

# Say Goodnight to Bed-Wetting

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Last month we talked about toilet training, this month we will talk about when your child continues to suffer bed-wetting. Most 3 to 4 year-old children are able to achieve daytime control, and by age 4 or 5 most will achieve nighttime control. The medical term for children who continue to suffer bed-wetting beyond the age expected is known as "nocturnal enuresis".

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM4V, American Psychiatric Association), the criteria for diagnosing a child with enuresis are: (1) repeated voiding of urine into bed or clothes (whether voluntary or intentional); (2) wetting that occurs twice a week for at least 3 consecutive months or the presence of clinically significant distress or impairment in social, academic, or other important area of functioning-, (3) chronological age is at least 5 years (or equivalent developmental level); and (4) wetting not due to a general medical condition (e.g., diabetes, seizure disorder) or to the direct physiological effects of a substance (e.g, diuretics).

Researchers have reported that 10 to 20% of five-year olds, 5% of IO year olds, approximately 2% of 12 to 14 year olds, and 1% of 18 year olds suffer nocturnal enuresis. Enuresis is more common in boys than girls.

Genetic factors play a strong role in bed-wetting. If both parents have a history of bed-wetting, their child has a 77% chance of being a bed-wetter. If one parent suffered bed-wetting, the child has a 44% chance of wetting the bed. The rate drops to only a 15 % if neither parent has a history of bed-wetting. Many researchers also believe a child's failure to learn how to control the urination reflex may cause bed-wetting.

Another factor that contributes to bed-wetting is that some children do not have a normal increase in the secretion of vasopressin (an antidiuretic hormone), which controls urine production during the night. As a result, these children's urine output exceeds bladder capacity during the night. For some children who bed-wet, the amount of bladder that can be accommodated before the urination reflex is activated is smaller than non-bed-wetting children. Research is still mixed as to whether sleep-cycle or arousability play a role in bed-wetting.

In general, emotional or adjustment problems are not found in the majority of children who suffer bed-wetting. However, these children are at risk for developing low self-esteem or feeling different when they reach school age because they are unable to participate in events such as sleep-overs or overnight camps due to fear of being teased. Parental anxiety and negative reactions may also create family conflicts.

This thinking about treating nocturnal enuresis, it is important to keep in mind that bed-wetting typically resolves with age. Usually, formal treatment before ages six or seven is not necessary.

Common treatment strategies for bed-wetting include:

Medication treatments.

Imipramine (Tofranil) is a tricyclic antidepressant, which is sometimes used to treat enuresis. However, it has limited efficacy and some side effects. There is a high relapse rate once the drug is withdrawn. Desmopressin is a nasal spray which is very effective in eliminating bed-wetting in children who do not produce normal levels of the hormone vasopressin during the night. It can be used as a long or short-term remedy (e.g., going to a sleep-over). It is a temporary solution. Once the drug is withdrawn many children continue to wet their beds.

### Urine Alarm or Bell and Pad.

This is one of the most effective treatments for enuresis. A urine sensitive pad is placed on the child's bed that is connected to a loud buzzer. As soon as a few drops of urine touch the pad, the buzzer goes off until it is manually turned off. The newer models involve the use of metal snaps that are attached to the child's pajamas and connected to a small "wristwatch like" apparatus, which also buzzes when the child wets. The child's muscles will automatically contract when awakened by the bell. This teaches the child to tighten the sphincter muscle and go to the bathroom before wetting. To prevent relapse, it is recommended that after dryness has been achieved, children increase their fluid intake before bedtime while continuing to use the alarm system. This principle is called over learning and reduces the relapse rate of the alarm method to 13%. To further lower the relapse rate, after achieving 14 days of consecutive dry nights with the over learning technique, use the alarm on an intermittent schedule.

Let your child know that some days you are going to disconnect the alarm after they are asleep. This will further strengthen the child's ability to sleep through the night without wetting.

### Urine Retention Exercises.

These techniques involve giving the child increased liquids, and when the urge to urinate appears, having him or her refrain as long as possible. Don't have the child drink more than 8-16 oz./hour or retain fluids over 1 to 2 hours.

### Sphincter Control Exercises.

Mothers may remember being taught to practice these while pregnant. The exercise involves starting and stopping the stream of urine while urinating. Have child do it three to five times during each voiding.

### Dry Bed Training-

This is an extremely intensive approach that involves the use of the urine alarm system, urine retention control training, positive reinforcement for appropriate voiding, training in rapid awakening, increased fluid intake, self-correction of wetting accidents, and toileting practice. A parent using this approach would require guidance and support from a qualified professional.

Although a child can help with cleanup, remember not to blame him for bed wetting. Using verbal praise or tangible reinforcers (e.g, stickers) to help encourage and support your child efforts is also helpful.

The wrist urine alarm may be obtained from Nytone Medical products, Inc., 2424 South 900 West, Salt Lake City, UT 84119.

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