

PSYCHOGENIC MEGACOLON IN CHILDREN
A STUDY OF ITS AETIOLOGY, CLINICAL FEATURES AND
TREATMENT

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PSYCHOGENIC MEGACOLON IN CHILDRENA STUDY OF ITS AETIOLOGY, CLINICAL FEATURES AND TREATMENT.Introduction.

Recent advances in the study of Hirschsprung's disease have brought about a radical revision in our concept of the aetiology and management of megacolon. Following the work of Bodian et al (9), Swenson et al (65), and others (32, 43, 73, 76), it is now known that cases previously classified as Hirschsprung's disease result from an absence of ganglion cells in the myenteric plexus of the distal bowel. The area of defective innervation fails to transmit peristaltic waves, remains constricted, and thus leads to progressive dilatation of the bowel proximal to the spastic segment.

The demonstration of this pathology permits a rational classification of megacolon, within which several aetiological mechanisms are now recognised. Megacolon is, in fact, a purely descriptive term. When applied to Hirschsprung's disease, it should be designated more accurately congenital neurogenic or aganglionic megacolon, a relatively rare condition. It is possible to differentiate this state from a more commonly occurring group of cases which are also characterised by colonic enlargement, but in which no spastic aganglionic segment, or other organic lesion, can be demonstrated. These have been designated idiopathic or functional megacolon. It is with this group that the present study is concerned.

Aim of the Present Study

The object of the present study is to demonstrate that progressive enlargement of the distal bowel may develop in children on a basis of emotional factors. It is hoped to show that this condition constitutes a definite clinical entity, distinct from Hirschsprung's disease, and characterised by typical signs and symptoms. Chief among these are chronic, often intractable constipation, resulting loading of the rectum and terminal colon with retained faeces, and subsequent overflow faecal soiling. Evidence will be adduced to suggest the identity of this disorder with idiopathic megacolon.

A series of thirty cases will be presented with the aim of demonstrating how the condition develops, and the reasons for its development. It will be submitted that the importance of the aetiological concept lies in the approach to treatment. Whereas definitive surgery is the treatment of choice for aganglionic megacolon, a surgical approach is not indicated in cases of psychogenic origin; nor are sustained results procured as a rule from purely symptomatic measures of relief.

It will be contended that the rational treatment of this disorder depends upon full appraisal of its underlying aetiological basis; and that satisfactory results are achieved only through adequate evaluation and correction of the relevant emotional factors which contribute to the condition.

Case Material

This consists of 30 cases, 19 male and 11 female, ranging in age from 22 months to 15 years. In all of them, there was a history of functional bowel disorder, varying in duration from 8 months to 15 years, and presenting mainly as chronic constipation, with colonic loading and overflow faecal soiling.

The series was collected over a period of 3 years, during which individual cases were studied, and have been treated, for varying lengths of time. The chief source of referral was from consultant paediatricians and paediatric surgeons who had previously had the cases under their treatment as out-patients, or within their hospital wards. They were satisfied upon investigation that no organic lesion existed, and had subsequently referred them for psychiatric opinion, either because of the unsatisfactory response to standard treatment measures, or because the disorder was suspected to have an emotional basis. Two of the series were referred direct from a general medical practitioner.

In 14 of the series, radiological study by barium enema had been included in the investigation. In no case was there any radiographic evidence of an underlying pathological lesion. The appearances indicated functional dilatation of colon.

For comparison, a series of 21 control cases was constructed from the record of admissions to a general children's hospital, over the 5 year period 1950-55.

Examples were sought of young children referred with a history of constipation, which warranted investigation and treatment in hospital, but which proved not to have an organic basis, and had responded satisfactorily to routine treatment measures, without subsequent relapse.

More than 200 case records were studied, bearing the diagnostic index of constipation. The group was restricted to children between the ages of 9 months and 4 years, for the time of onset of symptoms, with the aim of matching the controls, so far as possible, with the age range for onset of symptoms in the primary series. Rejection of cases as ineligible, because they were too young or too old at the relevant time, depleted the available records to 57.

Of these, a further 19 proved inadmissible because of a revision of diagnosis following hospital admission. In each of this sub-group, the condition was subsequently shown to have an acute organic basis, predominantly appendicitis. The potential group was thus reduced to 38.

10 of these could not be traced, because they had left the district in the interim. The remaining 28 were followed up and investigated in parallel with the primary series.

Of this residual group, 7 proved unsuitable for inclusion as controls, because their constipation, although functional in origin, had not in fact resolved with routine treatment measures. Follow-up investigation revealed persistence of the original symptoms, and the child's continued attendance currently at other hospitals or surgeries.

The final number of 21 children, 14 male and 7 female, satisfy the criteria evolved as a basis for comparison, and were thereafter designated the control group.

In all therefore, a total of 51 children provided the clinical material for the present study.

Method of Study

The following procedures were undertaken in each of the 30 children forming the primary series:-

- 1) A detailed case history was obtained, with particular reference to the presenting bowel disorder, its date of onset, duration, character, severity, and clinical course.

Information was sought as to the circumstances surrounding the onset of symptoms; the attitude of parents to the problem; their general attitude to the child; their method of upbringing; the method of toilet training

adopted; the emotional reactions of the child to the disorder, and his pattern of emotional response generally.

The history further included developmental data; details of pre-natal and natal morbidity; the relevant family history; the attitudes, beliefs, and fears of parents concerning constipation and faecal soiling; and details of the environmental setting, including family structure, within which the disorder had developed.

This information was obtained primarily from the mother, but was supplemented in certain cases by information from the father or grandparent.

- 2) Clinical psychiatric assessment of the child, his parents, and others concerned in his upbringing, with particular reference to personality structure, emotional adjustment, and relationships within the family.
- 3) Evaluation of the paediatric findings and treatment previously undertaken in all but two of the series, and the response to treatment.
- 4) Evaluation of the material which emerged during subsequent psychotherapeutic treatment, both of the children and their parents.

In each of the 21 children forming the control series, the method of investigation involved:-

- 1) A detailed case history similar in scope to that obtained in the primary series.
- 2) Current personality assessment of the child and his parents.
- 3) Evaluation of the equivalent paediatric findings and treatment originally undertaken in these cases and the response to treatment.
- 4) Follow-up of the present position in regard to bowel function.

To permit valid comparison of the data yielded by the 2 groups, follow-up assessment of the control cases, and the provision of a retrospective history in each case, were undertaken on behalf of the investigator, but independent of the main study, by a senior psychiatric social worker. She was instructed to base her assessments upon the model adopted for the primary investigation in order to facilitate subsequent comparison, but the aims and detailed findings of the primary study were not disclosed to her.

This procedure was adopted to safeguard against contamination of the data provided by the control group, through the element of personal bias.

The data so obtained were then correlated with the equivalent data derived from the primary series.

Case Presentation

Each of the 30 cases forming the primary series is presented in detail, giving the case history, the paediatric findings and treatment, the psychiatric assessment of parents and child, the further course of the condition, and its response to psychotherapeutic treatment.

The detailed programme of treatment, and the principles on which it was based, are described in a separate section.

Summarised versions are included of each of the 21 cases forming the control group.

Case No. 1 - 30.

History of Present Illness

Onset of symptoms

Course of Illness

Examination

THE PRIMARY SERIES

Cases No. 1 - 30.

Case No. 1

Case No. 2

Case No. 3

Case No. 4

Case No. 5

Case No. 6

Case No. 7

Case No. 8

Case No. 9

Case No. 10

Case No. 11

Case No. 12

Case No. 13

Case No. 14

Case No. 15

Case No. 16

Case No. 17

Case No. 18

Case No. 19

Case No. 20

Case No. 21

Case No. 22

Case No. 23

Case No. 24

Case No. 25

Case No. 26

Case No. 27

Case No. 28

Case No. 29

Case No. 30

Case No. 1. Male M.S. Date of birth -20.4.49.

Presenting Problem

- 1) Increasing constipation since the age of twelve months with intervals of up to one month between bowel actions.
- 2) Overflow faecal incontinence at intervals of 2 to 3 days.

Age at Psychiatric Referral - 6 years 9 months.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms - 6 years.

Paediatric Findings & Treatment

First referred to paediatric surgeon at age 5. Healthy well nourished child, difficult to examine because of his nervous tension. Protruberant abdomen with hard faecal masses palpable through anterior abdominal wall in left iliac fossa and hypogastrum. Rectum loaded with hard faeces. No local lesion of rectum or anus. Admitted to surgical ward for investigation, and treated with daily rectal washouts which yielded copious retained faeces. Barium enema investigation showed (Appendix I Plate Nos.1, 2) "Colon as a whole of rather large diameter with redundant looping. No evidence of Hirschsprung's disease". Subsequent treatment was by petrolagar with phenolphthalein. On this regime, daily bowel action was achieved five days after barium enema until patient discharged three weeks later. Referred back to surgical out-patients after six weeks at home. Rectum again loaded with faeces and faecal masses palpable abdominally. The loaded bowel was cleared by a course of daily enemata administered as an out-patient and case discharged on maintenance dosage of petrolagar.

18 months later, child readmitted to medical ward under paediatrician. Relapse had occurred within one month of previous discharge and intractable constipation with soiling had persisted in the interim. Re-examination revealed increased loading of terminal bowel with peri-anal soiling. No rectal washouts or enemata were administered on this occasion. Case was treated medicinally with petrolagar and phenolphthalein. Three days after admission, daily bowel action was resumed without apparent discomfort and maintained regularly for a further three weeks. Child then discharged home on maintenance doses of laxative. Follow-up two months later revealed complete relapse. Referred for psychiatric opinion.

Psychiatric Assessment

Child

Pale, tense boy, deferential in manner, but hostile to further examination. Remained inhibited and on guard throughout.

Mother

Age 34. Intelligent woman; rigid, determined personality. Fastidious in personal hygiene and insistent upon obedience from her children. The dominant partner in the marriage. Currently tense and anxious.

Father

Age 33. Placid, stable personality, much less disturbed by child's symptoms.

Family Structure

One sibling, a boy, 3 years younger than patient. Healthy. No bowel disorder.

Family History

No familial tendency to constipation. Maternal grandfather had been strict disciplinarian, who demanded implicit obedience from his children.

Developmental History

Normal pregnancy. Normal birth. Uneventful development until the age of twelve months. Toilet training instituted at 3 months, strict, and completed at 8 months.

Background Circumstances

Child conceived after 4 years marriage, following three miscarriages and gynaecological treatment. Mother was thrilled to carry this baby successfully to term. Because of previous mishaps, child's value very much enhanced. Mother constantly afraid of "something happening to him". "I had to take extra care of him".

Determined not to spoil him, and therefore adopted firm attitude from infancy. Particularly keen to institute early toilet training because she felt it so important. "After all the trouble I had getting him, I felt nothing must go wrong".

Parental Fears & Prejudices

During repeated admissions to Women's Hospital prior to this pregnancy, she recalled seeing many cases of "bowel stoppage" in adults. Felt horrified to think such cases might be due to pure neglect. She was determined to avoid the same development in her child and was conscious during his toilet training of this underlying fear. She entertained a secondary fear of underlying "bowel weakness" engendered by the persistence of symptoms in face of repeated courses of treatment.

History of Present Illness

In early infancy, bowel action normal. At age of 12 months, child had intercurrent systemic disturbance with some pyrexia, presumed due to teething. Bowel action became sluggish in association and baby cried at stool. At this time, child had an isolated major convulsion, diagnosed by family doctor as due to constipation. Mother extremely concerned at this and from that time, her determination to avoid further constipation has dominated her thoughts.

A variety of laxatives were prescribed with little effect, followed by use of suppositories, which child actively resented. During toddler stage, in his 2nd year, mother recalls prolonged sessions of forcing him to sit on pot, with both parents squatting beside him, exhorting him to defaecate for periods up to an hour. Rarely any result, even with use of soap suppositories, but later in day, napkin or underpants would be soiled.

Subsequently, there was positive refusal to sit on pot. Child would scream if force attempted, and run off into a corner of the room where he would crouch huddled up, red in the face, and obviously restraining the urge to defaecate. He would repeatedly complain of abdominal cramp for several days, followed by passage of bulky stool into underpants. Mother claims she avoided smacking him for the constipation,

(M.S. cont)

but admits chastising him severely for his "naughtiness" in soiling. At age 2, she considered he was old enough not to soil. By this time, his bowel disorder was centre of attention for both parents. Mother alternated between bribing and coaxing, and smacking and depriving him. Both types of approach proved equally ineffectual.

When old enough to use toilet, appeared less resistive. Sent up regularly twice a day and told to remain on toilet until he had produced a motion. Might sit for as long as an hour. Mother insisted on inspecting result personally. On this routine, bowel action occurred every 4 or 5 days at first, but subsequently at increasing intervals up to 1 month. Overflow soiling occurred at regular intervals. Mother became obsessed by this daily toilet regime. Would tiptoe upstairs to stand outside toilet door and listen for child straining. Often overheard him whispering to himself "My mum says I must go, I must try".

After first admission to hospital and assurance as to absence of organic basis, mother redoubled her efforts to "train him properly before he reached manhood". She continued to experience lurking fear about underlying "weakness" in the child's bowel. She became increasingly tense, overwrought, and pre-occupied with his bowel function.

Referring to absence of bowel disturbance in her younger child, mother confirmed she had had little time to devote to his toilet training because of her exclusive pre-occupation over patient. "But then my younger boy was always so normal, I never had to worry about him".

Further Progress

See Treatment Section p.120.

Mother was interviewed at regular weekly intervals during the next four months for intensive psychotherapeutic re-education. No direct therapy was employed with the child. All laxative treatment was discontinued. For the first six weeks, child remained constipated, with periodic overflow soiling. Bowel actions were occurring on average once a week, but later became more frequent with progressively less soiling. By the end of 2 months, child was beginning to use toilet regularly, unbidden.

Result of Psychotherapeutic Treatment - (September, 1956)

Spontaneous bowel action has now been maintained daily for a period of 6 months, with no recurrence of soiling and no evidence of further colonic loading. Mother has retained full insight. Both she and the child are free from tension, and the mother-child relationship is secure and amicable.

Satisfactory result.

Case No.2. Male R.T. Date of birth-12.7.52.

Presenting Problem

- 1) Intractable constipation since age of 5 months with overflow faecal soiling since age of 2.
- 2) Difficult and aggressive behaviour of 12 months duration.

Age at Psychiatric Referral - 3 years.

Mode of Referral - Referred by paediatric surgeon.

Duration of Symptoms - 2½ years.

Paediatric Findings & Treatment

First admitted to paediatric hospital at age 5 months with 7 days' history of constipation and reluctance to feed. Child was pyrexial because of bronchitis, assumed to be associated with teething. Faecal masses palpable in descending colon and rectum. Some degree of abdominal distension. Investigation for organic gastro-intestinal disease proved negative. Constipation responded to initial course of daily enemata. Bronchitis responded to antibiotics. Child developed gastro-enteritis prior to hospital discharge, and thereafter transferred to Isolation Ward. Retained for further month. Total period in hospital 6 weeks. No visiting by parents permitted throughout period in isolation.

Readmitted 2 months later because of recurrence of constipation. Rectum and descending colon again loaded with faeces. Child not pyrexial. Recurrence of constipation assumed to be due to impairment in tone of abdominal musculature following gastro-enteritis. Treated with course of bowel washouts and oil retention enemata. Discharged from hospital one month later with lower bowel adequately cleared. Regular enemata prescribed at home to be administered by District Nurse. Constipation recurred within 3 weeks of return home and persisted despite variety of purgatives. Six months later, at age 18 months, admitted to hospital for third time, on this occasion to a surgical ward to exclude Hirschsprung's disease. Found to have palpable mass in right iliac fossa extending to right hypochondrium; diagnosed as faecal accumulation, which disappeared upon repeated bowel washouts. Barium enema showed (Appendix I Plate No. 3) "Large atonic lower colon with considerable redundancy of pelvic loops of bowel. No evidence of Hirschsprung's disease. Segmental megacolon". Cascara mixture was prescribed. At one time child had a total of 21 tablespoons of Cascara mixture administered during the course of 7 days with no bowel evacuation throughout. Between the ages of 18 months and 3 years he was readmitted on a further 4 occasions because of persistence of intractable constipation, despite repeated enemata and trial of several purgatives. At 6th and 7th admissions, constipation had persisted for a whole month on each occasion, followed by massive overflow soiling. Throughout, general condition had remained healthy. Child was eating well with no complaint of pain or discomfort, and no vomiting. During the total period of hospital treatment, case records show that over 100 enemata and washouts were administered. Despite this and after 2½ years' treatment no improvement had been achieved. 7th admission was arranged specifically for purpose of partial colectomy advised by paediatric surgeon in view of redundancy of pelvic loops of bowel and because of failure/

failure of case to respond to non-surgical measures. Parents demurred and requested alternative opinion prior to operative intervention. Case referred at this stage for psychiatric opinion.

Psychiatric Assessment

Child

Slightly built but healthy boy, intensely suspicious and reluctant to leave mother's side. Remained mute and unresponsive throughout first interview, but later became more friendly and began to cooperate in play sessions.

Mother

Age 35. Highly intelligent and emotionally stable personality. A primary school teacher before marriage. No evidence of obsessional or perfectionist trends. Currently distressed and tense about child's condition.

Father

Age 42. Highly intelligent, forceful and aggressive personality. Headmaster of a primary school, Bitterly resentful at handling of child's case to date. Distressed by boy's condition.

Family Structure

One other child 2 years senior to patient. No history of bowel disorder.

Family History - Nil relevant.

Developmental History

Normal pregnancy. Normal birth. Uneventful development prior to first admission to hospital at age 5 months. No attempt at bowel training had been made at that time. No previous episodes of constipation.

Background Circumstances

No relevant predisposing factors were elicited. Bowel regularity had not been an issue with parents in respect of either child.

Parental Fears & Prejudices

No primary misconceptions or convictions entertained by either parent about constipation. Both parents secondarily preoccupied with fears of organic bowel disease resulting from conflicting opinions offered in hospital.

History of Present Illness

Following child's earlier admissions to hospital, both parents enforced rigorous measures of bowel training, accompanied by threats and exhortations, without success. Between

the ages of 2 and 3, child developed marked anti-social behaviour in addition to bowel symptoms. He had become increasingly aggressive and destructive, biting his older brother, smashing windows, spitting on food at table and entirely refractory to parental discipline. Had bitten father on two occasions, frequently butted mother, and seemed completely lacking in affection for mother. Bladder control originally attained by age 2, but in past 6 months diurnal enuresis had developed. Both parents seriously perturbed by child's behaviour and regarded him as unmanageable. They were convinced his conduct had resulted from emotional deprivation while in hospital with resulting sense of maternal rejection. At time of psychiatric referral household routine was dominated by child's bowel disorder and disrupted by his behaviour. All parental efforts to induce patient to evacuate his bowels were met by violent resistance.

Further Progress

See Treatment Section p. 115.

Both parents were seen regularly at weekly intervals for psychotherapeutic re-education and guidance upon the handling of the child's problems within the home. Father attended for two months. Mother attended for 9 months. No direct therapy was undertaken with the child. All laxatives were discontinued. The only injunction to the parents was to maintain child's adequate fluid intake. Two months after psychiatric treatment began, child's behaviour underwent marked further deterioration and bowel disturbance became more severe. Child was intensely resistive and obstinate, and at this stage a total of 83 days elapsed during which constipation was absolute and no overflow soiling occurred. Throughout this period patient remained perfectly healthy, ate well, was normally active and showed no evidence of pain or discomfort. The only sign upon examination was increasing abdominal distension. Thereafter, massive faecal soiling occurred and continued for several days without medicinal intervention.

During the next 3 months two separate episodes occurred indicative of impending intestinal obstruction. On each occasion child began to vomit, refused food, became listless, pallid and anergic. Brought to hospital by mother and impacted faeces manually removed per rectum without anaesthetic. Child permitted this procedure on promise that he would not be retained in hospital. Manual evacuation was followed by spontaneous massive soiling. On each occasion child was pyrexial due to intercurrent respiratory infection and faecal impaction was thought to have occurred because of state of relative dehydration and hardening of accumulated matter in lower bowel. At both examinations rectal contents were noted to be unusually hard as compared with pultaceous consistency previously noted. No adverse effects resulted from either episode.

During the ensuing 4 months, gradual but definite improvement occurred both in restoration of bowel function and in child's general behaviour. 7 months after start of psychiatric treatment patient performed spontaneously for the first time on toilet. This was a voluntary unsolicited effort, quite different from previous overflow soiling. Subsequently, spontaneous evacuation took place with increasing frequency and

with progressively fewer episodes of soiling. Regular contact with the case and guidance of parents was discontinued at the end of 9 months.

Result of Psychotherapeutic Treatment (September 1956)

15 months after psychiatric referral, complete remission of bowel symptoms has been maintained for a period of 6 months. Daily bowel action now occurs spontaneously and there is no faecal soiling. The child's behaviour has improved considerably and he now has an affectionate relationship with both parents. In particular, he shows emotional warmth towards his mother and is now capable of normal response to demonstrative affection by his mother. His former destructive and aggressive behaviour has subsided, although he remains obstinate and self-willed. Both parents are now free from anxiety. Satisfactory result.

Case No. 3. Female H.M. Date of birth - 3.2.50.

Presenting Problem

- 1) Constipation since infancy with intervals of 2 to 3 weeks between bowel actions.
- 2) Overflow faecal soiling from the age of 2.

Age at Psychiatric Referral - 4 years 6 months.

Mode of Referral Referred by consultant paediatrician.

Duration of Symptoms Approximately 4 years.

Paediatric Findings & Treatment

First referred to paediatrician at age 3; residing at that time in another city. Healthy child with distended abdomen and palpable faecal masses in descending colon. Rectum loaded with faeces. No local lesion. Admitted to paediatric ward for investigation. Barium enema reported "some dilatation of terminal colon but no evidence of congenital megacolon" (X-ray plates not available). No other abnormality found. Treated with course of colonic washouts and discharged on maintenance doses of laxative with medicinal paraffin. Mother advised to maintain "regular training", but despite these measures, relapse occurred within 3 weeks of leaving hospital. Subsequently family moved to this city and child referred for paediatric consultation locally. Clinical picture was exactly as described over a year earlier. Paediatric investigations were not repeated. Case was referred for psychiatric opinion.

Psychiatric Assessment

Child

Sullen, uncommunicative, suspicious and unresponsive throughout first interview. Refused offer of toys and remained close to mother's side. At subsequent interviews she became more friendly and relaxed but remained suspicious of physical examination. She was described by mother as being obstinate, determined and negativistic.

Mother

Age 35. Intelligent woman of determined and forceful personality. Currently tense, anxious and obsessed with her child's presenting symptoms, "I have been worried to death for years by her bowel trouble". Insists upon obedience from her children and was not prepared "to be their slave". Squeamish about "messy and dirty things", including faecal matter.

Father

Not available for interview. Described as equally concerned about child's bowel irregularity, but less intense in attitude.

Family Structure

Two other children, both girls, 3 years and 8 years older respectively than patient. Middle child healthy. Oldest child was asthmatic until the age of 8. No history of bowel disorder in either girl.

Family History

Nil relevant.

Developmental History

Normal pregnancy. Normal birth. Uneventful development except in sphere of bowel training which was rigid, coercive, and instituted during the neo-natal period. Successful training not achieved.

Background Circumstances

Patient is the youngest of 3 girls. The oldest now 12, was born while father serving in the Army in 1942. Several months after her birth father sustained serious head injury for which invalided from the Service and totally disabled for 18 months. Thereafter remained irritable, intolerant and moody for further 3 years. Domestic tension acute during this period with frequent violent scenes. Against this background eldest child developed asthma at age 2. This girl is similar in temperament to her father. If emotionally upset she does not readily show her feelings but becomes withdrawn and silent. Marital situation much improved by the time second child was born in 1947. Within the next year the oldest girl's asthmatic attacks began to resolve. The middle child's development was completely uneventful and the mother recalls complete freedom from domestic tension at that time.

Three years later in 1950, patient was born. Unwanted pregnancy, and mother recalls her resentment and chagrin at thought of having another baby. She felt she had already suffered sufficiently from her husband's post-traumatic disorder, the first child's recurrent asthma, and the limitations upon her freedom imposed by the second child. She had keenly anticipated liberation from these ties and was now to be restricted once more with the chores of babyhood. In particular felt revolted by thought of repeatedly washing soiled napkins. She was determined that she would train this last infant in toilet habits from birth.

Parental Fears & Prejudices

The child's persisting constipation and its failure to respond to vigorous laxative therapy prompted maternal fears of "bowel stoppage". These fears were augmented by avid study of advertisements for treatment of constipation. Mother was convinced her child had serious organic bowel disorder, despite reassurance to the contrary after initial hospital investigation.

History of Present Illness

Toilet training instituted by mother upon discharge from Maternity Hospital. Initially 72 hours might

elapse between infant's bowel movements. Commonly mother failed to obtain a response by holding out the baby, with resulting soiled napkins and the redoubling of maternal efforts to "train" her child. By the age of one year child was refusing to sit on pot and struggling violently against mother's efforts. During 2nd and 3rd years every attempt by mother to promote child's bowel evacuation created a major emotional scene. When it was clear from her facial expression that she felt the urge to defaecate she would crouch in a corner of the room holding her body rigid, or wriggling and contorting, gripping the back of a chair in her efforts to resist bowel action. These episodes recurred at intervals over a period of 2 to 3 weeks with repeated faecal staining on knickers and finally the passage of a voluminous stool in her knickers or in bed.

Mother alternated between threats and exhortations, both without effect. The child remained adamant in her refusal to use both pot and later, toilet.

A variety of purgatives was prescribed by family doctor with sole result of increasing the child's soiling. Her continuing constipation became the constant and central topic of conversation in the household.

Further Progress

See Treatment Section p. 120.

Mother was interviewed at regular weekly intervals during the next 6 months for intensive psychotherapeutic re-education. No direct therapy was employed with the child. All laxative treatment was discontinued. At the end of 6 months from the date of psychiatric referral, regular and spontaneous bowel function had been restored on average 5 days a week with no evidence of faecal soiling. The mother had gained full insight and had adopted an entirely different approach in handling the child, with satisfactory response.

Five months later at age $5\frac{1}{2}$, child was enrolled at a Convent school. School routine was strict and it was customary for girl prefects to accompany the infants to the toilet, stand outside while they performed and escort them back to class. In face of this regime, child again became seriously constipated with daily overflow soiling within a month of starting school. Mother promptly removed patient from this school and transferred her to Council school where no special attention was shown to toilet habits in the infants' class. At the end of further two months, normal pattern of daily bowel function had been restored with complete absence of soiling. There has been no subsequent relapse.

Result of Psychotherapeutic Treatment - September 1956.

Spontaneous and normal bowel action has now been maintained for a period of 12 months. Discounting the isolated lapse following enrolment at Convent school, bowel function has been normal for the past 18 months without recourse to laxatives.

Satisfactory result.

Case No. 4. Male J.McL. Date of birth - 30.5.40.

Presenting Problem

- 1) Apparent history of faecal soiling of 2 years duration.
- 2) Subsequently elicited history of intractable constipation since infancy, with recurrent episodes of overflow soiling at intervals of 2 to 3 days since age of 2 years.

Age at Psychiatric Referral - 15 years.

Mode of Referral - Referred by general medical practitioner.

Duration of symptoms Approximately 15 years.

Paediatric Findings & Treatment

No previous hospital investigation had been undertaken. Child had been treated by a succession of general practitioners with remedies ranging from laxatives and suppositories, to Mst. Cret. for the soiling. Upon current investigation, rectum was loaded with pultaceous faeces, and harder faecal masses could be palpated through abdominal wall. Abdomen not markedly distended. No local lesion of rectum or anus. A course of preliminary colonic washouts in hospital was necessary to clear the lower bowel in preparation for barium enema. Barium enema showed (Appendix I Plates 4, 5) "Considerable looping and dilatation of the pelvic and descending colon. No evidence of pathological lesion". All routine investigations negative. Bacteriological investigation of faeces negative.

Psychiatric Assessment

Child Tall, well built adolescent of superior intelligence but showing marked emotional immaturity. Apprehensive at interview, lacking in self confidence, pampered and overdependent. Became sulky and reticent when his symptoms were discussed.

Mother Age 44. Colourless personality, diffident and lacking in self assertion. Currently tense and anxious about her son's symptoms.

Father Deceased 1940.

Maternal Grandmother

Dogmatic, determined personality. Overprotective and overpossessive of grandson, towards whom she had assumed role of mother figure from child's infancy. She is the ruling influence in the household.

Family Structure

Patient is an only child. He and his mother share house with maternal grandparents and their two unmarried sons.

Family History

Maternal grandmother has suffered from chronic constipation throughout adult life.

Developmental History

Normal pregnancy. Normal birth. Uneventful early development, except in sphere of bowel training which was rigid, coercive and instituted by grandmother during neo-natal period. Successful training not achieved.

Background Circumstances

Child's father was killed on active service in January, 1940, 5 months before patient was born. Subsequently child pampered and over-indulged as war orphan. Mother prostrate and withdrew from social life for 4 years. Child virtually reared by maternal grandmother and subjected to adulation of all 5 adults in household. Throughout childhood led a sheltered and dependent life entirely within the family circle.

Grandmother's Fears & Prejudices

Because of her own tendency to chronic constipation, grandmother is obsessed with need for regular bowel action. Fearful of the adverse effects of constipation and convinced that bowel "sluggishness" would lead to appendicitis.

History of Present Illness

Initially mother gave a history of faecal soiling in her child of 2 years duration. Subsequently, grandmother admitted that "constipation" had been a problem with the child since earliest infancy. When baby was 4 days old she administered a suppository because of her fear of "sluggishness" and has continued ever since to dose child with magnesium hydroxide night and morning. Despite this, intervals between bowel actions increased during first year up to 7 or 8 days. Child resisted efforts at toilet training, refused to use pot, and from age 2, constipation was associated with periodic overflow soiling. At later stage, grandmother would sit for lengthy periods with child in toilet, pleading with him to open his bowels.

This earlier history of disordered bowel function had been successfully suppressed by grandmother from entire household, including child's mother. She did not want child to feel ashamed and wished to avoid distressing other members of family. Constipation and soiling were both kept a complete secret between child and grandmother, even during treatment by various family doctors. Child was enrolled at small private school and retained there as a special concession, until the age of 13. School staff unaware of his bowel disorders. Thereafter obliged to transfer to Grammar School where he failed to adjust and became increasingly unhappy. Symptoms in consequence became more obvious and could no longer be hidden from other members of the family. For the first time, mother became aware of the problem and insisted upon referral to another doctor. After trial of various laxatives, high residue diets and repeated explanations to the boy about the gastro-cholic reflex, all without success, family practitioner referred child direct for psychiatric opinion.

Further Progress

See Treatment Section p. 122

It was clear that no effective treatment could be conducted while child remained under over-protective influence at home. Admitted to hospital under supervision of therapist, ostensibly for observation, but actually for psycho-therapeutic rehabilitation. Retained for 3 months despite protestations of grandmother, but with mother's approval. Cooperation of nursing staff enlisted in programme of re-education. Concurrently mother interviewed at regular weekly intervals, with increasing promotion of insight for the emotional basis of her child's symptoms. All laxative therapy was discontinued. At the end of 3 months, spontaneous bowel action had been restored to the extent of one motion every 2 to 3 days, with faecal soiling at infrequent intervals. Upon re-examination, rectum was no longer loaded and no faecal masses were palpable abdominally. Colonic loading had not recurred in the interim.

Result of Psychotherapeutic Treatment - (September, 1956)

Remission of bowel symptoms has been maintained for a period of 15 months. Spontaneous bowel action now occurs 4 to 5 times a week without laxative therapy. There has been no recurrence of faecal soiling. Emotionally the boy has matured and now presents as a poised, and self-reliant personality. In retrospect, he has acquired good insight for the development of his own condition. Mother, with therapeutic support, has successfully asserted herself within the home, taken over the emotional role of mother to her child, and now adequately protects him from the grandmother's domination. She has benefited from her own emancipation, and the relationship between mother and child is secure and realistic. Patient currently treated as a responsible adolescent and is responding accordingly.

Satisfactory result.

Case No. 5. Male M.B.V Date of birth-31.12.45.

Presenting Problem

- 1) Intractable constipation since the age of 2, with intervals of up to 2 weeks between bowel actions and persistent overflow faecal soiling.
- 2) Previous diagnosis of "idiopathic" megacolon.

Age at Psychiatric Referral - 9 years.

Mode of Referral - Referred by paediatric surgeon.

Duration of Symptoms - 7 years.

Paediatric Findings & Treatment

First investigated in this area by senior paediatric surgeon at age 8. Previously investigated and treated by several physicians and surgeons at other hospitals where case had been diagnosed as "idiopathic" megacolon. Repeated courses of enemata and various purgatives had been administered without lasting beneficial effect. Assessed two years earlier by Child Guidance Clinic where described as a sensitive, highly-strung child with eye blinking and facial tics. Noted to be withdrawn and unresponsive, but these findings were regarded as secondary to the persistence of bowel disorder. Referred for further surgical opinion because of persistent faecal soiling, for which he had been sent down from boarding preparatory school. Admitted to surgical ward. Examination required general anaesthetic because of child's intense aversion to doctors. Abdomen was distended, with large faecal masses in descending colon, and gross rectal loading. No local lesion of rectum or anus. Tone of anal sphincter unimpaired. Barium enema showed (Appendix 1 Plate No. 6) "Large dilated colon with impacted faeces high up. No evidence of Hirschsprung's disease". In view of child's marked resistiveness, no further enemata were administered as treatment. Case was treated in hospital with petrolagar, phenolphthalein and amechol, coupled with warm baths and "retraining" in toilet habit twice daily. On this regime, two bowel actions occurred each day, but two weeks later at a second examination under anaesthetic, the rectum and terminal colon were still loaded and faecal soiling had persisted. Child was thought not to be emptying his rectum adequately, so that bowel action, although regular, was incomplete. Child remained aloof and withdrawn in ward. Referred at this stage for psychiatric opinion.

Psychiatric Assessment

Child

Sallow, reserved boy, polite but subdued and on guard. Remained unresponsive during initial interviews but subsequently became less suspicious and made closer contact.

(M.B. cont)

Mother

Age 34. Intelligent, cultured woman of sensitive, reserved personality. This is her second marriage, the first having ended in divorce. Since then she has become diffident and retiring, with difficulty in expressing her emotions. She had left child to the care of nursemaids and "never really got to know him". She felt that somehow she had failed the boy. Very willing to consider an emotional basis for child's bowel symptoms.

Father

Age 40. Successful business executive. Forthright man of military bearing and dominant personality. Showed little capacity for understanding emotional problems. Frankly intolerant of child's soiling, which he described as "distasteful" and "degrading". Relationship with child superficial and remote. Concerned only with the most direct treatment of the bowel disorder.

Nursemaid

The children's nurse at the relevant time in child's upbringing is described as having been excessively rigid, coldly efficient, determined and insistent upon strict toilet training.

Family Structure.

No children of mother's first marriage. Patient is oldest of 3 children in present marriage. The two younger are both girls; neither has history of bowel disorder. Father is the dominant influence within the home. Nursemaids were dispensed with in rearing the two younger children.

Family History

Nil relevant.

Developmental History

Normal pregnancy. Normal birth. Uneventful early development. Brought up from infancy by succession of trained children's nurses. No special emphasis laid upon bowel training until the age of 22 months. Earlier nursemaids not coercive in their approach.

Background Circumstances

No intimate association between mother and child during early years. Mother now expresses feelings of guilt about this attitude of emotional neglect.

Parental Fears & Prejudices

Neither parent initially preoccupied with potentially adverse effects of constipation, though father disgusted by soiling. Persistence of symptoms led parents to feel anxious ultimately about question of "a diseased bowel". Relevant nursemaid intensely concerned about need for bowel regularity.

History of Present Illness

Child developed gastro-enteritis at the age of 22 months. Treated at home. During convalescence bowel movements became "sluggish". New nursemaid appointed at that time. Concerned by irregularity of bowel function and instituted rigorous bowel training for the first time. She considered that such training had hitherto been neglected. Child responded with persistent refusal to defaecate, despite punitive measures. Subsequent development of progressive constipation which failed to yield to laxative measures and was associated with faecal soiling. Father's censure was added to that of nurse to discourage this "dirty habit". Mother felt uneasy about this approach but was unable to voice her misgivings. A succession of investigations followed, by various doctors, with no lasting response to physical treatment measures. At time of further referral to surgeon, enemata were being administered 3 times a week by district nurse under instruction from family doctor. Child resented this procedure so violently, that enema could only be given when father and another adult were at home to hold him down forcibly.

Further Progress

See Treatment Section p. 123.

The parents declined to attend further at hospital after their first consultation but agreed to be visited in their own home. Father was frankly sceptical. Mother remained excessively reserved. Realignment of parental attitude was undertaken over a period of 3 months by home visiting, during which child was also seen and treated directly. On advice, he remained at home for remainder of school term with provision of a private tutor. At the end of 3 months a much closer relationship had been established between mother and child with increasing emotional insight on the part of the mother. Father remained unconvinced but withdrew former attitude of censure and intolerance. Laxative therapy was discontinued. The child was allowed to play at his own level with initial increase of emotional dependence upon mother and evidence of regressive behaviour, followed by release of underlying aggressiveness. Concurrently, the child's bowel function gradually became more regular and spontaneous, with progressive decrease in frequency of soiling. Child became noticeably more friendly, relaxed and responsive. When examined by surgeon 4 months after initial psychiatric consultation, the child was reported to be well with spontaneous daily bowel movement and absence of soiling. The rectum was found to be empty and straight x-ray of abdomen showed no accumulation of faeces in colon. Thereafter the boy returned to boarding school.

Result of Psychotherapeutic Treatment (September 1956)

Child has now remained symptom free for a period of 18 months. He is now more self reliant, confident and at ease. His school report is satisfactory in work, sport and social activities and the parents are equally satisfied with his further personality development. Father's insight remains superficial and inadequate, although he now concedes that "the psychological element was greater than I was prepared to believe". Mother has retained full insight and the mother/child relationship is now secure. Satisfactory result.

Case No. 6. Male R.W.G. Date of birth-13.11.48.

Presenting Problem

Chronic constipation since the age of 18 months, with intervals of up to 7 days between bowel motions, and with overflow faecal soiling.

Age at Psychiatric Referral - 7 $\frac{1}{2}$ years.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms - 6 years.

Paediatric Findings & Treatment

First referred for paediatric opinion at the age of 3 $\frac{1}{2}$. A variety of aperients had been prescribed by family doctor without beneficial effect. No clinical abnormality noted at that time. Routine investigation of gastro-intestinal function proved negative, and condition was attributed to "faulty habits" and "deficient diet". Treatment prescribed was high residue diet, liberal fluid intake, and medicinal paraffin. Referred back to paediatrician 18 months later at age 5, with persistence of symptoms now of increased severity. Palpable faecal masses in descending colon. Abdomen was distended; rectum loaded with faeces; peri-anal soiling. No local lesion of rectum or anus. Child admitted to hospital for barium enema. Report stated (Appendix I Plate 7) "The colon is very large and appearances are consistent with megacolon. No evidence of Hirschsprung's disease". Treated by course of enemata, followed by training in "regular bowel habit", assisted by petrolagar. Discharged on this regime, but supervised regularly as out-patient. Subsequent condition fluctuated between transient improvement, with infrequent soiling; and phases of relapse, with constipation persisting for up to 7 days, after which enema would be administered by district nurse. Attended paediatric out-patients monthly for next 2 $\frac{1}{2}$ years. General health good. Appetite unimpaired. No abdominal symptoms. Despite treatment, masses of retained faeces could still be palpated in descending colon. At this stage referred for psychiatric opinion.

Psychiatric Assessment

Child

Alert, intelligent boy, described by mother as "stubborn in a quiet way". Has latterly become fearful of the dark and lacking in confidence. Superficially responsive but clearly suspicious of therapist. Good relationship with mother but fearful of father.

Mother

Age 44. A sensible and well balanced woman. Normally placid in temperament but currently tense and anxiety-ridden about child's symptoms.

Father

Age 46. Stern, rigid and determined personality with fixed ideas about personal hygiene and bowel regularity. Strict disciplinarian within the home.

Family Structure

2 siblings, both girls, 11 and 13 years older respectively than patient. No history of bowel disorder in either.

Family History

- Nil relevant.

Developmental History

Normal pregnancy. Normal birth. Early development uneventful. Toilet training initially lax, with no element of coercion until the age of 18 months in face of persistence of soiling.

Background Circumstances

Patient is the first boy in family, with interval of 11 years since previous pregnancy. Conception unplanned and unexpected. Mother annoyed at first, but accepted his birth more equably because she had always wanted a boy. Experienced subsequent feelings of guilt about rejecting child before his birth, and was conscious of trying to compensate for this by safeguarding his health more assiduously than in the case of her two older children.

Parental Fears & Prejudices

Neither parent primarily concerned about adverse effects of constipation. Father adopted attitude of disgust and annoyance at continued soiling. Persistence of faecal retention led to maternal fear of "bowel stoppage".

History of Present Illness

Parental concern first developed when child aged 18 months because of continued soiling. The two older sisters had achieved bowel control by comparison at the age of 15 months. Father considered that since the child could now talk, he should request the pot verbally and so learn to become clean in bowel habit. Accordingly applied coercive pressure. Father's attitude was punitive and included censure, smacking, belittling and deprivation of privileges. Mother acquiesced reluctantly, but would have preferred to leave child alone for further period. Torn between conflicting ties of supporting her husband and protecting child. Subsequent development by child of refusal to use pot, with increasing constipation, served to confirm father's conviction that "child was lazy", and that stern measures were necessary to "train" him.

Further Progress

See Treatment Section p. 121.

Both parents were interviewed regularly over a period of two months for psychotherapeutic re-education. No direct therapy was employed with the child. All laxative treatment was discontinued. Mother readily acquired full insight and proved entirely cooperative. Father resisted psychotherapeutic approach and it required supplementary interviews to realign his attitude. Insight in his case was acquired more slowly and to a lesser degree. Ultimately cooperative. Child responded with progressive restoration of normal bowel function. At the end of two months, spontaneous bowel action was occurring almost daily with no further episodes of soiling.

(R.W.G. cont)

Result of Psychotherapeutic Treatment - (September, 1956)

Child has now remained symptom free for a period of 3 months. Relationship between father and child is more satisfactory, with corresponding improvement in child's self-reliance and emotional stability. Currently his fears have receded. Father's depth of insight still inadequate but prepared to accept psychiatric counsel.

Satisfactory result.

Case No. 7. Male R.H. Date of birth - 24.10.45.

Presenting Problem

Intractable constipation with persistent overflow faecal soiling, ostensibly dating from age 5, but in fact extending back to earlier childhood.

Age at Psychiatric Referral - 10 $\frac{1}{2}$ years.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms - Approximately 9 years.

Paediatric Findings & Treatment

First admitted to paediatric surgical ward at age 7 for investigation of recurrent attacks of vomiting. 2 year history of constipation thereupon elicited. At examination, lower abdomen filled with hard faecal mass extending from suprapubic region to above umbilicus. Rectum loaded with soft faeces. Treated with course of colonic washouts. Barium enema showed "marked rectal dilatation which terminates at pelvi-rectal junction. Rest of colon appears normal". The vomiting was diagnosed as reflex in character from the constipation. Patient discharged after 2 weeks.

Re-admission necessary 4 months later because of recurrence of colonic loading. Repeat barium enema showed "there is now some redundant looping of pelvic colon in addition to rectal dilatation". Treatment again by daily enemata, followed by petrolagar and phenolphthalein. Spontaneous daily evacuation achieved after 2 weeks. Patient then discharged home. Followed up at surgical outpatients for further 8 months. No real improvement.

Between the ages of 8 and 10, re-admitted on further 5 occasions to paediatric ward because of reloading of colon in the intervals. Further washouts prescribed, and various laxatives used, including cascara and neostigmine bromide, without beneficial effect. No bowel evacuation could be achieved without enemata. Further barium enema at age 10 (Appendix I Plate No. 8) showed "no evidence of Hirschsprung's disease. Radiographic appearances suggest idiopathic megacolon". When child aged 10 $\frac{1}{2}$, paediatrician reported "rectum and lower colon again loaded with faeces. Case has probably been over-treated". Referred for psychiatric opinion.

Psychiatric Assessment

Child

Pallid, undersized child, tense, but subdued. Showed frequent eye blinking and twitching of facial muscles. Passively compliant during examination.

Mother

Age 45. Tense, anxious woman. Limited in intellect and of circumscribed personality. Stated that she had been given so many different versions of her child's bowel condition, and had been advised upon so many different lines of treatment, that she is now confused and does not know what to think. Distressed by failure of response to treatment.

Father

Age 47. Not available for interview. Described by wife as calm and not a worrier.

(R.H. cont)

Family Structure

Two siblings, male and female, 8 and 10 years older than patient, respectively. No history of bowel disorder in either.

Family History - Nil relevant.

Developmental History

Normal pregnancy. Normal birth. Uneventful early development. Mother cannot recall details of toilet training. Denies coercive approach. Claims that child's bowel movements have always been "sluggish". Mother preoccupied with child's health from birth, and had administered magnesium hydroxide daily since infancy.

Background Circumstances

At third consultation, mother divulged that child conceived as a result of extra-marital liaison while father serving in forces. She felt intensely ashamed, and withheld truth of child's paternity from husband for some years. Older siblings still kept in ignorance. Mother attempted unsuccessfully to procure abortion. Experienced marked feelings of guilt after child's birth, and was conscious of trying to compensate by overindulging and overprotecting him thereafter. Family interpreted attitude of overpossession as due to long interval since previous pregnancies.

Parental Fears & Prejudices

Mother was prompted to administer daily laxative to patient, from infancy, by vague fears for his health if bowel regularity was not maintained.

History of Present Illness

Mother is a poor historian and could not recall early details of child's bowel disorder. Vaguely remembers difficulty over use of pot during second year, despite her increasing exhortation. Bowel movements remained "sluggish", with persistence of soiling in face of maternal efforts to train him. Child responded to mother's excessive sheltering by remaining overdependent and emotionally immature. Mother acutely concerned at persistence of symptoms and increasing protuberance of abdomen after child started school. First sought medical advice at that time.

Further Progress

See Treatment Section p.116/121.

Mother too limited in intellect and currently too unstable emotionally to benefit from any attempt to promote insight. She was bewildered by the conflicting reports hitherto given about patient's disorder, and unable to accept any further medical opinion at first. Because of the intensity of mother's emotional investment in the child, and the chronicity of symptoms, it was considered advisable to remove patient temporarily from his home setting by re-

(R.H. cont)

admission to hospital, under supervision of therapist. Mother and child both reluctant but admission finally arranged. Child now under inpatient treatment for past 4 months. Treatment approach designed to encourage child's emotional development and maturation, while protected from maternal influence. Nursing staff have cooperated, under guidance of therapist, in this rehabilitative programme. Child unchanged for first 2 months. Gradual restoration of spontaneous bowel action was achieved during third month, without laxative therapy or physical measures. During the fourth month, daily bowel evacuation has occurred unprompted, with no further soiling. Faecal masses no longer palpable abdominally. Rectal examination avoided. Child increasingly self-reliant, healthily aggressive and boisterous. (See Treatment Section p. 116, 121)

Result of Psychotherapeutic Treatment - (September, 1956)

Child has been symptom free for past month. Still retained in hospital. Mother now responsive to didactic counsel and reassurance in the light of practical demonstration of child's management in hospital under therapist. Remains devoid of insight. Will require continued support after child's discharge. Patient being retained in hospital to consolidate recent remission.

Satisfactory short-term result.

Family History

Mother and maternal grandmother both suffer with chronic constipation. Both dependent upon regular purgatives for adequate bowel action.

Developmental History

Normal pregnancy. Normal birth. Healthy infant. Uneventful early development. Toilet training not yet instituted at time of onset of constipation at age 6 months.

Background Circumstances - Nil relevant.

Parental Fears & Prejudices

Mother and maternal grandmother both beset by chronic phobias of "twisted bowel" and "dropped seat", which they firmly believed could result from constipation. These fears pre-existed onset of child's symptoms.

History of Present Illness

Development of constipation at 6 months coincided with weaning, and was probably associated with it. No bowel action for 3 days. Mother acutely alarmed. Resorted at once to laxatives and suppositories, on grandmother's advice. Rigid toilet training henceforth instituted. Child resisted use of pot. Constipation persisted despite maternal threats and exhortation. Subsequently child would hide in another room when he felt urge to defaecate. Observed to wriggle and contort body at these times. Mother's thoughts dominated by child's bowel disorder. She became severely distressed. Purgatives prescribed by family doctor had no beneficial effect.

Further Progress

See Treatment Section p. 129, 130.

Both parents were interviewed initially, to promote orientation to psychiatric treatment. Thereafter mother interviewed at regular weekly intervals for psychotherapeutic support and re-education. Currently still attending. Mother has responded well to treatment. Has now acquired good insight. Much less tense and anxious. Handles child with detachment. Child's emotional disturbance warranted direct therapy as out-patient 3 times a week. Still attending. Has undergone some 40 treatment sessions with progressive improvement. Behaviour now much less inhibited and normal bowel function has latterly been restored.

Result of Psychotherapeutic Treatment (September, 1956)

Spontaneous bowel action restored within past six weeks. Concurrent resolution of soiling. Child will only attend toilet surreptitiously, and ostensibly without knowledge of parents, who are instructed to ignore these visits. Nevertheless known to have adequate bowel evacuation. Happier, more responsive child. Mother relieved and free from former anxiety. Attendance of mother and child being maintained to consolidate progress.

Satisfactory result.

Case No. 9. Male K.L. Date of birth - 26.5.47.

Presenting Problem.

Persistent faecal soiling since infancy, found upon examination to be overflow in character.

Age at Psychiatric Referral - 8 years 10 months.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms - Approximately 6 years.

Paediatric Findings & Treatment

First referred to paediatrician at age $6\frac{1}{2}$. Healthy well nourished child with good appetite. No symptoms of systemic disturbance. Abdomen distended with palpable faecal masses in descending colon. Rectum loaded with faeces. Peri-anal soiling. No local lesion of rectum or anus. Admitted Medical ward for further investigation. Barium enema showed (Appendix I Plate 10) "long colon with redundant looping; 'dolichocolon'. Emptying rate rather poor but no actual evidence of megacolon". A diagnosis was made of chronic constipation with irritation of bowel by retention of hard faecal masses and resulting spurious diarrhoea. Treated with course of colonic washouts and discharged upon maintenance therapy with petrolagar and phenolphthalein. Mother advised to persevere with "regular training". Follow-up not conducted, but 2 years later at age $8\frac{1}{2}$, case referred back for persistence of identical symptoms. Remission had lasted less than 2 months. Re-examination showed considerable abdominal distension, hard faecal masses in descending colon, and loaded rectum. Repeat barium enema (Appendix I Plate 11) showed "gross dilatation of the rectum, pelvic colon and descending colon. Appearance now suggests megacolon". Atony of terminal bowel was suspected and after course of colonic washouts, proctoscopy was performed. No evidence of bowel pathology. Upon suspension of washouts, child rapidly became constipated again with resumption of overflow soiling. Thereupon discharged from hospital and referred for psychiatric opinion.

Psychiatric Assessment

Child

Superficially responsive and cooperative; excessively conforming in behaviour. Claimed he visited toilet each day but did not feel sufficient urge to defaecate.

Mother

Age 48. Diffident, reserved, self conscious personality. Overanxious and overindulgent towards child since his birth. She holds fixed belief in efficacy of regular bowel action and is herself dependent upon daily laxatives for "regularity". Embarrassed by any reference to bowel function in herself or in her children. Currently tense, and guilt-ridden, with manifest anxiety features.

Father

Age 47. Unimaginative, stolid personality. He believes that child's habits are "dirty and degrading" and has adopted a punitive attitude accordingly.

Family Structure

One sibling, a girl, 9 years older, healthy and emotionally stable. No history of bowel difficulty.

Family History

Familial tendency to constipation in mother's family. Mother herself subjected to rigid upbringing by strict and perfectionist father. Maternal grandfather insisted upon regular bowel habit with his whole family, and personally administered "opening medicine" to each member every morning, even after they had reached school leaving age.

Developmental History

Difficult pregnancy. Mother in hospital 6 weeks before child's birth with ante-partum haemorrhage. Caesarean section necessary. Infant alleged to have suffered from neo-natal anaemia. Subsequent development uneventful until age of 12 months. Toilet training instituted at 7 months but not coercive till the age of 12 months. Successful training not achieved.

Background Circumstances

The interval of 9 years between the birth of the 2 children was due to the intervention of war.. Father was sent overseas almost immediately and taken prisoner till 1945. Following his repatriation, mother had miscarriage in 1946 which seriously distressed her. Thrilled to have live baby boy because of pre-existing circumstances. Infant equally overindulged by father as returned P.O.W. Mother felt nothing was too good for the child. Was constantly concerned to guard his health especially after neo-natal anaemia.

Parental Fears & Prejudices

Mother entertains deep seated fears about "evils" of constipation. Preoccupied with need for bowel regularity as instilled by her own father.

History of Present Illness.

Mother first began to worry about child's bowel function at age of 1 year. She was attending a Child Welfare Clinic with him and comparing notes with other mothers about the progress of their infants. She understood that most of these other babies were already clean and out of napkins at the age of 12 months. Became worried by this, and felt she was inadequate as a mother and neglectful of her child, through failing to train him properly. Prompted by these feelings to institute rigid bowel training which has been maintained ever since. Child failed to respond.

At age 2, was still soiling regularly despite trial on the pot every 3 hours. At age 3, had learned to use toilet and did not resist, but defaecation response remained inadequate, and soiling persisted. Punitive methods, including smacking, deprivation of sweets and use of disparaging terms, e.g. "dirty, filthy boy" were adopted by both parents,

(K.L. cont)

alternating with bribes and exhortation. Both methods were equally ineffectual. Mother cannot recall any period of constipation as such. In her view child was soiling in place of using toilet. Was forced to sit on toilet for half hour twice a day, mother sitting with him; no response. Mother concerned about possibility of organic bowel disease and when condition persisted after enrolment at school, she first sought medical advice. Family doctor diagnosed constipation and prescribed course of enemata to be administered by district nurse. Child showed violent resistance for the first time during these treatments. Following removal of accumulated faeces, constipation recurred after a short interval, with resumption of soiling. Case subsequently referred to paediatric out-patients.

The persistence of symptoms in a child of school age provoked mother's increasing embarrassment. She began to isolate herself from friends and relatives because of the imagined stigma. The boy's bowel function now dominated the household as a focus of concern. Mother could think of nothing else.

Further Progress

All laxative treatment was discontinued following psychiatric referral. Mother has been interviewed at regular weekly intervals for intensive psychotherapeutic re-education during the past 6 months. Direct therapy was also instituted with the child through the medium of play techniques. In the 6 months since referral, there has been considerable improvement in the presenting symptom. Soiling now occurs at intervals of 10 days or longer, with spontaneous bowel action, using the toilet 3 to 4 times per week. Considerable underlying hostility in the child has been uncovered through play therapy and satisfactorily discharged. He is continuing under treatment. Mother has now gained full insight. She is free from tension and has adopted a relaxed permissive attitude towards her child's bowel function. The mother-child relationship is free from conflict. (See Treatment Section p.24)

Result of Psychotherapeutic Treatment - (September, 1956)

Completely satisfactory in respect of mother whose attitudes and outlook have radically altered. In respect of child, he is responding well to continued treatment, and partial remission of symptoms has already been achieved, with some restoration of spontaneous bowel action.

Satisfactory response. Treatment not yet completed.

Case No. 10.MaleJ.W.G.Date of birth- 7.12.45.Presenting Problem

- 1) Faecal soiling since the age of 2 years, following acquisition of bowel control 6 months earlier.
- 2) Chronic constipation since the age of 3 years, with intervals of 3 to 4 weeks between bowel actions.
- 3) Subsequent development of intermittent overflow soiling.

Age at Psychiatric Referral - 10 $\frac{1}{2}$ years.Mode of Referral - Referred by consultant paediatrician.Duration of Symptoms - 8 years.Paediatric Findings & Treatment

First referred for paediatric opinion at age 7 $\frac{1}{2}$ years for investigation of "large abdominal tumour". Diagnosed by paediatric surgeon as massive faecal accumulation. There was associated rectal loading with perianal soiling. No local lesion of rectum or anus. Subsequent investigation in hospital revealed no organic basis for the findings. During the next 3 years, patient was admitted to hospital on 5 occasions for repeated courses of enemata and bowel washouts to clear the loaded bowel. Condition relapsed immediately after discharge on each occasion, with reloading of terminal bowel and reappearance of overflow soiling, despite maintenance treatment with petrolagar and phenolphthalein. Regular enemata as an outpatient, 3 times a week, proved equally ineffectual. During fifth admission to hospital at age 10, barium enema was performed and showed (Appendix I Plate 12) "Dilatation of rectum and part of sigmoid colon extending down to ano-rectal junction. Appearance is that of colonic inertia". Referred for psychiatric opinion.

Psychiatric AssessmentChild

Pallid, uncommunicative boy, taciturn, subdued and unresponsive. Mother describes him as "shut in".

Mother

Age 42. Diffident and retiring. Insecure, anxious and tense. Distressed by persistence of child's symptoms.

Father

Age 46 at death. Died when child aged 8 as a result of gastric carcinoma. Suffered from "chronic peptic ulcer". Irritable and intolerant of child's symptoms. Tyrannical in attitude to family, especially wife and boy. Rigid disciplinarian.

Family Structure

One sibling, a girl, 7 years older than patient. Stable, pleasant personality. No history of bowel disorder. Father's favourite child.

Family History

Father suffered from chronic constipation; insistent upon regular bowel habit.

Developmental History

Normal pregnancy. Normal delivery. Early development uneventful. Toilet training instituted during early infancy. Not coercive. Child trained in bowel habit by the age of 18 months.

Background Circumstances

Father was eldest of 3 sons, both his younger brothers being alcoholic spendthrifts. Their father had died as a young man, leaving responsibility of widow and 2 errant brothers to eldest son. He became embittered by brothers' irresponsibility, so that when his own son was born, he instituted rigid and restrictive upbringing to safeguard against any similar development. Openly expressed preference for daughter. Believed she would never disgrace him. Suspicious of male child from birth because of his sex. Adopted hostile attitude in consequence.

Parental Fears & Prejudices

During his terminal illness, father had instructed his wife "never to let the boy get into this state". He warned her that any serious development in child's bowel trouble would be her fault, and she must press for further treatment "while an operation could still cure him". Mother convinced thereafter that child had organic bowel disease and that he required surgical operation.

History of Present Illness

Father adopted carping attitude to patient from his infancy, restricting his activities and constantly finding fault with him. Adopted punitive measures to "cure" faecal soiling when it developed at age 2. Symptom persisted, with subsequent development of constipation and resistance to defaecation, despite threats and punishment by father, and bribes and exhortation by mother. Laxatives and suppositories equally ineffectual. Mother terrified of father's violent temper. Unable to intervene on child's behalf.

Further Progress

Mother has been interviewed at regular intervals during the past 6 months for psychotherapeutic re-education. Cooperative in attitude to treatment, but initially fearful of disclosing details of husband's behaviour. Has latterly developed increasing confidence in therapist, with resulting improvement in emotional state, and with acquisition of insight. Now relieved and self-reliant. Direct therapy has been instituted with child during the past 6 months. Because of his emotional inaccessability, it was

(J.W.G. cont)

necessary to readmit him to hospital initially for a period of 3 months, under supervision of therapist. He became increasingly responsive, and subsequently so provocative in conduct that he could no longer be retained in the paediatric setting. Further treatment has been continued as an out-patient. (See Treatment Section p. 123)

Result of Psychotherapeutic Treatment - (September, 1956)

Patient has now established a warm relationship with therapist. He is improving both symptomatically and in overcoming his emotional difficulties, under treatment. Progress is regarded as satisfactory. Favourable response. Therapy is being continued.

Case No. 11. Male P.C. Date of birth - 24.10.47.

Presenting Problem

Chronic constipation, with recurrent abdominal colic and overflow faecal soiling, since age of 2 years.

Age at Psychiatric Referral - 8 years.

Mode of Referral - Referred by paediatric surgeon.

Duration of Symptoms - 6 years.

Paediatric Findings & Treatment

First referred to paediatric surgeon at age 7. Faecal masses palpable through anterior abdominal wall; rectum loaded with hard faeces; peri-anal soiling. No local lesion of rectum or anus. Following initial investigation, surgeon stated "this child has paradoxical diarrhoea and incontinence due to his constipation. It is certainly not a psychological condition." Treated by a course of enemata 3 times a week coupled with phenolphthalein. This regime was maintained for three months. Child again became constipated immediately the enemata stopped. Thereafter admitted to surgical ward for investigation. Barium enema showed (Appendix I Plate No. 13) "Some dilatation of rectum and distal colon. No evidence of Hirschsprung's disease." Further treatment was by daily enemata with petrolagar and phenolphthalein. Following discharge, enemata were maintained twice a week at outpatient attendance. Upon cessation of these, relapse again occurred. One year after initial examination, patient referred back to paediatric surgeon with persistence of constipation, overflow soiling, and the presence of large faecal masses in lower colon. At this stage referred for psychiatric opinion.

Psychiatric Assessment

Child

Slightly built, intelligent boy. Remained detached and unresponsive throughout interview. Scholastic progress good but does not mix well with other children. Described by mother as a "queer bird; shut in; it is difficult to know what he is thinking". Child's replies to routine questions were evasive and tangential. He appeared disinterested and indifferent.

Mother

Age 42. Calm, quietly spoken, with strong emotional control. No evidence of obsessional traits; did not impress as primarily an overanxious personality. Currently tense and anxious about child's symptoms.

Father

Age 45. Determined personality. Self-opinated, intolerant of child's symptoms, and a disciplinarian within the home. Has always insisted upon implicit obedience from his 3 children. Regards soiling as a "filthy habit".

Family Structure

Two siblings - girl 6 years older and boy 4 years older. No history of bowel difficulty in either

(P.G. cont)

child. Girl has been independently referred for psychiatric opinion elsewhere because of frequent fainting attacks. Boy has similarly been referred because of persistent stammer.

Family History - Nil relevant.

Developmental History

Normal pregnancy. Normal birth. Early development uneventful. Toilet training instituted at 9 months and completed by 18 months. Not coercive. Child said to be biddable and cooperative prior to onset of present disorder.

Background Circumstances

A history of marital friction was subsequently elicited, involving a difference of opinion between the parents in the handling of all 3 children. Father has the more stern approach of the 2 parents. Emotional disturbance in the two older children had been attributed to this background.

Parental Fears & Prejudices

Specifically related to history of present illness.

History of Present Illness

At age 2, child admitted to hospital with electric burn of the hand. While there, developed dysentery and transferred to isolation ward where retained for total of 3 months. Visiting restricted to observation of child through glass wall of cubicle. No opportunity for direct contact. Child did not fret openly, but became increasingly quiet and withdrawn. Mother was informed that "a powerful drug" (streptomycin) had been necessary to control the dysentery.

Upon discharge, child reacted with marked behaviour disorder, which included persistent screaming attacks day and night, violent nightmares, aggressive outbursts towards mother, and repeated attempts to "run away from home". Mother stated "he seemed a completely different child. I am sure that being in hospital upset him although he did not show it on the surface. We did not expect him to be in so long". Behaviour disturbance persisted for 3 months, subsiding gradually.

During this period, parents noticed increasing difficulty in bowel evacuation. Interval between bowel movements at first 3 to 4 days, subsequently 7 days and longer, associated with abdominal colic. Child resisted use of pot.

Mother developed 2 separate phobias in relation to bowel difficulty. First, that the "dysentery germ" was still active in her child's bowel, and secondly, that the "powerful drug" used had in some way weakened the bowel and thus impaired its function.

Maternal anxiety mounted as the constipation failed to respond to increasing use of laxatives. On the advice of family doctor, child was made to sit on pot, and later toilet, for periods up to 2 hours twice a day. Exhortation, bribing

and threats, all proved without effect. Subsequently, constipation associated with overflow faecal soiling. Both parents incensed by this. They felt that while constipation was not the child's "fault", the soiling was a "dirty habit" which he could control. Father in particular, adopted punitive attitude. Child was physically punished, deprived of privileges, shamed and ostracized by turns. At one stage father repeatedly rubbed boy's nose in his soiled underpants. All these measures proved ineffectual.

Since starting school, child has increasingly withdrawn himself to play on his own; is not openly defiant but passively resistive in attitude to both parents. When thwarted, has become spiteful and underhanded, though not openly aggressive. The pattern of bowel difficulty has persisted and increased in severity.

Further Progress

All laxative treatment was discontinued following psychiatric referral. Mother has been interviewed at regular weekly intervals for intensive psychotherapeutic re-education over the past 9 months. Father similarly attended whenever possible. Direct therapy was instituted with the child through the medium of play techniques. Initially, child was admitted to paediatric ward, ostensibly for observation, but actually to remove him from the carping attitude of intolerance adopted by father at home. Management of case in the ward was controlled by therapist. Child responded to hospitalisation with some degree of restoration of normal bowel function and diminution of frequency in soiling. Concurrently, his behaviour became increasingly provocative and it was found impracticable after 3 months, to retain him in the paediatric setting. Thereafter treatment was continued on an outpatient basis. Child and parents are still attending. (See Treatment Section p.127/8)

Result of Psychotherapeutic Treatment - (September, 1956)

No radical improvement has so far been achieved in the sphere of modifying parental attitudes towards the child, or in the promotion of adequate depth of parental insight. Father continues to show lack of understanding for the emotional factors involved. Mother remains passively cooperative but basically non-committal. In respect of the child, marked underlying hostility has been uncovered during play therapy and continues to be discharged under treatment. A satisfactory relationship has now been achieved with therapist, but continuation of active therapy is envisaged for a prolonged period.

Unsatisfactory response. Treatment not yet completed.

Case No. 12.MaleD.M. Date of birth-3.3.47.Presenting Problem

- 1) Persistent constipation since infancy.
- 2) Recurrent episodes of pseudo-diarrhoea from the age of 3.

Age at Psychiatric Referral - 9 years.Mode of Referral - Referred by consultant paediatrician.Duration of Symptoms - Approximately 9 years.Paediatric Findings & Treatment

First referred for paediatric opinion at age $8\frac{1}{2}$, because of recurrent "diarrhoea" of 5 years' duration, in episodes lasting from one week to 3 months, with remissions of up to 2 months. Stools frequently contained mucus but no blood or pus. Sulphonamides and antibiotics previously prescribed by family doctor without effect. At examination, large faecal masses palpable abdominally. Rectum loaded with faeces. General health good. Admitted to paediatric ward for further investigation. Barium enema showed (Appendix I Plates 45) "Reservoir enlargement of rectum and pelvic colon. Colon otherwise normal". Biochemical and bacteriological investigation of faeces negative. Case diagnosed as severe chronic constipation with periodic overflow faecal incontinence. Subsequent history elicited of constipation since infancy. Despite enemata and petrolagar, child remained constipated in hospital, with recurrence of colonic loading and persistence of soiling. Also found to be contrary over eating. Basis of parental mishandling suspected and case ultimately referred for psychiatric opinion.

Psychiatric AssessmentChild

Intelligent boy with good school record. Superficially precocious. Supercilious towards examiner. Impressed as a self-willed, overindulged child. Impeccable in dress and appearance.

Mother

Age 34. Garrulous, excitable woman of anxious personality. Incapable of controlling child adequately.

Father

Age 37. Immature, unstable personality, who has undergone psychiatric treatment for hysterical fainting attacks. Intolerant of child's symptoms. Father-child relationship superficial.

Nursemaid

Age 46. Grossly hysterical paranoid personality. Overpossessive of child and jealous of parental intervention. Responsible for patient's upbringing since birth, and in sole charge of household for first 9 months because of mother's puerperal illness. Has no family ties of her own. Devoted to child. Preoccupied with need for bowel regularity from patient's neo-natal period.

(D.M. cont)

Family Structure - Only child.Family History

Maternal grandmother unstable and overanxious. Dotes upon patient as her only grandchild.

Developmental History

Normal pregnancy. Normal birth. Uneventful early development, except in spheres of toilet training and feeding habits. Difficult over food since infancy, with coaxing by mother and forced feeding by nursemaid. Coercive bowel training instituted by nursemaid from neonatal period. Constipation has been a problem from that time.

Background Circumstances

Child has been handled inconsistently throughout by both parents, who disagree over his management. Grandmother has frequently interfered, and nursemaid surreptitiously exerts her own influence contrary to the others. Child has played off one adult against the other since early childhood.

Parental Fears & Prejudices

Both parents concerned about the implication of child's chronic "diarrhoea". Hitherto unaware of underlying state of constipation. Nursemaid preoccupied with adverse consequences of irregular bowel function.

History of Present Illness

Coercive bowel training by nursemaid during child's infancy was in defiance of mother's wishes. Originally, mother too ill to intervene. Subsequently, took over supervision of child's toilet habit, but repeatedly discovered that nursemaid had re-imposed prolonged session on the pot with patient, whenever mother left the house. Child resisted use of pot, and violent scenes ensued. Nursemaid threatened to commit suicide whenever faced with dismissal by irate mother. Has retained her position in household by such threats. Neither parent competent to keep her in her place. Patient's resistance to defaecation was subsequently replaced by pattern of recurrent diarrhoea. His failure to attend the toilet between these episodes passed unsuspected by parents until retrospective enquiry during current assessment. Child remained difficult over food, pampered, and subject to inadequate parental discipline.

Further Progress

See Treatment Section p. 123.

Intensive psychotherapy has been instituted with mother over past 5 months, with gradual promotion of insight. She has cooperated readily. Father has attended whenever possible but his cooperation is superficial and no real depth of insight has been achieved. Uniformity of approach by parents in handling child remains lacking. They are clearly not competent to cope with his disdainful attitude and flouting of their authority, which is secretly en-

(D.M. cont)

couraged by nursemaid. Direct therapy has been instituted with the child over a period of 2 months. So far, no depth of contact has been achieved with him. He remains unresponsive and supercilious. Pattern of bowel disorder essentially unchanged.

Result of Psychotherapeutic Treatment -(September, 1956)

In view of failure by parents to adopt a consistent attitude within the household, and their failure so far, to counteract influence of nursemaid, or to consider dismissing her, the prognosis for successful treatment of patient while he remains at home is poor. Readmission to hospital, under supervision of therapist, is precluded by patient's refusal to submit to further hospitalisation. He states that no useful purpose was served by his previous admission. Any improvement achieved by direct therapy is being neutralized by counter influences within the home. It is proposed to arrange for child's long term placement in a residential special school for emotionally maladjusted children.

Unsatisfactory result.

Case No.13.MaleK.T.Date of birth - 9.4.49.Presenting Problem

- 1) Faecal soiling, persisting since infancy.
- 2) Chronic constipation since the age of 3 years, with refusal to use toilet, and with secondary faecal overflow.

Age at Psychiatric Referral - 6 years 10 months.Mode of Referral - Referred by consultant paediatrician.Duration of Symptoms - Approximately 4 years.Paediatric Findings & Treatment

First referred for paediatric opinion at age 5. Examination in hospital revealed protuberant abdomen with hard faecal masses palpable in descending colon; faeces retained in rectum; peri-anal staining. No local lesion of rectum or anus. Lower bowel evacuated with enemata. Barium enema then showed (Appendix I Plate 16) "Colon appears normal in calibre. No lesion demonstrable". Patient discharged on maintenance petrolagar.

Readmitted 18 months later with identical symptoms. Relapse had occurred within one week of return home following earlier investigation. Mother stated "He will soil even though the toilet is right beside him". Course of bowel washouts required to clear lower bowel. Repeat barium enema now showed (Appendix I Plate 17) "Dilatation of rectum and distal pelvic colon. Appearances suggest megacolon". Case suspected to have background of adverse social circumstances. Referred for psychiatric opinion.

Psychiatric AssessmentChild

Tense, inhibited boy, initially unresponsive. Rapidly settled down in ward, becoming friendly and cooperative. Expressed wish to remain in hospital in preference to returning home.

Mother

Age 30. Haggard, underweight and burdened with domestic problems. Currently tense and anxious over child's symptoms. Legally separated from husband on grounds of cruelty.

Father

Age 35. Not interviewed. From wife's description, paranoid personality, subject to outbursts of violent temper.

Maternal Grandmother

Domineering, strong-willed woman. Rigid, orderly and houseproud. Intolerant of patient's symptoms and had adopted punitive attitude towards them.

Family Structure

One sibling, a boy, 3 years older than patient. Virtually brought up by maternal grandmother. No history of bowel disorder. No evidence of emotional instability.

Family History

- Nil relevant.

Developmental History

Normal pregnancy. Normal birth. Early development punctuated by persistent sleep disturbance, feeding

(K.T. cont)

difficulties and fearful overattachment to mother. Toilet training not coercive. Child failed to gain bowel control.

Background Circumstances

Protracted history of severe marital friction. Mother married only because pregnant with first child, who was subsequently reared by grandmother in different environment. Patient born 3 years later. Witnessed repeated attacks of physical violence by father upon mother, until separation was procured. Thereafter, mother and child came to live with grandmother under conditions of gross overcrowding. Patient at that time still incontinent of faeces.

Parental Fears & Prejudices

Mother entertained fears of organic bowel disease in relation to persistence of child's symptoms.

History of Present Illness

Maternal grandmother assumed management of patient when age 3, after mother obliged to resume full-time employment. Domestic accommodation was shared by 3 families, and child's soiling unwelcome because of restricted living conditions. Grandmother discriminated against patient as a result. Attempted to "train" child by rigidly coercive measures, including physical punishment. Child responded with refusal to use toilet and with increasing constipation.

Further Progress

See Treatment Section p. 121.

Child was retained in hospital under supervision of therapist for a period of 5 months, during which attempts were made to re-house mother in separate accommodation. All laxative treatment was discontinued. Spontaneous restoration of bowel function was achieved within one week of patient's transfer under therapist's direction. There has been no recurrence of constipation or soiling since. Mother has responded to psychotherapeutic support and reassurance, with improved emotional stability.

Result of Psychotherapeutic Treatment - (September, 1956)

Alternative domestic arrangements were procured for mother and her family two months ago, independent of grandmother. Patient thereafter discharged from hospital. Has remained symptom free for a period of 7 months. Mother and child secure in happier environment.

Satisfactory result.

Case No. 14. Male B.D. Date of birth- 28.11.51.

Presenting Problem

- 1) Increasing constipation since the age of 9 months, with intervals of up to 2 weeks between formed bowel motions.
- 2) Persistent overflow incontinence presenting as pseudo diarrhoea (7-8 semi-fluid stools per day).
- 3) Associated feeding difficulty.

Age at Psychiatric Referral - 3 years.

Mode of Referral - Referred by paediatric surgeon.

Duration of Symptoms - Approximately 2 years.

Paediatric Findings & Treatment

First referred for paediatric opinion at age $2\frac{1}{2}$ because of faecal incontinence. Underlying basis of constipation confirmed by palpable faecal masses in abdomen, and loaded rectum. Treated as outpatient with enemata, followed by cascara. No improvement. Soiling increased. Admitted to paediatric ward for "bowel training" after each meal. Unsuccessful following 4 weeks in hospital. Transferred to surgical ward for investigation of suspected Hirschsprung's disease. Barium enema showed (Appendix I Plates 1819) "Large atonic colon. There is in effect a megacolon. No suggestion of Hirschsprung's disease". Regular evacuation achieved in the ward with petrolagar and phenolphthalein. Discharged after 3 weeks. At follow-up one month later, again constipated with overflow soiling. Referred for psychiatric opinion.

Psychiatric Assessment

Child

Thin, pallid boy. Responsive and friendly. Mother describes him as "naughty and defiant".

Mother

Age 36. Intelligent, cultured woman, of reserved but determined personality. Marked obsessional traits. Insistent upon obedience from her children. Fastidious in personal habits. Currently tense and anxious about child's symptoms.

Father

Age 34. Stable personality. Equally concerned over child's bowel disorder.

Family Structure

One sibling, a girl, 4 years older than patient. Attended paediatrician at age $2\frac{1}{2}$ for feeding difficulty. No further trouble after 6 months. Described as shy, sensitive and compliant in behaviour. History of rigid toilet training in infancy. No bowel difficulty.

Family History - Nil relevant.

Developmental History

Normal pregnancy. Normal birth. Early development uneventful. Toilet training instituted in neonatal period; coercive; successfully completed at 9 months. Difficulty over feeding developed during weaning at 8 months. Still persists.

Background Circumstances

Mother's childhood unhappy. Father was killed in France at end of World War I, and her French

mother abandoned her children. She was then brought up by paternal grandparents and maiden aunt. Determined she would not neglect her own children, but insistent that they must be model children. She would cherish but not spoil them.

Parental Fears & Prejudices

Neither parent preoccupied with primary fears of constipation. Mother embarrassed by reference to her own toilet habit. Pays close attention to personal bowel regularity.

History of Present Illness

Child began to resist use of pot at age 9 months. Formerly no difficulty. Resistance persisted despite strict handling by mother. Increasing constipation prompted use of laxatives and punitive measures, without effect. Subsequent development of soiling overshadowed the constipation and evoked parental alarm.

Further Progress

Mother was interviewed for intensive psychotherapy at regular weekly intervals for a period of 2 months. No direct therapy was employed with the child. All laxative treatment was discontinued. Mother initially resistive and hostile, but subsequently cooperated well as she gained increasing insight. Readjustment in her management of patient was followed by restoration of normal bowel function, with daily evacuation and no further soiling. Feeding difficulty concurrently resolved.

Result of Psychotherapeutic Treatment - (September, 1956)

Child has remained symptom free for the past 21 months. Routine follow-up at intervals of 3 months has been maintained during this period, but no actual therapy has been employed. Mother has retained full insight. Mother-child relationship free from tension and conflict.

Satisfactory result.

Case No. 15. Male M.D. Date of Birth: 27.11.47.

Presenting Problem

- 1) Faecal incontinence since the age of $2\frac{1}{2}$, following acquisition of "bowel control" in infancy.
- 2) Chronic constipation since the age of $3\frac{1}{2}$ with intervals of 4 to 7 days between bowel actions, and persistence of faecal soiling.

Age at Psychiatric Referral - 7 years.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms Approximately 5 years.

Paediatric Findings & Treatment

First referred for paediatric opinion at the age of 6. Examination revealed healthy, well nourished boy with distended abdomen, massive faecal accumulation palpable in descending colon, rectum loaded with faeces, and peri-anal soiling. Anal sphincter normal in tone. No local lesion of rectum or anus. Treatment was by daily rectal washouts in hospital, later replaced by enemata. Several courses were administered (30 treatments in all) over the next $3\frac{1}{2}$ months, during which child retained in ward. Concurrently, "toilet training" was instituted twice daily by nursing staff. Bowel action every third day achieved on this regime, but after each course of enemata the terminal bowel rapidly reloaded and overflow soiling recurred. Barium enema not performed. Organic bowel disorder excluded on clinical, bacteriological, and biochemical grounds. Because of fretting by the child in hospital, he was discharged home, despite failure of symptomatic treatment. Followed up as an outpatient during next 4 months, with trial of petrolagar and phenolphthalein. No improvement achieved and further course of enemata necessary to clear the lower bowel of faecal masses which had accumulated in the interval. Referred for psychiatric opinion at this stage.

Psychiatric Assessment

Child

Polite, well groomed and superficially cooperative. Impressed as subdued and tense and no adequate depth of emotional contact was established with him. His replies to enquiries about his bowel function were evasive or non-committal.

Mother

Age 47. Impressed as an intelligent, quietly determined personality, rigid, perfectionist, and with marked obsessional characteristics. Before her marriage, she had been a school teacher. Prim orderly and prudish. Currently showed evidence of marked overlying tension and anxiety about child's symptoms.

Father

Age 49. Appeared more stable and superficially placid. He gave a history, however, of chronic constipation since his childhood with complete dependence on daily purgatives.

(M.D. cont)

Family Structure

Only child.

Family History

Nil Relevant.

Developmental History

Normal pregnancy. Protracted labour. Uneventful early development. Toilet training instituted in neo-natal period. Coercive; "successful" both for bowels and bladder before the age of 12 months.

Background Circumstances

Mother married at age 39. Determined in advance to rear a model child, obedient, well mannered and "properly trained". She studied appropriate text books and firmly adhered to a rigid schedule for feeding, "potting" and sleeping from his birth.

Parental Fears and Prejudices

Father had always been convinced of the need for daily regularity in bowel function. Intensely preoccupied with fears of "internal poisoning" and "blockage" in respect of child. Mother initially concerned over soiling as a "dirty, naughty habit" but later became increasingly convinced that child had an "internal disorder, a growth or something twisted".

History of Present Illness

Child retained early acquisition of bowel control until the age of $2\frac{1}{2}$. At this stage he began to soil. No refusal to use pot, but would sit without bowel action taking place and shortly after removal, soiling occurred. Mother exasperated; adopted a variety of punitive measures without effect. During the next year, increasing constipation developed. Child would apparently try to defaecate but usually without result. Soiling persisted, was now more massive, less frequent, (at intervals of 7 days) and overflow in character. Various laxatives administered without effect; coercive schedule of toilet attendance reinforced with threats and exhortations but the disorder persisted unchanged. Now dominated the household as a topic of conversation. Condition continued after enrolment at school despite parental anticipation that child would be too self-conscious to soil in class. After first year at school, parents requested specialist's opinion. Mother and father both distracted by child's continuing symptoms.

Further Progress

All laxative treatment was discontinued following psychiatric referral. Both parents were interviewed at regular weekly intervals over a period of 7 months for intensive re-educative therapy. No direct therapy was instituted with the child. Marked resistance initially encountered from mother. Father was more cooperative but found it more difficult to understand the dynamics of the problem. Ultimately, mother achieved excellent

(M.D. cont)

insight but father's depth of insight not so adequate. At the end of 7 months, spontaneous bowel action was occurring in child on average 5 days each week. There was no further soiling. The child became increasingly responsive, self-confident and less subdued. 4 months after suspension of active psychotherapeutic treatment, examination showed rectum to be empty, and no evidence of colonic loading.

Result of Psychotherapeutic Treatment (September 1956)

Child has now remained symptom free for a period of 15 months. On 5 occasions in that time, 2 to 3 days have elapsed without a bowel motion but both parents have remained unperturbed and regularity was restored on each occasion spontaneously. Soiling has not recurred. Mother is manifestly more relaxed and handles child with less intensity and greater emotional warmth. Mother/child relationship secure. Father very relieved, though still retains original convictions about constipation. Satisfactory result.

Presenting Problem

- 1) Chronic constipation since infancy, with intervals of 10 days between bowel actions.
- 2) Overflow faecal soiling from the age of 2, latterly presenting as recurrent pseudo-diarrhoea.

Age at Psychiatric Referral - 10 $\frac{1}{2}$ years.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms - Approximately 10 years.

Paediatric Findings & Treatment

First referred for paediatric opinion at age 10 $\frac{1}{2}$. Healthy child. Abdomen distended; palpable faecal masses in pelvic colon and rectum; peri-anal soiling. No local lesion of rectum or anus. Case suspected to have basis of parental mismanagement. No barium enema performed. Not admitted to hospital for further investigation. Referred forthwith for psychiatric opinion.

Psychiatric AssessmentChild

Pallid, subdued, inhibited boy. Polite and compliant in behaviour. Mother describes him as non-complaining and cooperative, but "stubborn over bowels".

Mother

Age 41. Determined personality, prim and perfectionist in outlook. Overpossessive of patient. Currently tense, agitated and anxious about child's symptoms. Referred guardedly to marital disharmony.

Father

Age 43. Not available for interview. Described by mother as aloof and disinterested in his children; "not a family man". Disciplinarian in attitude. Was absent abroad for 5 years during patient's early childhood. Self-centred personality. Intolerant of patient's soiling.

Family Structure

One sibling, a boy, 5 years older than patient. Described as sensitive, nervous, unstable personality, prone to episodic enuresis. Underwent coercive toilet training during infancy, but no subsequent history of bowel difficulty. Attended child psychiatric clinic at age 7 for symptoms of nervousness.

Family History - Nil relevant.

Developmental History

Normal pregnancy. Normal birth. Uneventful early development. Toilet training instituted in neo-natal period; rigid and coercive; not successful.

Background Circumstances

Mother had gynaecological operation to enable her to bear children. Difficult pregnancy and delivery with first child. Entertained serious misgivings following conception

(K.S. cont)

of patient. Wished for daughter. Bitterly disappointed when son born. Father antagonistic to birth of further child. Subsequently, patient proved to be so much more contented than older sibling had been as a baby, that mother experienced acute guilt feelings over her earlier attitude of rejection, and valued patient all the more in consequence. The clinical impression was gained that mother had also tended to compensate through patient for her own emotional deprivation in marriage.

Parental Fears & Prejudices

No primary fears entertained by either parent about constipation. Child's faecal soiling increased at age 6 after father returned home from abroad, and father was afraid of having infected patient with the dysentery from which he himself had suffered. Mother shared this fear. Both parents ashamed and acutely embarrassed by persistence of soiling.

History of Present Illness

Mother recalls her determination to train child in bowel habits from early infancy. She held him on the pot for lengthy periods and subsequently employed threats, censure and punishment without effect. Too ashamed to refer child for medical opinion for many years. Now feels guilty about delay. Initial treatment by family doctor based on diagnosis of "diarrhoea". Child became increasingly secretive about soiling, in face of parental shaming.

Further Progress

See Treatment Section p. 120.

Mother has attended at regular weekly intervals for psychotherapeutic re-education over the past 5 months. No direct therapy was employed with the child. Mother initially resistive, but gained increasing insight and became progressively more cooperative in modifying her approach to child. Restoration of normal bowel function was achieved after 2 months, and there has been no further soiling in the ensuing 3 months.

Result of Psychotherapeutic Treatment - (September, 1956)

Child has remained symptom free for the past 3 months. Mother retains excellent insight, and is currently free from tension and anxiety following radical adjustment in her handling of patient. Clinic attendance now maintained purely to reinforce treatment approach with other cases. Father has returned to overseas station. Mother-child relationship sound.

Satisfactory result.

Case No. 17. Male I.W. Date of birth - 10.4.51.

Presenting Problem

Chronic constipation since infancy, with intervals of up to 3 weeks between bowel actions, and with overflow faecal soiling.

Age at Psychiatric Referral - 3½.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms - Approximately 3½ years.

Paediatric Findings & Treatment

First referred for paediatric opinion at the age of 3½, because of suspected Hirschsprung's disease. Examination revealed distended protuberant abdomen with large faecal masses palpable in descending colon. Rectum loaded with faeces. Peri-anal soiling. No local lesion of rectum or anus. General health good with unimpaired appetite. Initially treated as out-patient with course of daily bowel washouts, continued for one month. Lower bowel effectively cleared as a result, but one week later there was evidence of reloading, with no spontaneous bowel action in the interval, and reappearance of overflow soiling. No barium enema was performed. Child was not admitted to hospital. Diagnosis of Hirschsprung's disease excluded by paediatrician on clinical findings alone. Case referred for psychiatric opinion.

Psychiatric Assessment

Child

Bright, alert child; suspicious of therapist; remained unresponsive throughout initial interview. Mother described him as determined and obstinate.

Mother

Age 37. Determined dominant personality, but not excessively rigid in standards of upbringing. Normally stable in outlook but latterly obsessed with child's irregularity of bowel function. Showed marked anxious tension.

Father

Age 42. Not available for interview. Described as self-effacing personality, who took little part in child's upbringing.

Family Structure Only child.

Family History

Maternal grandfather has suffered from chronic constipation throughout adult life, with repeated episodes of rectal prolapse. On one occasion admitted to hospital with "threatened intestinal obstruction". Neither parent is affected by constipation.

Developmental History

Normal pregnancy. Premature birth at 8 months with no bowel action for the first 3 days. On fourth day, a suppository was administered by district nurse who warned the mother of possibility of organic bowel disease. Child alleged



to have been constipated ever since, i.e. to have difficulty in defaecation, with passage of hard faecal pellets at increasing intervals. Toilet training instituted during neo-natal period; coercive; not successful. In other respects early development uneventful.

Background Circumstances

Child born illegitimately 10 months before parents' marriage. At time of conception, father was in process of divorcing his first wife. Parents intended to marry subsequently, as soon as legally possible. Child's conception was premature, unpremeditated and socially inconvenient. Throughout her pregnancy, mother maintained intense aversion to unborn child, attempted unsuccessfully to abort, and fully intended to arrange child's adoption at birth. When informed by district nurse that serious consequences might result unless regular bowel action could be procured, mother experienced marked sense of guilt and became aware of complete reversal of feeling towards the child. Now experienced profound concern for his health and became increasingly preoccupied with need to promote regularity of bowel function. Prompted accordingly to institute rigorous methods of bowel training.

Parental Fears & Prejudices

Mother feared that child might develop the same condition as her own father, i.e. "bowel stoppage", if she were not successful in keeping his bowels open.

History of Present Illness

Constipation persisted from infancy despite regular use of various laxatives during the next three years, interspersed with the administration of suppositories. Every few months an enema was given by the district nurse. No lasting beneficial effect was obtained. By the second year, child was refusing to use pot despite repeated maternal exhortations and threats. Mother's anxiety had become severe and child's bowel function dominated her thoughts. Despite all treatment, interval between bowel actions had extended to 3 weeks, with massive overflow soiling at regular intervals.

Further Progress

Mother was interviewed on 3 separate occasions by paediatrician and psychiatrist in joint consultation. No direct therapy was employed with the child. All laxative treatment was discontinued. Maternal tension and anxiety was successfully reduced, with promotion of some degree of insight and corresponding improvement in child's symptoms. At this stage, mother ceased to attend and contact with the case was lost for a period of 15 months.

At subsequent follow-up, the child's condition was found to have relapsed. Mother had again resorted to powerful laxatives, her previous preoccupation had returned, and bowel action was confined to weekly episodes, with overflow soiling for 48 hours before each motion. In the interval, child showed much evidence of abdominal discomfort with

wriggling and contorting of his body in the effort of "holding back". At this stage, mother proved cooperative in attendance and responsive to re-educative therapy. This was continued for a period of 4 months at regular weekly intervals. At the end of that time, spontaneous bowel action had been restored, with defaecation every other day and no further evidence of soiling.

Result of Psychotherapeutic Treatment - (September, 1956)

Child has now remained symptom free for a period of 3 months. Mother has gained full insight. She is relaxed and free from tension and the relationship between her and the child is secure and stable.

Satisfactory result.

Psychiatric History

First referred for psychiatric opinion at the age of 10. Examination revealed disturbed character with immature social norms both in dressing and conversational skills. Mother noted with respect to toilet soiling, the usual history of wetting or soiling. Child intellectually capable. Some anxiety and phobias and have responded to food by mother without beneficial effects. The parents themselves had been treated initially as child syndrome but psychiatric examination of each parent negative. Child not admitted to hospital. No serious work performed, and no physical measures of treatment instituted. Further referred to but in general circumstances not referred for psychiatric opinion subsequently.

Psychiatric Interview

Child
Development and well-adjusted, precocious, obedient. His handling by both parents indicated over-indulgence and pampering.

Mother
Age 36. Nervous, good natural woman, limited to intelligence. Usually quiet with no evidence of obsessive traits, but extremely worried, tense and anxious about child's condition.

Father
Age 47. Intellectual and circumstantial in personality. Slightly limited in intelligence. Confirmed that the whole family has "worried" the child and as they could do nothing more.

Family History
3 other children, both girls, 17 years and 14 years older than patient respectively. No history of mental disorder in either sibling.

Family History - All relevant.

Case No. 18. Female F.B. Date of birth - 3.12.51.

Presenting Problem

- 1) Chronic constipation from the age of 2, with intervals of up to 7 days between bowel motions.
- 2) Recurrent episodes of pseudo-diarrhoea (overflow incontinence).

Age at Psychiatric Referral - $3\frac{1}{2}$ years.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms Approximately 18 months.

Paediatric Findings & Treatment

First referred for paediatric opinion at the age of $3\frac{1}{2}$. Examination revealed distended abdomen with palpable faecal masses both in ascending and descending colon. Rectum loaded with faeces. Peri-anal soiling. No local lesion of rectum or anus. Child systemically healthy. Senna, cascara and petrolagar had been prescribed by family doctor, without beneficial effect. The pseudo-diarrhoea had been treated initially as mild dysentery but bacteriological examination of stool proved negative. Child not admitted to hospital. No barium enema performed, and no physical measures of treatment instituted. Problem regarded as due to parental mismanagement and referred for psychiatric opinion accordingly.

Psychiatric Assessment

Child

Determined and self-willed, petulant, defiant. Her handling by both parents indicated over-indulgence and pampering.

Mother

Age 46. Bovine, good natured woman, limited in intelligence. Normally placid with no evidence of obsessive traits, but currently agitated, tense and anxious about child's symptoms.

Father

Age 52. Ineffectual and circumscribed in personality, similarly limited in intelligence. Confirmed that the whole family had "ruined" the child and now they could do nothing with her".

Family Structure

2 other children, both girls, 13 years and 20 years older than patient respectively. No history of bowel disorder in either sibling.

Family History - Nil relevant.

Developmental History

Normal pregnancy. Normal birth. Uneventful early development. Toilet training instituted at the age of 9 months; not coercive and both bowel and bladder control were achieved before the age of 2.

Background Circumstances

Interval of 13 years since mother's previous pregnancy. Child's conception was unpremeditated but readily accepted. Because of prolonged interval, child was fussed over by older sisters as well as by both parents from her birth. Regarded as something of a novelty and a toy by whole family; overindulged as a result.

Parental Fears & Prejudices

No primary fears admitted by either parent prior to development of bowel difficulty. Subsequent to onset of symptoms mother became obsessed with the danger of accumulated "body poisons" and father was firmly convinced of the danger of "convulsions" caused by untreated constipation.

History of Present Illness

At the age of 2, child believed to have been frightened by having to use an unsavoury and noisy toilet in the house of a neighbour, during temporary breakdown in the domestic water closet. Subsequently, she refused to use toilet at home, and reverted to voiding of urine and faeces in her knickers. Normal pattern of micturition was restored within several days, but refusal to defaecate either in pot or in toilet had persisted up to time of referral. Interval between bowel actions increased up to 7 days, with subsequent overflow soiling presenting as pseudo-diarrhoea. Both parents alarmed. They believed she was holding back the faeces deliberately but considered it vital to procure her bowel action because of their anxiety for her health. Exhortations, threats and bribes were all without effect. Each attempt to promote defaecation resulted in a violent domestic scene. The attention of the whole family became focused upon the child's bowel function.

Further Progress

See Treatment Section p. 116.

Both parents were seen at regular weekly intervals for a period of 2 months for the purpose of re-education in their method of handling the child. No direct therapy was employed with the child. All laxative treatment was discontinued. No real depth of insight was achieved by either parent because of their intellectual limitations but they responded satisfactorily to didactic counsel, instruction and reassurance. Child responded initially to alteration in handling with sharp deterioration in behaviour and became increasingly provocative. Within 2 months this phase had subsided and normal bowel function had been completely restored with no further occurrence of soiling.

Result of Psychotherapeutic Treatment - September 1956.

Child has remained symptom free for a period of 12 months, following suspension of active psychotherapeutic treatment. The relationship between parents and child is now free from conflict. They have refrained from over-indulgence and now handle her with sensible detachment.

Satisfactory result.

Case No. 19. Female R.J. Date of birth-14.2.52.

Presenting Problem

- 1) Infrequent bowel action from age of 6 months, at 4 to 5 day intervals.
- 2) Large palpable mass in left iliac fossa, associated with pyrexia, and suspected to be a pyonephrosis.

Age at Psychiatric Referral - 22 months.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms Approximately 1 year.

Paediatric Findings & Treatment

First referred for paediatric opinion at age 20 months. Examination proved the abdominal mass to be accumulated faeces in descending colon which disappeared after course of daily enemata. Rectum initially loaded with faeces. Pyrexia due to upper respiratory tract infection which responded to appropriate treatment. Child discharged home after 2 weeks when loaded bowel adequately cleared. No barium X-ray studies performed. Hirschsprung's disease excluded on clinical grounds. When seen as out-patient 2 weeks later, rectum again loaded and palpable faecal masses present. Child had only had 2 bowel movements in interim despite administration of medicinal paraffin and magnesium hydroxide in liberal dosage. A second course of enemata was given as out-patient. Upon completion after 4 weeks, the rectum and terminal colon rapidly reloaded with accumulated faeces, and spontaneous bowel movements continued to be hard and infrequent. Referred for psychiatric treatment at this stage.

Psychiatric Assessment

Child

Bright, alert baby, suspicious of examiner, initially unresponsive. Described by mother as defiant, obstinate and very determined.

Mother

Age 33. Strong-willed, dominant personality with marked perfectionist and obsessional traits. Disciplinarian in attitude towards both her children "I cannot stand children who disobey". Currently tense and anxiously preoccupied with child's bowel disorder.

Father

Age 36. Placid, tolerant personality, exerting less influence within the home than his wife. Much less concerned about child's symptoms.

Family Structure

One sibling, a girl 3 years older, described as more quiescent and compliant than patient. From the age of 1 year, the older child had shown difficulty in feeding for period of 18 months. Each meal time was punctuated by violent scenes while mother fed her forcibly. Subsequently, child had

(RJ. cont)

phase of persistent faecal soiling for 6 months, after acquiring bowel control. Currently no difficulty in eating or in bowel habits. Described as diffident, subdued, easily frightened, lacking in self-confidence and a poor mixer, in contrast to patient.

Family History

Mother has been "a martyr to constipation" since adolescence. Brought up rigidly by stern parents who insisted upon strict bowel regularity as "a good habit".

Developmental History

Normal pregnancy. Normal birth. Early development uneventful, except in sphere of bowel habit. Even in infancy, bowel action tended to be infrequent and the stools hard. Toilet training instituted in neo-natal period, coercive, and success in training not achieved.

Background Circumstances

Nil relevant.

Parental Fears & Prejudices

Mother entertained deep seated conviction about dire consequences of faecal retention; chief phobias were "poisoning of the system" and "bowel stoppage". Firmly believed in need for daily bowel action.

History of Present Illness

Mother preoccupied with patient's bowel function since early infancy. First became concerned because of passage of hard stools at infrequent intervals. Tendency to constipation became more pronounced during weaning at 6 months and persisted despite prescription by family doctor of various laxatives and modification of diet. Thereafter, district nurse attended for administration of occasional enemata to supplement effect of laxatives. No change in bowel pattern achieved. From the age of 9 months child actively resisted use of pot. Mother interpreted this as defiance and was determined to overcome child's resistance forcibly. She did not succeed. Scenes over defaecation became more frequent and violent, with persistence of faecal soiling. At time of child's hospital admission, mother was distracted by patient's symptoms and obsessed with her bowel disorder.

Further Progress

Mother was interviewed at regular weekly intervals for period of 4 months, the time necessary to realign her attitude and to promote adequate depth of insight. Marked resistance was initially encountered and insight was slow to develop. Subsequently, mother became increasingly detached, less tense and more flexible in her handling of child under therapeutic guidance. Child responded with progressive restoration of normal bowel function. At the end of 4 months, no further evidence of rectal or colonic loading. Pattern was now defaecation every 3 to 4 days without laxative treatment. No further soiling.

Result of Psychotherapeutic Treatment - September 1956

Child has now been symptom free for $2\frac{1}{2}$ years. Bowel action still occurs every third day but the stools are not hard. There is no soiling. Defaecation is spontaneous and the child is well. Mother now reports that "child is much easier to get on with than she used to be. She still has to argue with somebody but it is now usually her big sister. She remains determined but we are all very happy together". Relationship between mother and child satisfactory. Mother retains good insight.

Satisfactory result.

Case No. 20. Female 60. D.S.Q. Date of birth- 7.8.49.

Presenting Problem

- 1) Persistent refusal to defaecate since traumatic experience in hospital at age $4\frac{1}{2}$.
- 2) Subsequent colonic loading, overflow soiling and peri-anal dermatitis. Interval between bowel actions has extended to 21 days.
- 3) Marked nervous tension, clinging over-dependence on mother and frequent nightmares.

Age at Psychiatric Referral - $5\frac{1}{2}$ years.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms - Approximately 1 year.

Paediatric Findings & Treatment

No previous history of bowel disorder. Above symptoms developed during treatment in hospital for tuberculous dactylitis. Prior to hospital discharge, patient found to have abdominal distension with palpable faecal masses, rectal loading, and excoriation of peri-anal skin from overflow soiling. No local lesion of rectum or anal sphincter. Barium enema not performed. Condition treated initially with enemata, followed by petrolagar, phenolphthalein, and neostigmine bromide in turn. Bowel disorder persisted following return home, despite laxatives. Followed up at paediatric out-patients during next 12 months without satisfactory response to treatment. Ultimately referred for psychiatric opinion.

Psychiatric Assessment

Child

Fearful, resistive, and inseparable from mother. Remained withdrawn and unresponsive throughout successive interviews. Despite inhibited behaviour mother describes her as "determined in a sulky way".

Mother

Age 35. Overanxious in personality. Currently tense and agitated over child's symptoms. No obsessional traits. Has always been overindulgent towards child.

Father

Age 36. Not available for interview. Described by mother as placid and stable but equally over-indulgent towards child.

Family Structure Only child.

Family History Nil Relevant.

Developmental History

Mother suffered with pre-eclamptic toxæmia for two months before child's birth. Birth itself normal. Early development uneventful. No coercive toilet training. Child fully trained in bowel and bladder control by age 2.

Background Circumstances

Married 3 years before child's birth with one previous miscarriage. Mother warned against having more children. As a result, patient idolised by both parents. Over-attached to mother because of father's frequent absences at sea. Always regarded as sensitive, nervous child.

Parental Fears & Prejudices

No pre-existing concern about dangers of constipation. After onset of bowel disorder, mother entertained fear that child might have tuberculous disease of the bowel.

History of Present Illness

Child fretted following admission to hospital. Began to soil pyjamas in bed. Threatened by staff nurse with severe punishment if soiling continued. Thereafter refused to use bedpan for defaecation. Deliberately held back faeces. Subsequently threatened by same nurse that "her tummy would be cut open" and the faeces forcibly removed unless she opened her bowels. Child seemed petrified of this nurse but persisted in refusal to defaecate. Symptoms persisted after discharge from hospital, with frequent nightmares in which child called out the name of the offending nurse. Resistance to defaecation was followed by overflow soiling. Mother's fears prompted her to adopt coercive procedures, but without beneficial effect.

Further Progress

Psychotherapeutic treatment was complicated by need for follow-up surveillance for child's tuberculosis. Child continued to show marked fear during hospital attendances and mother continued to harbour her fears about secondary abdominal tuberculosis. The mother's response to psychiatric guidance became cooperative only after it was possible to reassure her categorically about her child's state of health. No direct therapy was attempted with child. Currently, the case is seen by paediatrician at intervals of 6 months for routine supervision.

Result of Psychotherapeutic Treatment - September 1956.

Restoration of normal bowel function has been achieved over the past 6 months, with no further soiling. The child has had no nightmares for almost a year. She has gained increasing self-confidence and stability. Mother's fears have finally been resolved, she retains good insight, is no longer tense, and handles child with greater detachment, though she remains overindulgent.

Satisfactory result.

62.
Case No. 21. Female C.C. Date of birth - 7.8.51.

Presenting Problem

- 1) Chronic constipation since "birth", i.e. the passage of hard faecal pellets at intervals of 3 to 4 days, latterly extending to 10 days.
- 2) Overflow faecal soiling from the age of 2.

Age at Psychiatric Referral - 2 yrs. 8 months.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms - Approximately 2 years.

Paediatric Findings & Treatment

First referred for paediatric opinion at age 2½. Child resistive to examination; hard faecal masses palpated abdominally; rectum loaded with retained faeces; peri-anal soiling. No local lesion present. Anal sphincter normal in tone. Problem diagnosed as due to parental mismanagement. No further paediatric investigation instituted. Case referred for psychiatric opinion.

Psychiatric Assessment

Child

Alert, intelligent girl, self-willed, obstinate and resistive. Rejected play materials and remained suspicious and unresponsive throughout interview.

Mother

Age 32. Intelligent, cultured woman, of rigidly obsessional personality. Impressed as reticent and quietly determined, with perfectionist trends; fastidious in personal hygiene. Currently tense and anxious about child's symptoms.

Father

Age 36. Solicitor. Stable, sensible personality. Showed no undue concern about child's constipation and considered that "too much fuss is being made by my wife".

Family Structure Only child.

Family History

Maternal grandfather had been strict disciplinarian, who insisted upon bowel regularity in his family. Mother had always maintained close attention to her own bowel habit "as a matter of good hygiene".

Developmental History

Normal pregnancy. Normal birth. Uneventful early development except in sphere of bowel habit. Bowel training instituted in neo-natal period; coercive. Successful training not achieved.

Background Circumstances

Married 4 years before birth of child. Mother was determined in advance to rear a model child, obedient, well trained, and clean in toilet habits. Admitted her aversion to handling soiled napkins, and instituted toilet training "from birth".

Parental Fears & Prejudices

Neither parent admitted preoccupation with potentially adverse effects of constipation.

History of Present Illness

From neonatal period bowel movements were infrequent and faeces hard. Family doctor adjusted the feed formula and prescribed magnesium hydroxide without effect. After weaning at 7 months, increased fluid intake and addition of vegetables proved equally ineffectual. Child resisted use of pot violently before age of 12 months. Concurrently, there was frequent refusal to feed. During 2nd year she persistently held back her faeces with much wriggling and contorting of her body in the effort. Thereafter, regular soiling occurred and persisted despite punitive measures adopted by mother. Mother regarded symptoms as "filthy and shameful", but despite her strict handling and frequent use of laxatives, the condition persisted with increasing interval between bowel actions.

Further Progress

All laxative treatment was discontinued following psychiatric referral. Mother was interviewed at regular weekly intervals for intensive psychotherapy over a period of 2 months. No direct therapy was instituted with the child. For first 3 weeks, mother remained tense, hostile and unconvinced. Thereafter, responded increasingly to treatment approach of re-education. After 2 months all overflow soiling had stopped and spontaneous bowel action every 3 to 4 days had been achieved. Further paediatric examination at this stage revealed an empty rectum and no evidence of colonic loading. Mother was noticeably more relaxed and had acquired good insight. Active supervision was discontinued at this point.

Result of Psychotherapeutic Treatment - (September, 1956)

Child has now remained symptom free for a period of over 2 years and mother has retained her insight. The pattern of bowel action in the child continues unchanged at intervals of 4 days, but neither parent is concerned. They regard this as quite normal for her and she suffers no adverse effects. She is no longer troublesome, either during defaecation or at meal times, and the former parent/child conflict is now resolved.

Satisfactory result.

Case No. 22. Female L.F. Date of birth - 20.8.49.

Presenting Problem

Increasing constipation since the age of 3, with intervals of 10 - 14 days between bowel movements, and with overflow faecal soiling.

Age at Psychiatric Referral - 6½ years.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms - 3½ years.

Paediatric Findings & Treatment

First referred for paediatric opinion at age 6½. At examination, healthy, active child. Large faecal masses palpable abdominally. Rectum loaded with faeces. Peri-anal soiling. No local lesion present. Condition suspected due to parental mismanagement. No barium enema performed; no further paediatric investigation instituted. Referred for psychiatric opinion forthwith.

Psychiatric Assessment

Child

Withdrawn, suspicious and unresponsive. Described by mother as obstinate and determined.

Mother

Age 29. Manifestly overanxious personality. A chronic worrier, particularly over the health of her children. Expressed feelings of guilt that she had "neglected" her child through failing to promote bowel regularity. No evidence of obsessional traits. Currently tense and agitated over child's symptoms.

Father

Age 32. Not available for interview. Described by mother as placid and much less prone to anxiety. Currently shares wife's concern over child's bowel disorder.

Family Structure

One sibling, a boy, 18 months older than patient. Described as different in temperament to sister; more compliant to parental discipline. This child developed Perthe's Disease at age 3. Still attending orthopaedic outpatient department. No history of bowel difficulty.

Family History - Nil relevant.

Developmental History

Normal pregnancy. Normal birth. Healthy baby. Uneventful early development. Toilet training instituted at 12 months. No evidence of coercion and child successfully trained by the age of 2.

Background Circumstances

From the age of 2, patient said to have resented extra parental attention shown to her brother, because of his persisting orthopaedic disability. Has always competed with sibling for mother's attention.

Parental Fears & Prejudices

Mother has entertained chronic fear of "twisted bowel" in relation to constipation; and for this

(L.F. cont)

reason, has been anxious to ensure bowel regularity in both her children. Coercive procedures not adopted until after onset of present bowel difficulty.

History of Present Illness

Bowel action regular and spontaneous until the age of 3. Constipation first developed while child suffering from ulceration of the mouth. No bowel movement occurred for 3 days on this occasion. Mother acutely concerned. District nurse was consulted and administered soap and water enema, during which child struggled violently, and had to be held down forcibly. No further enemata administered, but mother convinced that this experience frightened the child. Bowel difficulty has persisted since then. Exhortation, bribery, deprivation of privileges, and physical punishment, have all failed to affect the condition. A variety of purgatives prescribed by family doctor have equally had no beneficial effect. Mother believes that patient deliberately resists defaecation. Frequently wriggles and contorts her body, and is obviously experiencing abdominal pain, but consistently denies any intestinal discomfort and complains instead that she has toothache. Latterly, the intervals between bowel actions have increased, with periodic soiling in the interim. The stool has been streaked with blood on occasion. The child's bowel disorder is now the main topic of conversation among the entire family circle.

Further Progress

See Treatment Section p. 121.

Mother was interviewed at regular weekly intervals for a period of 2 months for psychotherapeutic re-education. All laxative treatment was discontinued. No direct therapy was employed with the child. Mother cooperated readily and gained increasing insight. Correspondingly became less anxious and more relaxed. Child's symptoms persisted, however, and were now associated with increased petulance, disobedience, and aggression towards older sibling. Subsequently, child admitted to hospital for 3 weeks, under supervision of therapist, to promote detachment in the handling of her behaviour, and to create the necessary atmosphere of disinterest in her bowel function. After the first week, no further difficulty was encountered, and spontaneous bowel movement on alternate days was restored prior to discharge. Soiling was no longer in evidence.

Result of Psychotherapeutic Treatment - (September, 1956)

Child has remained symptom free for a period of 4 months. She continues to show stubborn and self-willed behaviour, but mother has now learned to handle her with greater tact and without tension. Mother-child conflict no longer in evidence. Mother is free from concern about child's bowel function, and altogether more relaxed. She retains full insight.

Satisfactory result.

Case No. 23.

Female

P.A. McG.

Date of birth-24.9.51.

Presenting Problem

- 1) Increasing constipation since the age of 4 months, with intervals of up to 7 days between bowel motions.
- 2) Associated faecal soiling since the age of 1 year.

Age at Psychiatric Referral - 4½ years.Mode of Referral - Referred by consultant paediatrician.Duration of Symptoms - 4 years.Paediatric Findings & Treatment

First referred for paediatric opinion at age 4½. At examination, abdomen distended; faeces palpable in descending colon; rectum loaded with soft faeces; peri-anal soiling. No local lesion present. Healthy child. Basis of parental mismanagement suspected. No further paediatric investigation undertaken. Case referred for psychiatric opinion.

Psychiatric AssessmentChild

Petulant, sulky child, unresponsive at interview. Described by mother as determined and stubborn.

Mother

Age 26. Anxiety-prone, unstable personality, who suffers from chronic asthma. Asthmatic attacks precipitated by emotional upset. Circumscribed personality, limited in intellect. Tense and agitated over persistence of child's symptoms.

Father

Age 30. Sensible, stable personality. Convinced that wife's agitation has much to do with child's symptoms. Chiefly concerned about implications of soiling.

Family Structure

One sibling, a girl, 2 years younger than patient. No history of bowel disorder. Cooperative obedient child.

Family History - Nil relevant.Developmental History

Normal pregnancy. Breech delivery. Puny and underweight at birth. Admitted to hospital at age 3 months for hypertrophic pyloric stenosis. Successful operation. Bowel action sluggish upon discharge from hospital. Thereafter, mother preoccupied with child's health. Coercive toilet training instituted to offset mother's fear of recurrence of gastrointestinal trouble. Bowel training not successful.

Background Circumstances

Married 3 years before child's birth. One previous miscarriage. Mother obsessed by fear of losing child at operation after previous misfortune. Child's emotional value enhanced thereafter.

Parental Fears & Prejudices

Mother entertained vague idea of connection between pyloric stenosis and resulting bowel sluggishness. She considered close attention to child's bowel function was necessary to avoid any danger of relapse.

History of Present Illness

Excessive maternal concern over child's bowel action dates from the age of 4 months. Coercive measures of training were instituted at that time and have been maintained consistently since. They included punishment, exhortation and bribing, all of which had no beneficial effect. Laxative therapy similarly ineffectual. Subsequent development of soiling increased parental alarm, prompted greater rigidity over training, and evoked parental censure. Mother ultimately obsessed by child's bowel function and could think of nothing else.

Further Progress

See Treatment Section p. 116, 121.

Mother's limitation of intellect precluded her acquisition of adequate insight. She was quite unable to appreciate the dynamics of the child's behaviour. Didactic advice about her handling of child was followed temporarily, but regular attendance at clinic was not maintained. Subsequently necessary to remove child from home setting by admission to hospital, under supervision of therapist, for rehabilitation in controlled environment. Child retained for $3\frac{1}{2}$ weeks. Restoration of normal bowel function achieved after interval of 2 weeks. Child began spontaneously requesting pot. Some residual faecal staining persisted but cleared up prior to discharge. No direct therapy employed with child. All laxative therapy discontinued.

Result of Psychotherapeutic Treatment (September, 1956)

Child has remained symptom free for the past 3 months since discharge from hospital, with spontaneous daily bowel action. Regular supportive therapy is being maintained with mother to reinforce the example of handling child as demonstrated in hospital. Mother's response to dogmatic instruction is so far satisfactory.

Satisfactory short-term result.

Case No.24. Female K.K. Date of birth-10.10-52.

Presenting Problem

- 1) Severe right sided pain of 6 hours duration, suspected due to acute appendicitis. Diagnosis not substantiated.
- 2) Subsequently elicited history of persistent constipation since age 3, with intervals of 2 to 3 weeks between bowel actions, and with intermittent overflow soiling.
- 3) Diurnal enuresis since age 3.
- 4) Difficulty over feeding during concurrent period.

Age at Psychiatric Referral - 3 years 8 months.

Mode of Referral - Referred by paediatric surgeon.

Duration of Symptoms - (Apart from acute episode) 8 months.

Paediatric Findings & Treatment

Admitted to surgical ward at age 3 years 8 months as surgical emergency. At examination, no evidence of "acute abdomen". Palpable faecal masses in descending colon and rectum; peri-anal soiling and dermatitis; no local lesion of rectum or anus. Case diagnosed as chronic constipation. No further investigation conducted. Lower bowel cleared with enemata. Child then referred for psychiatric opinion while still in hospital.

Psychiatric Assessment

Child

Plump, healthy child, tearful and unresponsive. Described by mother as stubborn and contrary.

Mother

Age 34. Impressionable, overanxious personality, of limited intelligence. No evidence of obsessional characteristics. Emotionally unstable. Currently tense and alarmed by child's symptoms.

Father

Age 34. Stolid, unimaginative person. Much less concerned by child's chronic symptoms.

Family Structure

Two siblings, a boy 2 years older than patient, and a baby girl age 9 months at time of history. Patient jealous of younger sibling. Older boy developed dysuria and urinary incontinence at age 3. Ultimate surgical investigation revealed diverticulum of bladder, successfully removed at age 4. Since then, boy has remained symptom free. No history of bowel disorder.

Developmental History

Normal pregnancy. Normal birth. Uneventful early development. Toilet training instituted at 10 months; not rigidly enforced; completed by 18 months. Bowel action regular and normal until age 3.

Background Circumstances

Mother had been convinced that her oldest child's bladder disturbance had an organic basis. Reassured to the contrary by family doctor, but insisted on referral for specialist opinion. Need for surgical operation vindicated mother's original fears. Subsequently she adopted similar attitude to her second child's bowel disorder, and refused to accept family doctor's reassurance, in view of former experience.

Parental Fears & Prejudices.

Chronic fear of effects of constipation were entertained by mother, prior to onset of child's bowel difficulty. Now convinced child has "diseased bowels".

History of Present Illness

Symptoms developed within one month of birth of younger sibling. Initiated by refusal to use toilet for bowel evacuation. Obstinacy over defaecation has persisted since then, despite laxatives, and despite a variety of coercive measures adopted by mother. Associated development of diurnal wetting, and feeding difficulty. Child generally resistive and contrary, where formerly compliant. Intervals between bowel movements gradually increased, with subsequent faecal soiling. Mother both alarmed and embarrassed by symptoms. History culminated in admission to hospital after acute episode of abdominal pain.

Further Progress

See Treatment Section p. 116, 121.

Mother too limited in intellect to benefit from psychotherapeutic attempts to promote her insight. Psychotherapy was confined to authoritative reassurance and dogmatic instruction in the handling of child. Cooperative response. Child was retained in hospital for a further 4 weeks, under supervision of therapist, to initiate the necessary modification in her management, and to re-establish normal bowel function. No further laxatives employed. After first 2 weeks, spontaneous bowel action was restored, with daily movement, and no further soiling.

Result of Psychotherapeutic Treatment - (September, 1956)

Bowel regularity has been maintained during past 2 months since discharge from hospital, with no recurrence of soiling. Child is eating better unbidden; occasional diurnal enuresis persists. Mother now unconcerned. Handles child with detachment, and patient responds accordingly. Mother continues to attend clinic weekly for supportive therapy. Child does not attend. Mother-child relationship currently free from conflict.

Satisfactory result.

Case No. 25. Female G.B.C. Date of birth-26.2.53.

Presenting Problem

- 1) Increasing constipation since the age of 2 $\frac{1}{4}$ with intervals of up to 21 days between bowel actions.
- 2) Persistent refusal to use pot or toilet.
- 3) Overflow faecal soiling at intervals of 2-3 days, with chronic peri-anal dermatitis.

Age at Psychiatric Referral - 3 years 4 months.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms - Approximately 1 year.

Paediatric Findings & Treatment

First referred to dermatologist at age 3, because of peri-anal dermatitis. Subsequently referred for paediatric opinion because of underlying bowel disorder. Healthy child with distended abdomen. Hard faecal masses palpable in descending colon. Rectum loaded with retained faeces. No local lesion of rectum or anus. Severe peri-anal dermatitis partially responding to topical treatment. Child resistive during examination. No further paediatric investigations undertaken. Problem recognised as due to parental mismanagement. Local anaesthetic ointment prescribed for application to anal region. Referred for psychiatric opinion.

Psychiatric Assessment

Child

Anxious, insecure child. Refused to be separated from mother. Cried when spoken to. Unresponsive. Described by mother as "stubborn over bowels".

Mother

Age 47. Anxious, tense and unstable. Worried about husband's health and preoccupied with child's bowel function. Circumscribed, obsessional personality, guilt-ridden.

Father

Age 44. Overanxious, irritable, immature. Equally preoccupied with child's symptoms. Has cancer phobia and suffers from peptic ulcer for which he has refused hospital treatment.

Family Structure

One sibling, a girl, 7 years older than patient. No bowel difficulty. Described as "nervous and highly strung".

Family History

Mother suffers from chronic constipation and haemorrhoids. She is dependent on purgatives.

Developmental History

Normal pregnancy. Normal birth. Uneventful early development. Bowel training rigid, instituted at 6 months, completed at 2 years.

Background Circumstances

Father's peptic ulcer, hypochondriasis and irritability have reinforced mother's restrictive attitude towards the child's play. Mother did not want this second

(G.B.C. cont)

child; very upset by pregnancy. After patient's birth experienced feelings of guilt over former rejection, and has since overvalued child. Father resentful of preferential attention shown to patient.

Parental Fears & Prejudices

Both parents preoccupied with child's bowel function. Afraid that father may have cancer, and that this may have been transmitted to child. Alarmed at prospect of "stoppage of the bowels". Both parents concerned about attitude of neighbours to their child's symptoms.

History of Present Illness

At the age of 2 years 3 months, child had accidental bowel motion out of doors while at play. Mother very upset and embarrassed. She punished the child, who thereafter began to soil her underclothes. Every day after this, mother held child on the pot after breakfast, for lengthy periods, during which there were violent scenes. Mother also administered suppositories at night. This focusing of attention on the pot was accompanied by restriction of the child's play and distress at any evidence of normal aggression. The child reacted with persistent refusal to defaecate, and screamed whenever she saw the pot. Patient's constipation now superseded father's peptic ulcer as the centre of attention for the household.

Further Progress

Mother has been interviewed weekly during past 3 months for psychotherapeutic re-education. She remains resistive in attitude and lacking in insight. Any suggestion that the child's condition is not organic, results in distress, agitation and reiteration that "there must be something wrong with her". Father has been interviewed and proved equally devoid of insight. Child was therefore admitted to a paediatric ward under supervision of therapist, to relieve her of parental pressure, while attempts are continued to re-educate the parents. She has now been in hospital for a period of 7 weeks. Spontaneous bowel function was restored after an interval of 4 weeks, without laxatives, following treatment of perianal dermatitis. Child is now more responsive and self-confident.

Result of Psychotherapeutic Treatment - (September, 1956)

Child currently retained in hospital, where her improvement continues. Parents are attending for psychotherapy but progress with them is slow.

Interim result satisfactory. Long-term prognosis guarded, in view of personality structure of mother and father.

Case No. 26. Female J.N. Date of birth-14.12.48.

Presenting Problem

- 1) Chronic constipation since the age of 12 months, with intervals of up to 4 weeks between formed bowel motions, and with recurrent overflow faecal soiling.
- 2) Difficulty over feeding since the age of 6 months.

Age at Psychiatric Referral - 7 $\frac{1}{2}$ years.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms - Approximately 6 years.

Paediatric Findings & Treatment

First referred for paediatric opinion at age of 11 months because of feeding difficulty. Admitted to hospital for investigation to exclude diagnosis of Pink Disease. All findings negative. Problem recognised as due to gross maternal mismanagement. Discharged with appropriate advice.

Referred once more at age 6 $\frac{1}{2}$ for persistent incontinence of faeces, found to have a basis of intractable constipation. Multiple faecal masses were palpable abdominally. There was marked abdominal distension, rectal loading, and peri-anal dermatitis. Repeated courses of enemata as an out-patient failed to prevent subsequent re-loading of terminal bowel. Thereafter admitted to hospital for "re-training", with enemata and petrolagar. No barium enema performed. Feeding difficulty persisted, and residual masses of faeces were still palpable abdominally, despite resumption of regular bowel action. Discharged after 5 weeks because of fretting. Re-loading of lower colon recurred within one week of return home. Condition essentially unchanged. Referred for psychiatric opinion.

Psychiatric Assessment

Child

Pallid girl of slender build. Withdrawn, fearful and inhibited. Refused to be separated from parents. Markedly resistive during interview. Became tearful if spoken to.

Mother

Age 42. Markedly tense woman. Intelligent, cultured. Rigidly obsessional in personality with manifest evidence of neurotic instability. Obsessed with child's functions of feeding and bowel movement.

Father

Age 44. General medical practitioner. Distressed by child's symptoms but to a lesser degree. Nervous in temperament, with multiple facial tics. Clearly under tension.

Family Structure

One sibling, a boy, 7 years older than patient. Described as shy, docile and retiring, with multiple habit spasms. No history of bowel disorder.

Family History - Nil relevant.

Developmental History

Normal pregnancy. Forceps delivery. Early development uneventful, until onset of feeding difficulty during weaning at age 6 months. Toilet training adopted

during first few months; rigid and coercive; child allegedly clean before the age of 12 months. Constipation supervened thereafter.

Background Circumstances

Protracted history of marital disharmony due to serious difficulties in sexual adjustment between parents. No advice sought hitherto because of husband's professional position. During the war years, there had been a period of respite while husband serving in Forces. The older child had escaped emotional repercussion, in proportion, during that period. Recrudescence of intimate difficulties took place just before patient's birth, upon husband's return to civilian life, and have continued to operate thereafter. Psychiatric assessment strongly indicated displacement of maternal affection upon the younger child, to compensate for mother's emotional deprivation. Mother's attitude to patient intensely possessive and overprotective as a result.

Parental Fears & Prejudices

No primary fears of constipation admitted by either parent. Both parents entertain secondary fears relating to the harmful effects of colonic loading, and lack of nourishment due to persistence of feeding difficulty.

History of Present Illness

The child's management from the age of six months has been dominated by mother's attempts at forced feeding, and her coercive procedures to overcome the constipation. Patient has responded with sullen refusal both to eat and to defaecate. Exhortations, threats, laxatives and suppositories have all proved equally ineffectual, and have frequently resulted in violent domestic scenes. The household has for long been dominated by the patient's schedules of feeding and bowel movement.

Further Progress

Intense resistance was encountered from mother during initial attempts at psychotherapeutic re-education. Her own instability was so manifest that she was subsequently referred for independent psychiatric treatment. This has been maintained for the past 6 months without any improvement. She remains hostile and unresponsive, will not cooperate with her therapist, and refuses to enter hospital. She is regarded as bordering upon psychotic breakdown.

Direct therapy has been instituted with the child during the past 6 months. She has become increasingly responsive under treatment, but improvement is impeded by persistence of the mother's restrictive attitude. Her bowel disorder remains essentially unchanged. (See Treatment Section, Page 128/9)

Result of Psychotherapeutic Treatment - (September, 1956)

The mother's resistance and lack of cooperation have so far prevented a satisfactory response in the child. Treatment is being continued.

Case No. 27. Female J.E.B. Date of birth - 27.6.53.

Presenting Problem

Chronic constipation since age of 18 months with refusal to use pot.

Age at Psychiatric Referral - 2 years 9 months.

Mode of Referral Referred by general medical practitioner.

Duration of Symptoms Approximately 1 year.

Paediatric Findings & Treatment

No previous referral for paediatric examination. No abdominal distension and faecal masses could not be palpated in descending colon. Rectum loaded with retained faeces. No peri-anal soiling. No local lesion of rectum or anus. Special investigations not undertaken.

Psychiatric Assessment

Child

Self-willed, determined and precocious. Resistive to physical examination and suspicious of therapist.

Mother

Age 31. Manifestly neurotic personality. Has suffered from frank anxiety state for past 2 years. Treated by family doctor with psychotherapy and sedation. Markedly tense, and wept repeatedly at interview. No evidence of obsessive traits. Extremely concerned about child's bowel irregularity.

Father

Age 33. Nondescript personality. More concerned about wife's health than child's condition.

Family Structure Only child.

Family History Nil Relevant.

Developmental History

Normal pregnancy supervised at ante-natal clinic. Normal birth. Uneventful early development until the age of 18 months. Mother denied coercive methods of toilet training; claims child trained before the age of 18 months.

Background Circumstances

Mother suffers from mitral stenosis and was warned about the danger of having children. Married 5 years before pregnancy. Pregnancy supervised throughout at ante-natal clinic. During delivery mother had cerebral embolism with resulting apoplectic seizure from which she made a complete recovery. Warned against further pregnancies. Mother's emotional investment in this child resultingly high.

Parental Fears & Prejudices

Before marriage mother had worked in a factory where many girl employees suffered from chronic constipation and constantly complained of unpleasant symptoms. Following onset of bowel difficulty in her own child, she recalled these past impressions and was determined that her daughter would not suffer similarly. Entertained the associated fears of "bowel stoppage" and "poisoning of the system" which might result from continuing constipation.

History of Present Illness

At 18 months child first showed refusal to use pot for defaecation except under special circumstances. She insisted on both parents being present and "helping" her by laying a hand on her head or "rubbing her tummy". After prolonged sitting she might then defaecate but just as frequently rejected the pot by stiffening her body and protesting loudly. This attitude might be maintained for 4 days before passing a motion. There had been no faecal soiling. Mother intensely concerned and sought the advice of family doctor. No laxatives were prescribed. Treatment was confined to prune juice and coarse cereal with advice to ignore the bowel difficulty. Child responded for several months with decrease in constipation but gradually reverted to original symptoms. Mother admitted losing faith in this treatment approach and was ultimately referred for reinforcement of the family doctor's advice in handling the problem.

Further Progress

Both parents were interviewed on 4 separate occasions for the purpose of realigning their attitude in handling the child and promoting their insight for the underlying basis of the mother/child conflict. No direct therapy was employed with the child. At the end of 1 month complete bowel regularity had been restored with spontaneous bowel action daily in the absence of both laxatives and dietetic measures.

Result of Psychotherapeutic Treatment - September 1956.

Child has now remained symptom free for a period of 6 months. Relationship between mother and child is free from conflict and the child is developing satisfactorily. Both parents have retained full insight.

Satisfactory result.

Case No.28. Male P.76: Date of birth- 1.4.51.

Presenting Problem

- 1) Increasing constipation since the age of 21 months, with intervals of up to 14 days between bowel motions.
- 2) Overflow faecal soiling from the age of 2.

Age at Psychiatric Referral - 2 $\frac{1}{2}$ years.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms - 8 months.

Paediatric Findings & Treatment

First referred for paediatric opinion at the age of 2 $\frac{1}{2}$. Examination revealed abdominal distension with faecal masses palpable. Rectum loaded with faeces. Peri-anal soiling. No local lesion present. Child fearful and uncooperative. Resistive to examination. Basis of parental mismanagement suspected and case referred forthwith for psychiatric opinion.

Psychiatric Assessment

Child

Tense, anxious and insecure. Refused to be separated from mother. Became tearful and clinging when offered play material. Remained unresponsive throughout interview.

Mother

Age 25. Anxious, tense woman, burdened by domestic difficulties and preoccupied by child's bowel function. No evidence of obsessive characteristics. Impressed as a weak and impressionable personality.

Father

Age 24. Chronic worrier, introspective and over-conscientious. Equally alarmed by child's symptoms, but largely as reflection of wife's concern. A year earlier had been invalided from the navy because of peptic ulcer and forced to accept light, part-time employment.

Family Structure - Only child.

Family History

Maternal grandfather suffers from chronic and intractable constipation. Firmly addicted to patent laxatives. Maternal grandmother described by family doctor as "chronic cardiac neurotic".

Developmental History

Normal pregnancy. Normal birth. Uneventful early development. Bowel training instituted casually at 12 months. No coercive measures adopted. Child reported clean and dry by age of 18 months.

Background Circumstances

Father's discharge from navy resulted in lowering of family's economic standard. Forced to give up their own home and move into two rooms in home of maternal grandparents. Here, child overindulged and pampered, as first and only

grandchild. Soon learned to play off parents against grandparents. No consistent pattern of handling.

Parental Fears & Prejudices

Neither parent unduly preoccupied with need for bowel regularity prior to onset of child's symptoms. Maternal grandfather, however, firmly convinced of adverse effects of constipation and conveyed these fears to mother. Particularly alarmed at prospect of "bowel stoppage". Maternal grandmother intolerant of "filthy habit" of soiling and threatened to evict parents and child unless the boy "behaved properly".

History of Present Illness

Within two months of moving into grandparents' house, child's symptoms had their onset. Precipitated by accident which occurred during attempts to train child in use of toilet seat. A special small frame had been placed over existing seat but was accidentally dislodged on one occasion. Child jammed awkwardly within the toilet bowl. Badly frightened and thereafter steadfastly refused to use toilet and soon rejected use of pot. Interval between bowel motions progressively increased, despite prescription of various laxatives. Child seemed able to tolerate considerable discomfort without defaecation. Subsequently began to soil during intervals between bowel movements. Parents felt sure he experienced urge to defaecate but was deliberately holding back. All 4 adults in household began hounding child to defaecate, coaxing him, bribing him, threatening deprivation of privileges and even acting out for him the process of defaecation inimicry. Child reacted with persisting obstinate refusal. Mother became increasingly tense and agitated under dual pressure of threatened loss of lodgings and anxious concern for child's health. His constipation dominated the whole household.

Further Progress

Both parents were interviewed on 4 separate occasions for psychotherapeutic re-education. No direct therapy was employed with child. All laxative treatment was discontinued. Mother responded with marked reduction in her state of tension, following reassurance and support by therapist. No true depth of insight was promoted, but she was able to adopt a more relaxed and detached attitude in handling child. At this stage further attendance ceased without explanation and contact with the case was lost.

Result of Psychotherapeutic Treatment - (September, 1956)

Subsequent enquiry revealed that family had left the district and efforts to trace them failed. Ultimate result unknown.

Case No. 29. Male B.G. Date of birth - 8.10.50

Presenting Problem

- 1) Chronic constipation since the age of 2, with intervals of up to 7 days between bowel motions, and with overflow faecal soiling.
- 2) Feeding difficulty from the age of 18 months, with persistent refusal to eat.

Age at Psychiatric Referral 3½ years.

Mode of Referral Referred by consultant paediatrician.

Duration of Symptoms 18 months.

Paediatric Findings & Treatment

First referred to paediatric surgeon at the age of 3 because of a small anal fissure. Child had been constipated for approximately 12 months. Conservative treatment, with local anaesthetic ointment and lubricant laxatives, was tried at first, followed by stretching of the anal sphincter under general anaesthesia. The fissure healed but difficulty with defaecation persisted and child then referred to paediatric physician. Upon examination, palpable faecal masses noted abdominally; rectum loaded with faeces. Peri-anal soiling. No recurrence of local lesion. No organic basis found to explain history of chronic constipation. Barium enema not performed. Child not readmitted to hospital. Basis of parental mismanagement suspected and case referred for psychiatric opinion.

Psychiatric Assessment

Child

Tense nervous boy, excessively polite. Impeccable in dress and manners. Clear evidence of carping maternal pressure emerged during interview in her strict handling of child. Mother stated "he is very obedient and a good boy but his bowels are stubborn".

Mother

Age 33. Tense anxious, rigidly obsessional personality, reserved and undemonstrative but very strong-willed. Has always insisted upon implicit obedience from child.

Father

Age 31. Less dominant personality but equally orderly and obsessional in habits. Wife exerts the greater influence in the home.

Family Structure Only child.

Family History Nil relevant.

Developmental History

Normal pregnancy. Normal birth. Uneventful early development. Bowel training instituted in neo-natal period. Coercive and child successfully "trained" before the age of 12 months.

Background Circumstances

Three years before the birth of patient, their first child, a girl, had died at the age of 16 months from acute nephritis. Mother recalled that this child had been constipated for some time prior to onset of terminal illness. In retrospect, both parents associated the history of constipation with the subsequent development of nephritis. Overcome by child's death and following birth of second child, determined that he must never become constipated. Hence, from birth, rigid bowel "training" was imposed by mother with regular administration of magnesium hydroxide and medicinal paraffin.

Parental Fears & Prejudices

Both parents were convinced of the association between constipation and the illness from which their baby daughter had died, and were seriously alarmed at the persistence of bowel symptoms in second child.

History of Present Illness

Mother was determined to rear a model child. Programme of training accordingly rigid in all spheres. In second year, child became increasingly resistive during feeding with persistent refusal to eat despite maternal insistence. By age 2, equally resistive to defaecation. Now refused to use pot, repeatedly held back faeces, despite exhortation by both parents, alternating with strict punitive measures adopted by mother. Subsequently, defaecation became very painful (anal fissure), and child showed fear of opening bowels. Surgical opinion first sought because of this.

Further Progress

Both parents were interviewed on 3 separate occasions for psychotherapeutic re-education. Mother intensely resistive. Father remained non-committal. Rejection of psychiatric approach not expressed as such, but mother became increasingly anxious at implication of her personal involvement in child's symptoms, and failed to reattend after third interview.

Result of Psychotherapeutic Treatment - September, 1956.

No response has been obtained to repeated follow-up enquiries. Current position not ascertainable.

Unsatisfactory result.

Case No. 30. Male B.P.W. Date of birth - 4.11.51.

Presenting Problem

- 1) "Difficulty" in defaecation since the age of 18 months, with alleged fear of using pot or toilet, and with intervals up to 7 days between bowel motions.
- 2) Associated faecal soiling.

Age at Psychiatric Referral - 4 years.

Mode of Referral - Referred by consultant paediatrician.

Duration of Symptoms - 2½ years.

Paediatric Findings & Treatment

First referred for paediatric opinion at age 4. Child resistive to examination. No local lesion found to account for "difficulty" in defaecation. Rectum loaded with faeces; peri-anal soiling. Faecal masses palpable abdominally. Not admitted to hospital. No detailed paediatric investigation instituted. Problem suspected to be one of parental mismanagement; referred forthwith for psychiatric opinion.

Psychiatric Assessment

Child

Suspicious and unresponsive. Throughout interview sat on mother's lap with both hands held over his eyes. Refused to look at examiner. Frankly negative in behaviour. Mother described him as very determined and self willed.

Mother

Age 34. Rigid, obsessional personality. Strong-willed and insistent upon implicit obedience from her children. Markedly tense and anxious over child's symptoms.

Father

Age 36. Pompous and self-opinionated. Senior technician in pathological laboratory and anxious to demonstrate his pseudo-medical knowledge. Did not share wife's concern over child's symptoms. Considered them due to "naughtiness" and convinced he should be treated firmly.

Family Structure

One sibling, a boy 4 years older than patient. Described as sensitive, "highly strung", and much less determined by nature than patient. Suffers from "occasional" diurnal enuresis and "occasional" faecal soiling. Not constipated.

Family History - Nil relevant.

Developmental History

Normal pregnancy. Normal birth. Toilet training instituted during first few months of life. Coercive, and child said to be trained in bowel habit before the age of 12 months. Early development uneventful.

Background Circumstances

- Nil relevant.

Parental Fears & Prejudices

Mother convinced of underlying organic bowel lesion in child. Would not specify her fears. Father does not share this belief but intolerant of child's soiling and has adopted strict punitive measures.

History of Present Illness

Mother claimed child's resistance to defaecation resulted, at the age of 18 months, from fear of splashing of water in toilet during flushing. Father recalled episodes of rejection of pot prior to this. Both parents stated "child seems to make himself constipated". "When he feels the urge, he will hide under a chair or otherwise keep out of the way". Father has sat with child for $1\frac{1}{2}$ hours in toilet, coaxing and exhorting, without result. Ten minutes later he will soil his trousers. Smacking, deprivation of privileges, and rubbing the child's nose in faeces, have all been without effect. Father convinced child requires to be "trained" and insists that he visit toilet 3 times a day after meals to regain "the habit". Admits no success so far with this approach. Variety of laxatives have been used; their only effect is to increase soiling. Father determined "to break child's will". Mother's attitude divided between sense of shame at persistence of child's soiling, and intense concern for his health. Concedes that the bowel disorder dominates her thoughts.

Further Progress

Intense maternal resistance was encountered during two successive interviews with parents. Father remained supercilious and sceptical of psychiatric approach. All further appointments were failed and contact with the case was lost.

Result of Psychotherapeutic Treatment - (September 1956.)

No response has been obtained to repeated offers of further consultation. Current position unknown.

Unsatisfactory result.

THE CONTROL GROUP

Cases No. I - XXI.

Case No. I. Male M.S. Date of birth - 20.8.49.

Original Presenting Problem

Vomiting and abdominal pain of 2 days duration. No bowel action for 3 days.

Age at Hospital Admission - 3 years 4 months.

Paediatric Findings & Treatment

Rectum loaded with faeces.
Enema given with good result. Discharged after 6 days on maintenance petrolagar. Diagnosis - constipation.

Initial Response to Treatment

Symptom free at outpatient follow-up one month later. No further laxatives.

Follow-up - August, 1956.

Current Assessment of Personality

Child (aged 7) Affectionate, willing and responsive.

Mother (aged 41) Cheerful, flamboyant, extroverted personality.

Family History

Father suffers from chronic constipation, but unconcerned over his own or patient's condition.

Background Circumstances

3rd child. No over-valuation.

Parental Fears & Prejudices

Mother was previously a children's nurse. Trained to consider bowel regularity important. Free from fears and prejudices about constipation.

History of Coercive Toilet Training

No evidence of coercive approach by mother despite her previous professional training.

Present Condition

Symptom free for past 3½ years.
No relapse in interim.

Case No. II. Male M.J.M. Date of birth - 23.5.49.

Original Presenting Problem

3 months history of pain on defaecation. "Holds himself". Enema and suppositories previously administered coercively by family doctor. Child now fearful of bowel action.

Age at Hospital Admission - 3 years 4 months.

Paediatric Findings & Treatment

Rectum loaded with faeces. Faecal masses palpable abdominally. No local anal lesion. Proctitis suspected. Course of enemata given followed by proctoscopy. N.A.D. Discharged after 12 days on maintenance petrolagar and "roughage" diet. Diagnosis - constipation.

Initial Response to Treatment

Satisfactory. Laxatives discontinued.

Follow-up - July, 1956.

Current Assessment of Personality

Child (aged 7) Lively, affectionate, happy child.

Mother (aged 33) Intelligent, cultured, calm and efficient.

Family History - Nil relevant.

Background Circumstances

3rd child. No over-valuation. At time of patient's hospital admission, his younger sister was 4 weeks old. Mother aware of possibility of jealous reaction. Handled wisely.

Parental Fears & Prejudices

No fears about constipation elicited.

History of Coercive Toilet Training - None.

Present Condition

Symptom free for past $3\frac{1}{2}$ years. No relapse in interim. Occasionally goes one day without bowel action. Parents unconcerned.

Case No. III. Male J.G. Date of birth- 20.10.49.

Original Presenting Problem

Constipation from "birth".
Hard, blood-streaked faeces. Baby screams during defaecation.
Laxatives and suppositories previously prescribed without relief of symptoms.

Age at Hospital Admission - 11 months.

Paediatric Findings & Treatment

Anal spasm. Small anal fissure.
Palpable faeces in rectum. X-ray abdomen showed no evidence of megacolon. Anus dilated under general anaesthesia. Symptoms responded to course of enemata and magnesium hydroxide. Discharged after one month. Diagnosis - chronic constipation.

Initial Response to Treatment - Satisfactory.

Follow-up - July, 1956.

Current Assessment of Personality

Child (aged 6 $\frac{1}{2}$) Subdued, obedient child of asthenic build.

Mother (aged 27) Normally cheerful and easy-going.
Currently discouraged by overcrowded housing conditions.

Family History - Nil relevant.

Background Circumstances

First and only child at time of admission to hospital. No retrospective evidence of overvaluation. Mother cannot recall attitude to patient's disorder.

Parental Fears & Prejudices - None.

History of Coercive Toilet Training - None.

Present Condition

No trouble since discharge from hospital almost 6 years ago.

Case No. IV. Female M.C.C. Date of birth- 17.2.53.

Original Presenting Problem

One week's history of abdominal pain, vomiting and screaming attacks. No bowel action for 3 days. Faeces previously streaked with blood. Recurrent episodes of constipation since birth.

Age at Hospital Admission - 1 year 11 months.

Paediatric Findings & Treatment

Rectum packed with faeces. Enema gave constipated result. Investigated to exclude Hirschsprung's disease. Barium enema normal. Bowel action satisfactory following further enemata. Discharged after 8 days, on maintenance laxative treatment. Diagnosis - chronic constipation.

Initial Response to Treatment

At outpatient follow-up 3 weeks later, free from symptoms with aid of mild aperient.

Follow-up, -July 1956.

Current Assessment of Personality

Child (Aged 3 years 5 months) Intelligent, active child. No behaviour difficulties.

Mother (aged 30) Quiet, diffident person, who handles her three children calmly and sensibly, despite history of ill health in each. Previously suffered from pulmonary tuberculosis. Lesion now quiescent.

Family History - Nil relevant.

Background Circumstances

Oldest of 3 children. Previously overindulged by maternal grandparents, uncles and aunts, while family lived with them. This was recognised and offset by mother.

Parental Fears & Prejudices - None elicited.

History of Coercive Toilet Training - None.

Present Condition

Has been symptom free for past 18 months. No further laxatives for the past year.

Case No. V. Male M.B. Date of birth - 24.12.53.

Original Presenting Problem

Vomiting and colicky abdominal pain of 6 hours duration. No bowel action for 24 hours. Right sided abdominal tenderness. Suspected appendicitis - suspected intussusception.

Age at Hospital Admission - 9 months.

Paediatric Findings & Treatment

Vomited during examination - undigested food. Enema produced a constipated stool streaked with blood and mucus. No evidence of acute surgical condition. Discharged after 4 days on maintenance petrolagar.

Diagnosis - constipation.

Initial Response to Treatment

Condition satisfactory at out-patient follow-up one month later. Attendance discontinued.

Follow-up - August, 1956.

Current Assessment of Personality

Child (aged 2 years 8 months) Self-reliant, spirited and independent. Can be obstinate, but responds to tactful handling.

Mother (aged 24) Intelligent and responsible young mother of equable temperament.

Family History - Nil relevant.

Background Circumstances

Only child. Sensible management.

Parental Fears & Prejudices - None elicited.

History of Coercive Toilet Training - None.

Present Condition

Symptom free for past 2 years. No recurrence in interim.

Case No. VI. Male G.C. Date of birth-2.12.51.

Original Presenting Problem

7 days history of malaise; crying and drawing up knees as if in abdominal pain. Repeated vomiting of undigested food.

Age at Hospital Admission - 18 months.

Paediatric Findings & Treatment

Protuberant abdomen. No tenderness or guarding. No palpable faecal masses. Enema produced constipated result, following which symptoms resolved. Discharged next day. Diagnosis - constipation.

Initial Response to Treatment

Symptom free at outpatient follow-up one month and 3 months later.

Follow-up - August, 1956.

Current Assessment of Personality

Child (Aged 4 years 8 months) High-spirited, happy and friendly.

Mother (aged 36) Stable, intelligent person.

Family History - Nil relevant.

Background Circumstances

Only child. No evidence of spoiling or of undue restriction.

Paediatric Findings & Treatment - None.

History of Coercive Toilet Training - None.

Present Condition

Healthy. No recurrence in interim. Symptom free for past 3 years.

Case No. VII. Male J.P. Date of birth- 4.9.51.

Original Presenting Problem

Constipation and abdominal pain of 7 days duration. Blood-streaked faeces.

Age at Hospital Admission - 18 months.

Paediatric Findings & Treatment

Verminous child. Abdomen distended. No tenderness or guarding. No anal spasm or fissure. Rectum empty. One enema administered with good result. Discharged after 5 days. Diagnosis - unspecified constipation.

Initial Response to Treatment

Symptom free at outpatient follow-up one month later. Further attendance unnecessary.

Follow-up - July, 1956.

Current Assessment of Personality

Child (aged 4 years 10 months) Boisterous, affectionate and happy.

Mother (aged 30) Slovenly, lax, warm-hearted woman. Says "Happiness of my children matters more than the house".

Family History - Nil relevant.

Background Circumstances - Nil relevant.

Parental Fears & Prejudices - None.

History of Coercive Toilet Training - None.

Present Condition

No further trouble since discharge from hospital over 3 years ago.

Case No. VIII. Female S.C. Date of birth-3.11.51.

Original Presenting Problem

4 days history of constipation with central abdominal pain. No result from aperient or suppositories. Similar episode 3 weeks previously, lasting 3 days. Suspected appendicitis.

Age at Hospital Admission - 3 years.

Paediatric Findings & Treatment

No evidence of acute abdominal lesion. Soft faecal mass retained in rectum. Given enema with good result. No further symptoms. X-ray abdomen normal. Discharged after 6 days on maintenance petrolagar and phenolphthalein. Diagnosis - constipation.

Initial Response to Treatment

Bowel action regular, at out-patient follow-up one month later. Attendance discontinued. No further laxatives.

Follow-up July, 1956.

Current Assessment of Personality

Child (aged 4 years 8 months) Impudent, attention-seeking, and self-willed.

Mother (aged 30) Intelligent, balanced personality. Interference by paternal grandparents undermines her otherwise sensible management of child.

Family History - Nil relevant.

Background Circumstances

Only child. Activity restricted by elderly grandparents with whom family reside. Parents plan to have more children, when they acquire their own home.

Parental Fears & Prejudices - None.

History of Coercive Toilet Training - None.

Present Condition

No further bowel difficulty over past 18 months.

Case No. IX. Male W.T.C. Date of birth- 10.7.49.

Original Presenting Problem

18 months history of fear of defaecation following circumcision. Micturition originally painful after operation; child developed fear of pot, with consequent persisting constipation. Bowel movements occurred at 7-10 day intervals despite purgation and suppositories prescribed by family doctor, against mother's instinctive inclination.

Age at Hospital Admission - 3 years 11 months.

Paediatric Findings & Treatment

Palpable faeces in pelvic colon; no soiling. Barium enema showed no evidence of Hirschsprung's disease or idiopathic megacolon. Regular bowel action restored with liquid paraffin and phenolphthalein. Discharged after 11 days on maintenance laxative. Parents reassured and encouraged to maintain detached attitude to symptoms.

Diagnosis - Constipation with faulty habit formation following original trauma.

Initial Response to Treatment

Satisfactory condition maintained at monthly outpatient follow-up for 4 months after discharge. Parents responded to advice.

Follow-up. July, 1956.

Current Assessment of Personality

Child (aged 7) A quiet, shy and compliant child; attends speech-therapist because of stammer.

Mother (aged 36) Shrewd and perceptive; handles the 3 children with patience and understanding, helped by cooperative father.

Family History - Nil relevant.

Background Circumstances

2nd and youngest child at time of admission to hospital. No over-valuation.

Parental Fears & Prejudices - None.

History of Coercive Toilet Training

Clean habits achieved by 18 months of age without coercion. Rigid potting reluctantly enforced by mother on medical advice, only after child's post-traumatic refusal of pot. Mother felt this was wrong, and was relieved that hospital later endorsed her views.

Present Condition

No further trouble since discharged from hospital over 3 years ago.

Case No. X. Female S.M. Date of birth -26.12.53.

Original Presenting Problem

5 days history of recurrent attacks of vomiting with abdominal colic and absence of bowel movement. Child fretful. Referred for suspected intestinal obstruction.

Age at Hospital Admission - 1 year.

Paediatric Findings & Treatment

Abdomen distended. Faecal mass in rectum. No evidence of acute surgical condition. Symptoms resolved after single enema. Child well. Discharged after 2 days. Diagnosis - constipation.

Initial Response to Treatment

Condition satisfactory at out-patient follow-up 1 month later. Further attendance unnecessary.

Follow-up - August, 1956.

Current Assessment of Personality

Child (aged 2 years 8 months) A vigorous, merry, self-willed child of wiry physique.

Mother (aged 25) At present listless and apathetic consequent upon recent miscarriage. Usually energetic, congenial, easy-going.

Family History

Mother suffers from chronic constipation. Unperturbed by this or by patient's disorder.

Background Circumstances

Only child. No indication of over-valuation. Two months after patient left hospital, mother returned to full-time work. Child cared for by placid, equable, maternal grandmother.

Parental Fears & Prejudices - None.

History of Coercive Toilet Training - None.

Present Condition

No relapse. Symptom free 20 months after leaving hospital.

Case No. XI. Male R.D. Date of birth - 30.3.55.

Original Presenting Problem

12 hours history of attacks of screaming, vomiting and drawing up legs. Constipation of 2 days duration. Referred for suspected intussusception.

Age at Hospital Admission - 1 year 8 months.

Paediatric Findings & Treatment

No evidence of acute surgical abdominal condition. Enema gave good result, following which symptoms resolved. Child discharged after 3 days.

Diagnosis - constipation.

Initial Response to Treatment - Satisfactory.

Follow-up - July, 1956.

Current Assessment of Personality

Child (aged 3 years 4 months) An energetic and boisterous child of friendly disposition.

Mother (aged 27) Out-going sociable, tolerant personality; helped by kindly and understanding father.

Family History - Nil relevant.

Background Circumstances

1st and only child at time of hospital admission. No over-valuation.

Parental Fears & Prejudges. - None.

History of Coercive Toilet Training - None.

Present Condition.

No recurrence of symptoms since discharge from hospital over $1\frac{1}{2}$ years ago.

Case No. XII. Male I.M.H. Date of birth-25.5.55.

Original Presenting Problem

12 hours history of recurrent attacks of abdominal colic with screaming and drawing up of knees. Pallid and "collapsed" between attacks. Some mucoid diarrhoea previously. Referred for suspected intussusception.

Age at Hospital Admission - 9 months.

Paediatric Findings & Treatment

No evidence of acute surgical condition. Good result from enema; symptoms then cleared. Discharged on 3rd day. Diagnosis - constipation.

Initial Response to Treatment - Satisfactory.

Follow-up - August, 1956.

Current Assessment of Personality

Child (aged 15 months) Very active baby - walking, climbing, beginning to talk.

Mother (aged 24) Warm, permissive, motherly woman of limited intelligence.

Family History - Nil relevant.

Background Circumstances

First and only child. Accepted without fuss by mother who is eldest of a large family and has siblings near patient's age; accustomed to handling babies.

Parental Fears & Prejudices - None.

History of Coercive Toilet Training - None.

Present Condition

No return of symptoms since left hospital 6 months ago.

Case No. XIII.MaleA.M. Date of birth-10.10.51.Original Presenting Problem

Several hours history of severe spasmodic abdominal pain. Bowels previously constipated. Palpable tumour in right hypochondrium. Suspected intussusception.

Age at Hospital Admission

- 4 years.

Paediatric Findings & Treatment

No evidence to support suspected diagnosis. Abdominal tumour no longer palpable. Faeces in rectum. Pain relieved after administration of enema. Discharged after 6 days on maintenance petrolagar.

Diagnosis - constipation.Initial Response to Treatment

Satisfactory. Laxatives discontinued.

Follow-up - July, 1956.Current Assessment of Personality

Child (aged 4 years 9 months) An intelligent boy, vigorous, eager and responsive.

Mother (aged 49) Indolent, easy-going sociable woman.

Family History - Nil significant.

Background Circumstances

4th child, born 12 years after youngest sibling. Unwelcome pregnancy, but after patient born was fully accepted by mother and family. No evidence of over-valuation consequent upon ante-natal rejection. Mother not unduly disturbed by patient's disorder.

Parental Fears & Prejudices

- None.

History of Coercive Toilet Training - None.

Present Condition

Has remained symptom-free since leaving hospital 9 months ago.

Case No. XIV. Female B.A.S. Date of birth-10.1.52.

Original Presenting Problem

1 day's history of recurrent attacks of abdominal pain; screaming, drawing-up of knees, pallor. No bowel action since onset. Suspected intussusception.

Age at Hospital Admission - 9 months.

Paediatric Findings & Treatment

No physical signs to support diagnosis. Two enemata administered resulting in evacuation of hard constipated faeces. Symptoms thereafter subsided. Child discharged after 5 days observation.

Diagnosis - constipation.

Initial Response to Treatment

Condition satisfactory at out-patient follow-up 1 month later.

Follow-up - July, 1956.

Current Assessment of Personality

Child (aged $4\frac{1}{2}$) Sociable, happy and responsive child. no behaviour difficulties.

Mother (aged 27) Sympathetic and intuitive; deals composedly with her family.

Family History

Mother had intussusception in infancy but was not overanxious about patient's condition.

Background Circumstances

First and only child at time of hospital admission. No over-valuation.

Parental Fears & Prejudices

Free from fears and prejudices about constipation despite mother's own early history of intussusception.

History of Coercive Toilet Training - None.

Present Condition

No recurrence of symptoms since discharged from hospital over $3\frac{1}{2}$ years ago.

Case No. XV. Male G.P. Date of birth - 3.12.53.

Original Presenting Problem

24 hours history of intermittent abdominal colic, with screaming, irritability, vomiting and anorexia. Referred for suspected intussusception.

Age at Hospital Admission - 1 year 2 months.

Paediatric Findings & Treatment

No evidence of acute abdominal condition. Rectum loaded with hard faeces. Enema given with good result and resolution of symptoms. Discharged after 3 days observation on maintenance laxative.

Diagnosis - constipation.

Initial Response to Treatment

Regular bowel action reported at outpatient follow-up 1 month later. Laxatives discontinued.

Follow-up - July, 1956.

Current Assessment of Personality

Child (aged 3 years 4 months) Quiet, obedient, reserved.
No behaviour difficulties.

Mother (aged 37) Slatternly appearance, submissive and placatory manner, combined with poor intelligence.

Family History - Nil relevant.

Background Circumstances

3rd child. No over-valuation.

Parental Fears & Prejudices - Nil elicited.

History of Coercive Toilet Training - None.

Present Condition

Symptom free since discharged from hospital more than 2 years ago.

Case No. XVI.FemaleE.J.S.Date of birth -5.1.53.Original Presenting Problem

1 week's history of vomiting, abdominal pain and attacks of screaming. No bowel action for 3 days.

Age at Hospital Admission

- 9 months.

Paediatric Findings & Treatment

Hard faecal mass palpable in right iliac fossa. On rectal examination, bowel heavily loaded with faeces. After administration of enema, all symptoms and signs resolved. Child retained 9 days for further observation. Remained symptom free. Dis charged.

Diagnosis - constipation.Initial Response to Treatment

- Satisfactory.

Follow-up - August, 1956.Current Assessment of Personality

Child (aged 3 years 7 months) A sturdy child, with bright precocious manner. Actively friendly and attention-seeking.

Mother (aged 45) Histrionic in appearance and manner. Genial and garrulous.

Family History

- Nil relevant.

Background Circumstances

3rd child; 14 years younger than next half-sister, and the only child of mother's second "marriage". At time of patient's admission to hospital, mother was concerned about proceedings for bigamy being taken against patient's father. Patient a wanted child, not rejected because of father's deception; no subsequent over-valuation.

Parental Fears & Prejudices

- None.

History of Coercive Toilet Training

- None.

Present Condition

Symptom free since leaving hospital more than 2½ years ago.

Case No. XVII. Male P.C.T. Date of birth - 30.8.52.

Original Presenting Problem

Colicky abdominal pain and screaming attacks for 2 days. No bowel action.

Age at Hospital Admission - 11 months.

Paediatric Findings & Treatment

Hard faecal mass in rectum. Enema given with good result. Symptoms cleared. Discharged after 3 days on maintenance laxative.

Diagnosis - constipation.

Initial Response to Treatment - Satisfactory.

Follow-up - July, 1956.

Current Assessment of Personality

Child (aged 3 years 11 months) An acute and vivacious child with few inhibitions.

Mother (aged 36) Of good intelligence, tolerant and understanding.

Family History - Nil relevant.

Background Circumstances

4th and youngest child. No over-valuation.

Parental Fears & Prejudices - None.

History of Coercive Toilet Training - None.

Present Condition.

Remains symptom-free 3 years after leaving hospital.

Case No. XVIII. Male F.T. Date of birth - 26.3.55.

Original Presenting Problem

12 hours' history of screaming attacks, thought due to abdominal pain. Referred for observation as suspected intussusception.

Age at Hospital Admission - 9 months.

Paediatric Findings & Treatment

No evidence to support tentative diagnosis. Lower colon and rectum loaded with faeces. Enema administered with good result and resolution of symptoms. Discharged after 6 days. Diagnosis - constipation.

Initial Response to Treatment

Condition satisfactory when seen by Health Visitor 2 weeks after discharge.

Follow-up - August, 1956.

Current Assessment of Personality

Child (aged 1 year 5 months) Active; now walking and climbing, friendly.

Mother (aged 23) An indifferent housewife, slovenly and unsystematic. Friendly and imperturbable.

Family History - Nil relevant.

Background Circumstances

First and only child. No evidence of either over-indulgence or stringency.

Parental Fears & Prejudices - None.

History of Coercive Toilet Training - None.

Present Condition

Remains free of symptoms 8 months after leaving hospital.

Case No. XIX. Female C.R. Date of birth-30.1.55.

Original Presenting Problem

12 hours' history of abdominal pain and screaming attacks. No bowel action for 2 days.

Age at Hospital Admission - 2 years 9 months.

Paediatric Findings & Treatment

Hard faeces palpable in descending colon and rectum. Abdomen distended. Following course of enemata, symptoms cleared. Child discharged after 9 days on maintenance liquid paraffin. Diagnosis - constipation.

Initial Response to Treatment

Satisfactory, laxative discontinued.

Follow-up - August, 1956.

Current Assessment of Personality

Child (aged 3 years 7 months) A quiet, docile and submissive child of small physique.

Mother (aged 23) Placid, ingenuous, dependent.

Family History - Nil relevant.

Background Circumstances

First child; Mother had toxæmia of pregnancy, and delivery was prematurely induced at 8 months. Mother largely undisturbed by this or by patient's bowel disorder.

Parental Fears & Prejudices

History of insistence on regular bowel movement in mother's family, due to grandmother's fears of constipation. Mother does not subscribe to this attitude.

History of Coercive Toilet Training - None.

Present Condition

Has remained symptom-free since leaving hospital 10 months ago.

Case No. XX. Female K.H. Date of birth - 7.11.50.

Original Presenting Problem

Sudden paroxysms of severe abdominal pain, with screaming and drawing up of knees - 12 hours' duration.

Age at Hospital Admission - 4 years 9 months.

Paediatric Findings & Treatment

Hard faecal mass in rectum, symptoms relieved by repeated enemata. Discharged after 4 days.
Diagnosis - constipation.

Initial Response to Treatment - constipation relieved.

Follow-up - July, 1956.

Current Assessment of Personality

Child (aged 5 years 8 months) Confident, selfreliant and friendly.

Mother (aged 49) Easy-going, careless, cheerful personality.

Family History - Nil relevant.

Background Circumstances

Patient is youngest of 14 children.
No over-valuation. Fully accepted.

Parental Fears & Prejudices - None.

History of Coercive Toilet Training - None.

Present Condition

No further trouble since discharge from hospital nearly 1 year ago.

Case No. XXI. Male R.W. Date of birth- 25.3.51.

Original Presenting Problem

abdominal pain and vomiting. 3 days' history of recurrent
No bowel action for same period.

Age at Hospital Admission - 3 years 10 months.

Paediatric Findings & Treatment

Enema yielded good result; Rectum loaded with faeces.
after 9 days. symptoms then resolved. Discharged
Diagnosis - constipation.

Initial Response to Treatment

patient follow-up 1 month later. Condition satisfactory at out-
Attendance discontinued.

Follow-up - July, 1956.

Current Assessment of Personality

Child (aged 5 years 4 months) Timid, clinging and depend-
ent; although becoming more aggressive since
starting school.

Mother (aged 29) Well-intentioned but poorly endowed
intellectually. Indulgent.

Family History - Nil relevant.

Background Circumstances

Second-born of 3 children; patient's
elder sister died from spina bifida before he was born. Initial
over-valuation of patient subsequently offset by birth of younger
sister when patient aged $2\frac{1}{2}$ years.

Parental Fears & Prejudices - None.

History of Coercive Toilet Training - None.

Present Condition

Has remained trouble-free since
leaving hospital 18 months ago.

ANALYSIS OF CASE MATERIALWITHCOMPARISON BETWEEN PRIMARY AND CONTROL GROUPS.1) Age at Onset of Symptoms.

a) Primary Series.

In 29 cases, the onset of symptoms occurred during the first three years of life. In the remaining case, the age at onset was four years. 15 cases presented symptoms by the age of 12 months.

b) Control Group.

These were matched so far as possible to provide a comparable age range for onset of symptoms. Ages varied from 9 months to 4 years 9 months, but with the exception of 2 cases, none of the group had attained the age of 4 years. 8 cases presented symptoms by the age of 12 months.

2) Sex Distribution

a) Primary Series.	19 males	11 females
b) Control Group.	14 males	7 females

3) Clinical Pattern of the Disorder.

a) Primary Series.

In 25 cases, the bowel disturbance took the form of chronic constipation, with prolonged intervals between bowel actions. There was associated refusal to use the pot or toilet, and subsequent overflow faecal soiling.

7 of these children presented initially with persistence of soiling from infancy, or relapse of soiling following earlier acquisition of bowel control. In all these cases, constipation with secondary faecal overflow, developed subsequently.

Of the remaining 5 cases, 4 children presented as pseudo-diarrhoea, found to have a basis of underlying obstipation. (Cases No. 12, 14, 16, 18). One case (27), referred at an early stage, showed persistent constipation with refusal to defaecate, but no overflow soiling.

With the exception of this child, every case in the series showed some degree of abdominal distension, with faecal masses palpable through the anterior abdominal wall, loading of rectum with retained faeces, and peri-anal staining or dermatitis.

b) Control Group.

In 18 of the 21 cases, the disorder took the form of spasmodic abdominal pain or colic, with or without vomiting, and associated with constipation. Duration of symptoms had varied from 6 hours to 7 days.

6 of these children had been referred for suspected intussusception; 2 for suspected appendicitis; one as unspecified intestinal obstruction; and one as suspected Hirschsprung's disease, because of a previous history of recurrent constipation since birth.

Of the remaining 3 cases, one was referred because of constipation of 11 months duration, with blood-streaked faeces, and the presence of a small anal fissure; one presented with pain on defaecation of 3 months duration, with consequent refusal to defaecate; and one presented with fear of defaecation and resulting constipation, of 18 months duration, following painful circumcision.

In 15 cases, the rectum was loaded with retained faeces at examination, and faecal masses were palpable abdominally in 7 of these. There was no soiling.

No organic basis could be found for the symptoms in any of the group (apart from secondary anal fissure in one instance), and a final diagnosis of uncomplicated constipation was made in each case.

4) Radiographic Findings.

a) Primary Series.

Barium enema was performed upon 14 of the series. In each case, it provided evidence of megacolon, associated in some instances with redundancy of pelvic loops of colon.

b) Control Group.

4 cases were investigated with X-ray of abdomen, 2 of them by barium enema. Radiographic findings in each were normal, with no evidence of megacolon.

5) Response to Standard Treatment.

a) Primary Series.

All 30 cases had been variously treated by laxatives, suppositories, enemata, bowel washouts, or rigid training procedures. In no case had any of these measures produced sustained resolution of symptoms. Among the 18 children treated as in-patients, relapse had occurred in all, (and in some cases repeatedly), shortly after discharge from hospital.

b) Control Group

In all 21 cases, response to treatment by enemata, with or without subsequent laxatives, proved satisfactory and sustained, with no instance of subsequent relapse. Remission of symptoms has now been maintained for periods ranging from 6 months to almost 6 years, depending on the length of time since discharge from hospital.

6) Parental Personality Structure.

a) Primary Series

In 19 cases (63%), the personality of parent, or adult responsible for the child's upbringing, was assessed as primarily obsessive and perfectionist in type, or as rigid, strict or domineering. All showed evidence of strong determination, with insistence upon conforming behaviour from the child. Most showed evidence of secondary anxiety. These personality characteristics were present in 12 mothers, 3 fathers, 2 maternal grandmothers, and 2 nursemaids.

In a further 9 cases (30%), the maternal personality was assessed as primarily overanxious in type, with marked emotional tension and fearful pre-occupation.

b) Control Group

Neither of these personality variants was observed among the parents of any child in the control group. The restriction of activity imposed upon Case No. VIII in the group, was due to enforced sharing of accommodation with elderly grandparents, who were not intolerant by personality.

7) History of Coercive Toilet Training.

a) Primary Series

In all cases, parents had resorted to coercive training procedures secondary to the persistence of the child's bowel disorder.

In 17 cases (57%), there was a well-established history of primary coercive training in bowel habit, instituted during the first 12 months of life. Motivation for this procedure in 13 cases was obsessional rigidity in the parent or responsible adult. In the remaining 4 cases, the procedure was prompted by maternal anxiety to promote regularity of bowel function.

b) Control Group

No history of coercive toilet training was elicited for any of the control group.

8) Parental Fears, Prejudices & Misconceptions relating to disordered bowel function.

a) Primary Series

Universal concern over the implications of the disorder was aroused in parents secondary to the persistence of the child's symptoms.

In 22 cases (73%), pre-existing convictions were held by one or other parent (or responsible adult) relating to the harmful effects of constipation. The most commonly recurring were the fallacy of the stool's poisonous effects if retained in the bowel (auto-toxicity); fears of "bowel stoppage", "bowel weakness", "twisted bowel", or "dropped seat" (rectal prolapse); fear of appendicitis or convulsions.

In a few instances, specific fears were induced in the parent by special antecedent circumstances peculiar to their own experience.

In 13 cases (43%), the symptom of soiling evoked undue revulsion or disgust in one or other parent (chiefly the obsessional personality type).

b) Control Group

Evidence for the existence of comparable fears or prejudices among the parents of the control group was confined to one case (5%), in which the maternal grandmother entertained such fears (Case XIX). In case XIV, the history of intussusception in the mother during her own infancy, had not aroused her anxiety over similar symptoms in her child.

9) Antecedent Environmental Circumstances surrounding onset of the Disorder.

a) Primary Series

In 18 cases (60%), there was clear evidence of overvaluation of the child emotionally by the parents - usually the mother. In 5 of these cases, this was due to difficulties over conceiving the child, or to subsequent pre-natal, natal or neo-natal morbidity. In 6 cases, it arose from the patient's status as an only child, or virtually an only child, because of the prolonged interval since the birth of older siblings. The death or serious illness of a previous child in infancy, induced an attitude of parental overprotection in 2 cases. Compensatory oversolicitude was evident in 3 cases, exhibited by those mothers who had rejected the child before birth, because it was unwanted or illegitimate, and had later experienced reactive feelings of guilt. There were 2 instances of excessive emotional investment in the child by the mother, to compensate for her own emotional deprivation through marital disharmony.

This factor of overvaluation, however engendered, gave rise in turn to excessive parental concern about the child's well-being, and prompted the need for close supervision of his health.

In 2 further cases, jealousy of a rival sibling had evoked strong feelings of resentment in the child, which were active at the time of onset of bowel symptoms.

Thus in 20 cases (67%), circumstances surrounding the child's life situation had significantly affected his management by parents, or influenced the child's own pattern of behaviour, in relation to the subsequent onset of bowel disorder.

b) Control Group

Comparable situations were found among the control cases, several of whom were only children at the relevant time. In two instances, there had been a prolonged interval since the birth of older siblings. One of the group had been an unwanted child; another born following toxæmia of pregnancy.

Despite these findings, parental attitude and handling had remained unaffected in all except 2 cases. In Case No. XXI, the child's emotional value was enhanced following the death of an elder sibling in infancy. In Case No. IV, the patient had been overindulged by the maternal grandparents.

The control group thus yielded 2 examples (10%) of parental overvaluation of the child.

10) Immediate Aetiological Factors.

a) Primary Series

In 8 cases, the bowel disorder originated in simple constipation, assumed to have resulted from such intercurrent factors as pyrexial illness, debilitating systemic disturbance, teething, or change of diet during weaning. Two of these children exhibited a constitutional tendency to infrequent bowel action from infancy.

In 5 cases, fear of defaecation was initially produced by incidental shock or upset associated with bowel action. In 2 cases, there was a related history of emotional trauma resulting from hospitalisation experience.

In the remainder of the series, no history of precipitating factors could be elicited in relation to the onset of the condition.

b) Control Group

Fear of defaecation with resistance to bowel movement, was reported in 2 cases. In Case No. IX, it followed earlier circumcision, with resulting painful micturition. In Case No. II, there was a history of enforced administration of suppositories and an enema.

11) Pattern of Emotional Response in the Child

a) Primary Series

In all 30 cases, there was clinical evidence of a negativistic component in the child's pattern of behaviour, limited to the act of defaecation, or extending to other spheres of conduct in addition. Resistance to defaecation was reported not only from the children who were overtly stubborn-spirited, but from those who presented as fearful, inhibited and insecure (6 cases), and equally from those older children who were superficially compliant in attitude, or veiled in their emotional responses (11 cases).

b) Control Group

Resistance to defaecation was reported in 2 of the group (Cases II & IX), while a further 3 children (Cases V, VIII & X), were assessed as self-willed and obstinate, but not in relation to bowel movement. Some evidence of negativistic tendencies was thus apparent in 25% of control cases, either currently or in relation to the original disorder.

STATISTICAL EVALUATION.

All 51 cases had in common the factor of functionally determined constipation. Standard treatment of the condition was taken to be the independent variable, on the basis of their response to which, the cases could be divided into 2 groups - those who had responded satisfactorily (100% favourable response), who were designated the control group; and those who had failed to respond (100% failure of response) designated the primary series.

Statistical analysis of comparable findings in the respective groups was limited in value, because of the small number of cases involved. Using a Chi-Squared test, with Yates' correction for small numbers, the differences which emerged in the incidence of the following four variables were sufficiently marked to merit consideration.

	<u>Incidence</u>	
	<u>Primary Series</u>	<u>Control Group.</u>
1) Parental personality characterised by excessive rigidity and/or excessive anxiety.	28/30	0/21
2) History of primary coercive toilet training.	17/30	0/21
3) Parental fears and prejudices related to constipation.	22/30	1/21
4) Parental over-valuation of child.	18/30	2/21

For the control group, the absence of excessive parental rigidity or anxiety, the absence of a history of primary coercive toilet training, the very low incidence of parental fears and prejudices concerning constipation, and the low incidence of parental overvaluation, were all shown to be significant statistically at better than the 1% level of confidence, i.e. the probability of these findings being due to chance is less than one in a hundred.

For the primary series, the very high incidence of the parental personality variable proved equally significant at better than the 1% level of confidence, and the high incidence of parental fears and prejudices was significant at just short of the 2% level. The presence of a

history of primary coercive toilet training, and the presence of parental overvaluation were not in themselves sufficiently marked to qualify as significant.

When the 2 sets of results are compared however, the statistical significance of the negative findings in the control group, as contrasted with the positive findings in the primary series, indicates that the two groups are distinct in terms of the four variables on which they were assessed.

It would seem reasonable therefore to ascribe aetiological significance to each of these four factors.

FORMULATION.

From the foregoing analysis of case material, compared with the findings of the control group, the following formulation has been constructed to explain the aetiology of psychogenic megacolon.

The primary mechanism involved is believed to be a state of negativism on the part of the child, expressed as persistent refusal to defaecate, or less frequently, as defiant soiling. If handled unwisely, this may result in cumulative retention of faeces, with progressive loading of rectum and terminal colon, and with subsequent overflow faecal soiling. Ultimately, chronic dilatation of the distal bowel develops, which is demonstrable radiographically. Confirmatory evidence of negativistic trends in the children under study is provided in their clinical assessments.

It is regarded as significant that with one exception in the series, this negativistic pattern developed during the first three years of life. As such, it coincides with the period of resistance (Kanner)(41) or phase of defiance (Menninger)(48) undergone by most children at the stage in their emotional development when they become aware of their independence from the mother as a separate emergent personality. Provocative and testing behaviour towards parents is common during this period, and bowel negativism is one of the acknowledged forms which it may take.

It is indeed so universal a pattern that, in itself, it could hardly represent the entire psychogenesis of the disorder. Moreover, the onset of constipation in the control group, equally coincided with the period of resistance through which some of these children might be assumed to be passing; yet negativism in the control cases, where demonstrable, did not give rise to a degree of bowel disorder commensurate with that found in the primary series. Clearly therefore, additional factors must operate to bring about the differential response between the primary and control groups.

It is contended that anal negativism forms the basis of the disorder, but that it is aggravated or intensified, in appropriate cases, by specific conditioning factors, operative in the primary series to a significantly greater degree than they are operative in the control group. Given a basis of bowel negativism, it is the operation of these contributory factors, with sufficient intensity, or over a sufficiently prolonged period of time, which converts the case into one of psychogenic megacolon. These factors can be classified as pre-disposing, precipitating and perpetuating.

Pre-Disposing Parental Personality.

The two main personality variants found among the parents of the cases under investigation are the primarily perfectionist, rigidly obsessional parent, who seeks to train the child by coercive methods to acquire bowel control at a premature stage in his development, in advance of adequate neuro-muscular maturation; and the primarily over-anxious, oversolicitous parent, whose general attitude to the child is fraught with tension, and who closely supervises his bowel evacuation because of her fears for his well-being.

Pre-Disposing Parental Prejudices and Misconceptions.

Linked with these patterns of emotional makeup in the parent, are certain ingrained misconceptions with which the act of defaecation is still widely invested. These in turn give rise to various fears concerning the allegedly harmful effects of constipation. The overanxious parent is especially prone to such fears.

Equally widespread is the notion of filth which invests the faeces once evacuated. The obsessional and fastidious type of parent is most prone to experience a sense of obnoxiousness regarding the stool, and to imbue the child with an irrational feeling of disgust or shame towards a perfectly natural product of excretion.

The combination of personality type, and parental attitude to defaecation accounts for much of the pressure to which these children are subjected in attempts to promote regular bowel function.

Pre-Disposing Environmental Factors.

In addition, circumstances surrounding the life situation of the child may conspire to generate excessive tension in the parents' attitude towards him, and may provide the motive for excessive attention to his body functions. In the main, the factor involved is emotional overvaluation, which in turn, contributes to excessive parental concern for the child.

Precipitating Stress Factors.

Focal circumstances may provoke the immediate reaction of bowel difficulty against a background of any of the predisposing factors already discussed. They include fear of defaecation, resulting from accidental fright during bowel action. While such precipitating events may induce temporary inhibition of stool, it is doubtful whether the effect ever persists and becomes chronic, in the absence of predisposing factors already operating.

Similarly, although the disorder began as simple constipation, due to intercurrent factors, in 8 of the primary series, it required the introduction of additional factors to elaborate the disorder into one of major

bowel disturbance. It is significant that this did not take place in the control group, with an equivalent basis of simple constipation.

Perpetuating Factors.

Excessive parental anxiety, alone or combined with excessive parental rigidity, will continue to operate if the initial response by the child is unsatisfactory, and his disorder fails to resolve with standard treatment. In these circumstances, persisting parental tension will act as a perpetuating factor, enhanced in most cases by the fears and misconceptions already present, and augmented in some cases by the child's excessive emotional value.

Continuing obstipation may give rise to anal spasm, secondary anal fissure, rectal prolapse, or peri-anal dermatitis, any of which may perpetuate the disorder through the resulting pain on defaecation.

A further perpetuating factor may be the child's own reaction of anxiety and guilt, in face of the persisting symptoms, or in response to parental attitudes of censure or ostracism.

It is contended that the interaction of these several contributory factors, is responsible for initially evoking the child's resistance in the sphere of bowel function, and for subsequently elaborating the negativistic response to the stage of development of psychogenic megacolon.

Confirmation of this hypothesis was sought through its application to the programme of treatment now to be described.

TREATMENTPrinciples of Psychotherapeutic Approach.

Treatment was conducted in six stages.

- 1) Preliminary orientation of parental attitude, towards conceiving the problem as a total one of parent/child conflict, in place of the original symptomatic approach directed only at the local presenting disorder.
- 2) Dispersal of parental fears, prejudices and superstitions relating to disordered bowel function. This involved powerful and repeated reassurance to parents that no harm would result from persistence of the constipation, beyond local discomfort, and that no organic bowel lesion was present, or would develop.
- 3) The promotion of parental insight, to the degree that parents came to understand their child's symptoms as a negativistic pattern of reaction, either to their excessive rigidity, or to their excessive anxiety, or both, in handling him.
- 4) The cultivation, in consequence, of a modified parental approach and attitude towards the child; parents were induced to develop studied disinterest in, and withdrawal from conflict over the child's presenting symptoms, in order to divest these symptoms of their formerly excessive emotional value.
- 5) The adaptation of individual treatment with parents to a method of group therapy.
- 6) Direct therapeutic procedures with the child. These involved removal from home to hospital, temporarily, for initial rehabilitation; or the institution of expressive play therapy designed to unburden the child emotionally, i.e. treatment with the child rather than on his behalf. Such measures were indicated where withdrawal of parental pressure proved unsuccessful, or was not in itself sufficient to offset the chronicity of symptoms.

1) Preliminary Orientation of Parental Attitude.

Treatment was first directed at convincing the parents that what had formerly been regarded as a physical disorder, was in fact of emotional origin; and that in consequence, it was necessary to substitute psychological methods of treatment for the local treatment measures hitherto adopted.

Some parents misinterpreted this preliminary explanation. They protested that their child was not mentally disturbed, or expressed anxiety that this had been inferred. Parental reactions ranged from frank incredulity, through hostile resistance by obsessional parents, or increased concern by overanxious parents, to simple failure, on the part of intellectually limited mothers, to appreciate the relationship at all. In these latter, an authoritative approach was the only course practicable.

With the more intelligent parents, fortunately the majority in the present series, it proved possible after 2 to 3 interviews, to inculcate this new concept, but with certain reservations on their part. One of the difficulties was the implication that they themselves were intimately involved in the child's pattern of reaction, and that henceforth, treatment was to be directed away from the presenting symptoms, and to be conducted predominantly through them. In 2 of the cases (Nos. 29, 30), the maternal anxiety aroused by this implication proved too great for acceptance, and both cases were withdrawn from further attendance.

2) Dispersal of Parental Fears and Prejudices.

In every case, acute parental concern was felt about the potential danger to the child's physical health as a result of his bowel disorder. In 22 cases, this alarm was founded upon previously held convictions, now exaggerated through failure of the child's symptoms to respond to routine treatment. In the remaining 8 cases, it had developed secondarily to the child's disorder, but was no less acute. Parents of predominantly rigid personality were as much beset by these fears as those who were primarily overanxious.

The task of reassurance was hindered, in the majority of cases, by advice or instruction about the importance of bowel regularity, previously tendered by district nurses, health visitors, child welfare clinic staff, hospital medical and nursing staff, or the family doctor. Commercial advertising about laxatives, and books dealing with child care, had also helped to augment parental fears. The difficulty encountered in combating these fears is exemplified by Case No. 2. Here the parents had been informed by a senior surgeon that operation was necessary to cure the child (partial colectomy). They proved profoundly resistant to subsequent psychotherapeutic approach.

To overcome this attitude, and to dispel parental misgivings, certain procedures proved valuable:-

- a) Parents were initially interviewed, so far as possible, in joint consultation with one of two paediatric colleagues who subscribed to the tenability of the psychiatric approach. Some of the cases were in fact

referred by these same paediatricians, and continuity in treatment was thereby preserved. This combined approach was based on the principle that parents were more likely to accept reassurance from an acknowledged specialist in the organic field of children's diseases, whose authority they could less easily question.

- b) The reassurance given required to be unequivocal and authoritative. It was necessary to repeat it until no vestige of doubt or misgiving remained in the mind of the parent. Vague or generalised advice only served to heighten parental anxiety. It was important to stress that no organic disease or abnormality of the bowel was present, and that no harmful results would develop from persistence of the constipation.
- c) Parental acceptance was facilitated by explanation of the physiology of gastro-intestinal function, couched in simple, non-technical terms, and designed to dispel traditional fears of auto-intoxication, "twisted bowel", "bowel stoppage", "convulsions", and the like. With the more intelligent parents, experimental evidence (6) was quoted to discount the fallacy of auto-toxicity. In every case, it was valuable to cite the example of previous patients successfully treated by a policy of ignoring the constipation. Where necessary, reassurance was given that spontaneous bowel function would be restored despite the "stretching" of the lower bowel; that the child's rectal sensation had not been irrevocably lost; or that his wriggling and contortions did not indicate difficulty in expelling the faeces, but on the contrary, his attempt to retain them. Fears about anal fissure, rectal bleeding, rectal prolapse, were similarly dealt with.
- It was important to explain the soiling in terms of overflow from the loaded bowel, giving simple mechanical analogies where necessary. This served to allay the concern encountered among overanxious parents, about the implications of faecal incontinence, and to counter the punitive attitude of rigid and perfectionist parents who viewed the soiling as "a degrading habit" or as "naughtiness".
- At this point, the limitations and dangers of excessive purgation were emphasised. It was explained that this served no useful purpose at the present stage, it might further impair bowel function, and was likely only to increase the soiling.
- d) Dogmatic reassurance, though essential, proved to have no lasting benefit per se, save in the case of parents who were limited in intellectual endowment. The 4 mothers concerned (Cases Nos. 7, 18, 23, 24), were all of overanxious rather than obsessional personality. They were not capable

of appreciating detailed physiological explanations, and for them, didactic instruction was sufficiently convincing.

With the remainder however, it was important to supplement reassurance by encouraging parents to air freely their own beliefs and convictions before attempting to explode such theories. If didactic explanations were offered prematurely, parents tended to preserve their private views. Repeatedly, there was evidence that advice formerly given by the paediatrician, in terms which he believed left no room for misinterpretation, had not in fact registered with the parents as such. It proved imperative to determine by supplementary questions how much of this had been absorbed, and to reinforce repeatedly those points which had not been understood or accepted adequately. Interpretative reassurance could not be overemphasised, reiterated too often, or confirmed too insistently to ensure that it had been genuinely credited by the parent.

- e) It was essential that medical advice should be consistent. If for example, parents were being advised to ignore the child's constipation, it was important to support this counsel by withdrawing laxative therapy, or such physical measures of treatment as were still perhaps being continued. Otherwise, parents reasoned that if no danger was anticipated from permitting the constipation to persist untreated, why the need for maintaining laxatives?

Winnicott (75) has referred to the need for "symptom tolerance" in child psychiatric cases which present with physical symptoms. There is an understandable tendency among paediatricians to treat and remove presenting symptoms by direct approach, as early as possible in the course of the disorder; whereas the discipline of child psychiatry advocates the frequent need for toleration of symptoms, while basic treatment is directed at the underlying causative emotional factors.

This differential attitude, derived from the difference in training between paediatrician and child psychiatrist, is exemplified in the treatment approach to the present series of cases. Even among those paediatricians who subscribe to the psychiatric viewpoint, there was a tendency "to make quite sure" by continuing standard treatment measures parallel with psychotherapy; or a desire to resolve the disorder more rapidly by utilising both methods of treatment together. They were intolerant to the persistence of symptoms.

This practice is however exposed to two risks. First, there is the risk of misinterpretation by parents who regard it as evidence that the medical advisor himself lacks confidence in the policy of suspending physical and medicinal measures. Their confidence is correspondingly undermined. Secondly, the maintenance of standard treatment measures conveys to the child that emotional investment in his

symptoms has not been withdrawn, and his motive for persisting in his negativistic behaviour is thus given fresh impetus.

For these two reasons, standard treatment procedures, apart from upkeep of adequate fluid intake, require to be suspended.

- f) In the last analysis, the successful allayment of parental anxiety depended upon the degree to which parents could be encouraged to vest responsibility in the therapist for the persistence of the disorder, and for any repercussions which might ensue from the treatment now advocated. Once this had been achieved, parental feelings of guilt could be dealt with and resolved. Parents no longer felt a sense of blame at their failure to "cure" the child or "train" him. However hazardous the policy of non-intervention might appear, or however tenacious their convictions about the "evils of constipation", if absolute support was forthcoming, they were ultimately prepared to cooperate. This transfer of responsibility from parent to therapist, was therefore a necessary pre-requisite to the next stage of treatment.

3) Promotion of Parental Insight.

It was equally important to avoid premature explanation of the emotional dynamics of the disorder, in advance of the mother's state of preparedness to accept it. The more effective policy was to withhold such interpretation until parents had disclosed their own resistances and preconceived opinions.

Having first assured them that there was no physical basis to the disorder, suggestions were put to them along the following lines. If there was no organic reason to prevent the child opening his bowels, why did he continue to hold back? It was obviously causing him discomfort and pain to resist bowel action, therefore presumably he must be deriving some compensatory gain. What might his motive be?

By such provocative suggestions, parents were stimulated to enlarge their concept of the disorder to include the possibility of emotional motivation, and to appreciate how the child's behaviour could conceivably be directed against them.

It was explained to them in general terms, that young children often tried to even out the unequal balance between their own puny power and what appeared to them as the overwhelming authority of parents. They could not defy this authority directly, but they often sought to do so indirectly, by becoming obstinate and contrary in any sphere of behaviour which they sensed might upset their parents. The more concern shown over this conduct, the more they tended to persist with it. This was emphasised as an entirely normal, and almost universal pattern of behaviour, and parents must not feel therefore that they were necessarily to blame because of its development in the case of their child. They had simply made the

the

mistake of continuing to register excessive concern which the child had been quick to sense.

Broad examples were given of patterns of negativistic response among young children in other spheres of primary habit formation, notably eating and sleeping habits. But wherever possible, parents were encouraged to apply the analogy by their own effort of reasoning to the case of their child. Only then was it endorsed by the therapist. Following acceptance of the basic concept, it was possible to explain to the mother the contribution made in her case by such attendant factors as previous overvaluation of the child, excessive attention to toilet training, excessive demands upon his behaviour, or undue concern about constipation.

4) Modification of Parental Attitude.

Parents were now sufficiently receptive to cooperate in reversing their former attitude to the child's bowel function. They were advised to practice complete indifference towards the persistence of symptoms. No further mention must be made of the need for bowel movement, and no censure must be shown towards continued soiling. This was a difficult assignment for the mother. It meant in effect, a policy of ignoring the symptoms, in place of her former policy of agitated exhortation. Only confidence in the therapist and the knowledge of being absolved from responsibility should anything go wrong, made it possible for her to pursue it.

The following analogy was found useful in explaining to parents the need for altered handling of the child. They were invited to imagine that they were shopping in a city market, where the principle of bargaining over the price of articles was an accepted practice. A particular article appealed to them but the initial price asked was too high. If the stallholder were allowed to suspect their keenness to acquire the article, he would be most unlikely to lower his price. The only approach calculated to induce him to sell more cheaply would surely be a pretence of indifference.

Once the moral of this or a similar analogy had been understood, the mother was shown its application to the immediate problem of her own child's bowel negativism. The stallholder was analogous to the child, and the "article" he was "selling" was in effect his compliance over bowel action. So long as he felt that his mother, as the prospective "customer" was vitally interested in his "article", he would hardly comply without a show of resistance, once his negativism had been aroused. The only approach likely to succeed was genuine withdrawal, by the mother, of her former excessive investment in the disorder - genuine, because pretence is readily detected by the child and would merely confirm him in his obstinate attitude. As soon as he believed that the "customer" was really disinterested in whether or not he defaecated or whether or not he soiled, he might be prepared to "lower his price" or relinquish his negativism. There would be no point in submitting to continued discomfort or ostracism, since there was no further prospect of compensatory "scoring off mother".

In practice, the successful prosecution of this approach by parents, where they were capable of adopting it, produced the desired result.

A frequent sequel however was the transfer of the child's negativism to some alternative sphere of conduct. Deprived of the focus of parental concern over his bowel symptoms, he might first attempt to re-establish his position by intensifying his references to his own bowel activity. For example, several children resorted to repeated demands to be helped in their toilet procedure. They would follow mother round the house, insisting that she flush the toilet for them or unfasten their trousers, or in some similar way supervise their act of defaecation. Parents were instructed in advance to ignore all such overtures and to adhere strictly to their attitude of disinterest.

Balked in this sphere, the child might then adopt provocative behaviour as an alternative. He might become increasingly disobedient, or aggressive, or gratuitously destructive, with the clear object of testing out the realignment in parental handling. Parents were cautioned about the probability of such developments and their significance. They were reassured that if they remained unconcerned, this new pattern of reaction would be short-lived.

Finally, modification of parental attitude was extended to the total sphere of parent/child relationship. Parents were induced to appreciate that their child's bowel negativism represented only one aspect of the conflict which had arisen in their relationship with him. In the case of obsessional or perfectionist parents, it was important to have them lower the criteria formerly set for the child, and scale down the excessive demands hitherto made upon him. In the case of anxiety-ridden parents, the treatment indication was to promote emancipation of the child from parental oversolicitude and overprotection.

The aim in both instances was to secure more freedom of self-expression, and allow the child more scope for independent emotional development.

5) Group Therapy with Parents.

In the great majority of cases, therapy was conducted predominantly through the parents, chiefly through the mother. In the course of formulating the psychiatric treatment approach to cases in the present series, a scheme was evolved for treating mothers by group therapy. 15 cases were handled by this method.

Group leaders were chosen from among those mothers who had achieved the greatest depth of insight, who expressed enthusiastic support for the psychiatric viewpoint, and who were endowed with adequate talents for disseminating the principles they had themselves absorbed.

Four mothers emerged from the series as best suited for this purpose, and willing to cooperate (Cases No. 2, 3, 16, 1). Each in turn formed the nucleus of a group of 8 mothers, the constituent membership of which changed from time to time, as earlier cases acquired insight, and dropped out, to be replaced by new cases. The group leadership similarly changed as a new leader came forward.

Group meetings were convened at regular weekly intervals, for periods of $1\frac{1}{2}$ hours, under the general chairmanship of the therapist. His chief role was to supervise and guide the discussion, but to remain so far as possible unobtrusive. He sought to promote free interchange of views between the older and more recent members, prompted by the group leader.

Considerable support was derived by new members through introduction to the group. Each in turn was relieved to find other mothers in similar straits, and having to cope with identical problems. Prejudices, doubts, resistances and fears, were more readily resolved within the group, and the acquisition of insight was more readily promoted. Repeatedly, sceptical and insecure mothers showed more willingness to accept reassurance, and advice about their problem, from the older members of the group than from the therapist direct. The evidence of success achieved by the psychiatric approach in earlier cases, and now placed concretely before the new case by the mothers in question, was a potent therapeutic instrument.

As an extension of this method, and upon the suggestion of group members themselves, a smaller group of fathers was formed, with a membership of 4. The father of case No. 2, a Headmaster and a most capable personality, was appointed group leader. Useful work was achieved on a limited scale in helping to realign the paternal attitudes in case No. 6, and case No. 9. Significantly the father of case No. 11, a self-opiniated disciplinarian, was rounded upon by the other three members, for his failure to entertain a more enlightened approach. His reluctance to modify his attitude finally brought about the dissolution of the fathers' group.

The therapeutic influence exerted by the larger and more stable group of mothers, upon its constituent members, was a factor additional to the direct influence exerted by the therapist during individual treatment. It thus contributed to the successful prosecution of the psychiatric approach.

6) Direct Therapeutic Procedures With the Patient.

a) Admission to Hospital.

In 9 cases, it proved necessary to admit or re-admit the child to hospital for varying periods under supervision of the therapist. With 4 of these children, all products of maternal anxiety, (Cases 7, 22, 23, 24), the mother's response to reassurance had not been sustained, or she was too limited in intellect to benefit from guidance, without some concrete demonstration of how to manage the child.

In a further 3 cases (4, 13, 25), carping parental pressure, or excessive domination of the child were most effectively curtailed by temporary removal of the patient from home.

In the absence of separate in-patient facilities, all 7 cases were individually admitted to a general

paediatric ward. The nursing staff were prompted to adopt an attitude of bland detachment towards the persistence of bowel symptoms, and equally to ignore any associated symptoms, such as refusal to eat, temper tantrums or emotional withdrawal. The child was treated warmly and with tolerance, but with avoidance of fussing.

In the former 4 cases, the children responded rapidly to consistent and detached handling. They readily adjusted to ward routine, with restoration of spontaneity and regularity in bowel function, after a short interval. The parents were seen regularly during this period, and the success of the ward approach emphasised to them. Subsequent supportive treatment depended upon the practical example set by managing the child in hospital.

In the latter 3 cases, the patient's response was slower, and they required to remain in hospital for correspondingly longer periods. Ultimately, emancipation of the child was achieved from formerly restrictive parental pressure, and they responded with increasing stabilisation and re-establishment of normal bowel function.

In case No. 4, the problem was one of chronic overindulgence and sheltering by an overprotective, domineering grandmother, with resulting gross immaturity in the boy. The programme of hospital rehabilitation in this case involved promoting the child's emotional development and maturation over a period of three months, through the active participation of the nursing staff, guided by the therapist. It was necessary to foster a suitable ward environment in which the boy was encouraged to become increasingly self-reliant and independent. Concurrently, promotion of maternal insight was procured by regular clinic attendance, in preparation for the patient's return home.

In those 7 cases, no expressive play-therapy was practised with the child. Treatment essentially comprised placing the patient in a temporary residential environment designed to counteract pre-existing influences, and to achieve resolution of symptoms by engineering a suitable atmosphere.

In the 2 remaining cases (10 & 11), admission to hospital was arranged, not as an end in itself, but as a preliminary step. Both these children were markedly unresponsive, inured to their symptoms, and superficially indifferent to all treatment approaches. It was suspected that their facade of withdrawal masked considerable underlying aggression, but that no effective release and discharge of their hostility would be achieved while they remained at home.

In both cases, the deliberate adoption of a permissive attitude by the nursing staff in hospital, ultimately achieved the desired effect of encouraging them to express their inhibited emotions overtly, so providing an avenue of approach to direct psychotherapy with them.

After some 3 months, a stage was reached at which, in each case, the child's provocative behaviour became so marked that it was no longer practicable to retain him

in the paediatric setting. At this point, he was discharged home and further treatment, by expressive play-therapy, was continued as an out-patient. Initial placement in hospital, with appropriate handling, had served to overcome the child's defensive barrier and had permitted adequate depth of contact with him as a necessary pre-requisite to subsequent procedures.

b) Expressive Play Therapy.

Direct psychotherapy, as distinct from environmental manipulation, was instituted in 7 cases. It became necessary for cases No. 10 & 11, as explained, because of the chronicity and entrenchment of symptoms, with overlying bland facade. A similar indication applied to cases No. 5, 9 & 12.

With the remaining 2 cases (8 & 26), the pattern of emotional reaction was different. These two children were grossly inhibited, fearful and insecure, with overt evidence of anxiety. They were equally in need of direct therapeutic help.

A further important indication for direct intervention with the child, in 4 of the cases, was the unresponsive attitude of their parents to psychotherapeutic guidance, their failure to acquire insight, or the persistence of parental intolerance and rejection.

The aims of treatment were

1) to penetrate the child's defensive facade and establish adequate depth of contact with him, 2) to define his fundamental problem for him, through the medium of projective play techniques, 3) to promote the working through of his difficulties, with associated release of pent up hostility during play, and 4) to restore his emotional stability following resolution of those difficulties.

3 main techniques were employed.

1) The sand tray, using dry or wet sand, according to the patient's choice, in which he was invited to portray scenes of his own invention by introducing miniature toy figures representative of everyday objects. A wide variety of these figures was presented, housed in an open cabinet, and grouped in appropriate trays.

They included wild and tame animals; guns, cannon, bombing aeroplanes, tanks and other symbols of aggression; cars, buses, trains and ships, traffic signs; cowboys, indians, and robbers, policemen, soldiers; human dolls signifying family figures - mother, father, siblings, grandparents, baby; houses, buildings, household and farmyard effects, trees; symbols of restraining influence, such as fences, cages and railings; school and hospital equipment, nurses, ambulances.

The child was allowed a free selection from the figures available, with which to create what his phantasy dictated in the sand tray. He could, if he so wished, ignore the toys and confine his play to manipulation of the sand and water alone.

2) Drawing on paper, with free choice of subject, using thick pencil crayons.

3) The combination of expressive drawing with a device known as the Aggression Board. This apparatus was evolved by Meals & Summerskill (47) as a technique for diverting hostility in children under treatment. It consists of a sheet of thin plywood (3 ft. x 4½ ft.) held in a thicker frame and supported behind by a hinged brace which fits into a thick wooden base on the floor. In the plywood sheet, a square hole (8" x 8") has been cut out in the lower half. The brace supports the plywood at an angle of 45 degrees, facing the child, with the top of the board inclined away from him (Appendix II Plate 1).

In the present work, the apparatus was used by inviting the child to make a drawing on a large sheet of paper of something he particularly disliked. No other limitation was imposed. The paper was then taped across the aperture in the plywood board, so as to cover the hole. Facing the board, at a distance of 4 to 5 yards, the child was provided with 12 bean bags, and encouraged to throw these, one after the other, at the picture over the opening. If he struck the target, the taut paper was ripped by the impact; if he missed the drawing, the bean-bag hit the surrounding plywood with a resounding noise, obviously satisfying to the child.

The more inhibited children (Cases 8 & 26), were unwilling to use the apparatus, and showed fear when it was demonstrated. With the remaining cases, it proved both diagnostic and therapeutic in value. The subject matter drawn by the child, as an object of his dislike, provided diagnostic information; his treatment of the drawing permitted therapeutic release of his aggressive feelings.

The detailed programme of therapy adopted with each child, in the working through of his emotional difficulties, is exemplified by case No. 9.

This boy of 9 was initially polite, compliant, but detached. He showed marked aversion to messy play at first, and declined to use the aggression board. He chose to work with clean dry sand in which his first portrayal was a representation of a zoo. This was neatly laid out in the tray with the wild animals carefully enclosed in cages (Appendix II Plate 2).

It was explained to him that we often thought in terms of pictures. All of us had strong feelings about which we were not very sure. One way of dealing with these feelings inside of us was to fence them in, much like the dangerous beasts in his zoo, so that we could feel safe. The trouble was, that our private feelings sometimes would not behave by being shut away like this. They had a way of coming out when we least expected them to show, and then we could no longer control them. Perhaps he had felt like this at some time. If so, the therapist understood, and would try to help him to sort out these strong feelings so that he had no need to shut them away any longer. He was not pressed to make any comment.

For the next three weeks, he indulged in a pattern of meticulous "safe" play, in the dry sand, depicting neutral landscapes which showed no activity, and avoiding further symbols of aggression.

On his fifth visit, he elected to use the wet sand tray. He constructed islands of messy sand, using a spade to avoid dirtying his hands. These islands were manned by armed soldiers, who were firing at crocodiles infesting the surrounding water, to ward them off. The child became animated in his play, and engineered much activity. The attacking crocodiles were finally driven off (Appendix II Plate 3).

This was his first contact with messy material in the playroom, and the first occasion on which he showed animation. The emergence of uncontrolled aggression requiring vigorous counter-measures, was in contrast to his earlier portrayal of controlled or fenced-in aggression. No interpretation was offered at this stage.

During his next few visits, he retired to clean play in dry sand, avoiding aggressive subjects as if afraid of their implication. He returned to the messy tray during his 11th visit, tentatively assembled some toy figures to place in the sand, and then abandoned the toys and the spade in favour of working in the wet sand with his bare hands. His activity was unstructured and characteristic of a much younger child. He was uninhibited and clearly enjoying the experience, in the atmosphere of tolerance created by the therapist (Appendix II Plate 4).

Comment was confined to assuring him that we all like to do things like this sometimes, and it was fun just to handle the messy sand. His regression to an immature level of play, without any sense of restriction or embarrassment, was regarded as a definite therapeutic advance. It continued during several more sessions.

At his 16th visit, the boy again elected to people the sand tray with toy figures. The central feature of this portrayal was a cowboy trapped between two tigers. They are advancing menacingly and the cowboy fears he will fall victim to one or other. Someone is coming to the rescue, but it is doubtful if he will get there in time. The child concentrated on this section of the tray, but left the issue undetermined. He could not say whether the cowboy is saved or not. (Appendix II Plate 5).

Advantage was taken of this material to refer obliquely to the problem of nagging parents, and how they kept on at a child until he felt almost like the cowboy. Only in this case, it was like being caught between two angry people instead of two wild animals. It was as much use reasoning with parents when they behaved like that, as it was trying to argue with the tigers. A flicker of response indicated the patient's acknowledgment of the analogy.

For the first time, reference was made to how trying parents could be in making children attend the toilet. If they nagged too much, the child could get even with them by not performing when he did attend. Parents could not make him open his bowels however angry they became. On the other hand, it must be uncomfortable for such children to hold out. Sooner or later, the bowel got too full, and then some of the motion leaked out, and it was unpleasant. If one made a stand, one had to adhere to it, but children really liked their parents, however annoyed they might feel towards them.

Perhaps if one could get rid of this angry feeling, one would feel better. It might be a good thing to let these feelings out rather than keep bottling them up inside, like caged animals.

One could hardly let them come right out for parents to see, because they probably wouldn't understand, and it might only make things worse, but there were safer ways of removing these strong feelings, and the therapist could show them to the child, if he wanted to know about them. Perhaps the therapist was like the person coming to the rescue of the cowboy trapped by the tigers.

The patient showed keen interest in this discussion. He conceded that his own position was similar to the difficulties described and he would like to be helped.

During successive sessions, he was introduced to the aggression-board. He was invited to make a drawing of anything he particularly disliked. It would be taped over the hole in the board, and he could then let his feelings out on it with the bean-bags. He drew a series of crudely executed female faces, fearsome in appearance, which he then destroyed on the board by accurate throwing of the bags. This activity was accompanied by much show of aggression. He did not portray any male figure. No reference was made to the possible identity of the female faces.

At his 21st visit, he drew a picture of a child being given an enema by a nurse in hospital. This received the same aggressive treatment. He agreed that he "felt better inside" (Appendix II Plate 6).

The release of underlying hostility in this way coincided with a phase of increased frequency in soiling at home, which the mother was cautioned in advance to anticipate, and which she handled with detachment.

This discharge of aggressive feelings reached its peak during the next three sessions. The child now ignored the aggression board, and reverted to messy play with sand and water. He began to throw handfuls of wet sand violently against the walls and ceiling of the playroom, shouting repeatedly "This is how you give an enema". He repeated this play with intense feeling on 3 visits. He was assured that it was nice to have a place where you could "let yourself go" without fear of censure, and without doing any harm to anyone (Appendix II Plate 7).

On his 25th visit, he was more controlled and mature in his play. He chose the dry sand tray, in which he again portrayed a zoo. Now however, the wild animals were moving about quite freely in the open, while the visitors were watching them from behind the railings (Appendix II Plate 8).

He was reminded of his first zoo, and it was pointed out that the animals, formerly caged in, had now been allowed out into the open, for all to see, but yet they were not harming anyone. They were rather like his strong feelings, which he had formerly tried to shut away, but which he had now brought out into the open, without upsetting

anyone. The reversal of theme depicted in this material, in contrast to his original portrayal, was regarded as significant of his improved emotional state.

At present, his mother reports increasing restoration of spontaneous bowel action, with decrease in the frequency and extent of soiling. She has noted his more animated and responsive behaviour and now feels optimistic about the outcome. Treatment will be continued until full resolution of symptoms has been achieved, but it is felt that the prognosis is favourable, and that response to treatment by both child and parent has been satisfactory.

Parallel sequences in treatment occurred in case No. 11. At an early stage, he portrayed a scene dominated by a "hill" of messy sand. He took infinite pains over moulding this soft round mass, working the wet sand by hand, with obvious satisfaction. In contrast, he then constructed a road running across the tray and ending blindly at its edge in a roundabout from which there was no forward exit. He assembled a large array of traffic signals (safety symbols) with which he lined the road indiscriminately. Finally, he placed a bus in the terminal roundabout. The highway was otherwise devoid of traffic. (Appendix II Plate 9).

He explained that the bus was quite safe where he had placed it. It could not get out, except to come back along the road (lined with traffic signals).

The implication of this material was that the boy had clearly derived pleasure from his initial "anal" play, but had then reverted to play in which aggressive manifestations were severely controlled. It was as if he had felt uncomfortable through his originally uninhibited work, and had then retreated from his aggressive feelings by erecting a series of defences. The solitary bus was "quite safe" because of the layout of his road, the cul-de-sac, and the restrictive traffic signals arrayed in its path.

After transfer to the aggression board, at a later stage in treatment, he drew, as a subject of dislike, the picture of a child having an enema administered by a nurse. The nurse, menacing in appearance, is saying "I've never known anyone so rude. I'll give you another enema for that". The child, though sobbing, replies spiritedly "I'll give you an enema, you darned pest". Treatment of this drawing was vigorously destructive with bean-bags. (Appendix II Plate 10).

This theme was repeated at a subsequent session, during which the child threw handfuls of wet sand violently against the target, in addition to using the bean-bags. His aggressive feelings were by now at their height of frank expression (Appendix II Plate 11).

Nevertheless, the verbal exchange between nurse and child in this later version, is more conciliatory. The nurse, who no longer looks fierce, is saying "I'm sorry to have to do it". The child openly concedes his discomfort ("Boo hoo this hurts") but acknowledges the nurse's overture by replying "I know; tomorrow I will call you nursie". (Appendix II Plate 12).

This conciliatory trend was reflected in the patient's increasing stabilisation and the reduced intensity of provocative behaviour at home.

Clinical improvement was confirmed by his subsequent work in the sand tray. He constructed an elaborate network of bridges, tunnels, and roads, but now all the roads lead somewhere, more traffic is introduced (cars and train) and his traffic signals are all used meaningfully and appropriately. He also introduced pedestrians crossing the road at the zebra crossing to the bottom right of the tray. (Appendix II Plate 13).

The child's obvious pleasure in manipulating the wet sand to construct his tunnelling, signified continuing preoccupation with "anal" play. While this still evokes some anxiety, he can now handle his aggressive feelings more constructively, in contrast to the earlier portrayal, where safety symbols were employed to excess. Now he uses the same symbols appropriately, there is positive flow of traffic, and people appear, though they must be protected by means of a zebra crossing.

Both the children described had erected a facade of detachment and apparent unconcern which it was necessary to penetrate before achieving any depth of response in treatment. In the latter case (No. 11) frankly negative behaviour had been induced by preliminary conditioning in hospital.

By comparison, cases No. 8 and 26 presented the clinical picture of fearful withdrawal. They were mute, insecure, and markedly inhibited, so that adequate therapeutic response depended upon first gaining their confidence and overcoming their fears. The unfolding of the child's difficulties during treatment followed a correspondingly different pattern.

Case No. 26, an intelligent girl of 7, declined to use the sand tray at first, but agreed to draw on paper. Her unprompted first drawing depicted a nurse administering an enema to a child behind screens in hospital. The patient volunteered no comment and the picture itself seemed devoid of animation. (Appendix II Plate 14).

Later, she was invited to draw something she really disliked. Again she depicted the administration of an enema. This time however, she showed clear evidence of emotional disturbance in the process. The standard of execution deteriorated accordingly, but now the picture is animated, and captions are introduced. The patient is saying "I'll teach you old nursie a lesson". The nurse, wearing a frightening expression, replies "No you won't, you can't". (Appendix II Plate 15).

In contrast to the similar picture drawn by case No. 11, expressing spirited defiance (Appendix II Plate 10), this drawing denotes a more feeble protest by the child, which is emphatically over-ruled by the all powerful nurse. The different attitude expressed in these drawings

reflects the clinical difference between the first patient, the boy who was reacting with robust retaliatory behaviour, and the second patient, the girl so much more inhibited and passive in response.

Significantly, she declined to deal with her drawing on the Aggression Board and showed alarm at the invitation.

Later still, she developed a new theme. She drew a malevolent looking female figure, with encircling arms. Because this child was so much dominated and emotionally stifled by her intense mother, this drawing was suspected to portray the mother, but no interpretation was sought at that stage. (Appendix II Plate 16).

She repeated the drawing at her next visit, still without comment, but went on to elaborate it with much feeling. She drew black smoke belching from the region of both breasts, and red flames emanating from the perineal region. The total effect was fearsome, and the child was patently disturbed. (Appendix II Plate 17).

Concurrently, she became more accessible, and more frankly dependent in attitude in the playroom, as if in need of support while expressing her phantasies on paper. She was given strong reassurance, and the promise of helping her was reiterated. She responded by transferring her interest, for the first time, to the sand tray. The central feature of her portrayal was a large crater in the sand, surrounded by female figures, and with a male figure dancing in the centre. (Appendix II Plate 18).

She commented on her work thus :-
"People think women have three holes. Really they only have one big one. The mothers want to laugh at the little man dancing in the big hole, but they dare not". The child now seemed to be construing that her mother's attitude to anal activity was not really so forbidding as she had formerly feared.

Significantly, at her next play session, she drew the picture of her mother (spontaneously identified as such) wearing a coloured summer frock, with the sun shining. She commented that it was a happy picture. That completed the material which she produced in this particular sequence. (Appendix II Plate 19).

This child has developed a close and warm relationship with the therapist, on the basis of which she is gaining sufficient confidence to express her emotional difficulties during play therapy. Mother however, remains hostile, lacking in insight, and prohibitive in attitude to the child, thus impeding the successful advance of treatment.

By contrast, the acquisition of insight by the mother of case No. 8, and her active cooperation, have already resulted in the resolution of his presenting bowel disorder.

This boy's response to psychotherapy has been equally slow and equally hampered by fearful inhibition.

He showed characteristic avoidance of messy play at the beginning of treatment, adhering strictly to cautious manipulation of dry clean sand. As he gained confidence, he began to experiment with wet sand, using a wooden spade at first, then timidly introducing one finger, and ultimately both hands. For a time, he scrupulously cleaned his hands afterwards, but latterly omitted to do so. Subsequently, he resorted to aggressive play with messy sand, throwing handfuls freely round the play-room. He then retreated to "safe" play, with wooden bricks on the floor.

At a later stage, he began filling a series of buckets to overflowing with wet sand, using his bare hands, and repeating the play with patent satisfaction. The significance of this "anal" activity was pointed out to him, and he was reminded that if we got too full up inside, we overflowed in the same way. (Appendix II Plate 20).

Finally, he achieved the level of organised and structured play in the sand, as typified by his portrayal of a battle between cowboys and indians, with appropriate aggressive animation, and no reactive anxiety. (Appendix II Plate 21).

This final stage of treatment coincided with the emergence of healthy self-assertive behaviour at home, and with the restoration of normal bowel action, using the toilet unbidden.

Discounting individual variations in the content of projective material produced by these children, and allowing for differences in their mode of expression, due to differing personality structure, the sequence of therapeutic play described in the foregoing cases was broadly the same in each.

RESULTS AND EVALUATION
OF
PSYCHOTHERAPEUTIC TREATMENT.

<u>1) Failure of response.</u>	<u>Cases</u>	<u>Nos.</u>
a) due to withdrawal from treatment.	2	29, 30.
b) due to loss of contact.	1	28.
 <u>2) Unsatisfactory response (treatment continuing)</u> due to persisting emotional resistance in the parent.	 3	 11, 12, 26.
 <u>3) Favourable response (treatment continuing)</u>		
a) with current improvement in symptoms.	2	9, 10.
b) with remission of symptoms.	1	8.
 <u>4) Satisfactory immediate result</u> (remission of symptoms)		
a) child still retained in hospital, pending parental re-education.	2	7, 25.
b) child discharged home. Supportive therapy with parents continued.	2	23, 24.
 <u>5) Satisfactory result.</u>		
Remission of symptoms over periods ranging from 3 months to $2\frac{1}{2}$ years. (Mean = 11 months)	17	
	<hr style="width: 50px; margin: 0 auto;"/>	
	30	

Remission of symptoms has been procured in 22 cases in the series, 17 of whom have now been suspended from active treatment for periods up to $2\frac{1}{2}$ years. In addition, 2 of the children still continuing under direct therapy show increasing symptomatic improvement, with good prognosis.

Favourable response to treatment can thus be claimed in 24 cases.

Of the remaining 6 cases, 3 do not permit the value of psychotherapeutic treatment to be assessed adequately, because of their premature suspension of attendance.

In each of the other 3 cases, the unsatisfactory response in the child can be attributed to resistance or continuing emotional difficulties in the parent, which have proved so far unamenable to psychiatric treatment.

The latter finding lends support to the basic hypothesis of the present work, in so far as failure to realign parental attitude, or to modify parental management of the child, has tended to perpetuate the disorder of bowel function.

Further support for the basic hypothesis is derived from material which emerged during the treatment both of parents and children.

Among those children who underwent direct therapy, the content and trend of their play was characterised, significantly, by repeated reference to the administration of enemata (with appropriate treatment of this theme by the child); by pre-occupation with "anal" play, and reactive anxiety to such activity; and by subsequent release of underlying aggression directed against their coercive management.

Similarly, the resistances and prejudices brought to light during re-educative treatment of parents, bore witness to the operation of major parent/child conflict over bowel function, with resulting negativism in the child. The resolution of symptoms and the emotional readjustment in the child, which followed successful realignment of parental attitude, testifies to the validity of the concept upon which treatment was based.

DISCUSSION

Excluding cases secondary to gross organic lesions such as ano-rectal stenosis, or post-operative stricture in imperforate anus, Bodian et al (9) have classified two main groups of megacolon in children. These are:-

- a) megacolon due to segmental aplasia of enteric ganglia (Hirschsprung's disease).
- b) idiopathic megacolon, or megacolon due to colonic inertia.

Close resemblance between the more long standing cases in the present series, and the condition of idiopathic megacolon, is apparent from Bodian's description of his cases (10):-

"Increase in severity of symptoms is gradual, so that marked constipation dates only from several months or years of age, and may coincide with weaning or acute febrile illness. With continuing constipation, defaecation becomes painful, the child holds back, and the condition is thus aggravated. Through retention of faeces, first the rectum and later the sigmoid colon may become passively distended with faecal masses. Above this, there is gaseous distension which leads to abdominal enlargement, although never as severe as in Hirschsprung's disease. In time, constipation may be followed by overflow incontinence or pseudo-diarrhoea, and there is soiling. Although the child's general health remains good, he soon becomes a psychological problem, unhappy, shy, and introverted".

The author stresses that the condition is essentially benign although chronic. It does not tend to acute crises of neo-natal or infantile intestinal obstruction, but the symptoms are difficult to eradicate, and most cases persist for many years.

This description might equally apply to the current case material.

It is emphasised that in Hirschsprung's disease, the rectum is found to be empty below the spastic segment of terminal bowel, while in megacolon due to colonic inertia, the rectum is loaded with faeces down to the anus. (Appendix III Plate I). In the present series, rectal examination yielded findings identical with the latter.

Bodian describes two variants of the skiagraphic appearance in his idiopathic group. In the first:- "Barium enema shows that rectum and distal pelvic colon form a pear-shaped, unilocular, dilated chamber, filling the pelvis and rising to the iliac crests, umbilicus, or even the xiphisternum. Proximal to this, the colon assumes normal diameter". He refers to this as "the terminal reservoir type". In the second variant, "rectal distension continues proximally into the entire sigmoid colon which is wider and more tortuous than usual". This is referred to as "tubular dilatation". (Appendix III Plate 2).

The difference in radiographic appearances between these two variants, and Hirschsprung's disease, is illustrated by schematic representation. (Appendix III Plate 3). These schematic X-ray appearances in megacolon due to colonic inertia, are similar to the skiagraphic findings in some of the cases in the present study.

It is thus apparent that in pattern of development, in the age group affected, the clinical features, radiographic appearances, the findings upon examination, and the natural course of the disorder, close affinity exists between Bodian's cases of idiopathic megacolon and cases in the current series. It is submitted that, in fact, both sets of cases belong to the same group.

Theories of aetiology of idiopathic megacolon.

Bodian regards the aetiology of the idiopathic case as manifold. Among the factors involved, he includes alterations in feeding habits, intercurrent illnesses, and poor tone of the bowel musculature. He concludes that "further information as to aetiology is desirable."

Lee & Bebb (43) advocate adoption of the term "functional" in preference to "idiopathic", because in their view, the condition develops on the basis of faulty bowel care and training, perhaps associated with improper diet.

Norman (50) puts forward two theories to explain the aetiology of the condition. He refers to the possibility of a very short aganglionic segment, low down in the rectum, and therefore unsuspected because it is more difficult to demonstrate. Swenson (67) has identified such cases, but concedes that they are very rare. Alternatively, Norman suggests that some deficiency of rectal sensation may exist in these cases, but he concludes that this would more probably result from chronic distension than represent the initial cause of the disorder.

Burnard (14), describing a series of 17 cases of idiopathic megacolon, attributes the cause to "a state of chronically distended and unresponsive rectum, the result of simple neglect of bowel habits". This is reminiscent of Hurst's concept of dyschezia (34), and is supported by Schlesinger (61):- "The condition is really a very severe dyschezia, due to bad bowel habits". Stephens (63, 64) identifies his cases of idiopathic megacolon with "a functional state of chronic constipation", and lists among exciting causes, "domestic family disturbance involving parental neglect".

From the surgical standpoint, Gardiner (27) identifies a group of cases variously referred to as idiopathic megacolon, pseudo-megacolon, dolichocolon, or colonic inertia, (in contrast to Hirschsprung's disease). He suggests for preference the term "simple megacolon". He attributes the fundamental cause of the condition to "congenital elongation of the sigmoid colon, followed in time by dilatation and hypertrophy due to slowly acting and benign

obstructing factors, including faulty bowel habit". The author states that congenitally elongated sigmoid colon is found in 20-25% of individuals. His theory as to aetiology may therefore be questioned on the grounds that the incidence of idiopathic megacolon in children is considerably lower than the percentage computed to have this congenital variant. Meyer (49), believes that there is in fact no correlation between colonic length and symptomatology:- "The word 'dolichocolon' is not a diagnosis and should not be used as such".

More recently, Garrard and Richmond (25, 58), have described 10 cases which bear the characteristics of idiopathic megacolon, but which they regard as having a definite psychogenic basis. These authors stress the frequency with which coercive toilet training had been adopted in their cases, and show how it results in refusal to defaecate, with inhibition of stool. They point out that in contrast, toilet training is usually successful in Hirschprung's disease without coercive methods, and there is no refusal to use the toilet. They conclude that "psychogenic" megacolon, as exemplified by their series, is identical with the condition formerly designated "idiopathic".

The diagnostic criteria listed by Garrard and Richmond, to differentiate psychogenic from neurogenic megacolon, have since been described independently by Swenson (66), Braid (13), and Wilson and Gundry (74). These workers were primarily concerned to emphasise the absence of organic factors in "functional" megacolon, rather than to stress its psychogenesis. James (36) however envisages megacolon as the potential end result of psychogenic constipation, while McKeith (46) refers to "secondary megacolon" and attributes its development to psychological factors.

Bodian et al (9) have reported the tendency among these children to pass stools either in the standing position, or when supine, as in bed at night. They consider that the extended position facilitates defaecation. Stephens (63) describes the same feature, and deduces that it may be less painful for the child to defaecate standing up than in the normal posture. Most of the children in the current series exhibited this tendency. The implication (shared by many parents) is that the squirming movements, grasping of chair backs, and clasping of abdomen, adopted by these children prior to bowel movement, are essentially accessory devices aimed at facilitating the otherwise difficult act of defaecation.

McKeith (46) believes that this interpretation is unlikely, while Garrard and Richmond (58) consider that the reverse is true, namely that these devices are adopted in an effort to hold back the passage of faeces. They maintain that Bodian's contention is "contrary to available information concerning the physiology of defaecation. The squatting position places the accessory muscles of defaecation at a mechanical advantage and supplies a fulcrum action for the levator ani muscles. The extended position is assumed when an individual attempts to withhold the stool voluntarily". The weight of evidence derived from the current series supports

the view that these children assume the standing position, with associated accessory movements, in their efforts to resist defaecation. This would correspond with the general hypothesis of bowel negativism as a basis for the disorder.

Referring to redundancy of pelvic colon, Garrard and Richmond agree that excessive loops of bowel might accentuate the constipation by enhancing stasis, and increasing the absorptive surface in the distal bowel. In their view however;- "Redundancy is the result of chronic constipation rather than the cause of it". They cite the example of one child in whom redundancy actually recurred after 2 feet of the colon had been removed surgically. These observations contradict Gardiner's theory of aetiology (27), and it is noteworthy that where redundant looping was demonstrated among cases in the present series, the children concerned ultimately achieved normal bowel function while retaining their bowel configuration unchanged.

Similarly, the theory of deficiency of rectal sensation would seem to be discounted, by resumption of spontaneous bowel function in those cases in the present group, who had claimed before psychiatric treatment that they were unaware of the urge to defaecate, and unaware when they soiled. Assuming that chronic distension of the rectum had impaired rectal sensation in these cases, the restoration of normal function indicates that such insensitivity is reversible and not permanent.

In brief, there is agreement that colonic inertia forms the immediate basis of the condition, but less uniformity of opinion upon the factors which give rise to this state. There is some support for the concept of psychogenic megacolon, as a clinical entity distinct from Hirschsprung's disease, and identifiable with Bodian's idiopathic cases; but Garrard and Richmond consider that the psychodynamics of this group of children warrants further study.

Treatment Considerations.

Hitherto, standard treatment procedure has involved three principal measures. As described by Bodian (10), these are a) thorough evacuation of the loaded bowel by daily bowel washouts until the rectum or colon is clear b) purgation, which is only effective after complete evacuation of the bowel c) re-education of normal bowel habit by regular daily training. Burnard (14), Stephens (63,64), and others (43, 50, 74), subscribe to this treatment regime, while Gardiner (27) recommends that resection of redundant sigmoid colon should be considered, if there has been no adequate response to conservative therapy after three months. He quotes Lee et al (44) in support of this policy of resection in selected cases.

Excluding surgical measures, the foregoing principles of treatment were adopted in the 18 cases in the present series who had undergone inpatient therapy before referral for psychiatric opinion. In none of these children, had a satisfactory response been achieved.

Quite apart from this, a number of workers have advised against the routine use of physical and even medicinal measures, on grounds of their potentially harmful effects. Reichert (56) states that "mechanical aids such as suppositories and enemata should be avoided, because they are harmful and tend to blunt the normal response to faeces in the rectum. They are also quickly habit-forming". Similarly :- "Cathartics have no place in treating constipation in children. It is illogical to irritate the entire intestinal tract in order to stimulate its terminal few inches. Even mineral oil has a limited place in treatment because it absorbs vitamins and prevents their assimilation". In the same vein, James (36) warns against the adoption of :- "Drastic remedies such as glycerine suppositories, which may destroy the normal reflex pattern of defaecation, and thus precipitate normal infants, with infrequent evacuation, into states of true chronic constipation". She advises that :- "Drastic cathartics, frequent enemata, and suppositories should be stopped". Gyllenswärd (31) emphasises his preference for laxatives as compared with enemata, in the treatment regime :- "It is striking how much less troublesome these children are with laxative pills than with enemata". Anderson (5) discounts even the use of laxatives, and relies upon elaborate "retraining" programmes to give the child confidence in controlling defaecation unaided. Walther (69), advocating the avoidance of enemata, claims that there is no need even for modification in the child's diet. He considers that all physical measures can be dispensed with, and stresses the value of "repeated talks with parents". Gardiner (27), in advocating partial colectomy after three months trial of conservative treatment, believes that medical measures should not continue beyond three months, because "after this time, the child becomes bowel conscious and repeated enemata may cause psychological trauma".

On the one hand therefore, there is a substantial body of opinion, in favour of employing purgatives and washouts as standard treatment, especially of the long-established condition. On the other hand, there would seem a valid case for avoiding such procedures.

In support of physical treatment measures, it might be claimed that they are necessary to promote evacuation of accumulated faecal matter, which otherwise could not be extruded because of the atonic state of the terminal bowel. Within the present series however, a number of cases were accepted for psychiatric treatment at the chronic stage, when repeated courses of enemata had failed to prevent reloading of colon. Yet following suspension of physical measures, spontaneous unloading of faeces subsequently occurred, and normal bowel function was restored, despite the presumed colonic atony. This finding would seem to discount both the need for enemata and the need for "retraining"; and to demonstrate that the atonic state of bowel, when present, need not be a permanent development.

In this respect, Burnard (14) cites two of his 17 cases, in whom a follow-up barium enema showed that the previously dilated colon had resumed normal proportions,

by comparison with the original radiographic appearances. Bodian (10) agrees that dilatation of rectum and colon does, in time, regress, after resolution of the presenting symptoms.

There is further presumptive evidence that permanent loss of muscle tone does not in fact take place. The characteristic stool, when passed periodically, is large and bulky in these cases, and presumably adequate contractile power must be retained to promote its extrusion. It seems unlikely that the passage of these voluminous stools is solely the result of passive increase of pressure within the rectum, due to faecal accumulation higher up in the sigmoid colon. If this were so, we would have to assume the loss of anal tone to an equivalent degree. In fact, the tone of the anal sphincter is sufficiently good to retain massive accumulation of faeces for weeks at a time, and it would seem therefore that the extrusion of faeces under such circumstances must involve powerful reflex contraction of colonic and rectal musculature to overcome the tonicity of the anal sphincter. Reference has been made to the way in which these children, in their efforts to continue suppressing defaecation, will bring their voluntary muscles into play, by wriggling and contorting themselves, and by forcing their nates tightly together, presumably in the attempt to reinforce anal tone against the action of the detrusive rectal musculature. This would seem to indicate that there is no serious impairment of muscular contractility in the terminal bowel.

Among the more chronic cases, there is the potential hazard of intestinal obstruction, resulting from faecal impaction. Gardiner (27), refers specifically to this complication, and the risk of its development might be thought to increase, during the course of psychiatric treatment, through the policy of avoiding physical measures. It is argued that the use of enemata obviates the development of faecal impaction, and thus reduces the danger of obstruction supervening. In practice, in most of the current series of cases, the rectal contents were found to be of pultaceous consistency and as such, would not present excessive difficulty in evacuation. Symptoms of impending obstruction developed in only one of the series (Case No. 2). It was assumed in this case, that faecal impaction had developed through hardening of the retained faecal mass, as a result of relative dehydration during intercurrent pyrexial illness. It might have been avoided by increasing the child's fluid intake still further. Intestinal obstruction was in fact prevented by manual dislodgment of the impacted faeces, without recourse to enema.

With this hazard in mind, the parents of the children under treatment were instructed routinely to maintain fluid intake beyond the child's normal demands. McKeith (46) emphasises the importance of this point.

Significantly, at an earlier stage in the psychiatric treatment of Case No. 2, the child successfully resisted defaecation for a period of 83 consecutive days, without overflow soiling in the interval. During this period, there was no pyrexial illness, and presumably the fluid intake was adequate in preventing excessive hardening of stool. In

the event, the child suffered no adverse effects from the prolonged period of constipation, and incontinent voiding of faeces subsequently took place without difficulty.

In this same case, redundancy of pelvic loops of colon was demonstrated radiographically, and provided the rationale for the operation of partial colectomy which was envisaged. Despite the assumption that such redundancy promotes dehydration of retained faeces, by increasing the absorptive surface in the distal bowel, the faecal mass in this case retained its pultaceous consistency throughout the phase of intractable constipation. Swenson (66) reports a similar example of a child with this condition who had no bowel movement for 8 months without adverse repercussions.

In a number of other cases in the current series, hard scybalous masses were palpated abdominally in the descending colon, and it might be assumed that such retained matter would be more difficult to evacuate without bowel washouts. Nevertheless, spontaneous unloading of bowel ultimately took place without resort to mechanical measures.

In terms of psychodynamics, the use of enemata or bowel washouts is calculated to provoke further resistance by the child, as a revolt against the enforced removal of faeces which he is determined to retain. It would be expected therefore that following cessation of enemata, the child would begin to "reload". This occurred repeatedly in the present series. In addition, a child coercively subjected to enemata becomes understandably hostile, and suspicious of any future therapeutic approach. This again was a common finding in the current group. The material which emerged during expressive play therapy, testifies to the aggressive feelings and punitive interpretation evoked by mechanical procedures. (Appendix II, Plates, 10, 12, 15).

A further hazard inherent in the use of repeated enemata is the risk of anal overstimulation, which may give rise to erotic associations.

Thus, both physiological and psychiatric grounds exist for curtailing physical treatment measures or avoiding their use over a prolonged period. Nevertheless, Bodian (10), Stephens (64), and others, (14, 27, 43, 74), claim a satisfactory response to routine programmes of treatment (including enemata), in a proportion of their cases. In Burnard's series, follow-up after 1 year showed that 7 of his group had remained well, without further treatment, but 6 others still required regular purgation to secure defaecation. The remaining 4 (significantly, those with the longest history), continued to prove unsatisfactory, with recurrent loading of the colon, despite repeated courses of enemata.

The explanation for this differential pattern of response may well be, that in those who responded

favourably, the constellation of pre-disposing factors which originally evoked the disorder, had ceased to apply or were materially reduced in severity at the time of treatment. In a number of cases in the present treatment group, parental concern had been noticeably allayed, so long as some form of active treatment, such as purgation, was being administered. This might account for the improvement in those 6 cases in Burnard's series, who were still dependent upon regular purgation.

All the children in the current control group had responded satisfactorily to physical treatment measures without adverse sequelae. It would seem therefore, that physical measures in themselves do not usually give rise to deleterious effects, unless the child has already been conditioned to respond adversely, because of pre-existing factors of emotional stress. Given such circumstances however, as in the primary series, the adoption of drastic physical procedures tends only to aggravate the existing disorder, and achieves no more than temporary symptomatic relief at the expense of further emotional trauma.

This situation explains the reference by Bodian and others to the occurrence of relapse in some of their cases. Bodian concedes that:- "Not uncommonly, relapses occur even after prolonged courses of treatment, and further courses of bowel washouts may be necessary. Relapse will occur if pre-disposing causes such as environmental difficulties persist". He includes among such difficulties, the factor of parental mishandling which, in his view, necessitates psychiatric help. Norman (50) similarly concludes that :- "In those cases who fail to respond to (medical) treatment, or who recur after each course (of washouts and laxatives)..... some other form of treatment is required. Psychological treatment may be urgently necessary from the beginning, and physical treatment contra-indicated".

Among workers who subscribe to the psychogenic basis of the condition, the view is expressed that treatment in the paediatric setting is relatively ineffectual, and that deeper psychotherapy with parents, and where necessary with the child, is the only effective approach. This is the opinion of Garrard and Richmond, shared by Lehman (45), by Huschka (35), and by Warson et al (70).

Essentially, standard treatment is directed at the relief of presenting symptoms, and the so-called "restoration of normal bowel habit". Sometimes, there is inadequate appreciation of the emotional factors involved. The current study provides evidence that satisfactory long-term results are achieved, only when as much consideration is devoted to the whole child, in his emotional setting, as has hitherto been devoted to his dilated colon.

Faecal Soiling as a Leading Symptom.

29 of the 30 cases in the primary series presented with faecal soiling as a major symptom. In 4 of these cases, it took the form of "paradoxical diarrhoea" which masked the underlying constipation. In most cases, parental concern was as much centred upon the soiling as upon the faecal retention. This aspect of the disorder therefore warrants more detailed consideration.

Faecal soiling has long been recognised as a manifestation of emotional disturbance. In 1882, Fowler (21) attributed the symptom to emotional stress. Schilling (30) referred to "defaecatio involuntaria juvenilis" in 1891. Goodhart and Still (29) suggested "mental instability" as a cause and recommended "moral rather than local physical treatment". (1905)

The term "encopresis" was introduced in 1926 by Weissenberg (72), to signify the involuntary passage of stools in the absence of organic disease. The word was formed by analogy with enuresis, both conditions being found among a large group of Ukrainian children, who were accommodated in an orphanage during the aftermath of the Russian revolution, and were presumably suffering the effects of chronic emotional deprivation.

Subsequent workers have confirmed this relationship to emotional deprivation. Shirley (62), describing a group of 70 cases, commented that many children with encopresis suffer lack of parental love and come from unhappy homes. Pearson (53), noted the absence of parental affection among his cases of soiling. He described the lapse of bowel control common among previously trained foster-children, when placed in a fresh foster-home. Schachter (59), referred to the frequent incidence of encopresis in asylums for illegitimate children and orphans; while more recently, Burns (15) has emphasised the prominence of soiling as a problem among children evacuated to rural foster-homes during World War II.

Biermann (8) stresses the significance of chronic faecal incontinence among children who are victims of "broken" marriages. In his view, encopresis of this type represents "a heightening of enuresis through increasing neglect" and signifies "regression into the security of infancy". Bradley (12) similarly regards encopresis as "essentially a symptom of regression".

It is thus apparent that faecal soiling, in the setting described, and in the absence of organic factors, is a regressive symptom, reactive to emotional insecurity. It is not normally associated with loading of the terminal bowel, or constipation. Among the present series, a history of this pattern of reaction was elicited in 3 cases, (Nos. 10, 13, 20). In each case, there had been evidence of marked emotional stress operating at the relevant time, and adversely affecting the child's sense of security; and in each case, regressive soiling preceded the development of negativistic bowel disorder.

In contrast, soiling may develop during bowel training in infancy, as an aggressive symptom,

interpreted by Bismantas—"the expression of early sexuality in the anal-sadistic phase of the child's development". Freud (25) refers much earlier to soiling as "an expression of defiance," and in a later essay, quotes Abraham (2), as differentiating two stages in the anal-sadistic phase. In the first of these stages, faecal soiling symbolises destructive tendencies to annihilate.

Within the present series, 4 cases, (Nos. 6, 9, 15, 30), presented originally as persistent faecal soilers rather than as cases of constipation. There was presumptive evidence in each of these that soiling was prompted by defiance rather than by regressive withdrawal. It was essentially aggressive in character. Subsequently, the pattern of "holding back" became established in these children.

Regressive soiling and aggressive soiling both differ in mechanism from the soiling which occurs in the established case of psychogenic megacolon. Here, soiling is the mechanical result of overflow from an already loaded and constipated lower bowel. This differentiation has not always been appreciated in the literature dealing with encopresis, and much confusion still exists about the three types. Diagnostic distinction is rendered more difficult by the fact that in psychogenic megacolon, the soiling, though not the primary symptom, is often the most obvious feature, and as such, tends to overshadow the underlying basis of constipation.

Further difficulty arises if regressive soiling is later replaced by faecal retention, as may occur if the child's negativism is evoked in this sphere. Similarly, aggressive soiling may give place to obstinacy in defaecation. This progression can be interpreted as the substitution of one pattern of defiance for another. Such a transition occurred in Case No. 9, and the resulting overflow incontinence was misinterpreted by the parents as a continuation of the original symptom.

Ostheimer (52) in 1905, described 3 cases of soiling associated with severe constipation. Nussey (51), considered that some children exhibit soiling because of long-standing faecal impaction of the rectum, which in turn results from long-standing failure to empty the lower bowel satisfactorily. He likened the condition to overflow incontinence of the bladder. Jekelius (37) in 1936, used the term "obstipatio paradoxa" to designate faecal soiling associated with severe constipation. The term "paradoxa" denoted the simultaneous existence of obstipation and involuntary voiding of faeces.

Clearly, the soiling described by these authors is of the type mainly encountered in the present series of cases, i.e. overflow soiling. The description of "obstipatio paradoxa" by Jekelius closely resembles the clinical findings in the current study.

Thus, where faecal soiling is a leading symptom in the child's disorder, and where an underlying organic lesion can be excluded, distinction may be made between three separate aetiological mechanisms, (apart from states of mental deficiency in which incontinence may be a feature of retarded maturation.)

These are 1) Soiling of regressive character, encountered as a withdrawal pattern of reaction in face of hostile emotional stress. 2) Soiling of aggressive character, encountered as a pattern of defiance in face of coercive pressure in toilet training. 3) Mechanical overflow soiling from a previously loaded bowel. Pseudo-diarrhoea is a variant of this third pattern, to which mucous discharge may contribute, through irritation of the rectal mucosa by the hard mass of retained faeces.

Data in Support of the Present Concept.

1) General.

The importance of emotional factors in the condition under study, is recognised by various paediatric workers. Thus Bradley (12), referring to this type of case, states:- "By common consent among paediatricians, emotional factors are more important than structural defect in its genesis". Braid (13) and Reichert (56) express similar views. Wilson and Gundry (74), describing 10 cases of paradoxical diarrhoea, refer to the frequency with which diagnostic mistakes are made in this condition, with consequent delay in treatment, through failure to investigate and treat the underlying psychological factors. In the view of these workers, emotional factors are prominent enough in ordinary childhood constipation, but are especially so in paradoxical diarrhoea. Editorial comment upon this work reads (18) :- "Too much stress cannot be placed on this condition On the basis of our experience, we are considerably discouraged with the lack of success in handling this condition from a medical, as well as psychiatric approach".

Swenson (66) affirms that "Faulty habit cases are extremely difficult to cure, require long periods of treatment involving parents as well as child, and seldom respond unless carefully supervised by paediatric psychologists". James (36) concludes :- "It cannot be too often emphasised that chronic constipation, excluding constipation from organic causes, results from mismanagement of the child by its parents or medical advisors, or both, and once it develops, it presents a real problem, difficult to remedy".

2) The Phenomenon of Holding Back.

From the present investigation, the phenomenon of "holding back" emerges as the immediate starting point of the disorder. McKeith (46) aptly refers to it as "a declaration of independence". He and Reichert (56) assert that while under-feeding is the most common cause of constipation in infancy, the most frequent cause after the first year of life, is faulty habit resulting from resistance to coercive training. Similar views are held by Comly (17), Erickson (19), and others (6, 12, 36, 66). Chapman & Loeb (16) endorse these opinions:- "A great deal of psychiatric work has demonstrated that withholding of faeces has the psychological function for many constipated children of expressing feelings of negativism. Toilet training is one of the first areas where socially con-

forming behaviour is demanded of the child by his parents, and he has an opportunity to resist by refusal to comply".

This resistance corresponds to the obstinacy described by Freud (22, 23) as developing during the anal-erotic stage of infantile sexuality. In the psycho-analytic view, the process of defaecation affords the first occasion on which the child must decide between a narcissistic and an object-loving attitude. "He either parts obediently with his faeces (offers them up), or else he retains them for purposes of auto-erotic gratification, and later as a means of asserting his own will. The latter choice constitutes the development of defiance (obstinacy). Defiance thus springs from anal erotism".

Jones (38), describes the same phenomenon, and refers to the child's efforts "to retain his individual control (of defaecation) in opposition to the educative aims forced on him by the environment. This opposition..... may attain a chronic attitude of defiance".

Adler (3) regards retention of faeces by the child as one of a number of means of "exacting support from other persons". "The pampered child thinks it right that his mother should attend him on every possible occasion. He attains this goal of superiority most easily by opposing the development of his functions", (e.g. bowel control).

3) Pre-disposing Parental Personality.

The personality characteristics found to predominate among the parents of the children in the present study, have been noted by other workers, in association with difficulties over toilet performance. Comly (17) refers to "the punctilious, meticulous and perfectionistic parent who demands high standards of performance from her 2 to 3 year old child". Lehman (45) describes the typical mother as "Domineering and despotically demanding strict discipline". "They were feminine dictators who expected their children to respond with the alacrity of soldiers". McKeith (46) speaks of maternal concern becoming so excessive that regularity of bowel function in the child assumes a moral issue. Braid (13) stresses the danger of such anxiety provoking voluntary inhibition of the defaecation reflex in early childhood; the need to avoid this development is endorsed by Swenson (66). Bakwin (6) refers to:- "Tension about the toilet situation, generated by excessive maternal zeal, arousing the child's negativism". Garrard and Richmond (58), analysing the parental attitudes found in their 10 cases of "psychogenic" megacolon, comment upon the presence of situations such as rigidity of feeding and daily routine, insistence upon conformity and cleanliness, and the ready adoption of physical punishment in default of these attainments. They assess these parents as "incapable of expressing genuine warmth of feeling towards their children".

Vaughan and Cashmore (66) corroborate the importance of parental attitudes in the aetiology of the disorder. They refer to the characteristic finding of "unusual concern with anal behaviour and its derivations, in

association with intense interest in toilet training and the demand for early conformity in the child's behaviour". They believe that part of the problem lies in the personality structure of the parent. They state that:- "Where the parent is repressing her own predominantly anal sexuality, she finds herself most disturbed by 'anal' activity in her child. She is therefore likely to adopt an irrational and unconsciously determined attitude towards this phase of infantile development." The authors conclude that "unless the mother can be helped to recognise her own emotional problems in this sphere, treatment of the child is unlikely to be successful".

Among the present series of cases, the personality features of obsessional rigidity, determination, and perfectionism, prominent in the parents concerned, correspond to the characteristics of the "anal character" elaborated by Freud (24, 26a) - the triad of orderliness, parsimony, and obstinacy - and described in other psychoanalytic texts (1,20,38). Study of the family backgrounds of these parents yields repeated evidence of the strict code of upbringing to which one or other parent (usually the mother), was herself subjected in her own childhood. In this respect, the background history was significant, in its demonstration of how often the parental attitude adopted towards the child had in turn been determined by the parental attitude obtaining in the previous generation.

Reference to the overanxious type of maternal personality is made by Jung (40), in describing his treatment of a 4 year old girl, who had suffered from intractable constipation for 3 years:- "She had undergone every conceivable kind of physical treatment, all of them proving useless because her doctors had overlooked the one important factor in the child's life, namely her mother". This child was "the pet of a neurotic mother, who projected all her phobias onto the child, and surrounded her with anxious care". Treatment of the mother secured remission of the patient's symptoms.

4) Coercive Toilet Training.

In a study of the adverse effects of coercive toilet training among a group of 213 children, Huschka (35) confirms the resulting tendency to obstinate constipation through provoking the child's negativism. She defines coercive training as "the premature institution of a toilet training regime using overactive and destructive training methods". As examples, she lists the following methods:- "Frequent and marked employment of shame; punishment for failure to comply; the use of suppositories as educative aids; rigidity of toilet schedule; unduly frequent placement on the toilet; placing a high love premium upon perfect performance; refusing to place the child on the toilet until he expresses his wants verbally; and mechanical measures such as strapping the child to the toilet".

Some form of overdiligent training had been instituted in all 10 of the cases of "psychogenic" megacolon described by Garrard and Richmond (58). Swenson (66)

and Bakwin (6) both deplore the aggravating effect of coercive methods upon the child's negativistic refusal to defaecate. Bakwin however refers to the possibility that in terms of neuro-muscular development, the infant's ability to retain the stool may be acquired earlier than his ability to release it at will. Hence "the young child may have learned to wait till he is placed on the pot, but may be unable at once to release the stool there. He may therefore soil inadvertently after removal from the pot". Bakwin considers that this may be the explanation in some cases for what is interpreted by the mother as defiance by her child.

Reichert (56) stresses that:-"Evacuation of stool and urine is almost always an unconscious act until the age of 12 months and may remain so to the age of 30 months. No training should be instituted until there is a definite and conscious neuro-muscular connection between the child's brain and his lower bowel".

This point was emphasised with parents in the present series. Mothers frequently claimed that they had achieved a successful response to "potting" after feeds during the first few months of life, and they accordingly interpreted subsequent events as a breakdown in previously acquired "training". It was essential to impress upon them that the infant's response, prior to adequate neuro-muscular maturation, had been purely reflex and did not signify the conscious acquisition of a habit. They were therefore incorrect in referring to subsequent developments in terms of "breakdown".

Melanie Klein (42), considers that "training in cleanliness, if applied without pressure, and at a stage when the urge for it becomes apparent (usually in the course of the second year), is helpful for the child's development", because it serves to allay "the infant's anxieties and guilt feelings which result from his aggressive phantasies concerning the destructive power of his faeces". She adds however, that such training "if imposed on the child at an earlier stage, may be harmful. At any stage, the child should only be encouraged, but not forced to acquire habits of cleanliness."

Prugh (54) found that constipation, with or without faecal soiling, occurred twice as frequently in a group of children who had been subjected to early bowel training, as in an equivalent group who had been trained at the usual time. He concludes however that it is not the timing or the nature of bowel training which alone promotes difficulties over defaecation. In his experience, mothers who enjoy a warm and close relationship with their offspring can adopt premature or coercive training without incurring the serious risk of subsequent bowel disorder. "If however, the relationship between mother and child is strained, undesirable procedures may offer a focus around which these tensions are expressed". He therefore considers that:- "The personality make-up of the mother and her relationship to her child, are more important than her technique of toilet training".

This view is borne out by the findings in the present series of cases, among whom 57% had been submitted to primary coercive training, whereas 93% showed evidence of parent/child tensions due to personality difficulties in the parents.

5) Pre-disposing Prejudices and Misconceptions.

Constipation is still widely invested by the laity with ingrained fears and fallacies concerning its adverse effects. McKeith (46) contends that the British public is so preoccupied with regularity of bowel action, that it is estimated to spend £70,000,000 annually on purgatives outside the auspices of the National Health Service; and that it frequently uses the word "medicine" to mean an aperient. In his view:- "Symptoms of constipation are largely due to fear of constipation, which in turn is partly due to skilful commercial advertising". In similar vein, Reichert (56) asserts that:- "Many cases of constipation in children are largely imagined by the parents".

Both authors stress the importance of emphasising to parents the wide range of normality in bowel function during infancy, in order to avoid their unwarranted alarm. James (36) emphasises the same point:- "Infrequent bowel action causes great concern to parents, whereas in fact normal evacuation in infancy may not be more frequent than at 3-6 day intervals, and even 10-12 days may elapse, especially in healthy breast-fed babies. No harm will result unless the child is treated for supposed constipation".

Within the present series, two cases, (Nos. 19, 21), had shown a constitutional tendency to infrequent bowel action, dating from the neo-natal period. In both instances, the mother had interpreted this as constipation, with resulting undue concern, and correspondingly rigorous treatment. Significantly, although the overlying behaviour disturbance has now been resolved, and the parental attitude correspondingly re-aligned, the child's pattern of bowel action, at 3-4 day intervals, has remained unchanged in each case.

Bell and Levine (7) similarly refer to the rigidity of traditional belief regarding bowel regularity:- "There are many constitutional variations in the child which are accepted without question by mothers and physicians alike - size, rate of growth, onset of teething, etc. But where bowel movement is concerned, all children are expected to follow a most rigid pattern, i.e. one movement daily".

Regarding the common fear of alimentary intoxication, Bakwin (6), cites experimental evidence for discounting this belief. He asserts that in most cases of psychogenic constipation, general symptoms are lacking, but where they do occur, (e.g. abdominal discomfort, apathy, and headache) they are due, not to absorption of "toxins", but to mechanical distension of the rectum by retained faeces. He describes how in fact these symptoms have been reproduced experimentally by filling the rectum with an inert substance from which no absorption could take place, and how relief of symptoms followed promptly upon emptying the rectum. He emphasises, with McKeith (46) and Bradley (12), "the importance of disabusing anxious parents about superstitions concerning auto-intoxication, or the need for prompt and regular removal of waste".

Referring to the attitude of disgust concerning faeces once evacuated, McKeith comments:- "Maternal behaviour during toilet training may appear to the child as most inconsistent. She first praises him for his achievement, and next blames him for his interest in the product, adding further insult by throwing the gift away".

As distinct from the commonly occurring superstitions and fears about bowel function, specific circumstances surrounding the life situation of the child may give rise to particular misconceptions by parents regarding constipation. Bradley (12), cites the illustrative case of a seriously boy aged 8; an only child whose mother had lost a previous baby in infancy through amyotonia. As a result, she had been apprehensive about the patient's health since birth and correspondingly oversolicitous. She had expressed her concern through over-zealous attention to the child's bowel habit, thus provoking his resistance to defaecation. Two similar examples occurred within the present series. (Cases No. 24, 29).

6) Precipitating Stress Factors.

Bell & Levine (7), mention the fear possibly engendered, during toilet training by precarious balance on too large a seat, or by the cold splashing and loud noise of flushing, where the maternal approach is impatient or thoughtless. Kanner '41) refers to faecal retention being initiated, in homes which have an outside toilet, by the child's fear of attending the toilet after dark. The anxiety thus evoked may induce retention of faeces temporarily, but it is unlikely that these or similar focal factors, operating alone, would result in the persistence of bowel disorder over a protracted period.

Anal fissure, with painful spasm of the sphincter, is claimed (61), to be an immediate cause of faecal retention. However, Bodian (10) holds that it is more likely to develop as a result of pre-existing constipation, and to act thereafter as an aggravating factor.

In two of the current series, (Cases Nos. 2, 11), the bowel disorder was related in onset to emotionally traumatic experience in hospital. Both these children were isolated from their parents, in hospital, over a period of several weeks, at a stage in their development when they were unable to withstand maternal separation without experiencing anxiety and a sense of rejection. Bowlby (11) has described this pattern in detail, and has shown how some children tend to react with testing and provocative behaviour toward their parents upon reunion with them. Both the cases in the present series demonstrated this pattern of reaction. In view of the history in both, of normal behaviour prior to the hospital experience, it would seem that separation anxiety was the starting point of the disorder, with the child's provocative tendencies expressed as bowel negativism. Vaughan and Cashmore (68), cite a similar example among their series of 26 encopretics.

7) Comparison of Primary Series with their Siblings.

When the attitudes to defaecation and the emotional responses of the patients in the primary series, are compared with the corresponding patterns of reaction found among their siblings, significant differences emerge. Examination of these differences and the suggested reasons for them, yields further evidence in favour of the current formulation.

In almost half the series, this comparison was not practicable owing to the status of the patient as an only child (9 cases), or his virtual status as an only child because of the prolonged interval since the birth of older siblings (4 cases). The remaining 17 cases may be grouped and analysed in the following manner.

In 3 cases (Nos. 1, 8, 23) the patient is the oldest of a young family. Circumstances surrounding the birth or early development of this first baby served to evoke excessive maternal anxiety concerning its health. In particular, overconcern was experienced about toilet habits because of intercurrent constipation or local bowel disorder. In each case, the mother had become so exclusively preoccupied with the child's bowel function, that in comparison, scant attention was paid to the toilet training of the children who were born subsequently. None of these developed evidence of bowel irregularity, and the absence of bowel symptoms may be explained in terms of the different circumstances obtaining.

In 2 further cases (Nos. 5, 13), the milieu of upbringing was quite different for the patient, as compared with his siblings. In the case of the patient, it involved coercive training in bowel control. The corresponding absence of such coercion in the case of the siblings, might explain the difference in their response.

In Case No. 10, the sex of the child was the determining factor in evoking the father's attitude of intolerance towards the patient, in contrast to the favouritism shown towards the patient's sister. In her case, no paternal pressure was exerted over bowel function, and significantly no resistance was encountered.

In Case No. 2, the main aetiological factor was assumed to be the traumatic experience of emotional deprivation in hospital, and as such, independent of factors operating within the home. In this case, the contribution to the disorder made by parental personality was not regarded as of primary significance; correspondingly, the older sibling, brought up in identical home circumstances, but not subjected to isolation in hospital, has remained symptom-free.

In Case No. 11, the patient had undergone a similar experience of maternal separation in hospital. In this case, however, there was evidence in addition, of parental mishandling, personality difficulties in the parents, and marital discord. All three children of

the family presented symptoms of emotional disturbance, presumably reactive to domestic tension. Significantly however, the pattern of disturbance alone presented as bowel disorder in the patient, while his siblings have shown no such disorder. The difference in life experience between the patient and his siblings is presumed to account for this differential response. He alone was subjected to hospitalisation with excessive focus upon his bowel function during this time.

In 2 further cases, (Nos. 22, 24), a negativistic response was activated by sibling jealousy. It took the form of bowel negativism because of intercurrent events at the relevant time, and it was subsequently aggravated by parental mishandling. There had been no equivalent indication to adopt the same attitude or approach towards the siblings, and they had remained symptom-free.

In the remaining 7 cases, the parental attitude was dominated by obsessional rigidity, with anxiety as a secondary feature. There was evidence that the siblings of these patients (all older) had equally been affected by restrictive pressure, but with a different type of reaction. In case No. 26, the older brother is described as unduly diffident and retiring in demeanour, with manifest habit spasms. In Case No. 3, an older sister had developed asthma, concurrent with a period of severe emotional stress within the home. In Case No. 25, the older sister is described as "nervous and highly strung". Among the siblings of these 3 cases, there had not been the same motivation for maternal pressure over bowel function at the equivalent stage in the child's upbringing. This might explain the absence in those siblings of bowel negativism.

In the other 4 cases (Nos. 14, 16, 19, 30), both sibling and patient had been subjected during infancy to coercive training in toilet and feeding habits. In each case, the older sibling had also reacted for a time with obstinacy over feeding or bowel action, but had not maintained this pattern. It is perhaps significant, that in 3 cases, the older child is excessively docile and compliant, in contrast to the more robust and determined character of the patient. In the 4th case, (No. 16) the older brother has required treatment by a children's psychiatrist because of his excessive fearfulness, nervous tension, and lack of self-confidence.

In those four instances, it would seem that the older sibling, in face of identical coercive pressure, had reacted at first with symptoms of negativism similar to those of the patient; but the reaction was not sustained, possibly because of a different personality organisation underlying. Certainly, the personality development in these children has suggested difficulty in withstanding parental pressure.

Consideration of these findings leads to the conclusion that, given a common basis of excessive parental rigidity, or anxiety, or both, the differences in emotional response between patient and siblings were determined

either by materially different situations, obtaining at the relevant stage of the child's development, or by differences in personality structure.

Such personality differences are discussed by Jung (39):- "Two children of the same mother may exhibit opposite personality types at a very early age, without the smallest accompanying change in the attitude of the mother. While not underestimating the importance of parental influence, the decisive factor must be looked for in the disposition of the child.....When there is an extreme attitude in the mother, the children can also be coerced into a relatively similar attitude, but this entails violation of their individual disposition, and as a rule, whenever such falsification of type occurs, the individual later becomes neurotic".

Variations in personality profile based on clinical assessment, must be interpreted with caution, because of the subjective element involved in the appraisal. Assessments based on psychodiagnostic techniques merit equally cautious interpretation, at the present level of accuracy of these tests. Therefore any attempt to correlate personality variants with different patterns of emotional response among the children in the present series, must be tentative rather than conclusive.

The characteristics of determination and obstinacy found in the majority of these children, were frequently observed to be features of the parental personality. Whether genetically transmitted, or induced by parental attitude, such characteristics increased the potentiality for negativistic behaviour in the children concerned; and parents found it the more difficult to handle this behaviour because of their own stubborn disposition.

Adler is reported to have observed that:- "The faults of children generally parody faults in the parents, and it is this humiliation of seeing such a reflection of oneself, which usually causes parents to lose their objectivity and to become angry". (71).

Several children in this series, (Cases Nos. 8, 20, 25, 26, 28, 29), at one time presented the antithetical picture of a sensitive, fearful, inhibited state. Such children seem specially vulnerable to episodes of precipitating stress which frighten them during the act of defaecation, and to which they react with inhibition of stool. There is evidence however, that continued retention of faeces in these cases, is the result, not of fear, but of supervening negativism, evoked and sustained by constant harping and exhortation from the anxiety-ridden parent. It would seem therefore that despite a personality structure different from the self-willed and independent child, these children may yet develop a negativistic response under appropriate circumstances.

Bowel negativism is thus not associated exclusively with the personality characteristics of obstinacy and determination, nor need such characteristics necessarily give rise to difficulty over defaecation.

8) Variations within the Primary Series.

Within the primary series itself, manifest differences in personality organisation were observed, as between the younger children, and the older children whose symptoms were more chronic.

Garrard and Richmond (58) have described the clinical picture presented by these older children:- "The majority are unusually obedient, conforming, and over-neat, except in bowel habit. Their school performance is good; they are often teacher's favourite. They show unusual control of hostility and aggressiveness, and impress adults favourably. Their attitude is often stoical, with infrequent displays of overt emotions. They impress as being immature". Biermann (8), analysing a series of 21 children with faecal soiling which was often associated with constipation, describes a similar group who were "immature, unemotional, introverted, and restricted". Reed (55) reports much the same picture in a patient aged 11 whom he designates a case of anal character formation.

Most of the older children in the present series (11 cases), showed resemblance to these descriptions in a number of aspects. Some were typically bland in their responses, at significant variance to the persistence of bowel irregularity and soiling.

By contrast, the impression created by most of the younger children was one of overt defiance and obstinacy, with less tendency to hide their hostility and resistance.

Vaughan and Cashmore (68) explain this differential pattern in the following terms:- "Among the younger patients, the children have usually been able to indulge in normal untidy activities, and to feel safe in expressing their hostile feelings openly. As the children grow older, stronger defences are called into play, in face of continued parental prohibition, so that the child himself may begin to show traits of excessive cleanliness, orderliness, and conforming passivity, with faecal soiling persisting as the only 'leakage' past these newly-erected defences. Overt demonstrations of hostility tend to disappear completely in these older children". McKeith (46), whose cases of "secondary" megacolon range from age 4 to age 14, considers that "the older cases in the group have a serious degree of emotional disharmony with their environment, and often need specialist psychotherapy. Younger children may respond to simpler measures". This proved to be the experience with the current series.

It would seem as though, among the younger children, the pattern of bowel negativism remains as yet freely expressed, while among the older children, the response tends to become encapsulated or suppressed. With these older children, it proved necessary to penetrate this facade during treatment, and to uncover, and permit the expression of underlying aggressiveness, before a satisfactory therapeutic result could be achieved.

14 cases showed radiographic evidence of megacolon to a varying degree; and it is likely from the clinical findings that at least a further 3 cases (Nos. 15, 16, 26), would have shown similar evidence had a barium enema been undertaken. Of these 17 cases, the majority were of longer standing, or showed deeper entrenchment of symptoms than the remaining 13. The latter group were mostly referred at an earlier stage of the disorder, or following less investigation and treatment.

It is submitted that these 13 cases, although not yet at the stage of megacolon development, bore the same aetiological features as the group of longer standing; that in fact, they belong to the same category of case. In the main, their treatment at the abortive stage presented less difficulty, and required less time. Of the 6 cases whose response to psychiatric treatment has so far proved unsatisfactory, 3 belong to the more chronic group with serious personality disturbance (Nos. 11, 12, 26), and contact with the remaining 3 has been lost. In none of the 13 earlier cases who were submitted to treatment for an adequate period, has there been any failure of response.

In contrast, the persistence of symptoms into early adult life is recorded by Bodian et al (9). In their original group of 34 cases of idiopathic megacolon, the age range extended from 18 months to 21 years.

Almy (4), referring to the early background of 29 adult cases under investigation for "spastic constipation", found that:- "They were usually raised in a strict moral atmosphere in which bodily functions of an intimate nature were never unashamedly discussed, but in which great stress was laid upon the achievement of a daily bowel movement. Defaecation had often assumed moral implications and the mother had often treated the patient from an early age with laxatives or enemas. This painful experience had yielded an attitude of hostility towards the mother". The similarity between these findings, and the findings provided by the present study suggests a possible relationship.

References to the treatment and prognosis of "congenital" megacolon in the earlier literature, included cases which ran a relatively benign course, and seemed to have a more favourable prognosis as to mortality. Grimson et al (30) in 1944, reported 12 such cases in a series of 24. In the light of the criteria subsequently established for differentiating between aganglionic megacolon and the non-aganglionic or functional type, it seems likely that at least some of these cases were functionally or psychogenetically determined.

These data indicate that in the main, satisfactory response is achieved more readily, the earlier the case is referred for treatment; while at the other extreme, there is the potentiality for persistence of bowel disorder into adult life. It seems clear that early diagnosis and treatment of the condition has much to commend it.

9) Sex Distribution.

Of the cases forming the primary series, 19 were male and 11 female. There was thus a preponderance of male children in the ratio of almost 2 to 1. In Bodian's group of 34 cases of idiopathic megacolon, the corresponding numbers were 25 boys and 9 girls. Bakwin (6), commenting upon the greater tendency to constipation among girls, adds that in contrast, resistance to bowel training and persistence of soiling is twice as common in boys. This finding corresponds to the sex ratio in the present series, and more approximately to the sex ratio in Bodian's series.

An explanation for this differential sex incidence may lie in Freud's observation that:- "The little girl is as a rule less aggressive, less defiant and less self-sufficient.....The fact that she is more easily and more quickly taught to control her excretions is very probably only the result of this docility". (26b).

In several of the current series, there was a manifest tendency among the mothers to overvalue their male children relative to their female children. This might conceivably provide the motive in some cases for excessive focus of attention upon bowel regularity in the male.

10) Corroboration of Treatment Procedures Adopted.

Corroboration of the therapeutic approach developed in the present study, is provided by a number of references in the literature, both to the direct treatment of children with bowel negativism, and to the re-education of their parents.

Most of the detailed studies upon children have hitherto consisted of single case presentations.

Warson et al (70), discuss the treatment of a six year old girl with chronic constipation and overflow soiling. They describe her gradual transition during play therapy, from meticulous avoidance of "messy" play, to the uninhibited use of sand, water, and brown finger paint. Bell and Levine (7), Reichert (56), and Comly (17), similarly advocate the use of finger-painting, and allied "messy" play materials, in the treatment of this kind of problem. Huschka (35), describing treatment of a 3 year old boy suffering from intractable constipation, refers to his choice of modelling clay as a means of expressive play. Comly (17) reports a similar case, using the same treatment approach.

The problem of the child's increased aggressiveness, through release of underlying hostility during play therapy, is referred to by Richmond (57). He describes the difficulties of controlling such behaviour, especially since the parents are so accustomed to a formerly compliant child. Further reference is made to this problem by Hunt and Parnet (33), who discuss the treatment of 2 cases of serious constipation in children, simulating megacolon.

These authors describe a variant of the joint approach adopted in the current study; namely concerted therapy by the child psychiatrist and paediatrician, in collaboration with the family doctor. Their aim is to educate the family practitioner through treatment conferences, so that he may in turn educate the parents. Therapy is designed to "give parents insight into the emotional and personality relationships surrounding the child's condition, so that they will modify their attitude, with resulting resolution of the constipation. The family doctor, through his own enhanced insight, is better able to support the parents in coping with, and tolerating, the child's increased aggressiveness".

Discussing the approach to parents, McKeith (46), advises against "trying to fight the child upon whether he does or does not want either to eat or to defaecate. He can always win". He recommends leaving the child to return spontaneously to more acceptable behaviour when he is not driven to assert himself. He concludes that:- "Treatment of the condition essentially involves removal of the cause, whether that be underfeeding, absence of ganglion cells in the terminal colon, or a 'state of war' between child and mother".

Swenson (66), similarly stresses the need for "convincing parents not to supervise the child's bowel performance". Bakwin (6) advocates free discussion by parents of the problems concerning them, in preference to a dogmatic approach. Comly (17), emphasises the principle of parental guidance in treatment, rather than domination by the physician. Reichert (56) underlines the value of citing detailed clinical examples of similar cases:- "Parents learn by such examples to draw analogy with their own family situation and equivalent emotional tensions. In this way, they are given insight". Reichert's technique is reminiscent of the principle underlying group therapy with parents adopted in the current study. Finally, Comly and McKeith both stress the value of anticipatory guidance to parents during the infant's first year of life:- "By sensible enlightenment of parents at this early stage, major problems can be avoided in subsequent development". (46)

In the last analysis, much depends upon the orientation of the paediatric specialist, since it is to him that the majority of cases of this kind will be referred in the first instance, because of their physical presentation. Chapman and Loeb (16), aptly comment:- "The ultimate success of referral for psychiatric opinion depends on the referring paediatrician's skill in allaying parental guilt and anxiety about seeking such help. His ability to explain the importance of emotional factors is itself an important factor in whether parents will actually follow up the suggestion of psychiatric referral. A small amount of extra time devoted by the paediatrician to talk to parents about these gastro-intestinal problems, and how life stresses and personality factors affect the ailment, is often one of the most therapeutic things he does. It is often useful to remember that the word "doctor" derives from the Latin verb "docere" to teach".

CONCLUSIONS.

Each of the 30 cases described in the current study, despite their diversity of background, had in common the factor of conflict between parent and child in the sphere of bowel function. Parental efforts to promote bowel regularity had induced a reactive state of negativism in the child, manifested as resistance to defaecation. This in turn, led to chronic faecal retention, with ultimate dilatation of rectum and terminal colon, if allowed to persist for a sufficient length of time. The megacolon so produced could not be attributed to any underlying organic lesion. On the evidence presented, it is of psychogenic origin.

Comparison of psychogenic megacolon, as exemplified in this study, with the condition formerly designated idiopathic megacolon, demonstrates close affinity between the two entities, in clinical features, pattern of development, and radiographic appearances. It is concluded that the two conditions share a common origin.

Idiopathic megacolon is attributed to colonic inertia, which is variously ascribed in turn, to faults in bowel training, dietetic faults, or impaired tone of the bowel musculature. The conclusion to be drawn from the current investigation is that while colonic inertia forms the immediate basis of the condition, its development is secondary to the state of chronic constipation which results from persistent bowel negativism.

Rational treatment of the condition should therefore be directed towards resolving the child's negativistic behaviour, since this represents the ultimate basis of the disorder.

Treatment must include exploration for the emotional factors within the parent-child relationship, which determine the patient's negativistic response; and appropriate realignment of parental attitude, so that the state of conflict over bowel function is removed. Unless the therapeutic approach is extended beyond symptomatic treatment, to take cognisance of the underlying emotional problems, such parent-child tensions may remain unrecognised, and failure to deal with them may undermine the long term therapeutic result.

Joint consultation between paediatrician and child psychiatrist ensures that such a comprehensive approach is instituted. Parental reassurance is more effectively promoted, continuity in treatment is preserved, and although the physical symptoms are viewed with detachment, there is no risk of neglecting the local bowel disorder while pursuing the broader treatment indications. The paediatrician gains insight for the emotional dynamics of the condition, and the psychiatrist gains perspective upon its physiological aspects. Each discipline reinforces the contribution of the other, and the prognosis for successful treatment is thereby enhanced.

The difficulties encountered in the programme of treatment undertaken, emphasise the need for educating the laity both in more enlightened methods of infant and child management, and in the elementary physiology of defaecation. It would seem advisable to propagate these principles among student nurses and medical undergraduates at an early stage in the course of their training; to impress upon them the potential hazards of coercive habit training; and to underline the importance of firmly discrediting ill-founded fears and superstitions among parents regarding bowel function. Ultimately, these doctrines would reach and influence the public through the medium of the family doctor and district nurse, or through infant welfare clinics and hospital out-patient departments, staffed with enlightened personnel. By so counteracting and dispelling ingrained prejudice concerning constipation, and by promoting the practice of less rigid methods of primary habit training in infants, much could be achieved in the prophylaxis of bowel negativism and its ultimate development as psychogenic megacolon.

APPENDIX I

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APPENDIX I.

Plate No. 1.



Case No. 1. M.S. (Male)

Barium enema (patient age 5):- Colon as a whole of rather large diameter with redundant looping. No evidence of Hirschsprung's disease. (See Text p. 6).

APPENDIX I.

Plate No. 2.



Case No. 1. M.S. (Male)
Appearances after barium evacuation.

(See Text p. 6)

APPENDIX I.

Plate No. 3.



Case No. 2 R.T. (Male)

Barium enema (patient age $2\frac{1}{2}$):- Large atonic lower colon, with considerable redundancy of pelvic loops of bowel. No evidence of Hirschsprung's disease. Segmental megacolon.

(See Text p. 9.)

APPENDIX I.

Plate No. 4.



Case No. 4. J.McL. (Male)

Barium enema (patient age 15):- Considerable looping and dilatation of the pelvic and descending colon. No evidence of pathological lesion.
(See Text p. 16)

APPENDIX I.

Plate No. 5.



Case No. 4. J. McL. (Male)

Appearances after barium evacuation.

APPENDIX I.

Plate No. 6.



Case No. 5. M.B. (Male)

Barium enema (patient age $8\frac{1}{2}$):- Large dilated colon with impacted faeces high up. No evidence of Hirschsprung's disease.

(See Text p. 19)

APPENDIX I.

Plate No. 7.



Case No. 6. R.W.G. (Male)

Barium enema (patient age 5):- The colon is very large and appearances are consistent with megacolon. No evidence of Hirschsprung's disease.

(See Text p. 22.)

APPENDIX I.

Plate No. 8.



Case No. 7. R.H. (Male)

Barium enema (patient age 10):- No evidence of Hirschsprung's disease. Radiographic appearances suggest idiopathic megacolon.

(See Text p. 25)

APPENDIX I.

Plate No. 9.



Case No. 8. R.A. (Male)

Barium enema (patient age $5\frac{1}{2}$):- Dilatation of terminal bowel, with redundant looping of pelvic colon. No evidence of Hirschsprung's disease (film after evacuation).

(See Text p. 28)

APPENDIX I.

Plate No. 10.



Case No. 9. K.L. (Male)

Barium enema (patient age $6\frac{1}{2}$):- Long colon with redundant looping; 'dolichocolon'. Emptying rate rather poor but no actual evidence of megacolon.

(See Text p. 30)

APPENDIX I.

Plate No. 11.



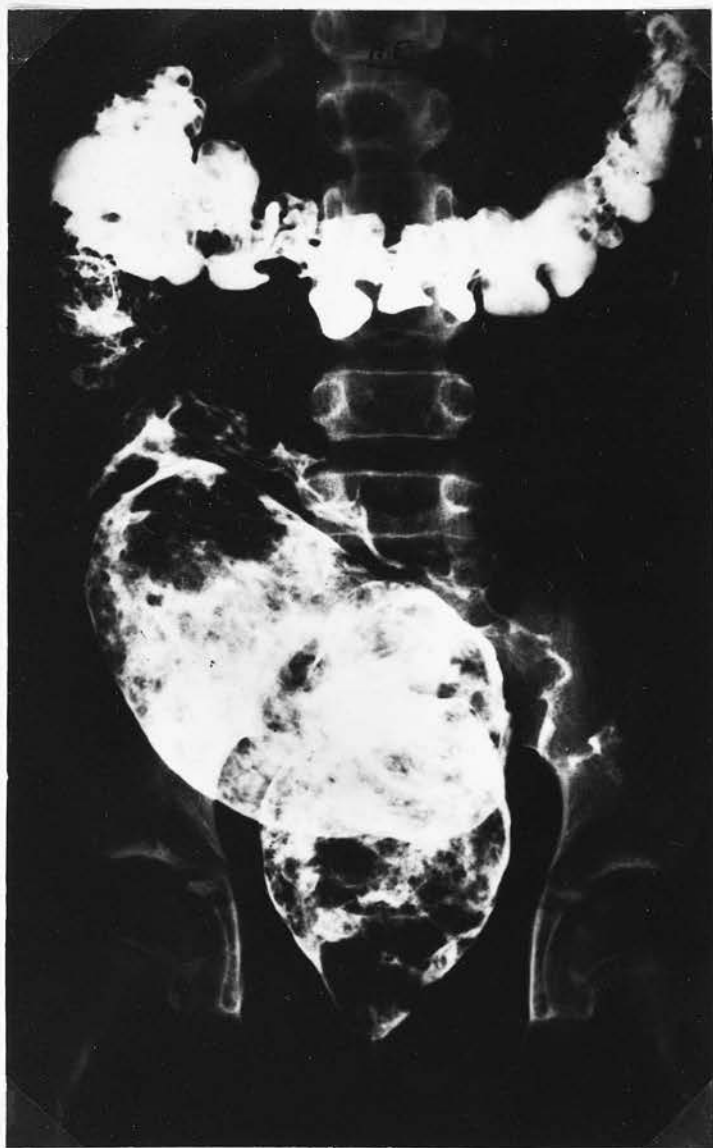
Case No. 9. K.L. (Male)

Barium enema (patient age $8\frac{1}{2}$):- Gross dilatation of rectum, pelvic colon, and descending colon. Appearance now suggests megacolon.

(See Text p. 30)

APPENDIX I.

Plate No. 12.



Case No. 10. J.W.G. (Male)

Barium enema (patient age 10):- Dilatation of rectum and part of sigmoid colon extending down to ano-rectal junction. Appearance is that of colonic inertia.

(See Text p. 33)

APPENDIX I.

Plate No. 13.



Case No. 11. P.G. (Male)

Barium enema (patient age 7):- Some dilatation of rectum and distal colon. No evidence of Hirschsprung's disease.

(See Text p. 36)

APPENDIX I.

Plate No. 14.



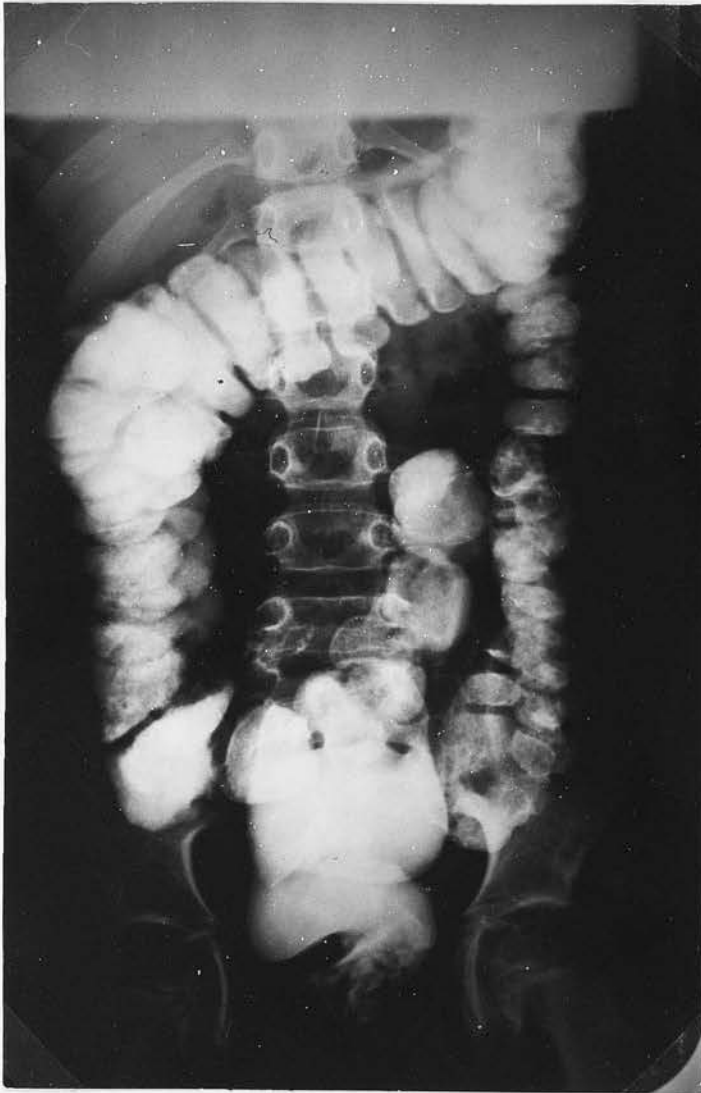
Case No. 12. D.M. (Male)

Barium enema (patient age $8\frac{1}{2}$):- Reservoir enlargement of rectum and pelvic colon. Colon otherwise normal.

(See Text p. 39)

APPENDIX I.

Plate No. 15.

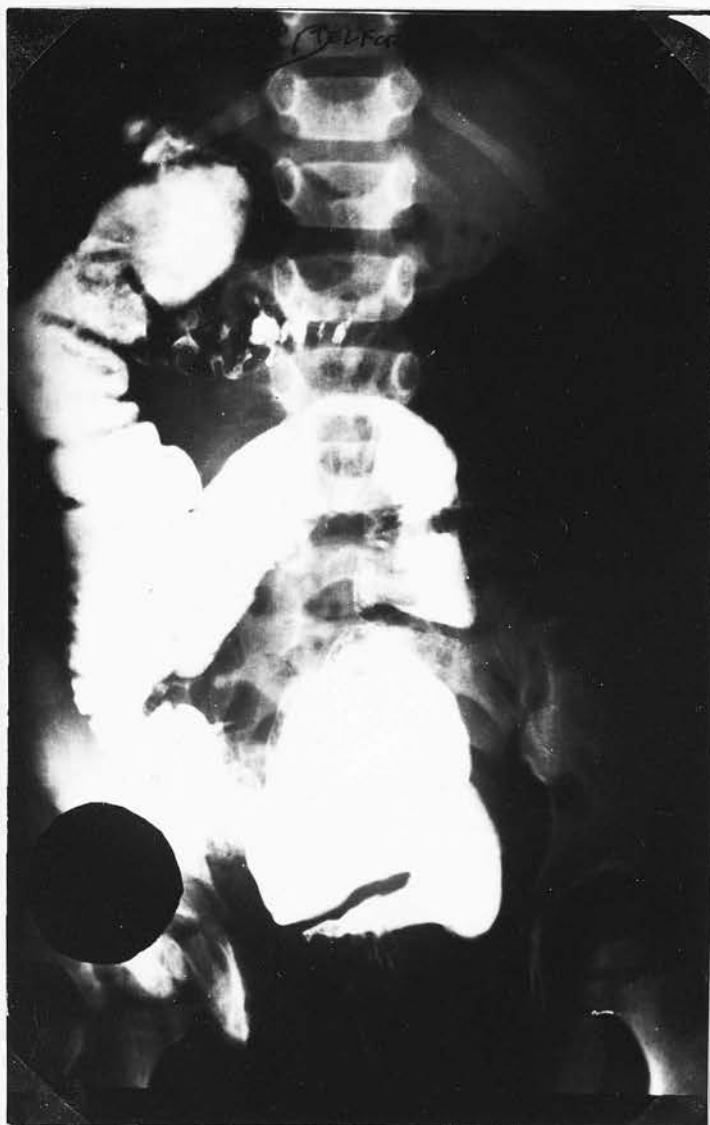


Case No. 12. D.M. (Male)

Appearances after barium evacuation.

APPENDIX I.

Plate No. 16.



Case No. 13. K.T. (Male)

Barium enema (patient age 5):- Colon appears normal in calibre.
No lesion demonstrable.
cf plate No. 17 eighteen months later.

(See Text p. 42)

APPENDIX I.

Plate No. 17.



Case No. 13. K.T. (Male)

Barium enema (patient age $6\frac{1}{2}$):- Dilatation of rectum and distal pelvic colon. Appearances now suggest megacolon.

(See Text p. 42)

APPENDIX I.

Plate No. 18.



Case No. 14. B.D. (Male)

Barium enema (patient age $2\frac{1}{2}$):- Large atonic colon. There is in effect a megacolon. No suggestion of Hirschsprung's disease.

(See Text p. 44.)

APPENDIX I.

Plate No. 19.



Case No. 14. B.D. (Male)

Appearances after barium evacuation.

APPENDIX II

Pages 177 - 197

APPENDIX II.

Plate No. 1.



The Aggression Board.

One of the three techniques principally employed in expressive play therapy with the children under study.

(See Treatment Section p. 124)

APPENDIX II.

Plate No. 2.



The Sand Tray.

an alternative medium for expressive play therapy.

Case No. 9. K.L. Boy age 9.

Portrayal of a zoo, indicative of controlled or "fenced-in" aggression, at an early stage in treatment.

(See Treatment Section p. 124)

APPENDIX II.

Plate No. 3.



Case No. 9.

Portrayal of soldiers warding off attacking crocodiles, indicative of emergent aggression, later in treatment.

(See Treatment Section p. 125)

APPENDIX II.

Plate No. 4.



Case No. 9.

Unstructured play in "messy" wet sand -
regression to immature level of play,
signifying a further advance in therapy.

(See Treatment Section p. 125)

APPENDIX II.

Plate No. 5.



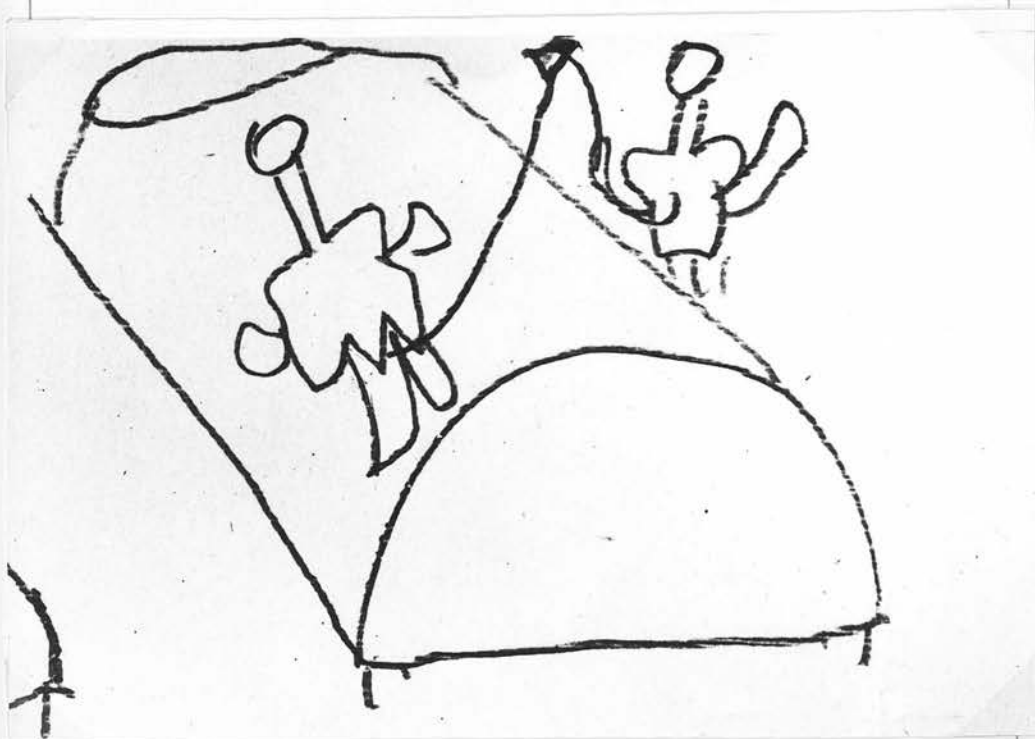
Case No. 9.

Central theme portrays cowboy trapped on mound of sand, between two menacing tigers. Potential rescuer is advancing to his assistance.

For interpretation, see Treatment Section p. 125.

APPENDIX II.

Plate No. 6.



Case No. 9.

The administration of an enema, to patient,
drawn as an object of dislike, for destructive
treatment on the Aggression Board.

(See Treatment Section p. 126)

APPENDIX II.

Plate No. 7.



Case No. 9.

Release of frank aggression during therapy.
Uninhibited splattering of walls and ceiling
of playroom with wet sand.

"This is how you give an enema".

(See Treatment Section p. 126)

APPENDIX II.

Plate No. 8.



Case No. 9.

"Open" zoo, with animals moving about freely, in contrast to earlier portrayal of caged-in animals
(Plate 2)

Reversal of theme indicates patient's tolerance of his own newly released aggressiveness, without reactive anxiety. Corresponding clinical improvement.

(See Treatment Section p. 126)

APPENDIX II.

Plate No. 9.



Case No. 11. P.G. Boy aged 8.

Scene depicting solitary bus, placed in terminal roundabout, from which return exit is lined with redundancy of traffic signals (safety symbols). "The bus is quite safe". Car in background is parked off the road, and not in use. Farm tractor is immobile in the field. Reversion to "safe" play, after uninhibited moulding of sand mound in left background.

For interpretation, see Treatment Section p. 127.

APPENDIX II.

Plate No. 10.



Case No. 11.

The administration of an enema to patient, drawn as an object of dislike, for destructive treatment on the Aggression Board.

Nurse:- "I have never known anyone so rude".
 "I'll give you another enema for that".

Child:- "I'll give you an enema, you darn pest".

(See Treatment Section p. 127)

APPENDIX II.

Plate No. 11.



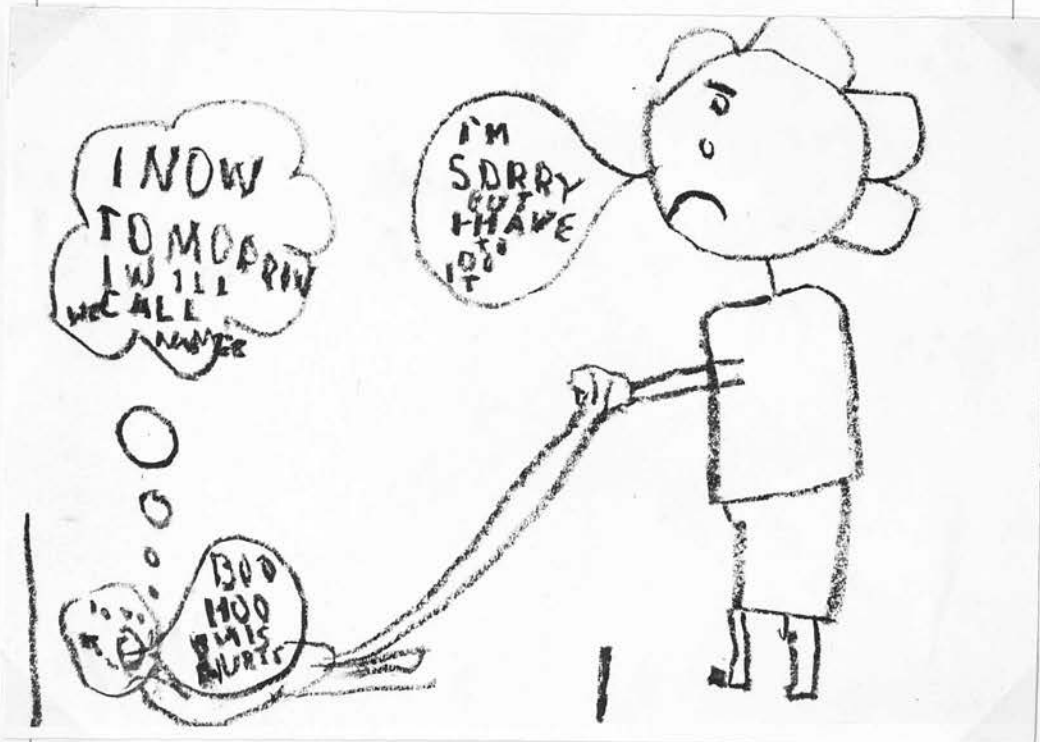
Case No. 11.

Release of frank aggression during therapy.
 In addition to the bean-bags, wet sand has been thrown
 violently against the drawing (Plate 12) on the
 Aggression Board.

(See Treatment Section p. 127)

APPENDIX II.

Plate No. 12.



Case No. 11.

Further portrayal of enema being administered to patient, drawn as an object of dislike, and treated as shown on Plate 11. The verbal interchange between nurse and patient is now more conciliatory.

Child:- "Boo-hoo this hurts".

Nurse:- "I am sorry but I have to do it".

Child:- "I know; tomorrow I will call you nursie".

(See Treatment Section p. 127)

APPENDIX II.

Plate No. 13.



Case No. 11.

Elaborate network of bridges, tunnels, and roads, constructed with obvious satisfaction. At this stage of treatment, reversion to "safe" play is significantly less precipitate. cf. Plate 9.

There is positive flow of traffic, pedestrians are introduced (protected by zebra crossing in rt. foreground) and traffic signals are now used appropriately.

For interpretation see Treatment Section p. 128.

APPENDIX II.

Plate No. 14.



Case No. 26. J.N. Girl aged 7.

Unprompted choice of subject for drawing - the administration
of an enema to patient. (cf. Plate 15)

(See Treatment Section p. 128)

APPENDIX II.

Plate No. 15.



Case No. 26.

Further portrayal of an enema being administered to patient, now drawn as an object of dislike.

Child:-"I'll teach you old nurse a lesson".

Nurse:-"No you won't, you can't".

(See Treatment Section p. 128)

APPENDIX II.

Plate No. 16.



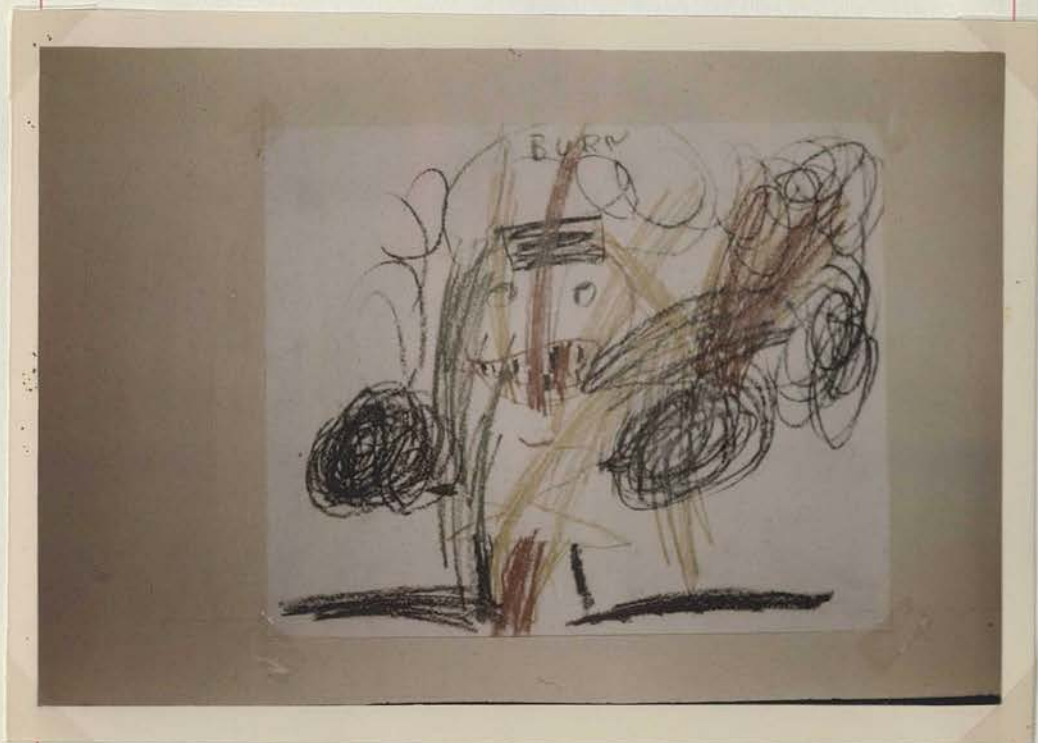
Case No. 26.

Unprompted drawing of fearsome female figure,
with encircling arms, identified from subsequent
versions as the mother-figure. (cf. Plate 17)

(See Treatment Section p. 129)

APPENDIX II.

Plate No. 17.



Case No. 26.

Elaboration of drawing depicted in Plate 16.
 The female figure is now shown with black smoke
 belching from the region of both breasts, and
 red flame emanating from the perineal region.
 The figure is being consumed by fire.

(See Treatment Section p. 129)

APPENDIX II.

Plate No. 18.



Case No. 26.

Transfer of play medium to sand tray.

Child's spontaneous comment:-

"People think women have three holes. Really they only have one big one. The mothers want to laugh at the little man dancing in the big hole, but they dare not".

For interpretation see Treatment Section p. 129.

(See Treatment Section p. 129)

APPENDIX II.

Plate No. 19.



Case No. 26.

Female figure (spontaneously identified as child's mother) has lost its fearsome appearance. Now transformed by summer frock, with the sun shining.

"This is a happy picture".

(See Treatment Section p. 129)

APPENDIX II.

Plate No. 20.



Case No. 8. R.A. Boy aged 6.

Uninhibited "messy" play in wet sand,
filling buckets to overflowing.

For significance of this activity, see Treatment Section
p. 130.

APPENDIX II.

Plate No. 21.



Case No. 8.

Advance in level of play, at penultimate stage of treatment, to organised and structured portrayal of battle between cowboys and indians, with aggressive animation, but without former evidence of reactive anxiety. Corresponding clinical improvement.

(See Treatment Section p. 130).



FIG. 2.—Diagram to illustrate the sigmoid flexion in Hirschsprung's disease (left) and in sigmoid flexion of the normal colon (right).

APPENDIX III



FIG. 1.—Progression of dilatation of rectum and sigmoid colon in the "terminal reservoir" and "tubular dilatation" varieties of megacolon due to colonic inertia.

APPENDIX III.

Plates 1 & 2.

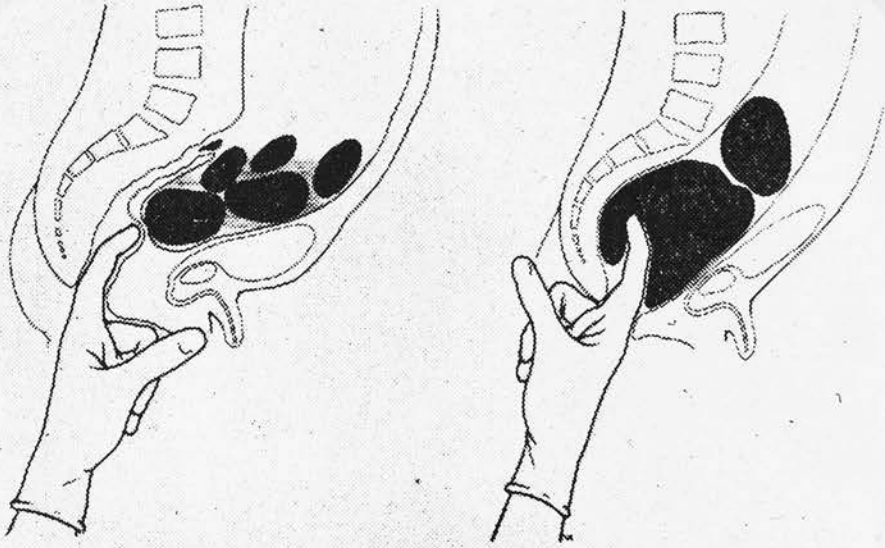


FIG. 3.—Diagram to illustrate the findings on rectal examination in Hirschsprung's disease (left) and in megacolon due to colonic inertia (right).

See Text p. 133.

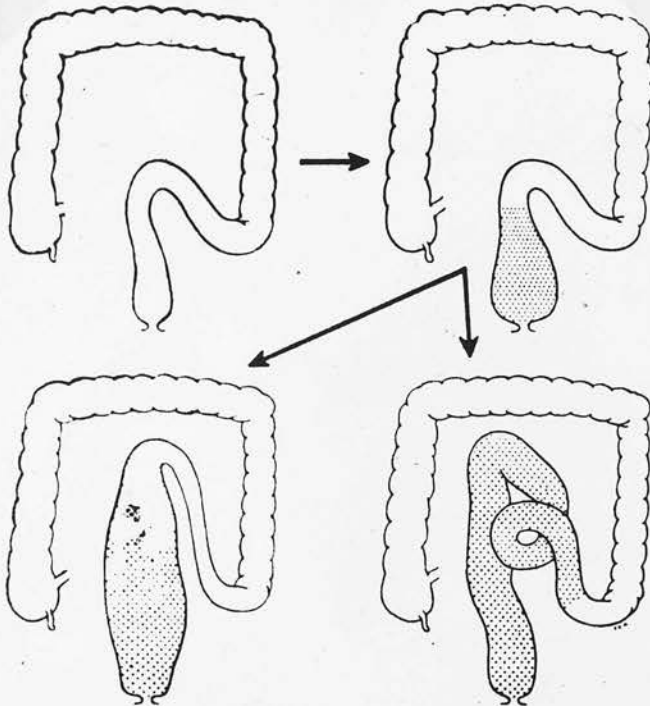


FIG. 1.—Progression of dilatation of rectum and sigmoid colon to the 'terminal reservoir' and 'tubular dilatation' variants of megacolon due to colonic inertia.

APPENDIX III.

Plate 3.

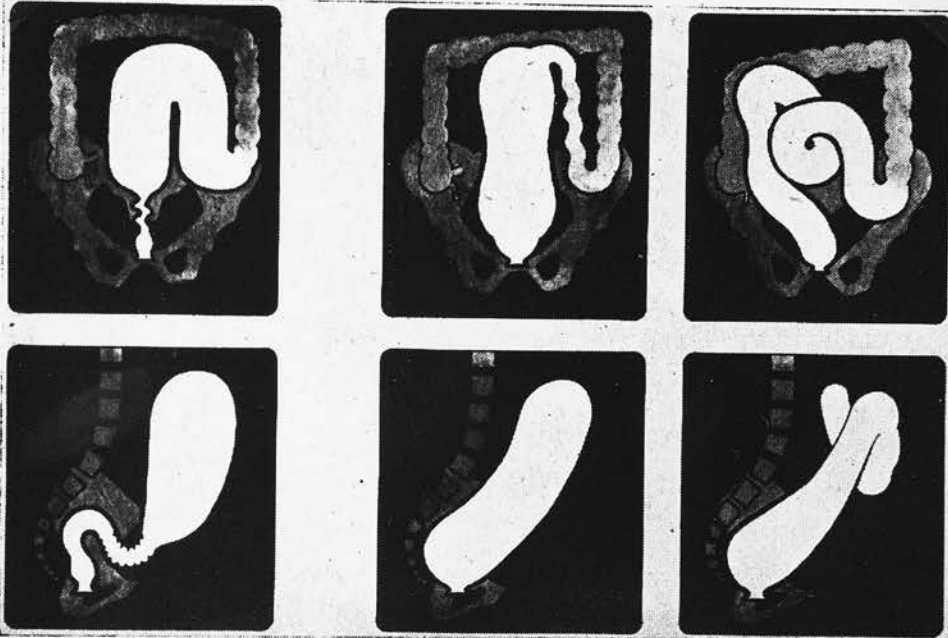


FIG. 4.—Diagram of the skiographic appearances in Hirschsprung's disease (left), 'terminal reservoir' megacolon (centre), and 'tubular dilatation' megacolon (right).

The narrowed aganglionic segment of terminal bowel is shown in the representation of Hirschsprung's disease (left); while in megacolon due to colonic inertia (centre & right), the dilatation of bowel extends down to the ano-rectal junction.

A number of the plates in Appendix I, showing the radiographic appearances of cases in the present series, resemble the schematic representations depicted above for idiopathic megacolon.

Plates 1, 2 & 3, abstracted from:—

"Chronic Constipation in Children, with particular reference to Hirschsprung's disease" - Bodian, M.
The Practitioner 169:2. 517/529. 1952.

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