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From defence mechanism to insufficient bladder control: Dutch experts on *enuresis nocturna* in an age of developing child sciences (*c.* 1950-1990)

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ABSTRACT

This article discusses the conceptualisation of *enuresis nocturna* by Dutch experts between *c.*1950 and 1990, years in which across the West new child sciences rapidly developed. Today, bedwetting is conceived as a mental illness caused by a mixture of nature- and nurture-bound factors. Have organic and environmental causes always figured as twins, even in the post-war decades of predominant environmentalism in psychological theory and clinical practice? Or is only the more recent biological turn in psychiatry responsible for a revaluation of organicism in expert discourses on the aetiology and treatment of childhood mental illnesses such as *enuresis nocturna*? Using Ian Hacking's dynamic nominalism as interpretive framework, the article shows that, in the Dutch case, environmental factors continued to be referred to after the biologising of children's mental problems, alongside an increasingly important role for brain-related, physiological and genetic causes of *enuresis nocturna*.

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Introduction

Today, bedwetting (*enuresis nocturna*) in childhood is seen as a mental illness that influences both the child and its social environment. In the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM, published in 2013) we find a separate chapter on this condition, in which the diagnostic criteria, accompanying symptoms and possible causes are described. According to the manual, several factors may be involved, such as a small bladder capacity or a delay in the 'development of normal urine production', leading to problems in controlling the pressure of having to go to the toilet. A genetic component can also play a role. Alongside organic conditions, the environment may be to blame. The DSM describes how 'psychosocial stress', growing up in an institution and delayed toilet training can likewise produce bedwetting.[1] In this way the manual indicates a mixture of nature- and nurture-bound explanations.

Although nocturnal enuresis did not figure in the dominant child-rearing discourse until the interwar years, it is safe to assume that children and their care-givers have

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[1]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders. Fifth edition. DSM-5* (Washington DC: American Psychiatric Publishing, 2013), 355–7.

always struggled with this problem, not so much as an illness but as irritating behaviour. Ever since the establishment of child guidance clinics from the 1920s this nuisance has become one of the most frequently mentioned reasons for parents to apply for help.[2] Therefore, it is no surprise that child guidance practitioners were among the first experts to conceptualise nocturnal enuresis as mental illness. A pioneering theorist was Robina S. Addis, one of the first British psychiatric social workers. She analysed the 1705 case records of the six child guidance clinics that were operating in England in 1932 and found that on average 18.4% of the cases concerned enuretics, with a relatively low average age of between eight and 10. As only a small number of all bedwetting children were referred to these clinics, this number was said to testify to the huge prevalence of the problem. Unlike today's DSM, Addis did not conceive of nocturnal enuresis as an illness in itself. To her it was 'a symptom belonging to several conditions and brought about by various mechanisms'. Concerning the latter, she saw an urgent need for more research, envisioning both 'endocrine' and 'psychological' causes.[3] Have researchers, both within and outside the burgeoning post-war mental health movement, of which child guidance was a prominent part,[4] tried but failed to solve this puzzle? Have organic and environmental causes always figured as twins, even in the post-war decades of predominant environmentalism in psychological theory and clinical practice?[5] Or is only the more recent biological turn in psychiatry[6] responsible for a revaluation of organicism in expert discourses on the aetiology and treatment of childhood mental disorders such as *enuresis nocturna*?

According to the philosopher of science Ian Hacking, experts working in institutions guaranteeing their status, and the knowledge they generate or legitimise, play a key role in the interaction between classifications of mental illnesses and the people thus classified. Using his dynamic nominalism as interpretive framework, we can say that case descriptions of child guidance practitioners such as Addis created the category of enuretic children who suffered from an illness that required treatment. In his words, they 'made up' a new, medicalised 'kind of people', classified as 'enuretics'. Next to 'medicalisation', he recognises other 'engines of discovery' creating knowledge and making up people, among which are 'biologising' and 'geneticising' complaints.[7] After the initial medicalisation of bedwetters by turning them into enuretic patients of child

[2]Kathleen W. Jones, *Taming the Troublesome Child: American Families, Child Guidance, and the Limits of Psychiatric Authority* (Cambridge, MA: Harvard University Press, 1999); John Stewart, *Child Guidance in Britain, 1918–1955: The Dangerous Age of Childhood* (London: Taylor & Francis, 2013).

[3]Robina S. Addis, 'A Study of Nocturnal Enuresis', *Archives of Disease in Childhood* 10 (1935): 177.

[4]Jones, *Taming*; Stewart, *Child Guidance*; Nelleke Bakker, 'Child Guidance, Dynamic Psychology and the Psychopathologisation of Child-Rearing Culture: A Transnational Perspective', *History of Education* 49, no. 5 (2020): 617–35.

[5]*Cultures of Psychiatry and Mental Health Care in Post-War Britain and the Netherlands*, ed. Marijke Gijswijt-Hofstra and Roy Porter (Leiden: Rodopi, 1998); Mona Gleason, *Normalising the Ideal: Psychology, Schooling and the Family in Post-War Canada* (Toronto: Toronto University Press, 1999); Nelleke Bakker and Milou Smit, '"An oedipal conflict on an epileptic basis": The Diagnosing and Treatment of Behavioral Problems in a Dutch Child-Psychiatric Clinic (1952–1962)', *Paedagogica Historica* 56 (2020): 341–59.

[6]Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: Wiley, 1997), 239–328; Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton, NJ: Princeton University Press, 2007).

[7]Ian Hacking, 'Kinds of People: Moving Targets', *Proceedings of the British Academy* 151 (2007): 285–318; Ian Hacking, 'The Looping Effects of Human Kinds', in *Causal Cognition: A Multidisciplinary Debate*, ed. Dan Sperber, David Premack and Ann James Premack (Oxford: Clarendon Press, 2012), 351–83; Ian Hacking, *Historical Ontology* (Cambridge, MA: Harvard University Press, 2002), 99–114.

guidance clinics, these engines may in later decades have contributed to the development of new expert knowledge regarding the causes and treatment of *enuresis nocturna*, after older, often nurture-bound interpretations no longer fitted, notwithstanding the apparent continuity in the behaviour of 'the enuretic child'. The 1980s in particular may have brought new conceptualisations of such children thanks to the rise of biological psychiatry, in which organic causes and treatment with medication instead of psychotherapy figure prominently.[8] There are, however, indications that even in the heyday of psychoanalysis in western societies, the 1950s and 1960s, the focus on nurture did not imply that biomedical factors were ignored in the theorising on the aetiology of problem behaviour or that biomedical treatment was completely avoided.[9]

This article discusses the changes in the conceptualisation of *enuresis nocturna* by representatives of three new kinds of academic child study in the Netherlands in the period *c*.1950–1990: child psychiatry, child psychology and special-needs education studies. The Netherlands provides a good case for this research as child guidance arrived there relatively early, from in 1928, and was imported directly from the United States, where it had first developed. In the years following the Second World War, when the mental health movement flourished across the West, child guidance even turned out to be its leading division in this country and the clinics were the main training ground for the most prestigious of the new child sciences: child psychiatry. We focus on changes in the expert discourse on enuresis, particularly on traces of biologising and geneticising the complaints of the recently created medical category of 'the enuretic child', searching for shifts in the balance between nature and nurture in classifications and instructions published in the leading manuals and journals for professionals.[10] We consider the assumed causes and proposed types of treatment of the condition and try to find out to what extent experts' professional background – medical, psychological or educational – mattered in their role as 'engines of discovery' who brought new conceptualisations of *enuresis nocturna*. And if nature-bound explanations, such as brain dysfunction or a constitutional defect, did become more prominent, how does this relate to the development of clinical practices in the institutions these experts represented?

First, we discuss the three academic kinds of child study that developed in the postwar years and the institutions where the new child scientists practised. Next, we discuss the changes in the conceptualisation of bedwetting by the three professions involved during the years in which *enuresis nocturna* was already medicalised, but not yet biologised and geneticised to the extent we have grown accustomed to since the arrival of biopsychiatry. We analyse the expert discourse along the lines of our foci in the subsequent models of explanation.

[8]Shorter, *A History*, 239–328; Rose, *The Politics*.

[9]Jonathan H. Sadowsky, 'Beyond the Metaphor of the Pendulum: Electroconvulsive Therapy, Psychoanalysis, and the Styles of American Psychiatry', *Journal of the History of Medicine and Allied Sciences* 61 (2006): 1–25; Edo Nieweg, 'Van kinderanalyse tot Y-chromosoom. Over eenzijdigheid in de psychiatrie', *Tijdschrift voor Psychiatrie* 42 (2000): 887–94.

[10]Manuals for children's health-care professionals, school social workers and teachers in special education were mostly written by child psychiatrists. Professional journals recruited authors from each of the three new academic fields of child study, besides school doctors and paediatricians; they covered teaching, special education, social work, children's health care and mental health in general. The articles regularly discussed individual cases of children's behaviour problems, describing possible causes and kinds of treatment. From the 1980s, research with larger groups in which the effects of different treatments were compared figured more often, while case studies did not disappear.

Three new child sciences and their institutions

In post-war years, children's behaviour problems were studied and treated in different kinds of institutions, of which the child guidance clinics were most important. Before the war only seven of these outpatient clinics had been established. These were staffed with a multidisciplinary team, headed by a child psychiatrist and including a paediatrician and a psychiatric social worker who was the only full-time employee. After the war, the number of these clinics increased rapidly: from eight in 1946 to 15 in 1952 and no fewer than 69 fully staffed clinics in 1960 (including 30 Roman Catholic and four Protestant ones), together with 25 outposts offering consulting hours less than once a week by a travelling team. Unlike in the United States, psychologists did not join the teams from the start but only from the 1950s, when they first became available. The paediatrician examined the child physically, the psychologist tested him or her and the psychiatrist observed the child's play or drawings and talked with the child in search of a diagnosis, while the psychiatric social worker collected information from the parents. The psychiatrist was also responsible for the treatment of the child with psychotherapy or, in the case of a young child, play therapy. The psychiatric social worker was expected to help the parents to change their attitude towards the child by means of a series of talks ('influencing the environment'); this was conceived as the key therapeutic intervention. Despite the rapid growth in the number of child guidance clinics, waiting lists soon became the rule. Shortages of child psychiatrists and psychiatric social workers, both of whom trained at these clinics, continued to exist and limit the proliferation of the clinics' work.[11]

Theoretically, this work was based on psychodynamic theory, especially psychoanalysis. It is interesting to note that, with a few exceptions, the whole first generation of post-war Dutch academic child psychiatrists, who were appointed from the 1950s, were psychoanalysts who had trained at one of the oldest child guidance clinics.[12] After they were appointed at one of the universities they established clinics of their own, in which they combined the child guidance outpatient approach with a small ward for observation and treatment of the more serious cases.[13] This first generation of child psychiatrists subscribed to the idea of the booming post-war international mental health movement that prioritised prevention of mental ill-health in adulthood by providing, if necessary, long-term psychoanalytic treatment during childhood. Nevertheless, as in England in 1932, ordinary, everyday children's problems prevailed among the complaints that were treated in the clinics: anxieties, learning problems and bedwetting, most of which were interpreted as maladaptation and often explained as expressions of neuroticism.[14] The cause of the trouble was almost invariably found with the parents, who were blamed for 'neurotic' parenting. That is why, in child

[11]E. C. Lekkerkerker, 'Tien jaar na de bevrijding', *Maandblad voor de Geestelijke Volksgezondheid* 10, no. 3 (1955): 173–200; *Geestelijke gezondheidszorg voor kinderen. Rapport* (Amsterdam: Nationale Federatie voor de Geestelijke Gezondheidszorg, 1961), 28; *Verslag 1962 t/m 1965* (Utrecht: Katholiek Nationaal Bureau voor Geestelijke Gezondheidszorg, 1967), 25; Tom van der Grinten, *De vorming van de ambulante geestelijke gezondheidszorg. Een historisch beleidsonderzoek* (Baarn: Ambo, 1987), 186–209.

[12]Leonie de Goei, *In de kinderschoenen. Ontstaan en ontwikkeling van de universitaire kinderpsychiatrie in Nederland, 1936–1978* (Utrecht: NcGv, 1992); Van der Grinten, *De vorming*, 186–209; *Geestelijke gezondheidszorg*.

[13]Bakker and Smit, '"An oedipal conflict"'.

[14]Bakker, 'Child Guidance'.

guidance propaganda, the family appeared at the same time as both the origin of children's behaviour problems and the only safe haven where a young child could develop towards mental health in adulthood. This made the family a key focus of the movement.[15]

In 1982, the child guidance clinics were integrated into regional institutes for mental health, within which they became relatively independent youth departments. Still, the link with adult psychiatry became more pertinent. This may be one of the reasons why in the 1980s child psychiatry changed in such a way that behaviour problems were more often understood in terms of activities or defects of the 'brain'.[16] The sociologist Nikolas Rose describes this process as the development of 'neurochemical selves', in which the brain became decisive in defining people's identities. This shift towards the neurochemicals of the brain also implies that medication was more often prescribed instead of psychotherapy.[17] It is, however, suggested that this did not undo the tendency among child psychiatrists to use 'psychosocial explanations' as well.[18]

The two Dutch denominational universities proceeded in a different way. In the 1930s both the Calvinist Free University in Amsterdam and the Roman Catholic University in Nijmegen had established a Paedological Institute for the diagnosing and treatment of all kinds of 'difficult' children. As in the child-psychiatric clinics that were established later at the other universities, the more serious cases were hospitalised for observation, while the other patients and their parents were seen during consulting hours, usually by a psychologist.[19] Both kinds of institution focused on academic research and theory and both focused more particularly than child guidance clinics on the child itself and his/her problems. An important difference between the two, however, was that the child-psychiatric clinics were led by psychiatrists, whereas the paedological institutes had a mixed staff in which psychologists predominated and took charge of the research. In post-war years academic child psychiatrists and clinical child psychologists of Roman-Catholic and Calvinist background trained and learned to do research at these centres, whereas the child guidance clinics continued to be the place where psychiatric social workers and some of the other psychiatrists learned their trade. From the 1970s, the paedological institutes developed many new therapies, focusing particularly on learning problems such as dyslexia and on autism, in which special-needs educationalists played a key role.[20]

[15]Leonie de Goei, 'Psychiatry and Society: The Dutch Mental Hygiene Movement 1924–1960', in *Cultures of Psychiatry and Mental Health Care in Post-War Britain and the Netherlands*, ed. Marijke Gijswijt-Hofstra and Roy Porter (Leiden: Rodopi, 1998), 79–101.

[16]Marijke Gijswijt-Hofstra, 'Within and Outside the Walls of the Asylum: Caring for the Dutch Mentally Ill, 1884–2000', in *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, ed. Marijke Gijswijt-Hofstra, Harry Oosterhuis, Joost Vijselaar and Hugh Freeman (Amsterdam: University Press, 2005), 35–72; Timo Bolt and Leonie de Goei, *Kinderen van hun tijd. Zestig jaar kinder- en jeugdpsychiatrie in Nederland 1948–2008* (Assen: Van Gorcum, 2008), 75–100.

[17]Rose, *The Politics*, 187–223.

[18]Bolt and De Goei, *Kinderen*, 75–100.

[19]*Een buitengewone plek voor bijzondere kinderen. Driekwart eeuw kinderstudies in het Paedologisch Instituut te Amsterdam (1931–2006)*, ed. Marjoke Rietveld-van Wingerden (Zoetermeer: Meinema, 2006); Rogier Chorus, *Alfons Chorus. Beeld van de mens en psycholoog* (Amsterdam: SWP, 2019); Annemieke van Drenth, 'Rethinking the Origins of Autism: Ida Frye and the Unraveling of Children's Inner World in the Netherlands in the 1930s', *Journal of the History of theBehavioral Sciences* 54 (2018): 25–42.

[20]*Een buitengewone plek*; Chorus, *Alfons Chorus*.

Child psychologists and special-needs educationalists presented themselves in other expanding fields as well. In the 1950s and 1960s, they acquired their first academic chairs. Child psychologists focused mainly on testing and on diagnostics and observation of 'problem' children. As testing experts, they practised not only in child guidance clinics and paedological institutes, but also on admission committees for special schools and more and more also in outpatient youth psychiatric and child welfare services.[21] From the late 1960s, special-needs educationalists supported teachers in the treatment of learning-disabled and emotionally disturbed children at special schools and became experts in the diagnosing and remedial teaching of these children.[22] In 1972, their testing expertise was recognised as equal to that of test psychologists by allowing them to participate in admission procedures for special schools.[23] In the 1970s, special-needs educationalists also became heavily involved in institutional and ambulatory care for delinquent, neglected and other 'difficult' children.[24] At the time, child protection and welfare services focused more particularly on keeping families together and on preventing institutionalisation of 'difficult' children.[25] This included providing therapy to children, particularly behavioural therapy,[26] and to families, such as family system therapy. In each case the emergence of the new academic professions such as therapists and counsellors implied that psychiatrists lost part of their influence in these fields, as educational and remedial treatment replaced psychiatric care.

According to Margret Winzer, as compared with child psychiatrists, special-needs educationalists in the United States demonstrate an inverse development regarding the nature–nurture emphasis in the way they have conceived of children's learning and behaviour problems. Having used biomedical and brain-related labels already in the 1950s and 1960s, around 1970 they moved towards using psychosocial explanations more often. The same has been suggested to have happened in the Netherlands.[27] In their case, a social model with an emphasis on human interaction would have discarded a decades-old medical one, while child psychiatrists were just about to discover children's 'neurochemical selves'. Does this hold true for enuretic children and if so, why?

[21]Eric Haas, *Op de juiste plaats. De opkomst van de bedrijfs- en schoolpsychologische beroepspraktijk in Nederland* (Hilversum: Verloren, 1995), 132–57, 168–75; Pieter van Strien, *Nederlandse psychologen en hun publiek. Een contextuele geschiedenis* (Assen: Van Gorcum, 1993), 117–18.

[22]Nelleke Bakker, 'A Culture of Knowledge Production: Testing and Observation of Dutch Children with Learning and Behavioural Problems (1949–1985)', *Paedagogica Historica* 53 (2017): 7–23.

[23]Fedor de Beer, *Witte jassen in de school. De schoolarts in Nederland, ca. 1895–1965* (Assen: Van Gorcum, 2008), 263.

[24]Herman Baartman, 'Ontwikkelingen in orthopedagogische visies op opvallende kinderen', in *Het perspectief van de orthopedagoog*, ed. Herman Baartman, Aryan van der Leij and Joop Stolk (Houten: Bohn Stafleu Van Loghum, 2000), 3–28.

[25]Ido Weijers, 'Zestig jaar kinder- en jeugdpsychiatrie in Nederland (1920–1980)', *Kind en Adolescent* 23, no. 2 (2002): 51–60; Evelien Tonkens, *Het zelfontplooiingsregime. De actualiteit van Dennendal en de jaren zestig* (Amsterdam: Bakker, 1999), 99.

[26]Nelleke Bakker, 'Brain Disease and the Study of Learning Disabilities in the Netherlands (c. 1950–85)', *Paedagogica Historica* 51 (2015): 350–64.

[27]Baartman, 'Ontwikkelingen in orthopedagogische visies'; Herman Baartman, 'Ontwikkelingen in de theoretische orthopedagogiek', in *Orthopedagogiek: Inzicht, uitzicht, overzicht*, ed. R. de Groot and J. van Weelden (Groningen: Wolters-Noordhoff, 1992), 46–73; Margret Winzer, *From Integration to Inclusion: A History of Special Education in the 20th Century* (Washington, DC: Gallaudet University Press, 2009), 110–11; M. A. Winzer, 'Confronting Difference: A Brief History of Special Education', in *The SAGE Handbook of Special Education*, ed. Lani Florian (Los Angeles: Sage Publications, 2014), 23–38.

Psychiatrists and the mother–child relationship (*c.*1950–1975)

In the Netherlands, a country in which child guidance clinics were established from 1928 and were modelled after the American example,[28] bedwetting was not discussed openly until the 1930s. The first discussants often belonged to the medical profession; they practised as child psychiatrists, general practitioners and school or toddler welfare bureau doctors. School doctors are known to have acted as confidential persons for mothers struggling with bedwetting school children.[29] The second profession involves child protection authorities responsible for children's homes, which are known to have struggled for centuries with and have often cruelly punished children for this fault. From the 1930s and 1940s, however, child protection experts insisted that for an institutionalised or foster child, bedwetting was an extremely humiliating experience that should not be aggravated by shame-inducing punishments.[30] A common characteristic of the early contributions to the discourse on *enuresis nocturna* are complaints that parents would not seek professional help due to feelings of shame. These shrank after the Second World War, as the problem was more often discussed in popular and professional journals.[31] Unlike British children, Dutch children had not been exposed to large-scale evacuation during the war, an experience that is said to have caused a substantial increase in both complaints about bedwetting and expert interest in its causes and treatment.[32] Nevertheless, in post-war years Dutch experts – like their British counterparts – gave considerably more attention to the pressing problem, a development that may partly be explained by the rapid growth in the number of child guidance clinics and the remarkable mood of child-focused reform that inspired child protection professionals at the time.[33]

One reason for this more frequent breaking of the silence may be the immediate popularity of the 1950 Dutch translation of the American paediatrician Benjamin Spock's best-selling *The Common Sense Book of Baby and Child Care*, in which bedwetting of toddlers is discussed as a 'normal' problem that could happen to every child and in every family. Like many of his contemporaries Spock conceived of enuresis as an almost exclusively psychological, nurture-related problem of primarily 'nervous' children, that could in many cases be solved by simple parental measures such as limiting fluid intake in the evening hours or using a special alarm for a deep-sleeping child. His readers were advised to visit a psychiatrist or a child guidance clinic for psychotherapy only in exceptional cases.[34]

Although school and family doctors were likely to be the ones who were most frequently confronted with desperate mothers of bedwetting children, in post-war years doctors of children's minds almost monopolised the presentation of theories

[28]Bakker, 'Child Guidance'.
[29]Nelleke Bakker, 'Promoting School Efficiency: Dutch School Doctors and the Meaning of Child Health (1930–1970)', *HSE-Social and Education History* 6 (2017): 196–219.
[30]D. Q. R. Mulock Houwer, 'Van falende kinderbescherming tot doeltreffende bijzondere jeugdzorg', in *Vijftigduizend kinderen roepen om hulp*!, ed. D. Q. R. Mulock Houwer, F. Grewel and Reine Friedman-van der Heide (Amsterdam: N.V. De Arbeiderspers, 1946), 6; D. Q. R. Mulock Houwer, *Gezinsverpleging* (Eibergen: Heinen N.V., 1940), 136–8; D. Q. R. Mulock Houwer, *Gestichtspaedagogische hoofdstukken* (Eibergen: Drukkerij Heinen, 1938), 72–84.
[31]Nelleke Bakker, *Kwetsbare kinderen. De groei van professionele zorg voor de jeugd* (Assen: Van Gorcum, 2016), 106–21.
[32]Niko Gärtner, *Operation Pied Piper: The Wartime Evacuation of Schoolchildren from London and Berlin, 1938–46* (Charlotte, NC: Information Age Publishing, 2012).
[33]Bakker, 'Child Guidance'; Geertje Dimmendaal, *Heropvoeding en behandeling. Meisjes in Huize de Ranitz, Groningen 1941–1967* (Groningen: RUG, 1998), 51–82.
[34]Benjamin Spock, *Baby en kleuterverzorging* ('s-Graveland: De Driehoek, 1950), 382–6.

about possible causes of and cures for *enuresis nocturna*, which, incidentally, could bother a toilet-trained child from the age of three up to adolescence.[35] From the 1950s to the mid-1970s child psychiatrists' analyses pointed first of all to parent–child interaction, particularly between a mother and her child, as the prime cause of enuresis. Anxiety and nervousness often appeared as accompanying problems.[36] Punishment and harsh treatment of enuretics were scorned as unnecessarily humiliating.[37] However, despite their one-sided focus on the environment, it was agreed that a physical examination was always needed to exclude a physical illness, such as abnormalities of the urethra.[38]

Child psychiatrists' discussions of enuresis often referred to theoretical concepts developed by psychoanalysts, particularly Anna Freud, John Bowlby, August Aichhorn and Alfred Adler. They situated the origin of childhood neuroses in a child's inner and unconscious conflicts, which could be identified and solved in psychotherapy. Freudian interpretations prevailed, but organic causes of enuresis were not ignored. The most authoritative professor of child psychiatry and head of the Groningen university's child-psychiatric clinic for example, Theo Hart de Ruyter, admitted in 1953 that enuresis could be caused by a physical illness or a constitutional condition, but made clear that it was more likely to be a neurotic symptom of an 'unconscious inner conflict', to be cured by analytic treatment.[39]

Comparable explanations can be found in the subsequent editions of leading manuals on child psychology and psychiatry, issued from the 1950s up to the 1970s. For example, in his authoritative manual for teachers and social workers, *Introduction to Child Psychology*, Hart de Ruyter claimed that a two-year-old infant could only be toilet-trained successfully if the relationship between mother and child was affectionate and had developed well. This meant that when a child was a victim of 'affective neglect', it could not be toilet-trained effectively. He distinguished between *enuresis nocturna* caused by either neglect in early childhood, the 'stubborn phase' of a two- to three-year-old child or neurotic problems. Treatment should consist of psychotherapy and education.[40] His view remained remarkably stable over the years, as the seven editions of his manual that were published between 1952 and 1968 presented this same interpretation. The child psychiatrist Reinier Vedder likewise emphasised the neurotic character of many childhood problems in his manual on learning and behaviour problems, but did not exclude physical causes or symptoms of stubbornness either. For him, enuresis, like thumb sucking, was a most important symptom of regression, falling back into an earlier stage of development, caused by nervous anxiety or exhaustion originating from an unconscious conflict.[41]

[35]S. Santema, 'Enuresis nocturna bij mannelijke adolescenten. Onderzoek van ambachtsscholieren te Leiden', *Tijdschrift voor Sociale Geneeskunde* 37 (1959): 519–21; A. J. de Leeuw-Aalbers, 'Uitzending van kleuters naar een koloniehuis in Petten', *Maandblad voor de Geestelijke Volksgezondheid* 12 (1957): 279–98.

[36]R. Vedder, *Kinderen met leer- en gedragsmoeilijkheden* (Groningen: Wolters-Noordhoff, 1960), 193; D. Wiersma, 'Z.M.O. K. of L.O.M., een dilemma?', *Tijdschrift voor Orthopedagogiek* 1 (1962): 204–24; D. A. Van Krevelen, *Nederlands leerboek der speciële kinderpsychiatrie. Deel I Stoornissen van het verstandelijk rendement* (Leiden: H.E. Stenfert Kroese N.V., 1952), 320–21; H. Alberda-Hankes Drielsma, 'Overbelasting van de kleuter en verzorging in groepsverband', *Tijdschrift voor Sociale Geneeskunde* 20 (1956): 211–15.

[37]'Boekbesprekingen. Bedwateren en verwante toestanden', *Maandblad voor de Geestelijke Volksgezondheid* 10 (1955): 367–8.

[38]M. Brandenburg, 'De praktijk van het kleuterbureau', *Maandblad voor de Geestelijke Volksgezondheid* 12 (1957): 427–38; Th. Hart de Ruyter, *Inleiding tot de kinderpsychologie,* 4th ed. (Groningen: Wolters-Noordhoff), 173; F. Holtzer, 'Een methode ter behandeling van enuresis nocturna in de algemene praktijk', *Huisarts en Wetenschap* 4 (1961): 329–34.

[39]Th. Hart de Ruyter, 'De betekenis der psycho-analytische paedagogie voor de opvoeding van kinderen met aanpassingsstoornissen', *Tijdschrift voor Buitengewoon Onderwijs en Orthopedagogiek* 33 (1953): 173–8.

[40]Th. Hart de Ruyter, *Inleiding tot de kinderpsychologie* (Groningen: Wolters-Noordhoff, 1952), 39, 141–3.

[41]Vedder, *Kinderen*, 76, 193.

A disharmonious mother–child relationship could be particularly harmful for a stepchild. Stepmothers made enuretics, some psychiatrists claimed.[42] In 1953 Hart de Ruyter, for example, described the case of 11-year-old Aaltje. She was beaten frequently for her bed- and pants-wetting by her grandmother whom she lived with after her mother could not take care of her anymore. Upon moving to her father and stepmother, the problem had not disappeared. According to the psychiatrist, the enuresis was an expression of fear of having to go back to her abusive grandmother and a way of punishing herself in order to accept her being rejected and unloved. Hart de Ruyter described this behaviour with Anna Freud's concept of a 'defence mechanism'. According to him, the girl sought punishment out of feelings of guilt: 'We can easily forgive her for her offence because she is obviously punishing herself.'[43]

Experts agreed that bedwetting happened more often to children in institutions or living with foster parents because they longed for their own parents and struggled with an unfulfilled hunger for affection.[44] A child who felt unloved could easily fall victim to this disturbing problem, it was agreed.[45] Foster children, moreover, could experience enuresis when they had to visit their biological parents who were unable to take care of them.[46]

As well as neurosis, child psychiatrists incidentally considered other causes of enuresis as well, such as genetic and organic problems like a hormonal abnormality[47] or a dysfunction of the bladder,[48] in which case an alarm could help the child to wake up in time.[49] Sleeping too deeply could also cause bedwetting, which could be remedied with medication or limiting the child's fluid intake in the evening hours.[50]

Because of the predominant role of neurosis in causing enuresis, parenting support and advice were needed, child psychiatrists insisted.[51] They agreed that advising the mother on her child-rearing style could reduce the symptom. Reassuring the child – who was never at fault – was part of the advice. (S)he needed to be encouraged to find his/her own way in overcoming the problem and in learning that it was not something to worry about. As Hart de Ruyter and his colleague from Utrecht, Lucas Kamp, stated in 1972 in a new textbook on child psychiatry: 'It is necessary that children know that the flaw will in

[42]J. Lampl-De Groot, 'Groepsbesprekingen met stiefmoeders', *Maandblad voor de Geestelijke Volksgezondheid* 9 (1954): 305–12; Holtzer, 'Een methode'.

[43]Th. Hart de Ruyter, 'De betekenis der psycho-analytische paedagogie voor de opvoeding van kinderen met aanpassingsstoornissen II', *Tijdschrift voor Buitengewoon Onderwijs en Orthopedagogiek* 33 (1953): 194.

[44]Br. Gabriël M., 'Kees-Historie uit een observatiehuis', *Mozaiek* 7 (1956): 117–8; H. Marcus, 'Willen we wel of willen we geen vakantie-pleeggezinnen?', *De Koepel* 17 (1963): 176–9; J. van Zijverden, 'Inrichtingskinderen in vacantie-pleeggezinnen', *De Koepel* 12 (1958): 64–9; M. J. A. van Spanje, 'Kind en pleeggezin III', *De Koepel* 18 (1964): 336–46; Th. Hart de Ruyter and L. N. J. Kamp, *Hoofdlijnen van de kinderpsychiatrie* (Deventer: Van Loghum Slaterus, 1972), 107–9.

[45]P. J. A. Calon, 'Aan welke eisen moet de opvoeding van onze pupillen voldoen', *Mozaiek* 2 (1951): 185–96; D. Timmers-Huigens, 'Preventieve gezondheidszorg via een opvoedkundig konsultatiebureau', *Maandblad voor de Geestelijke Volksgezondheid* 29 (1974): 379–81; Hart de Ruyter, *Inleiding* (1966), 49.

[46]Jaarverslag 1957 van de Vereniging Kinderhulp te Amsterdam: De relatie ouders-kinderen in het pleeggezin, *De Koepel* 12 (1958): 446–52.

[47]W. Strubbe, *Anders dan gewoon. Beknopte inleiding tot de psychopathologie van het kind* (Nijkerk: Uitgeverij G.F. Callenbach B.V., 1976), 55–60.

[48]L. A. Notschaele, 'Bedwateren bij kinderen van de kleuter- en lagere school', *Tijdschrift voor Sociale Geneeskunde* 42 (1964): 226–30; Santema, 'Enuresis nocturna'.

[49]E. Pereira-D'Oliveira, 'Onder de leeslamp, Enuresis Nocturna, behandeld volgens de wekkermethode', *Mozaiek* 13 (1962): 171; Santema, 'Enuresis nocturna'.

[50]L. A. Notschaele, 'Bedwateren en slaapdiepte', *Tijdschrift voor Sociale Geneeskunde* 46 (1968): 749–53; Notschaele, 'Bedwateren bij kinderen'; Holtzer, 'Een methode'; S. Koster, *Bedwateren en verwante toestanden* (Haarlem: De Erven F. Bohn N.V., 1953), 25–41, 42–69.

[51]S. Wiegersma, 'Gedragsproblemen bij twaalfjarige kinderen', *Maandblad voor de Geestelijke Volksgezondheid* 12 (1957): 41–56; Hart de Ruyter, *Inleiding* (1952), 141–3.

the end disappear.'[52] Too much attention was, however, to be avoided. In cases of 'nervous enuresis', parents could bring about what Adler called 'feelings of inferiority' by emphasising the problem behaviour. Therefore, parents also needed to be reassured before a child would be able to stop wetting his/her bed; a child guidance team reported on a case: 'Concerning the bedwetting, [since] the mother is much calmer, Marian starts to get dry at night.'[53]

A particular kind of stress in the mother–child relationship could be caused by bad timing of the toilet-training of an infant, which in turn could bring about enuresis. This explanation especially attracted the few child psychiatrists who were not psychoanalysts,[54] as well as school doctors. Starting the toilet-training too soon after a little baby brother or sister had been born could for example cause regression, with enuresis as symptom, out of jealousy and having to share the parents' attention.[55] During such a busy period, a young child instead needed extra attention, which could take away the jealous feelings and instantly solve the enuresis problem.[56] School doctor Dirk Herderschêe, who chaired the Amsterdam admission committee for the special schools, discussed a more complicated case of a boy who started to wet his bed because of feelings of guilt about his jealousy. The seven-year-old boy felt guilty about his younger brother's death, because he had been jealous and wished him dead: 'During his brother's life, the boy had frequently thought: "I wish that he was dead, so they would start to love me again."'[57] After the little brother had died, he felt guilty about his parents' sadness. This case convinced the school doctor that parents should not start the toilet-training at the time of important life events.

Other mistakes regarding the toilet-training could likewise cause bedwetting, such as starting too early or making too strict demands.[58] The Amsterdam professor of child psychiatry, Bets Frijling-Schreuder, explained, for example, how such demands could be caused by a mother's increasing anxieties about a child's bedwetting, particularly in a later stage. Therefore, anxious parenting itself was a likely cause of enuresis as neurotic regression, she explained.[59]

Unlike their Amsterdam colleague,[60] in the 1970s Hart de Ruyter and Kamp showed more openness as to organic and genetic causes of enuresis. In their new textbook on child psychiatry they still mentioned neuroticism as prime cause, but added that a neurological condition could also be responsible. Even when an electro-encephalogram (EEG) of

[52]Hart de Ruyter and Kamp, *Hoofdlijnen*, 109.
[53]A. R. Elte, A. A. van Heusden and E. C. M. Frijling-Schreuder, 'MOB en Kleuterbureau', *Maandblad voor de Geestelijke Volksgezondheid* 8 (1953): 330.
[54]F. Grewel, 'Over Partiële defecten', *Tijdschrift voor Buitengewoon Onderwijs en Orthopedagogiek* 39 (1959): 21–4.
[55]D. Fokkema, W. Bordewijk, P. van den Broek and H. Nieuwenhuis, *De nieuwe kweekschool 3. Leergang voor opvoedkunde en psychologie. Kinderpsychologie en opvoedkundige psychologie* (Groningen: Wolters-Noordhoff, 1969), 41; Holtzer, 'Een methode'; Th. Hart de Ruyter, *Moeders en kinderen. Het ABC der opvoeding* (Nijkerk: Uitgever G.F. Callenbach N.V., 1959), 26–7; A. Bonekamp, *Milieu-moeilijkheden. Benadering en beïnvloeding van kinderen met ernstige gedragsmoeilijkheden* (Haarlem: Uitgeverij De Toorts, 1962), 164.
[56]A. R. Elte et al., 'M.O.B. en Kleuterbureau'; Hart de Ruyter, 'De betekenis II'.
[57]D. Herderschêe, 'De zin der kinderpsychologie', *Tijdschrift voor Buitengewoon Onderwijs en Orthopedagogiek* 36 (1956): 67.
[58]G. J. van Lookeren Campagne, *Wat kan een kind van zijn opvoeders verlangen? Het ABC der opvoeding* (Nijkerk: G.F. Callenbach, 1968), 40; E. Isaac-Edersheim, 'Opvoeding en cultuurpatroon', *Maandblad voor de Geestelijke Volksgezondheid* 8 (1953): 343–55; E. C. M. Frijling-Schreuder, *Preventie van neurotische gezinsrelaties*, 3rd ed. (Assen: Van Gorcum, 1970), 35–6.
[59]Frijling-Schreuder, 'Kleutermoeilijkheden'.
[60]E. C. M. Frijling-Schreuder, *Kind en Volwassene. Ervaringen uit de psycho-analytische en kinderpsychiatrische praktijk* (Assen: Van Gorcum, 1984), 112, 121–23.

a child's brain showed irregularities, neurotic problems remained the first cause to look for, they explained. This implied that treatment should still focus on changing the mother's attitude. In blaming her faults, the professors of child psychiatry now used American-style typologies in English, such as a 'low-tension' mother causing enuresis by showing insufficient control and a 'high-tension' mother creating neurotic symptoms by her own neuroticism, which had to be cured by psychotherapy.[61]

Bladder control and behaviouristic therapies (*c.*1970–1990)

In the 1970s new psychological theories, developed in the United States, focused more particularly on a child's interactions with the environment in bringing about problem behaviour. Therefore, the new kinds of interventions that were developed along these lines focused on family and group dynamics and on the reinforcement of social competency within the context of the family or a wider ecological setting.[62] Three new forms of treatment were imported from America by child psychologists: behavioural, family system, and group therapy.[63] They easily found their way into child guidance and other outpatient clinics, as well as into leading professional manuals on child psychiatry.[64]

Behavioural therapy was founded on the principle that problem behaviour was a habit that the child had somehow learned and which could, therefore, be unlearned in therapy. In this kind of therapy, child psychologists explained, a child was rewarded for good behaviour, whereas problem behaviour was ignored instead of punished.[65] As regards bedwetting, psychologists discussed how children could learn to stop wetting their beds by constantly receiving a negative stimulus, for example hearing a buzzer go off loudly, upon initial signs of bedwetting. In this way, they would learn to respond to a full bladder. When the child switched off the alarm and went to the toilet in time (s)he was rewarded. It was a matter of motivation, a psychologist explained: 'Bedwetting does not occur as a waking-up problem, but because the environment does not give enough reason to control the pressure and get up and use the toilet.'[66] Rewarding the child was the key to success in the new therapy that linked the enuresis with the stimulus of the alarm. Its therapeutic use helped the child to unlearn the problem behaviour.[67] Alongside the child, the parents needed behavioural therapy to learn how to encourage and reward their child properly.[68] This implied a focus on giving 'positive attention' at moments of success for the child. In this way, psychologists claimed, enuresis could easily be cured.[69]

[61]Hart de Ruyter and Kamp, *Hoofdlijnen*, 67, 107–9.
[62]J. D. van der Ploeg, *Behandeling van gedragsproblemen. Initiatieven en inzichten* (Rotterdam: Lemniscaat, 2005), 97–112, 121–2, 144, 210–52.
[63]Eysenck and Rachman, 'Gedragstherapie'; F. Harinck, 'Kindertherapie-research', *Kind en Adolescent* 7 (1986): 120–36; J. W. C. Jansen, E. M. J. Breukers, A. C. Driessen and J. P. Hommes, 'Forumdiskussie', *Mozaiek* 19 (1968): 343–58; R. Lago-Kiemeney and F. van de Rijdt, 'Groepswerk met kinderen', *Maandblad voor de Geestelijke Volksgezondheid* 31 (1976): 141–50.
[64]R.B. Minderaa, 'Stoornissen in de sfinctercontrole', in *Leerboek Kinder- en Jeugdpsychiatrie*, ed. J. A. R. Sanders-Woudstra and H .F. J. de Witte (Assen/Maastricht: Van Gorcum, 1985), 80.
[65]Eysenck and Rachman, 'Gedragstherapie'; Strubbe, *Anders dan gewoon*.
[66]J. M. Cladder, 'Zeer moeilijk beïnvloedbaar eten en moeilijk beïnvloedbaar bedplassen. Een eerste reactie', *Kind en Adolescent* 1 (1980): 100.
[67]Strubbe, *Anders dan gewoon*.
[68]D. Gelfand and D. Hartmann, 'Overzicht en evaluatie', *Mozaiek* 19 (1968): 255–62; Cladder, 'Een eerste reactie'.
[69]J. D. Bosch, 'Boekbespreking. Bedplassen: droge bed-training: Handleiding voor ouders om kinderen droog te krijgen', *Tijdschrift voor Orthopedagogiek* 24 (1985): 279–80.

'Dry Bed Training' was a particular kind of behavioural therapy developed by the American psychologist Nathan H. Azrin. Dutch child psychologists and child psychiatrists frequently discussed it in the 1980s. In this training, practising with the alarm was combined with rewarding the child and training the bladder with 'structured' assignments concerning drinking, waking up at night and going to the toilet.[70] This method could, however, put high pressure on parents, as the child needed to be woken every hour to help him/her control the bladder. As with other kinds of behavioural therapy, its focus was on the process of unlearning a habit. Although parents also had to unlearn certain habits, the attractiveness of this optimistic approach was certainly to be found in the absence of blaming parents for faults.

In the 1970s and 1980s two other new kinds of therapy were discussed by Dutch child psychologists and child psychiatrists as possible interventions to cure enuresis: family system therapy and group therapy. In group therapy, a child could learn how to play with others and practise with sharing his/her feelings in a group and learn to manage these feelings, it was explained.[71] Family system or structural therapy, on the other hand, had its roots in psychodynamic theory. Its focus was the relationships and interactions between family members.[72] Enuresis was conceived as a symptom of difficulties in these relationships. The psychologist Kai Welzen, who had practised as a family therapist, and the special-needs educationalist Pierre Smeets interpreted bedwetting as an expression of loyalty of the child, trying to help solve tensions in the family system, particularly between the parents. By showing this behaviour, the child was said to make his/her parents work together in solving his/her problems and thus re-create a new harmony in the family system:

> Parents often could not succeed in dealing with this situation. From the child's perspective, however, it did what it could do and it succeeded at least in addressing the parents as a couple, in such a way that it was not forced to make an impossible choice between the one or the other.[73]

This meant that the problem behaviour had to be treated on the level of the family as a whole.

In the 1980s, as well as these ecological approaches, nature-bound explanations of problem behaviour and related therapies were discussed more frequently. Child psychiatrists in particular considered organic and genetic conditions more often as possible causes of *enuresis nocturna*, though without denying the contribution of nurture-bound factors altogether. A new 'generation' of textbooks on child psychiatry for professionals, published in the 1980s, demonstrates this shift of focus. Two of these pointed to neurological problems and a delayed maturation of the nervous system as likely causes of enuresis.[74] Although neurotic causes, such as childhood trauma and problems in the mother–child

[70] A. van Londen and G. A. L. A. Mulder, 'Enuresis nocturna', *Kind en Adolescent* 7 (1986): 96–101; R. A. Hirasing, 'Schoolgezondheidszorg voor 4- tot 12 jarigen', in *Nederlands leerboek voor de jeugdgezondheidszorg*, ed. P. B. Schuil, J. A. Bolscher, E. A. Brouwers-de Jong, H. Hengeveld, E. M. van Lokven, T. M. A. Menu and A. G. H. Norg (Assen/Maastricht: Van Gorcum, 1987), 320–5; F. C. Verhulst and J. A. R. Sanders-Woudstra, *Kinderpsychiatrie voor de praktijk* (Alphen aan den Rijn/Brussel: Samsom Stafleu, 1987), 115–22.

[71] Lago-Kiemeney and Van de Rijdt, 'Groepswerk'.

[72] Ibid.; J. J. P. Hendrickx and H. van Engeland, 'Intrafamiliale agressie bij een kinderpsychiatrische populatie', *Tijdschrift voor Orthopedagogiek, Kinderpsychiatrie en Klinische Kinderpsychologie* 12 (1987): 90–102; Minderaa, 'Stoornissen'.

[73] P. Smeets and K. Welzen, 'Groepsleider tussen ouder en kind', *Kind en Adolescent* 5 (1984): 216.

[74] D. N. Oudshoorn, *Kinder-en adolescentenpsychiatrie. Een pragmatisch leerboek*. (Deventer: Van Loghum Slaterus, 1985), 226–32; Hirasing, 'Schoolgezondheidszorg'.

relationship, continued to be mentioned as well,[75] organic explanations clearly became more important. Representatives of the second generation of professors of child psychiatry, Frank C. Verhulst and Jannie A. R. Sanders-Woudstra, presented them on an equal footing in 1987: 'Psychological factors in interaction with factors that have to do with the biological maturation play a role in acquiring control of the bladder function.'[76] Psychotherapy was now less frequently suggested in authoritative manuals on child psychiatry, as child-psychiatric clinics had largely replaced it with less time-consuming behaviouristic therapies.[77] This openness towards nature-related explanations, however, did not imply that authors agreed upon which of these were the most likely or the preferred ones.

Unsurprisingly, experts with a medical background chose more often to discuss physiological or neurological factors behind enuresis. Child psychiatrists sometimes referred to an organic disorder or a delayed maturation in the 'neurophysiological area'.[78] One psychiatrist, for example, was convinced that late maturation of the 'neural mechanisms' that were involved in the development of bladder control could cause enuresis.[79] Others mentioned urological illnesses, such as infections or dysfunctions of the bladder, and discussed epilepsy more often.[80] Moreover, most physicians now agreed that bedwetting could have a genetic component.[81] As a professor of youth public health care stated in a manual in 1987: 'In 35% of the cases at least one parent has been a bedwetter too'.[82] Consequently, gathering information from family members about their medical histories, which was routinely done by school doctors and child psychiatrists, became an even more important part of the diagnosis. Although some child psychiatrists were convinced that enuretics often had an irregular EEG,[83] there was no consensus as to the role of brain dysfunctions.

Insufficient bladder control was another explanation that was more frequently discussed in the 1980s by both doctors and psychologists. A child suffering from enuresis might have trouble with waking up, which made him/her fail to notice a full bladder and reach the toilet in time.[84] A psychologist presented, for example, sleeping too deeply, combined with a small bladder and non-receptivity to 'pressure' to have to go to the toilet at night, as most important causes.[85] An alarm could help the child to wake up more easily. A small or 'less stable' bladder could be treated by teaching the child how to control the 'pressure' of having to go to the toilet after drinking and to improve his/her 'bladder capacity'.[86] The child psychiatrist Dirk Oudshoorn stated in 1985 that the

[75]J. D. Bosch and E. Jansen, 'Enuresis nocturna', *Kind en Adolescent* 3 (1982): 184–95; Oudshoorn, *Kinder-en adolescentenpsychiatrie*, 226–32; H. B. H. Rensen, 'Schoolgezondheidszorg voor 4- tot 12-jarigen. Socialisatieproces', in *Nederlands leerboek voor de jeugdgezondheidszorg*, ed. P. B. Schuil, J. A. Bolscher, E. A. Brouwers-de Jong, H. Hengeveld, E. M. van Lokven, T. M. A. Menu and A. G. H. Norg (Assen: Van Gorcum, 1987), 300–8.
[76]Verhulst and Sanders-Woudstra, *Kinderpsychiatrie voor de praktijk*, 117.
[77]Oudshoorn, *Kinder-en adolescentenpsychiatrie*, 226–32; Hirasing, 'Schoolgezondheidszorg'; Minderaa, 'Stoornissen'; Bolt and De Goei, *Kinderen*, 53–61, 75–100.
[78]Oudshoorn, *Kinder-en adolescentenpsychiatrie*, 226–32; Hirasing, 'Schoolgezondheidszorg'.
[79]Minderaa, 'Stoornissen'.
[80]Ibid.; Oudshoorn, *Kinder-en adolescentenpsychiatrie*, 226–32.
[81]K. Gill, 'Zeer moeilijk eten en moeilijk beïnvloedbaar bedplassen', *Huisarts en Wetenschap* 23 (1980): 204–5; Hirasing, 'Schoolgezondheidszorg'.
[82]Hirasing, 'Schoolgezondheidszorg', 321–22.
[83]Minderaa, 'Stoornissen'.
[84]Hirasing, 'Schoolgezondheidszorg'; Gill, 'Zeer moeilijk eten'; J. M. Cladder, F. Verhage and A. P. Messer, 'Zeer moeilijk eten en moeilijk beïnvloedbaar bedplassen', *Kind en Adolescent*, 1 (1980): 95–7.
[85]R. Kohnstamm, *Kleine ontwikkelingspsychologie. Deel 2. De schoolleeftijd* (Deventer: Van Loghum Slaterus, 1987), 204–5.
[86]Oudshoorn, *Kinder-en adolescentenpsychiatrie*, 226–32; Hirasing, 'Schoolgezondheidszorg'.

enuretic child could be trained to 'withhold' urination once or twice during the day. Another cure, he suggested, was postponing urination for half an hour from the moment a child felt the pressure.[87] Like behavioural therapy, this training obviously involved both a child's physical capacities and his/her mental strength.

Moreover, in the 1980s discourse, we find more pertinent claims as to the positive effects of treatment with medication, such as anti-depressants. Drug therapy was also suggested by a general practitioner, who reported on his treatment of a girl with 'bladder control problems'.[88] Their use was as yet often combined with nurture-bound therapies, such as psychotherapy and behavioural therapy.[89] For example, according to a psychiatrist and geneticist, enuresis occurred frequently with children with chromosomal deficiencies, such as having an additional X or Y chromosome. Along with hormonal treatment of the child, his/her parents had to learn to create an affectionate relationship with their child, he suggested, no matter how hard this could be.[90]

Despite these new nature-oriented explanations and therapies, nurture-bound causes did not disappear from the scene in the 1980s. Traumatic experiences could obstruct the treatment of enuresis, even if it was caused by genetic or neurological factors, experts agreed. The child psychiatrist Oudshoorn discussed, for example, the Bowlbyan 'separation anxiety' of a nine-year-old boy, suggesting that this could be the cause of his bedwetting. In this case, the environment seemed a more important factor than delayed maturation of the nervous system: 'His enuresis is a regression phenomenon in which emotional factors and mostly fears played an important role.'[91] That was why the boy's treatment was focused on curing his fears.

Conclusion

Between about 1950 and 1990 in the Netherlands childhood nocturnal enuresis was mostly discussed by doctors, primarily child psychiatrists and to a lesser degree school doctors. This relates to the fact that physical examination of a bedwetting child was always deemed necessary, if only to exclude a physical illness. It was, moreover, conceived as a medical problem, the treatment of which required medical expertise. However, a small number of child psychologists also became involved in the discourse on this particular childhood problem, especially in the 1970s when new kinds of therapy were introduced in which they could act as therapists. Special-needs educationalists contributed even less to the debate, and only as far as behavioural and family therapy were concerned. This limited involvement of non-medical experts explains why we do not recognise any inverse development as compared with the biologising of child psychiatry that made doctors discover children's 'neurochemical selves'.

From the 1950s to the mid-1970s, experts regarded the environment as the prime cause of enuresis, assuming a nurture-related aetiology. It was held to be an expression of neuroticism, probably caused by a disharmonious mother–infant relationship. Therefore, foster and step-children especially were likely to experience this disturbing problem due to feelings of rejection

[87] Oudshoorn, *Kinder-en adolescentenpsychiatrie*, 230–1.
[88] 'Uit de praktijk. Anneke de Bruin komt met haar moeder op uw spreekuur', *Huisarts en Wetenschap* 20 (1977): 58–60.
[89] M. Rientsma, D. Duyvis and R. Beunderman, 'Bedplassen, een volwassen probleem', *Maandblad voor de Geestelijke Volksgezondheid* 41 (1986): 737–55.
[90] J. Nielsen, 'De psychische ontwikkeling bij een groep ongeselecteerde kinderen met geslachtschromosomale afwijkingen', *Tijdschrift voor Orthopedagogiek, Kinderpsychiatrie en Klinische Kinderpsychologie* 7 (1982): 55–79.
[91] Oudshoorn, *Kinder- en adolescentenpsychiatrie*, 230.

and an unfulfilled longing for attention and love. On the basis of psychodynamic theories, it was agreed that enuretics often showed unconscious inner conflicts and problems, such as anxiety and nervousness. Psychotherapy would solve these problems. During these years, parenting faults were pointed to as prime cause of *enuresis nocturna*. One of these, starting toilet-training too early or at the wrong moment, could have damaging effects, experts explained. Parents' strict demands were counterproductive as well. Therefore, parenting support and advice were indicated to teach mothers how to change their attitude. A child was never at fault and both parents and child needed to be reassured.

From the 1970s, new kinds of treatment were introduced and discussed by experts, such as behavioural and family system therapy, which temporarily reinforced psychologists' authority. In the 1980s, however, we see a major shift in the assumed aetiology of enuresis, as nature-bound causes and therapies became more important. This meant that, apart from parenting, organic causes and physiological explanations gained credit. As regards treatment, alongside all kinds of behavioural and psychotherapy, medication was now more often accepted as a reliable means to cure an enuretic child. This shift to nature-bound causes and therapies was particularly manifest in the leading child-psychiatric manuals for professionals that guided their practices.

These findings are in line with more general developments in post-war western child psychiatry, which was at first dominated by psychoanalysis and, from the 1980s, saw the rise of a new biological psychiatry. They indicate that, from the initial medicalising of the childish habit of wetting the bed to the 'discovery' of *enuresis nocturna* as a category of illness, child science first chose a psychoanalytic perspective and pointed at parenting before processes of biologising and geneticising made its focus shift towards natural causes and cures, ranging from a child's physical constitution to medication. Nevertheless, nurture-bound causes of and therapies for enuresis did not disappear from the scene. By 1990, we can conclude, a mixed nature–nurture landscape had emerged that was not unlike the one that had created 'the enuretic child' as a 'kind of people' in the 1930s. Once more, experts combined nature- and nurture-bound explanations and therapies, but with a much stronger emphasis on brain-related, physiological and genetic factors and on biomedical kinds of treatment. However, this did not completely undo the idea of parental responsibility for a child's misfortune that had been emphasised so one-sidedly by Freudian theory.

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No potential conflict of interest was reported by the authors.

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