The Treatment of an Enuretic Child in Residential Care

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**ABSTRACT:** A study is presented in which conditioning is successfully used by a houseparent as a treatment for chronic nocturnal enuresis for a child in a residential facility. Data are plotted over an extended period and the point is made that, though the effect of the conditioning treatment was rapid and pronounced, persistence on the part of worker and child is needed if such procedures are to be applied properly. The effects of the method on other children in the facility, the results of changes in houseparents and fluctuations in bedtimes, and the cost of the program are discussed.

Houseparents, child care workers, and other direct-care personnel encounter a variety of problem behaviors when working with children in a residential setting. Often several of an individual child's problems may be traced to a single cause. For example, Jehu, Morgan, Turner, and Jones (1977) point out that the incidence of enuresis is particularly high among children in residential homes. Such a problem can be very socially distressing for a child in this setting. Other children are sure to notice an individual who changes his bed each morning and may respond by teasing or avoiding the child. Child care staff, in addition to other duties, must take time to assure that the enuretic child washes up properly. Housekeeping staff may resent the unpleasant and additional daily burden of wet sheets. It is clear that both staff and residents may treat an enuretic child differently than they would a child who does not wet the bed. The additional morning activities (showering, changing sheets) may cause the child to be late completing other responsibilities such as chores, resulting in additional unpleasant consequences for the child. It comes as no surprise, then, that enuresis may be related to lowered self-esteem in children (Fritz & Anders, 1979).

This paper reports the efforts of a houseparent to find a treatment method for enuresis, adapt it for use in a residential facility, and use it to intervene in a situation similar to that described above.

The author gratefully acknowledges the contribution of Jan Houghton and the cooperation of the staff and administration of the St. Vincent Home for Children, and is indebted to Dr. John Hurley, Department of Psychology, Michigan State University, for his support and editorial assistance in the preparation of this manuscript. Requests for reprints should be addressed to the author, Department of Psychology, DePaul University, 2323 N. Seminary Ave., Chicago, IL 60614.
There are two general views of the etiology of nocturnal enuresis. The psychoanalytic school views the problem as a symptom of a deeper underlying disorder (Lovibond, 1964). An opposing view is that enuresis is primarily a learning deficit. Members of this theoretical school attribute the disorder to a child's failure to have learned to respond properly to the stimulus of a full bladder (Eysenck, 1959). In a discussion of the process of acquiring continence, Mowrer (1950) points out that some children require more assistance than others in acquiring the required degree of control. The adequacy of this assistance will vary among families, he observes, and the result may be a certain percentage of children failing to acquire the proper habits in a timely manner.

By viewing enuresis as the result of a habit deficiency one does not necessarily eliminate emotional and psychological factors as contributors to the problem. McGuinness (1935) has said that enuresis may be an aggressive act in a very submissive child. He points out that although adults can always prevail physically, the child is in total control of his elimination functions and may thus voice his protests. Mowrer (1950) concedes that emotional factors may be of predominant etiological significance in isolated cases of enuresis, and may be contributing factors in many other cases. He concludes, though, that there are a considerable number of cases in which habit deficiency is the predominant (if not sole) causal factor. It follows, then, that treatment should address this habit deficiency.

**Method**

**Subject**

Tom¹ (who wet the bed almost every night) was a Caucasian male aged eight years three months, living in a private, nonprofit, residential treatment facility which can accommodate up to 38 boys and girls. Operated 24 hours a day throughout the year, the institution provides therapeutic intervention for children with emotional problems and for dependent and neglected children who are unable to live in their own homes or foster homes. To qualify for the treatment, the patient was required to meet the following criteria: (a) had to be a fairly constant wetter, i.e., four or more times per week; (b) the enuresis has to be known to deleteriously affect the child's adjustment (e.g., severely interfering with his ability to effectively complete his morning routine); (c) as can best be determined, no bell and pad conditioning method has been used to treat the child within the past year; (d) the child indicates a desire to reduce the frequency of enuresis; (e) a medical examination has revealed no significant medical pathology which may result in enuresis (including present drug use). Prior to recording any data, all existing techniques of enuresis treatment (e.g., restricting evening fluid intake, awakening child during the night) were discontinued.