

DISCLAIMER

The information contained within this document does not constitute medical advice or diagnosis and is intended for education and information purposes only. It was current at the time of publication and every effort is made to keep the document up to date.

The information contained herein includes both psychological and non psychological interventions. The delivery of psychological services requires a medical referral whilst non psychological services do not.

Each person is an individual and has a unique psychological profile, biochemistry, developmental and social history. As such, advice will not be given over the internet and recommendations and interventions within this website cannot be taken as a substitute for a thorough medical or allied health professional assessment or diagnosis.

Nocturnal Enuresis – Bed Wetting

Article QUICK LINKS :

[What Is Nocturnal Enuresis?](#) / [Prevalence](#) / [What Causes Enuresis?](#) / [What Interventions are available?](#) / [Conclusion](#) / [References](#)

WHAT IS NOCTURNAL ENURESIS?

Nocturnal Enuresis is persistent bed wetting without accountable organic pathology after the age of 4-5 years. It is generally divided into two types - *primary enuresis* where there is no sustained period of dryness, and *secondary enuresis* where there is a period of lengthy sustained dryness (3-6 months) without intervention.

Most children are toilet trained for daytime between the ages of 2 1/2 to 5 years, and night training usually follows around six months later.

PREVALENCE

It is estimated that 15-20% of children wet their beds at age 5, about 5% at age 10, 2-3% at age 14 and 1-2% in young adulthood. It is slightly more common in younger males than females, but the ratio increases to 2:1 around age 11.

It is thought that about 15% of children wetting between the ages of 5-19 years will become dry within a year without intervention. This increases to around a 45% chance of becoming dry over a 5 year period.

Deferring intervention can have profound psychological ramifications and is not advisable for school age children and adolescents. There is hope.

WHAT CAUSES ENURESIS?

There are many theories as to what causes enuresis.

Genetic and/or familial factors play an important part for many children. When both parents have, or have had enuresis, there is a higher chance that their children will. Underlying emotional disturbances, behavioural (ADHD, Dyspraxia etc.) and Learning Difficulties (Children who are slow in reaching other milestones may take longer to stay dry at night.) are all considerations.

Sleep depth and/or arousal levels (85-95% of enuresis occurs during NREM [Non Rapid Eye Movement] stages of sleep, but studies by Sharf and Jennings, 1988, indicated that enuresis is more related to the time of night than sleep stage); a small bladder capacity; nocturnal polyuria (Increased urination during sleep because of overproduction of urine as the kidneys are not properly concentrating the urine.); and dysfunctional detrusor muscle (the muscle surrounding the bladder); or dysfunctional perineal muscles (the muscles which form the pelvic floor and are used for 'holding') may all be contributing factors. Stress and illness may also play a significant part.

It is important that a full familial, as well as medical history and workup be undertaken, including urology, a functional QEEG (Quantified Electroencephalogram or brain wave study), and testing for retained reflexes.

WHAT INTERVENTIONS ARE AVAILABLE?

It should be noted that each and every person is unique. Sleep enuresis may best be described as a biobehavioural problem requiring consideration of multifarious biochemical, physiological and learning theory variables. Many factors will need to be examined before suggesting which interventional modality will be suitable in each instance.

ALARMS

The 'night alarm' is generally the most popular choice, and has been in use for the past 60 years. There are many different kinds on the market. Most have a sensor which sets off an alarm as soon as the child begins to wet the bed. Progress is usually very slow, and interrupted sleep patterns may exacerbate the problem or cause others.

MEDICATION

Medication produces side effects, is expensive, and will not help all children. Drugs are not a cure for enuresis, and wetting will resume when treatment has stopped. Drugs should only be used in the most extenuating of circumstances such as night time sleepovers, camp and the like, - that is, when the psychological benefit of use outweighs the risks of side effects. You will need to discuss this with your health care professional.

EXERCISES

Bladder stretching exercises and muscle strengthening techniques may be suggested. Talk to your health care professional before undertaking these.

NEURODEVELOPMENTAL THERAPY

Exercises and training for inhibition of retained reflexes to address problems associated with neurodevelopmental delay.

SOUND THERAPY

Samonas Sound Therapy with applied bone conduction has been very successful in many instances of enuresis.

BOWEN THERAPY

The Bowen Technique offers specific protocols for enuresis and many other childhood problems. Properly administered by a trained practitioner, it has a good track record with enuresis, and is gentle enough for use with all ages.

EEG BIOFEEDBACK

If the enuresis has a level of arousal, behavioural or a psychological basis, then EEG biofeedback can help.

DIETARY

Elimination of specific foods and adherence to dietary guidelines and supplementation has been of benefit to most people with enuresis.

CONCLUSION

Experience has shown that the most successful interventions for enuresis are individualised programmes tailored to the person's unique needs and comprise multiple interventional methods applied synergistically to address the whole person - not just the symptom. Whichever methods are decided upon, behavioural and learning techniques will need to be applied in conjunction to the chosen mode of intervention.

The programme is intensive and may be demanding for many people, but has shown long term benefits both for the enuresis and on the family levels in the shortest timeframe.

For more information or to make an appointment please contact us on (02) 9637 9998 during business hours.

REFERENCES

1. Andreassi J.L. 1995. Psychophysiology - Human Behaviour and Physiological Response. Erlbaum & Assoc. Hillsdale New Jersey.
2. Sternberg, R.J., 1994, In Search of The Human Mind, Harcourt Brace, New York.
3. Schwartz, M.S., & Associates, 1987, Biofeedback - A Practitioner's Guide, The Guilford Press, New York, NY.
4. Sharf, M.B., & Jennings, S.W., 1988, Childhood Enuresis: Relationship to sleep, etiology, evaluation and treatment., *Annals of Behavioural Medicine*, 10, 113-20.
5. Evans, J.R., & Arbanel, A., 1999, Quantitative EEG and Neurofeedback., Academic Press, London, UK.
6. Wagner, W.G., & Mathews, R., 1985, The treatment of nocturnal enuresis: A controlled comparison of two models of urine alarm, *Journal of Developmental and Behavioural Paediatrics*, 6(1), 22-26.
7. Upledger, J., 1996, A Brain Is Born., North Atlantic Books, Berkley, California.
8. Tortora, G.J. and Grabowski, S.R., 2000, Principles of Anatomy and Physiology, 9th Edition, Wiley & Sons Publishers, New York, NY.