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# Psychotherapy and Enuresis

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## Abstract

Nocturnal enuresis in children and adolescents assumes a variform aspect, of course, paraphysiological. This is a clinical problem destined to spontaneous resolution. The psychotherapic approach was engaging, in our study, like second instance for the children who were non-respondents to the other treatments.

The results were promising though the set of treated children was narrow. This treatment has to perform by specialists, with the involvement of the family and the environment of the enuretic child.

**Keywords:** Enuresis; Psychotherapy; Token Economy

## Introduction

Nocturnal enuresis is urinary incontinence for night time, beyond six years: primary enuresis concerns the children who have never been successfully trained to control urination, while secondary enuresis goes back again to children who have been successfully trained but revert to wetting in a response to some sort of stressful situation [1,2].

In the middle of different therapeutic approaches for enuresis, the Authors took the Cognitive Behavioral Therapy (CBT) for the children and the youth non-respondents to all the treatments employed in first instance [3].

## Method

By our clinical experience, we treated 200 children and adolescents suffering from nocturnal enuresis, divided into three treatment groups. The patients with primary enuresis were 166 and 34 those who were suffering from secondary enuresis; afterwards, 116 were belonging to male gender and 84 to the female gender. We have initiated the first therapy for 91 children 6 to 9 years old and for 109 adolescents 10 to12 years old. Our Study got the approval from the Ethics Committee of Veneto Country.

The single child from a family were 29, while 43 children had an elder brother (or sister) and 82 children had a younger brother (or sister); 46 children had both younger and elder brothers and sisters. 108 children were belonging to the lower classes and 92, on the contrary, to the middle or to the higher classes.

The school interest was good for 145 young patients and poor for the others.

The threefold modality of initial therapy was arranged as follows: the first group of children was following a simple behavioral approach; in this group half (15/30) of the children did not get good outcome that is the return of the dry night for two months in succession, at least. The second group was following the acoustic alarm: in this cohort of therapy 13/75 (17.3%) children were non-respondents. The non-respondents in the third group were 12/95 children (12.7%): these were following the treatment with Desmopressin 120 µg/night, with a maximal therapeutic time equivalent to six months (by courses of three months).

The medium comprehensive follow-up was amounting to 15.07 m.

Therefore, we had been treating by cognitive behavior therapy for forty non-respondents children, with an average age equivalent to 10.2 y. (25 M. – 15 F.) . The medium term of the CBT was amounting to 7.13 m, a fairly short period. Of course, the other modalities of treatment were suspended in advance of the psychotherapy commencement. For these forty children, we noticed the prevalence of the lower classes and the high presence, inside the family, of younger brothers or sisters.

We employed the "Token Economy" like modality of psychotherapy, with the use of a micturitional day-book.

## Results

The initial outcomes pointed out a good response to CBT, especially in favor of the children and the families motivated.

29 children (72.5%) showed a satisfactory reduction or the whole disappearance of the enuretic symptom. Here, the clear reduction was meaning a residual, entirely occasional, appearance of the nocturnal enuresis, more evident to the young patient in the community (Figure 1).

Only for eleven children we didn't obtain a substantial change of the symptom.

## Discussion

The cognitive behavioral therapy like a careful and continuative psychotherapy for the infantile and juvenile enuresis, really, wasn't widely done. Often the employment of the psychotherapy is restricted and the apanage is for the non-specialists. Consequently [4-6] we keep very importantly the sharing of a definitive therapeutically decision and the choice of the patient's non-respondents to the other therapies, with

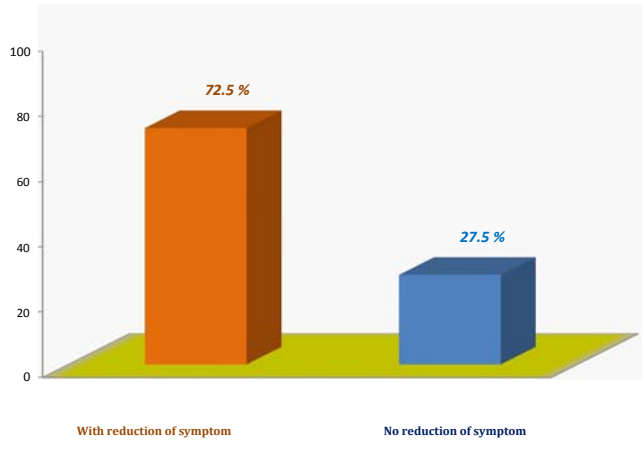


**Figure 1:** Tendency of recovery from enuresis treated by psychotherapy.

the necessary timing and the intervention of the dedicated therapeutics'.

By the token reinforcement, a therapeutic approach based on reward for an appropriate behavior, one counter an award is delivered to the child who behaved properly. Indeed, a token is an object or symbol that is exchanged for goods or services.

This therapeutic modality necessarily demands small and identifiable things, reinforcement as exchange and a precise behavior [7]. The clinical Studies about the employment of CBT against infantile enuresis are still not many. We have reference to the experience of Ronen and Coll. [8], with a similar approach and comparable results (even if our number of cases is rather small).

This modality of therapy also is sound, in pediatric age, for encopresis and recurrent abdominal pain [9,10].

It's obligatory the collaboration in the therapeutic journey of the whole family and, for selected situations, also of the teacher. Really, we believe that, while the bladder instability or a sleeping-sickness aren't the main problems for the enuretic child, but the anxiety and the anomalous attitude of the environment are the starting point for enuresis, the enuretic symptom could persist without a specific psychotherapeutic treatment.

## Conclusions

According to our experience, we privilege, for the nocturnal pediatric enuresis, a psychotherapeutic approach precisely in favor of some children who didn't benefit from the other therapies.

An attitude is very important: the involving for the children together their own families and personal surroundings.

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