Curing Bedwetting on the Spot: A Review of One-Session Cures

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Introduction

Bedwetting, or nocturnal enuresis, is one of the most common behavioral and urologic problems faced by pediatricians, affecting 5 to 7 million children over the age of 5 in the United States.[1] The prevalence of children with enuresis declines with age from 15% of 5 year olds to 1% of 15 year olds, making maturational delay the most probable etiology of enuresis.[1] Only 5% of enuresis is due to a specific organic cause.[1] Not surprisingly, behavioral therapies, such as enuresis alarms and hypnotherapy (relaxation mental imagery), have the highest reported long-term cure rates.[1,2]

At least seven studies and numerous case reports[3-9] have demonstrated the successful treatment of enuresis with hypnotherapy. Treatment generally lasts from 4 to 20 weeks with follow-up between 6 months and 1 year. The children studied are generally between the ages of 7 and 18.

The largest review was that of Kohen and associates, who kept data on 257 children treated at the Minneapolis Children's Medical Center. Forty-four percent achieved complete dryness (30 consecutive dry nights with no relapse after 12 months), and 31% showed significant improvement. Many of these patients had already tried medication or the alarm, without success.[6]

Banerjee and associates (1993) compared treatment with hypnotherapy to treatment with imipramine in 25 children between 5 and 16 years old. Both groups had similar positive responses (72% vs. 76%) within three months, while in follow-up six months later only 24% of the imipramine group was still dry, while 68% of the hypnosis group still had dry beds.

For a child to achieve dry beds, he must be interested in a "cure." For hypnosis to work, there must above all be rapport and trust between him and his pediatrician. Any organic cause, such as chronic constipation, obstructive sleep apnea, or urinary tract infection, should be ruled out. Any significant stressors should be discussed. The practitioner usually draws a picture of the child's body featuring the brain and genitourinary system and discusses the connections between them, in an age-appropriate manner. The child should be reminded that there are messages, like telephone conversations or computer circuits working between their brain and bladder at all times, even when s/he is sleeping.[10] S/he should be reminded that s/he is the boss of her/his body. Only s/he can remind her/his own "gate" to stay shut, and her/his own "alarm" to sound if the bladder gets too full. The child should be in charge of her/his hypnosis practice; and parents cannot remind her/him.

Formal hypnotherapy generally involves trance induction, visualization, relaxation, therapy, and ratification or reflection. Hypnotherapy for enuresis generally takes between 4 and 20 weeks. I report four cases of children with successful cures of enuresis using hypnotic techniques after one session, three of them involving no trance induction.

Case Reports

Patient 1

Patient 1 is a 12-year-old girl who was 8 at the time of treatment. At the time of her 8-year-old well child examination, she

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had wet beds almost every night since birth. She had recently failed treatment with desmopressin nasal spray for her primary nocturnal enuresis, a fact attributed to her chronic nasal congestion She was status post tonsillectomy and adenoidectomy, but still had chronic snoring, a history of recurrent sinusitis, and gastroesophageal reflux, treated with antibiotics, nasal budesonide, famotidine, and cisapride. She was growing and developing normally. The patient and her younger sister were both Amerasian girls; adopted at birth. The biologic mother's history was unremarkable and the biologic father's history is unknown. There were no stresses identified at the time of the visit, but there was marital discord identified later.

After ruling out common organic causes for nocturnal enuresis, I explained the anatomy and physiology of bedwetting. The child was urged to think of dry beds, not wet. A picture was drawn and she was instructed to draw her own. She was reminded of the connection between her brain and her bladder and the gate holding the urine in, and told that she could simply adjust the volume switch so her brain would get the message at night.

She did not return for follow-up, because she became dry by the following day, and has stayed that way—although she has since been seen for alopecia, probably related to stress.

Patient 2

Patient 2 is a 9½-year-old girl who presented at age 7 with primary nocturnal enuresis. Her medical history was significant only for recurrent otitis, an episode of reactive airway disease, and one episode of periorbital cellulitis. She is a delightful girl with a strong personality, like her mother—who is creative and very involved with the children's activities. She is one of four children. There is a positive family history of enuresis.

Again, organic etiologies were ruled out with a history, examination, and urinalysis. At the time, she had only 2 dry nights a week. This session was similar to that of the first case, except that an informal trance induction was carried out, and the patient imagined herself doing a few of her favorite activities: cycling and playing with dolls, as well as visualizing the brain-bladder connection.

Follow-up was planned for 2 weeks, but the child did not come in until she was seen for the flu a month later, because she was 100% dry by the next week. That winter she suffered from significant snoring from adenoidal hypertrophy, treated with nasal steroids, but the bedwetting did not recur.

Patient 3

Patient 3 is a 9-year-old boy seen for primary nocturnal enuresis at age 6½. His medical history was significant for coronal hypospadias surgically repaired at age 22 months. He had normal stream and bladder control during the day. A urinalysis was normal. The boy was accompanied by his father, a former military officer who had served in Vietnam, works in computer repair, and spends many hours working on their home. The mother had enuresis as a child.

The patient had between five and no dry beds each week before being seen with his parents waking him at night, which occasionally helped. This child's case was approached much like the first one. He drew a picture in the office with emphasis on the brain-body connection. He was seen in the office 2 weeks later. His parents continued to awaken him the first four nights after the office visit, but he then proceeded to wake himself every night. He had dry beds every night. His father admitted to being quite skeptical of my approach initially, and was very pleasantly surprised.

The patient continued to have 100% dry beds until 2 months later, after some extreme familial stressors that involved three cousins moving into the house on an emergency basis, but was dry again after 1 week. Two years later, he has had no recurrence of enuresis.

Patient 4

Patient 4 is a 9-year-old girl who had no dry beds until the time of the visit. She is the second of two children and has been healthy except for adenoidal hypertrophy requiring surgery. During a sick visit for what was diagnosed as pneumonia, her mother brought up the topic of her wet beds.

The patient agreed that she would like to have dry beds at night. The brain-bladder connection was discussed in a developmentally appropriate way, along with a suggestion to allow a signal from her bladder to awaken her at night if need be. She was seen months later for a well-child visit. She said she had 100% dry nights after her earlier sick visit.

Discussion

Children do not usually suffer from enuresis because of a psychological disorder, although stressors may act as a trigger. It is interesting that out of these four children, three of them had ongoing stressors in their lives, two of them had symptoms of nasal obstruction, and one had a cor-

rected urologic anomaly, all of which may complicate the treatment of enuresis—making their one-session cures all the more surprising.

Of course bedwetting itself creates stress. In fact children with enuresis have lower self-esteem than children with chronic, debilitating illnesses.[1] Teaching self-hypnosis to kids enables them to achieve their own cure, and reinforces a sense of competency, mastery, and self-esteem.

Whether formal hypnosis with trance is required to achieve bladder control is debatable. Edwards and van der Spuy found no difference in results between those boys who were treated with trance plus suggestions, and suggestion alone.[5] This study is similar to others that found formal trance induction is not necessary for successful self-regulation of autonomic responses.[2]

Three of the four cases presented involved no formal hypnosis, yet children are often open to suggestion.[10]

Most enuretic children treated with hypnosis show improvement after one or two sessions if they are going to be successful with this method.[2] Stanton reported that of the 28 patients he treated with hypnosis, 20 successfully achieved dry beds. Seven of these had dry beds after only one session, although some of these may have been among the five children who did not maintain dry beds on follow-up 12 months later.[6] Stanton's approach in his hour long sessions involved formal induction and ego-enhancement scripts, with indirect suggestions to achieve dry beds.

In contrast to this rather elaborate approach, the four patients in this report achieved dry beds after only a simple explanation and drawing of the bladder and the brain, and almost casual suggestions—with light trance and visualization of a favorite activity used in one case only. It is as if there is a neural trigger or switch that can be turned off or on fairly easily. These exciting success stories remind us of the power of our young patients' imaginations and how we may use their powers for self-healing and self-regulation during visits for many common pediatric diagnoses.

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