CHAPTER 28

Is Enuresis Preventable?

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Definition of Enuresis

Before I can discuss enuresis, I must define my concept of what it means. I have revised my definition many times in twenty years of pediatric practice (most recently in favor of our own boy, the last of four, who was still wetting his bed at the age of five and a half*), and would now recognise the symptom of bedwetting as a departure from the normal, *i.e.* a disease with the name 'enuresis', at the point where it is met with cyclical concern by the child's parents and by the child himself. When a child's concern is compounded by those around him (his parents, grandparents, siblings and peers), and is met with negative rather than positive responses, his feelings of inadequacy are likely to be reinforced, and his attempts to arrive at the stage of dryness at night (one of many skills the mastery of which will encourage him in his efforts to be grown up and identify with successful grown-ups around him) undermined. Enuresis may occur at any time, and need not be diagnosed on the basis of age. When emotional pressure secondary to the bedwetting contributes to a vicious circle, the symptom should be called enuresis, and dealt with accordingly by concerned medical caretakers.

Can Enuresis be Thought of as a Preventable Entity?

The definition I have just given implies that enuresis is likely to be the result of a basic imbalance between the child and his environment. When this imbalance becomes serious, as it does in a portion of our population (though hopefully this portion need be no larger than the 1·5 per cent in my practice in 1962), I doubt that any efforts directed at rectifying it will be of any use, although it may be possible to alleviate the disturbance (of which the enuresis is but one symptom) by long-term expensive therapy.

Rather than waiting until the enuresis and the underlying disturbance require long-term therapy, we can adopt a preventive approach, pediatricians and family physicians taking responsibility for allowing the child to develop night-time control, considering that this an important step for the child in his mastery of himself. This approach should be a less expensive one, but it will demand a new kind of involvement with families on the part of the doctor. We know how inadequate our out-patient response is to the concerned family of older (seven- to eight-year-old) enuretics—the age group on which we have focused most attention as far as statistics and therapy

*One morning, he asked me why I was so 'upset' about his wet bed every day. I rushed to assure him that I wasn't, realising I was. I then began to relax myself inside, seeing that *he* was not as upset as I was, and within a week his bedwetting came permanently to an end!

are concerned. Adopting a thumb-in-the-dyke approach to a symptom has never worked, and as far as bedwetting is concerned it is unlikely to work much better in the future, *even with improved techniques for treatment.* This approach assumes pathology, treats the symptom as if it were a reflection of pathology, and by its attention to the symptom reinforces with iatrogenic pressure the tip of what is by this time an entrenched iceberg.

Can a preventive approach avert the vicious circle which creates this iceberg? I think so, and would like to propose a preventive approach to all toilet training as a way of avoiding the symptomatic pitfalls of overanxious concern in this area. Given by the removal of his anxiety a fresh opportunity to achieve a developmental step, the child would experience success, and profit from this success with a feeling of self-fulfillment, which would in turn fuel his total ego development. The same model applies to parents—when a task as responsible as toilet training has been surmounted, their confidence in themselves as parents must grow, and their inability to cope with their shortcomings in this area must decrease.

Proper timing of environmental cues is essential to help the child achieve mastery in this area. While the arrival of the stage of nocturnal control may be inherent, there is little evidence for any 'instinctive' or 'built-in' forces which push a two- or three-year-old child to realise the advantages of conforming to an environmental requirement as complex as the achievement of day-time bladder control. We should, therefore, be aware of all the forces within the child which we can use as reinforcers for our demand on him. If we can strengthen his own steps towards the emergence of the skill, I am certain that with the achievement of each step the child will receive a definite reward of self-realisation. We have also to be aware of factors which could interfere with the emergence of the desired skills, so that these factors may be avoided.

Conditioning of Reflex Sphincter Control versus Voluntary Co-operation

That the achievement of each developmental step can be brought about by training reflexes is by now well-known. However, a skill developed spontaneously at the child's own speed, though later in appearing, is likely to be more lasting and of better quality. For example, a child can be trained to walk at six months, but will do so with a fixed rigid gait, which may persist for years. Indeed, in one girl it persisted for so long that even at the age of three years she was unable to turn or reach out and pick up a toy while walking. Also, a child who has, without 'training', developed a skill will reap more benefit from the feeling of excitement on achieving his goal, and will be better able to incorporate other contingent activities (*c.f.* Piaget's model of accretion). The disadvantages of early day-time training tend to show up later. The child who has received early toilet training is more susceptible to later breakdowns. In such a child, the encopresis or enuresis may not show up for several years until stress presses him into regressive behavior patterns.

The Utilization of Motor Skills to Promote Dryness

When a child can walk towards or away from the toilet, he has a greater capacity for co-ordinating his responses to his own desires as well as to the desires of those

around him. When sitting down is a pleasure and not a chore (as it is after the initial excitement of walking is over), that skill becomes an asset as far as the acquisition of bowel and bladder control is concerned.

Impulse Control

The following impulses can be harnessed to assist the child in his efforts to become dry during the day:

(a) the 'compulsive' organising which crops up in the second year;
(b) the desire to please his parents, which comes and goes with equal intensity during the second year;
(c) the wish to identify with and imitate grown-ups, which appears at the end of the second year; and
(d) the desire to master new, more complex skills.

The joy of self-mastery was demonstrated by a two-year-old who brought her 24-hour production of urine into my office for my approval!

Night-time control seems to be a somewhat different kind of developmental step, demanding more maturation of the central nervous system connections controlling the autonomic nervous system, as well as of the smooth musculature of the genito-urinary system. Allowing the child more time for this maturation, reinforced by the desire to control himself, is usually helpful. But ensuring that the parents are aware that this is a step better left to the child's own maturation and emerging desire for mastery seems absolutely essential to an atmosphere in which the emergence of this behaviour can proceed without unnecessary delay and conflict.

The Parents

Spock (1946) feels that unless the feelings of the *parents* are considered seriously, their unconscious ambivalence will interfere with and undermine the effects of a child-oriented programe. I certainly agree. For this reason, it is important when counselling the parents of an enuretic child that we should consider and expose their feelings, and discuss with them how these feelings are likely to affect their child's eventual adjustment. When we do not, we can expect *any* program we design (because of many parents' concept of us as authoritarian, omnipotent and critical figures) to gather a kind of negative force leading to failure. When, as described in my 1962 paper, the doctor does consider their feelings, as well as adopting a developmental approach to the child, I would expect 98 per cent success!

We must prepare parents for our program at a time when they begin to think of starting training, or perhaps are being urged to by a grandparent, probably during the first year of the child's life. By discussing with them our plan for a developmentally-oriented program, we can expose and explore feelings and any conflict there may be between their desire to start training and a feeling that they ought to wait. As the second year progresses, and their tension mounts, these feelings must be brought out and dealt with again. The major effort on the part of the pediatrician or physician must be aimed at diverting or dispelling the parents' tension in this area.

Unless the program is seen by parents as an opportunity for the child to master his own steps to bladder control, there will be many opportunities for their

tension to flood over to the child, to set up resistance in him, and to hamper the emergence of the desired behavior by arousing unnecessary conflict. At each stage, I find it necessary to remind parents of our goal, of the necessity of leaving it up to the child (once he had been shown the steps outlined in my 1962 paper), and discuss with them any feelings they may have that by giving up their training they are failing in one of their parental duties. This has been easier with each new generation of parents in the U.S.A., for the word has spread that it is a successful way for a child (and his family) to achieve mastery in this area.

When using this approach to toilet training, there are many situations (*e.g.* the arrival of a new baby, a move, a temporary absence of a parent) which are likely to lead to regressions. On these occasions, the support and guidance of the physician is needed in order to prevent mounting parental concern. I am convinced that the effect of such parental concern about a symptom like bedwetting is to increase the child's concern to an abnormal level, so that the failure to become dry becomes further established as a symptomatic expression of the child's inner anxiety. It is then that the lack of emergence of night-time bladder control becomes the pathological entity that we see in clinical practice.

Conclusion

According to the above model, the late emergence of day-time and/or night-time dryness may essentially be a failure not of the child, but of the family and their guiding physician. The physician may comfort himself by postulating contributory factors, such as maturational delay in the development of bladder capacity and so on, but he might do better to consider a re-definition that '*nocturnal enuresis occurs when the parents are worried about the bedwetting* (*without obvious cause*) *of a child over the age of five years*'.

REFERENCE

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