CHAPTER 27

Enuresis: a Child Psychiatrist's Approach

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Referral

Clearly it would not be appropriate for all children with enuresis to be seen by a child psychiatrist. This would not only be impossible but would also be undesirable. Most enuretic children are not suffering from psychiatric (emotional or behavioural) disorder, but from a specific developmental delay, which is probably primarily physiologically rather than psychologically determined. There is, however, a group of disorders in which enuresis seems related to stress of one sort or another, and in which psychiatric treatment is more clearly indicated. It is the aim of this brief chapter to define such disorders, and to describe a child psychiatrist's approach to diagnosis and treatment following referral of an enuretic child.

In Which Cases of Enuresis is Psychiatric Referral Indicated?

(*a*) *The enuresis can be seen to form but one part of an emotional disorder.* The presence of encopresis (the passage of formed motions in inappropriate situations) would usually be an indication, and this symptom is not uncommonly associated with enuresis. However, nocturnal enuresis without encopresis can be a symptom of an anxiety state. In these circumstances, there will be associated fearfulness, timidity, inhibition, and possibly signs of depression. Bedwetting can also accompany signs of a severe conduct disorder characterised by bullying, stealing, and other antisocial behaviour.

(*b*) *Monosymptomatic enuresis in a pattern which strongly suggests that it is a manifestation of a disturbed parent-child relationship.* The mere fact that monosymptomatic enuresis is occurring alongside a disturbed family situation is inadequate evidence for a psychological causation of the symptom. After all, both bedwetting and unhappy families are commonly found in our culture, so that the association of the two cannot provide sufficient evidence to assume a causal relationship. Further, although the *onset* of a period of enuresis may be associated with environmental stress (such as the birth of another child), it does not necessarily follow that the *persistence* of the symptom is emotionally determined. A learned habit may persist long after the initial conditions in which the original learning took place have significantly changed.

It is probably true to say that enuresis occurring after a period of dry nights is more likely to be psychologically determined than when there has been no such period of continence. However, this pattern of enuresis can also arise from physical causes, such as the occurrence *de novo* of a urinary infection.

The pattern of occurrence of the symptom can provide strong supporting evidence for an emotional origin. The child who wets whenever his father is away from home

provides one example. Another is the child who wets only in the day-time, and then only in circumstances when his mother is bound to notice. The child who seems to wet consciously and deliberately furnishes another example, although some would not classify this as enuresis.

(c) *The enuresis fails to improve with physical and supportive methods of treatment, and the secondary distress is so severe as to require treatment in its own right.* Excessively punitive parental attitudes may produce this picture, but, in addition, some children experience such an acute sense of personal failure, even in the absence of such parental attitudes, that they may need psychiatric help to come to terms with their feelings.

(d) If a child seems, quite apart from his or her wetting, to be sufficiently unhappy or disturbed in behaviour to deserve psychiatric assessment, he or she will naturally be referred.

The Mode of Referral

Referral to a psychiatrist may raise anxieties both in the family and in the referring doctor. It is important for the doctor making the referral to explain that he is asking for a psychiatric opinion and why this is so. There is no need to say that the child is disturbed. It is, in fact, usually better to indicate to the parents that some children who wet the bed or their pants do so because they are upset in some way, that this might be the case with their child, and that a doctor experienced in understanding emotional disorder is being asked to help sort this out. A number of parents express doubt or hostility to the idea, and their fears need to be understood; on the other hand, parents sometimes turn out to be quite relieved at the idea of psychiatric referral, because it confirms their own view of the problem which they may feel is now being appropriately considered.

The Psychiatric/Diagnostic Approach

Inevitably this will vary according to the orientation of the individual child psychiatrist. The following account of diagnosis and treatment is necessarily a personal one.

Parents and child are seen together initially by all those members of the psychiatric team who are going to be involved in the case. This will usually include a social worker, and, if there is a possibility of educational problems, a psychologist. The family's feelings about referral are clarified, and it usually aids communication if parental doubts about referral can be expressed as soon as possible.

An account of the presenting symptoms is then obtained. Particular attention is paid to the circumstances which affect the presence of the symptoms and, in cases of discontinuous enuresis, to the child's situation at the time the wetting recurred. After a discussion about the child's schooling, the psychologist takes the child off for psychological testing. The psychiatrist and social worker (if one is involved) then take a full history from the parents of the present situation (including early development, family structure, family life and relationships). Throughout the interview, attention is given to parental attitudes, as well as to the more factual details.

The child is then seen by the psychiatrist alone, for an exploration of his mental state. After an initial period of getting to know the child, the psychiatrist will want to make judgements about the presence of significant anxiety or depression, and will discuss further the presenting symptoms. The child's feelings about the symptoms, and his fantasies about its origin and likely future course, are important areas to be covered.

After a meeting of the psychiatric team to discuss their impressions and to formulate a plan of management, the parents and child are seen again together. There should at this point be time for a full discussion of the views and suggestions of the psychiatric team and the family's reactions to them.

This procedure is varied with children who have reached puberty. Here the child is first seen by the psychiatrist, before enquiries are made from the parents. Further, the lengthy diagnostic procedure outlined above is only justified where referrals have been appropriately made after a briefer assessment, and often after an unsuccessful trial of treatment elsewhere. In other circumstances it may be sufficient for the psychiatrist alone to put aside an hour or so for a more superficial appraisal of the problem.

Management

In some children referred to him, the psychiatrist is likely to feel that the enuresis is developmentally determined and relatively uncomplicated by psychiatric disorder. In this situation he has to make a choice. He can refer the child back to the general practitioner or paediatrician for symptomatic management along the lines indicated by Meadow (page 181), or, alternatively he can continue to see the child and family himself and dispense similar treatment. If he makes the latter choice, it is, of course, important for him to have access to a supply of enuresis alarms.

In those children with a more widespread emotional disorder, the psychiatrist will probably wish to undertake some form of psychotherapy himself, or to refer elsewhere for this purpose. The nature of the psychotherapy is likely to vary according to the orientation of the psychiatrist. It is important that a positive relationship develops between child and psychiatrist, although this may take some time, and the child may go through a period of hostility. Usually the psychotherapy will be conducted on a verbal level, especially with the older child, but, in those patients who find verbal communication difficult, play, painting and modelling can be useful ways of helping the child to reveal his feelings.

Children with conduct disorders, particularly those with limited capacity for forming a relationship in general, do much less well with individual psychotherapy. In such cases, supportive interviews for the family, and physical methods of treatment (drugs, and/or conditioning apparatus), should be offered, but often co-operation is lacking. The outlook generally is less good for personality development, though in most cases the enuresis eventually clears up spontaneously.

When a symptom is most appropriately seen as part of a faulty pattern of communication within the family, an attempt can be made to conduct conjoint family therapy (Skynner 1969). Although it is often helpful to have the other sibs present, in practice much useful insight can be achieved by the family if attendance is restricted

to both parents and the affected child. The aim of this method of treatment is to uncover the real feelings of each member of the family towards the others, and thus indirectly to enable the enuretic symptom to be replaced by a less maladaptive form of communication.

The fact that the child shows signs of psychiatric disorder should not inhibit the psychiatrist from using physical methods of treatment. Indeed, one of the most difficult situations arises when the disturbed child has had an inadequate trial of drugs or the bell-and-pad, and the psychiatrist has to decide whether to re-institute a method of treatment which has already partially failed.

The psychiatrist who tries to treat all cases of enuresis the same way is like a golfer who goes round the course with a single club. It can be done, but it takes an inordinate length of time.*

The following three cases illustrate the flexibility of approach which may be necessary, and reflect also the varying amounts of therapeutic response which may be expected.

Nigel S, aged 6, was referred by the consultant urosurgeon. He wet only during the day-time, and even then only in the afternoon shortly before returning home from school. He was a passive boy, who preferred the company of girls, and had no friends of his own sex. His mother was separated from her husband, and was moderately depressed. Initially, the mother was seen alone for supportive interviews with the psychiatric social worker. The boy was then seen at fortnightly intervals for a period, to try the effect of systematic rewards for dry pants in the afternoons on an operant conditioning regime. This procedure failed. The boy was then seen for insight psychotherapy, and after two further sessions began to play with soldiers and fight pretend battles for the first time. The therapist merely indicated the masculinity of the soldiers, and the fact that they too, like Nigel, had 'widdles' (his word for penis). Nigel became more aggressive and masculine in his behaviour, both in his therapeutic sessions and everyday life. It seemed as though previously he had unconsciously denied his own masculinity and even the presence of his penis. It was as if his urine came away from a part of his anatomy which did not exist for him. Over the next two months, the enuresis improved, although it did not cease, and the child began to play more appropriately with other boys.

Henry R was a 13-year-old boy, with a passive personality, from a united family, who had received weekly analytically-orientated psychotherapy for two years. At this point, with the agreement of the psychotherapist, use of the bell-and-pad apparatus was instituted, to which the enuresis initially responded. Following a relapse, the symptom finally cleared up in response to a second trial of the bell-and-pad apparatus. The boy's personality did not change, but he and his family experienced great relief at the cessation of the symptom. Further psychotherapy was then refused by the boy, and it is arguable whether the cure of the enuresis did not result in an inability to admit the extent of other personality problems.

*There is no reason, for example, why drugs should not be used at the same time as psychotherapy.

Marlene was a 13½-year-old girl with lifelong enuresis, referred from the Neurological Department where she was being seen for her epilepsy. Her father was out of work, and chronically unemployed. She was the oldest of five children: three of her sibs were in ESN schools and suffered from epilepsy. Two of these sibs were also enuretic. Her mother was a rejecting, embittered woman, who accused Marlene of deliberately wetting herself. Marlene herself was a pale, discouraged girl, of low average intelligence, chronically depressed both as a result of her family situation and her failure to 'beat' the enuresis. All the organic treatments had failed for one reason or another. Regular appointments for supportive psychotherapy were arranged, and Marlene turned up regularly for these and talked about her difficulties. After three months, her mother refused to allow her to attend any more. The enuresis had not improved, but certainly the girl had a more realistic idea of her own value as a person, and some of her secondary depression lifted.

In general, the outlook for many children referred to a psychiatrist is even less hopeful than the account of the above three cases would suggest. The families of quite a large number of enuretic children present with wide-spread intractable psychosocial problems. Here the psychiatrist's approach has limited value. A social worker competent to deal with the wide range of problems such families present will often provide a greater degree of support.

Despite this proviso, the child psychiatrist's skills are likely to prove of limited but significant value in the treatment of enuresis. The child psychiatrist is most likely to be of help in this connection if he is working in a hospital setting, where there is ease of communication between himself and the paediatricians, and where he has access to a wide range of ancillary investigatory and treatment facilities.

REFERENCE

Skynner, A. C. R. (1969) 'A group-analytic approach to conjoint family therapy.' *Journal of Child Psychology and Psychiatry*, **10**, 81.