge until I had an interview with the boy.

Parents.—I was able to gather that the father and mother had the ability to form and to maintain a good home, but that the disturbances of the war had caused serious disruption which affected Philip more than the brother. The small sister was obviously developing normally and was able to derive full benefit from the mended home. The parents were inclined towards spiritualism but they made it clear to me that they were not trying to impose their way of thinking on the children. The mother had a dislike of psychology and claimed to know nothing about it, and this proved to be valuable to me in my management of the case, since I was able to rely on her feelings and on her native or intuitive understanding of human nature and not on her sporadic reading and thinking.

Early history.—The brother was breast fed for five months and was a straightforward personality from the beginning. He was much admired by Philip.

Philip's birth was very difficult; the mother remembers it as a long struggle. The amniotic fluid broke through ten days before the birth, and from the mother's point of view the birth started and stopped twice before the boy was actually born, under chloroform. Philip was fed at the breast for six weeks; there was no initial loss of weight, and there was an easy transfer to the bottle. As a baby he was what is usually called bonny, until the age of 2, when the war started to interfere with his life. From this age he had no nursery days at home and he developed into rather a quiet child, perhaps too easy to manage. Nursery life had to be shared with tough and strange children. At this point he became excessively catarrhal and he developed an inability to try to blow his nose. The catarrhal tendency has continued and was not favourably affected by tonsillectomy at 6 years. The mother is subject to asthma and she thinks that the boy occasionally had asthma of slight degree. The mother looked after Philip most of the time although with the help of a nanny, and she early noticed the difference between the two boys. Not only was Philip less healthy on account of the catarrh, but also his co-ordination was poor.

Effect of the war years.—When Philip was 2–4 years old he and his brother were away with the mother, after which they were back in the original house. The home, however, which was broken up when he was 2, was not restored until the father retired from the Army, not long before the date of the consultation. The children's possessions were necessarily scattered, never all available at one time, and any one object was liable to become lost. As compared with the brother, Philip was not demonstrative. He was, however, affectionate enough with his mother and sister. The mother felt him to be a stranger and what possessions he had were very private to him. Actual difficulties did not show, however, till he was 6 years old.

In regard to what is called toilet training, he had been easy, and bed-wetting had never been a trouble.

Original thieving.—When Philip was 6, which the mother reminded me was the time of his tonsillectomy, he came back home with the nurse's watch. In the course of the next three years he stole another watch and he also stole money which he would always spend. Other objects were stolen and they always got damaged. He was not without money of his own and he developed a passion for book collecting. Being very intelligent and a good reader, he actually read the books that he bought, but the buying of the books was very important to him. They were mostly small books on moths and grasses and dogs, books of classificatory type. It was noticed that he paid 15s. for a small book on ships without seeming at all to recognize that this was expensive. Along with these symptoms the parents had noticed a change in the boy's character but they could not easily describe it. The parents were really disturbed when the following incident occurred: staying at a house, on the way home from a holiday, he stole a car registration book that belonged to the people that owned the house. He did not attempt to hide it and the parents put down the theft to his undoubted love of documents of all kinds. On looking back they could see that at this time he began to become an untidy person. Moreover he became less and less interested in possessions except new books, and along with this was an exaggeration of the wish to give things away to his sister of whom he was very fond.

This was in the period when he was 6–8, up to the year in which he was brought into my care.

Birth of sister.—At the birth of the sister (when he was 6) the mother said that he was first of all disturbed and openly jealous but he soon became fond of her and returned to a fairly good relation with the mother, not as easy, however, as before the birth. At this time the father began to discover that his children were interesting for the first time, partly because he had a daughter and mostly because he was now able to be living in his own home more and more. Incidentally, the mother told me that both she and the father had longed for a girl for their second child. When Philip appeared they took some time to adjust to the idea of another boy. The birth of the daughter eventually brought great relief to the family and undoubtedly released Philip from a vague feeling that he was wanted in some way to be unlike what he was. I made a special note that the tonsillectomy, which had apparently brought about the change in this boy's personality, had been done soon after the birth of the sister, and later I was to discover that the birth of the sister was the more important disturbance. At this time, the boy being 8, he became shy of anything that might make people laugh at him. The mother reported as an example that he had a swelling on the face caused by a sting. Rather than risk being laughed at he would be excessively tired and would stay in bed. In defence

against being laughed at he developed the art of mimicry and in this way he became able to make people laugh at will. He also developed a fund of amusing stories, and in this way he further warded off derision. While telling me this the mother felt in despair as she recognized while talking how much she had been at sea in her dealings with this boy while she had not had difficulty in understanding the brother and the sister. She had the ability to be closely in touch with a normal child but not the ability to keep in touch with a child who was ill, and it was important for me to recognize this as I needed her co-operation. Later on I described what the boy needed of her not in terms of the needs of a psychiatric case but in terms of the need of a normal infant, explaining that the boy would need to be allowed to go back and to be an infant in relation to her, thus making use of his newly founded home. Thus I avoided having to instruct her against her will in psychopathology.

Sleep.—Sleep was always disturbed by nasal obstruction. Philip would wake and require his mother to help and it is likely that he was able to use this physical difficulty, without knowing it, of course, in order to get his mother's presence at night; had he not had the nasal obstruction the mother would have been brought to his bedside by nightmares or some phobia. He had a phobia of being hurt and after tonsillectomy he had a phobia of doctors.

When I asked what happened when he got excited, did he get ill or just jump around?—the mother said, "When you expect him to get excited he becomes quiet and retiring and asks repeatedly 'Oh what shall I do? What is there to do?' " The mother had noticed that it was important to him that he should be alone for some part of every day. He could make use of distractions, and for instance when taken to Switzerland he soon learned to ski, but more by effort of will than by natural skill.

The mother reported that he had bouts of increased urgency and frequency of micturition which she connected with the nasal obstruction. At the school the boy was considered to be healthy and the nasal obstruction seemed to be less in evidence. I went with the mother and boy to an oto-rhinologist who gave valuable specialist advice, but also ordered a whole host of symptom relievers from which the boy had to be rescued.

At school Philip was thought to be intelligent but lazy. The headmaster gave him a bad report but in a letter to me he said that he had never thought of this boy as being in any way abnormal until the stealing started. He was not unaccustomed to laziness and expected the boy to make good in the end. From this detail I think it can be seen how a really good school can miss psychiatric illness.

Philip was fond of the country. He possessed a greyhound of his own and this turned out to be very important, playing a vital part in his cure. While he was in trouble at school he wrote a letter in which there was no indication that he was in distress.

Summary of case history.—This history which the mother was able to give me showed that the boy started life well but that there was a disturbance in the child's emotional development dating from 2 years. In defence against environmental uncertainty he became withdrawn and relatively unco-ordinated. At 6 he started a degeneration of the personality which was progressive, leading up to the major symptomatology at 9 for which he was brought to me.

Management.—Although I had not seen the boy I was able to begin on the arrangement of his management. It was clear that psycho-analysis was out of the question, since a daily journey to London or even a weekly one would be a disturbance of the use that the boy could make of his mended home, and it would be this mended home that would carry the major burden of the therapy.

I told the mother that this boy would need her help as it was clear that he had missed something at the age of 2 years and he would have to go back and look for it. She quickly understood, and said, "Oh well, if he has to become an infant, let him come home, and as long as you help me to understand what is happening I can manage". She proved that this was no idle boast and eventually she was able to take the credit for having brought the child through a mental illness; the home provided the mental hospital that this boy needed, an asylum in the true sense of the word.

In technical terms, the boy regressed. He went back in his emotional development in a way that I shall describe presently, and then came forward again. It was at the depth of this regression that the bed-wetting appeared which is the link between this case and the main theme of my Address.

Interview with Philip

My next task was to see the boy. I needed this interview in order to know where I stood in the management of the case over the next few months (mostly by telephone), and also because the boy was ready for insight which he got in this one and a half hours and which, although not psycho-analysis, was certainly the application of knowledge gained in psycho-analytic work.

First interview with Philip.—There was no initial difficulty. The boy was an attractive intelligent lad, rather withdrawn, not showing much evidence of making objective observations about me. He was evidently preoccupied with his own affairs and slightly bemused. His sister came with him and he behaved in a natural way with her, and easily left her with her mother while he and I went into the playroom. I adopted a technique which suits these cases, a kind of projection test in which I play my part. Figs. 1–8 show the results of this. It is a game in which first I make a squiggle and he turns it into something, and then he makes a squiggle and I turn it into something.

(1) *My* squiggle (Fig. 1). He turned it round and quickly called it a map of England, adding a line which was needed in the region of Cornwall.

I saw immediately from this that he was in a highly imaginative state, and that I would get results that were very personal since this squiggle could have been made into almost anything.

(2) *His* squiggle, and I delayed making it into anything myself, thus giving him a chance to display again his imaginative capacity. He immediately said it was a rope going up into the air and he indicated the air by thin strokes crossing thick strokes of the rope.

(3) *He* again made a squiggle (Fig. 2) and I quickly turned it into a face which he called a fish. Again this was an indication that he was preoccupied with his personal or inner reality and not particularly concerned with being objective.

(4) *My* squiggle (Fig. 3). It was astonishing to witness the way in which he immediately saw in it a mother and baby sea-lion. As events turned out it was justifiable to understand from this drawing that the boy had a powerful maternal identification; also that the mother-baby relationship was of especial importance to him. Moreover this picture has beauty, not indeed on account of the squiggle, but on account of his use of it.

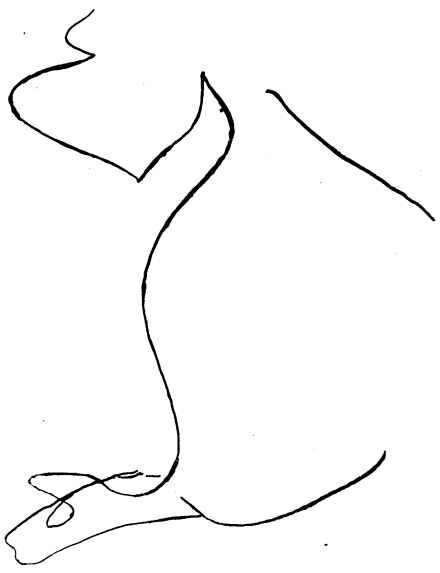

FIG. 1.

FIG. 2.

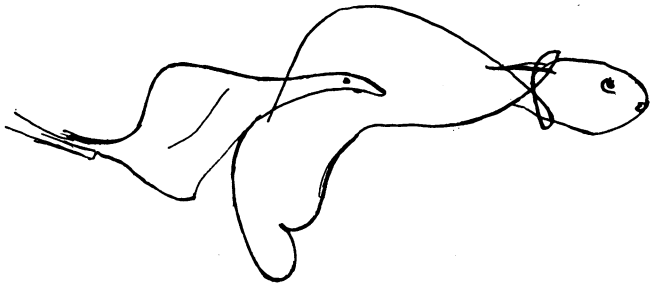

FIG. 3.

FIG. 1.—My squiggle. His modification. His comment—England.

FIG. 2.—His squiggle. My modification. His comment—a fish.

FIG. 3.—My squiggle. His modification. His comment—a sea-lion with a baby.

(5) *His* squiggle. Before I could make anything of it he had turned it into men roped together climbing rocks. This belonged to his recent experiences in Switzerland.

(6) *His* squiggle again, which he interpreted as a small whirlpool with waves and water. For him this was quite clear, though not so clear to me.

(7) *His* squiggle again, which he turned into a boot in water, again something absolutely personal to himself. I had already recognized that he was almost in what could be called a sleep-walking state, and this prepared me for the psychotic features about which I was to learn a little later on.

(8) *My* squiggle (Fig. 4). He immediately turned it into what he called Punch with tears in his clothes. He was now very much alive in a creative sense and he said "There are tears in his clothes because he has been doing something with a crocodile, something dreadful, probably annoying it, and if you annoy crocodiles you are in danger of being eaten".

(9) He was now talking about dream material and I was therefore in a position to investigate his dreams. I spoke about the frightening things that could occur to him in his thoughts, whereupon he drew Fig. 5 which he called a wizard. There was a long story with this. The wizard turned up at midnight at school. Apparently he did a lot of watching for the wizard in the night. This wizard had absolute power and magical power. He could put you underground and turn you into things. This wizard turned out to be an important clue in the understanding of the compulsion to steal.

He was now willing to tell me dreams. He was going in a car with his mother. The car was going downhill. There was a ditch at the bottom of the hill and the car was going so fast that it could not possibly stop. At the critical moment magic happened, good magic, and the car went over the ditch without falling into it.

I put into words what was implied by this and by the way that he told it to me. I said that he was frightened, that in the dream he had had to use good magic because this meant that he had to believe in magic and if there was good magic there was also bad magic. His inability to deal with reality and the necessity to employ magic was the awful thing.

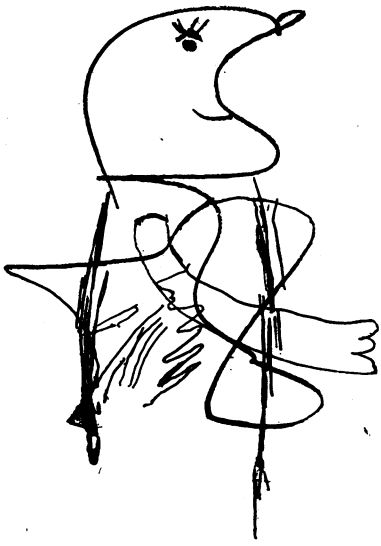

FIG. 4.—My squiggle. His modification. His comment—Mr. Punch with tears in his clothes.

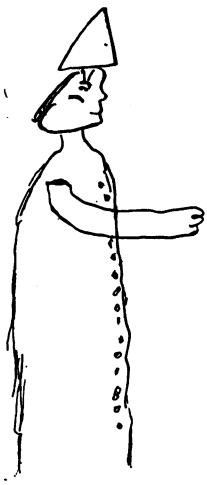

FIG. 5.—Drawing No. 9. The wizard.

He told me a further dream. He had hit his headmaster in the tummy, "But the headmaster is nice", he said; "he is a man you can talk to". I asked him if he was ever sad and he was now communicating with me from very deep in his nature when he said that he certainly knew what sadness meant. He had a name for it. He called it "dreary times". He said that the worst sadness happened a long time ago and he then told me about his first separation from his mother. I was not sure at first what was his age at the time of the experience. He told me: "Mother went away. I and my brother had to live by ourselves. We went to stay with my aunt and uncle. The awful thing that happened there was that I would see my mother cooking in her blue dress and I would run up to her but when I got there she would suddenly change and it would be my aunt in a different coloured dress."

He was telling me that he was constantly hallucinating his mother, employing magic but constantly suffering from the shock of disillusionment. I spoke to him about the awfulness of finding things you thought real were not real. He then drew a mirage (10) and took a holiday from the subject of hallucinations by giving the scientific explanation of a mirage. His uncle had told him all about it. "You see lovely blue trees when there are really no trees there."

He also said that he was very fond of beautiful things. "Now my brother, he thinks of nothing but ships and of sailing, and that is quite different. I love beauty and animals and I like drawing." I pointed out to him that the beauty of the mirage had a link with his feelings about his mother, a fact which I deduced from the blue colour of the mirage and of the mother's frock.

My notes at this point become less clear as the situation had become very tense and the boy had become deeply serious and thoughtful. He told me quite spontaneously about his depression, or what he called dreary times. It now turned out that the worst dreary time had occurred when he was nearly 6 and I was now able to see the importance of the birth of the sister. By his mother's going away he had meant that she had gone to a nursing home to have the child. It was then that he and his brother stayed with the aunt and uncle and although the brother was able to manage easily, Philip only just managed to keep the thread of experience unbroken.

He was not only hallucinating but also he was needing to be told exactly what to do and his uncle, recognizing this, had deliberately adopted a sergeant-major attitude and by dominating the boy's life he had counteracted the emptiness which resulted from the loss of the mother. There was one other thing that kept him going, which was that his brother, who was a great help, constantly said: "It will end; it will end."

The boy now had the first opportunity he had ever had for talking about his real difficulty at the time, which was to come to terms with the mother's capacity to have a baby, which made him acutely jealous of her. The picture of the mother and baby sea-lion showed how much he had idealized the mother-infant relationship. The fact that the baby had turned out to be a girl had been a relief to him.

He said, "I spent all the time thinking of how soon the end would come, or else I just felt sick". Once at school he had felt homesick, which was another kind of dreariness or depression, and he went to the headmaster. He said: "The headmaster tried everything but he could not help." He then compared the headmaster with me and quite openly said that, whereas the headmaster had only been able to say "Cheer up" I had been able to give him some understanding, of which he was in great need.

We were now able to return to the wizard who turned out to have the overcoat of his soldier uncle who had dominated his life, thus saving him from the emptiness of depression. He now told me that the wizard had a voice which was exactly that of the uncle. At school this voice continued to dominate him. The voice told him to steal and he was compelled to steal. If he hesitated the voice would say: "Don't be a coward; remember your name." "In our family there are no cowards." He then told me about the main episode for which he had been expelled. A boy had said to him, "Oh well, there's nothing very much about what you've done; anybody might have stolen pound notes and things like that. It isn't as if you had stolen poison drugs from the Matron's cupboard." After this the voice of the wizard told him that he must take poison drugs from the Matron's cupboard and he did this with consummate skill. It was when he was found to be in possession of dangerous drugs that he was expelled, but for him there was no shame since he had obeyed the voice and had not been a coward. Moreover I would add that in stealing he was in the direction of finding the mother that he had lost, but this is another subject which cannot be followed up here.

I have tried to give a faithful account of the interview but I cannot hope to convey the feeling of something having happened which was very real to both of us.

I was somewhat exhausted and ready to stop but he sat down to one final picture (Fig. 6).

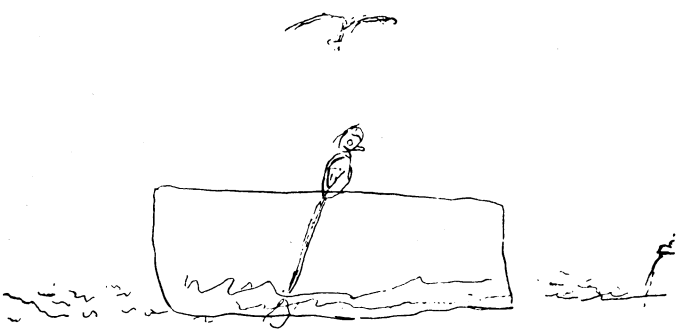

FIG. 6.—Drawing No. 11. "His father in a boat; over the boat is an eagle and the eagle is carrying a baby rabbit".

(11) After drawing in silence he said that this was his father in a boat. Over the boat is an eagle and the eagle is carrying a baby rabbit.

In the setting it was clear that Philip was drawing not only to "seal off" the interview but also to report progress. I started to put this into words. I said that the eagle stealing the baby rabbit represented his own wish or dream at the time of maximum distress, to steal the baby sister from the mother. He was first of all jealous of the mother for being able to have a baby by the father, and also he was jealous of the baby since he had an acute need to be a baby and to have a second chance to make use of his mother in a dependent state. (Of course, I used language appropriate to his capacity to understand.) He took up the theme, and he said: "And there's father, all unconcerned." You will remember that his father had been overseas. The fact that his father was away fighting for his country is now of great importance to him, and he can boast of this at school. But in respect of his childhood needs the father was neglecting his son's urgent need for a father actually on the spot, friendly, strong, understanding, and taking responsibility. But for his uncle and his brother he would have been sunk when his relation to his mother was interrupted by the separation and by his jealousy of her. The boy was now ready to go.

Second Interview.—I saw him again within a week and I shall not need to give a detailed account. I show his drawing, however (Fig. 7), through which he announced that the wizard and his voice had gone since the first interview. In this drawing of the wizard's house I am in the wizard's house with a gun, and the wizard is retreating. The smoke indicates that the wizard's wife is in the kitchen cooking. I go in and take the magic from her. You will remember his need to find his mother cooking—the alternative was the witch, and the cauldron, and the magic spells of the woman of early infancy, who is terrible to think of in retrospect, because, of the infant's absolute dependence. This already has some flavour of fantasying, of operation at a less deep level and indeed the tenseness of the atmosphere of the first interview was missing. I was no longer within the inner circle of the child's personal and magical world, but a person listening to him talking and hearing about his fantasies.

Two more drawings:

One shows the wizard going down the school corridors. After this he told me again about the hallucination of the mother who changed to the aunt when he put what he saw to the test. Also here there was an important bit about the way in which the wizard's candle belonged to genital erection and to ideas of fellatio and ideas of burning hair. I had to be able to take this, along with the magic and whatever else might turn up, else I would suddenly intrude myself, as much by any display of prudery or blindness as by an active introduction of my own ideas. But this was not to be an analysis and I had to avoid giving understanding in relation to the repressed unconscious. One learns to keep a sensitive balance in doing this work—comparable with the skills that are acquired by those whose practice takes them to cisternal punctures or to the transfusing of the newly born.

The last drawing of the second series (Fig. 8) shows the wizard again. This time the wizard is being laughed at. It is a "funny" picture. It will be remembered that it was part of the child's illness that he expected to be laughed at; the object of the derision had now been got outside the house (himself), and in the place of the wizard was his highly subjective idea of me. I was simply a person who fits in and understands, and who verbalizes the material of the play. In verbalizing I talk to a conscious self and acknowledge the PLACE WHERE FROM in his total personality, the central spot of his ENTITY, without which there is no HE.

FIG. 7.—The wizard's house.

FIG. 8.—A "funny" picture of the wizard.

Figs. 1 to 8 have been selected out of 14 drawings.

The Third Interview.—This started with a drawing in which his enemy drops a knife on his greyhound. The enemy is the son of the uncle who played such an important role in his life during the depression and whose voice and Army overcoat supplied the details for the wizard that he employed to counteract his "dreariness". This cousin was hated because of Philip's powerful love of the cousin's father.

This third interview changed into an ordinary play hour, and I just sat and watched Philip make a complex plan with my train set rails. Whenever he came to me subsequently he just played with the train, and I did no more psychotherapy. Indeed I must not, unless I had been able to let the treatment develop into a psychoanalytic treatment, with its reliable daily session arranged to last over a period of one, two, or three years. This was never contemplated in Philip's case.

THE ILLNESS AT HOME

I now come to the illness that the boy had to have during which the parents provided him with asylum. It can be briefly described. This child needed my personal help, but at the borderline there are the common cases in which the psycho-therapeutic session can be omitted, and the whole therapy can be carried out by the home. The loss is simply that the child fails to gain insight, and this is by no means always a serious loss.

Philip was accepted at home as a special case, an ill child needing to be allowed to become more ill. By this I mean that there had been a controlled illness and this was to be allowed to come to full

development. He was to receive that which is the right of every infant at the start, a period in which it is natural for the environment to make active adaptation to his needs.

What it looked like was this: Philip gradually became withdrawn and dependent. People said he lived in a fairy world. His mother described how he did not so much get up in the mornings as change from being in bed to out of bed, this simply because someone dressed him. This is a lay method of saying that the boy was in a somnambulistic state. On a few occasions the mother tried encouraging him to get up but he was quickly reduced to tears of distress and she abandoned all encouragements. At meals he gathered the utensils around him and ate alone, although with the family. He seemed uncivilized, taking big gulps of bread, and eating the jam down first. He would eat everything that was there rather mechanically, not seeming to be either able to want or to reach a stage of having had enough. All the meal he was in a preoccupied state.

He went downhill steadily, becoming less and less able to live in his body or interested in his appearance, but he kept in touch with the enjoyment of body by watching his greyhound for hours on end.

His gait became unco-ordinated, and towards the bottom of the regression he progressed by a hop-skip technique, arms waving like windmill sails, or by a series of lurchings, as if propelled by some crude agency living within the self, certainly not walking. While progressing in this way he made noises which his brother called "elephant noises". No remark was ever made about his many oddities and eccentricities and bizarre behaviour patterns. He had the cream from the one cow, and also he figuratively skimmed the cream off the homeliness of the home.

On occasions he would come out of this state for an hour or two, as when the parents gave a cocktail party, and then he quickly returned to it.

Once he went to the local "Hop" and there his queer attitude to girls came to the fore. He danced a little, but only with a very odd and fat creature known as "the galleon", assumed in the locality to be mentally defective. Dick Barton became an obsession during this period, and his life revolved round this and watching the dog.

Then the bottom was reached. He was always tired. He had increasing difficulty in getting up at all. At last I have reached the symptom which made me choose this case for description. He became for the first time since infancy a bed-wetter. The mother got him up, between 3 and 4 a.m. each night, but he was usually wet. He said to her: "I dream so vividly that I have got to the pot." Also at the time he was addicted to water, drinking to excess. Of this he said: "It's such fun, it's delicious, it's good to drink."

All this took about three months.

One morning he wanted to get up. This marked the beginning of his gradual recovery, and there was no looking back. The symptoms peeled off and by the summer (1948) he was ready for a return to school. This was delayed, however, till the autumn term, one year after the start of the acute phase of the illness.

There was no return, after the first psycho-therapeutic interview, either of the wizard or of the voice, or of the stealing.

On the return to the same school Philip picked up quickly, and there was no difficulty about living down a reputation for thieving. Soon the headmaster was able to write the usual letter one expects, asking what was all the fuss about, the boy being perfectly healthy and normal. He seemed to have forgotten that he had expelled him a year previously.

At 12½ Philip went to a well-known public school, rather a tough one, and at 14 he was reported to be 5 ft. 5 in., broad in physique, manly by nature, always out of doors, and good at the usual games. He was reported to be one year ahead of his age group scholastically.

Additional Facts

The treatment cost the parents £15 15s. 0d. which was well within their capacity to pay.

No Intelligence Test or Rorschach Test was done, as this was quite unnecessary.

There was no need for Psychiatric Social Worker help, as the whole problem was well within the personal scope of one person.

Moral

I now come to the moral. If a pædiatrician had been consulted on account of the bed-wetting, what would it have seemed to him had he become involved in the case at the point of the child's maximal regression? Ordinarily the mother would not know what was going on, nor would the child. Possibly in this particular case a sensitive pædiatrician, giving plenty of time to history-taking and to a personal interview, might have been able to place the bed-wetting in its setting along with the compulsive stealing. In the case of Philip there was an exceptionally favourable setting for an illness to develop to its full extent and to come to its natural end. Usually the setting is too complex or insufficiently stable to allow of a clear exercise of the complex processes that could be watched in Philip's case. There is nothing more difficult to treat than the child who is apparently normal except for bed-wetting. In these cases the regression is a brief one recurring at a certain period in the night-time, hidden, but important to the child just as the regression was to this boy that we have studied in greater detail.

(I must put in a note here that I am over-simplifying again since not all cases of enuresis can be described in terms of regression, and beyond the question of regression there is the place of the excretory function as an experience in every infant's life, part of a highly complex development of the capacity for object relationship.)

It would have been futile to have tried to cure Philip's enuresis.

Recapitulation

I do see the point of view of the pædiatrician who, not being concerned specifically with psychology, must ignore the meaning of symptoms and must try to cure them. But I do ask these doctors to give the psychologist credit for his point of view, just as the psychologist gives the pædiatrician credit for special knowledge of infant physiology, the biochemistry of fluid loss, the grouping of blood, and the early diagnosis of brain tumour. The two disciplines should produce different kinds of pædiatrician each with a healthy respect for the other.

I had to keep to one simple thing—enuresis, and indeed to one aspect of this one symptom. We need some organization for the joint study of the developing human being, body and soul; or shall I say, psyche, soma, and intellect?

The phrase "Department of Child Health" (not Pædiatrics) pre-supposes an eventual growth of mutual understanding, one in which the child-psychiatrist can be understood by his pædiatric colleagues even when he shows a maddening degree of symptom tolerance.

BOOK RECEIVED FOR REVIEW

(As no reviewing is undertaken in the "Proceedings" this list is the only acknowledgment made of books received for review)

Société des Sciences Médicales de Tunisie. Médecine et Médecins de Tunisie de 1902 à 1952. pp. 344. Tunis: Société des Sciences Médicales de Tunisie. 1953.

BOOKS RECENTLY PRESENTED AND PLACED IN THE SOCIETY'S LIBRARY

Blotner (H.). Diabetes insipidus. pp. 190. New York: Oxford University Press. $4.50 (36s. 0d.). 1951.

Bostock (J.). The dawn of Australian psychiatry. pp. 241. (Typescript.) 1951.

Cyriax (J. H.). Disc lesions for the general practitioner. pp. 37. London: Cassell. 5s. 0d. 1953.

Derbes (V. J.), and Weiss (T. E.). Untoward reactions of cortisone and ACTH. pp. 51. Oxford: Blackwell. 8s. 6d. 1951.

Dubos (R. J.), ed. Bacterial and mycotic infections of man. 2nd edit. pp. 886. Philadelphia and London: Lippincott. $7.50 (60s. 0d.). 1952.

Esaguy (A. d'). Jacob de Castro Sarmento: notas relativas à sua vida e à sua obra. pp. 119. Lisbon: Ediçoẽs Ática. 1946.

Glueck (S. S.), and Glueck (E. T.). Unraveling juvenile delinquency. pp. 399. New York: Commonwealth Fund. $5.50. 1950.

Kornorski (J.). Conditioned reflexes and neuron organization. Translated from the Polish MS. under the author's supervision by Stephen Garry. pp. 267. Cambridge: Cambridge University Press. 18s. 0d. 1948.

Kretschmer (E.). Medizinische Psychologie. 10te Aufl. pp. 304. Stuttgart: Thieme. M. 24. 1950.

Kretschmer (E.). Psythotherapeutische Studien. pp. 215. Stuttgart: Thieme. M. 13.50. 1949.

Monroe (R. T.). Diseases in old age: a clinical and pathological study of 7,941 individuals over 61 years of age. pp. 407. Cambridge, Mass.: Harvard University Press. $5.00 1951.

Most (H.), ed. Parasitic infections in man. (Symposia of the Section of Microbiology, No. 4, 1949.) pp. 229. New York: Columbia University Press. $4.50 1951.

Riches (E. W.), ed. Modern trends in urology. pp. 476. London: Butterworth. 75s. 0d. 1953.

Rivers (T. M.), ed. Viral and rickettsial infections of man. 2nd edit. pp. 719. Philadelphia and London: Lippincott. $7.50 (60s. 0d.). 1952.

Scherf (D.), and Schott (E. A.). Extrasystoles and allied arrhythmias. pp. 531. London, etc.: Heinemann. £5 5s. 0d. 1953.

Smith (R.). The surgery of pancreatic neoplasms. pp. 157. Edinburgh and London: Livingstone. 35s. 0d. 1953.

Town (A. E.). Ophthalmology. pp. 511. London: Kimpton. 70s. 0d. 1951.