



HOW YOU CAN BE  
**BOSS OF  
THE BLADDER**

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## BEDWETTING MANAGEMENT AND TREATMENT

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The following recommendations are made as a result of my experience at **The Boss of the Bladder Program** in Melbourne, Victoria.

### MEDICAL ADVICE

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Parents usually do not take a child to the doctor specifically for bedwetting treatment. It is more likely that a concerned parent may take the child to the doctor for some physical complaint like a viral infection, and mention the bedwetting as a persistent annoyance.

Unfortunately many doctors recommend the parents *'to just wait, the child will grow out of it'*. Such advice is usually given in the best of intentions to protect the child from being pressured by anxious parents. In the long run however, waiting may often cause extreme frustration for the child and the parent. It is especially damaging to the child's self-esteem.

As children become of primary school age, and are encouraged to go on school camps and stay overnight, bedwetting can be a particular source of embarrassment, confusion and low self-confidence.

I recommend that children from five years of age are able to be motivated and parents guided by a professional. Sometimes younger children can be treated, but usually five years of age is the minimal age for professional intervention. There are exceptions with very bright young children and extremely motivated parents, when the indicators are positive for the child learning to become dry. For instance, a child may be waking during the night distressed at the wet bed that has been causing discomfort and the reason for waking.

## DRUGS

Doctors may prescribe medication for children. The most commonly used is Tofranil. This drug acts to relax the bladder muscle so that the bladder is less likely to empty spontaneously.

Unfortunately, Tofranil is also widely prescribed as an antidepressant for adults. Parents have reported that there are possible side effects such as hyperactivity symptoms, irritability and lethargy.

Tofranil may successfully stop a child wetting, but often the child will start wetting again as soon as the drug is withdrawn. The success rate for permanent stopping of wetting is less than forty per cent.

One child seen by me had been taking Tofranil for over three years and yet was still occasionally wetting the bed. At age eleven, an enuresis alarm and motivation program was devised and after FOUR weeks, the child was dry. Three months later, the mother reported that the child's grades at school had improved from a C to a B, his self-confidence had improved and he was generally more co-operative and calm.

Some doctors are now prescribing a nasal spray called Desmopressin (DDAVP) to help children stop wetting. Some children have become dry, some have become wet again when the drug is stopped and some don't get dry at all. Of greatest concern is the risk of accidental poisoning. Desmopressin is only effective when being taken, so it may be useful in helping with a social dilemma like going on a school camp. It is not a cure.

Whether you choose a drug method for treatment for your child's bedwetting depends on you and your doctor. As a mother, I would not like my child to take drugs, especially if there may be side effects and no guarantee of getting dry.

## THE IMPORTANCE OF THE PROFESSIONAL COACH

The most important aspect of seeking professional supervision for bedwetting, is that of motivation. A solution to any problem can be blocked by emotional closeness between family members. A child is much more likely to become enthusiastic about a program offered by a bright and positive therapist. The child can be inspired to believe that he or she is responsible and can independently contribute to gaining dryness.

**REMEMBER THE CHILD IS THE PLAYER,  
THE PROFESSIONAL IS THE COACH  
AND THE PARENTS ARE THE SUPPORTERS  
WHO STAND ON THE SIDELINES**

## ENURESIS ALARMS

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As a result of experience I make a strong recommendation that alarms should be used with professional supervision. The success rate under these circumstances can be as high as ninety per cent.

The alarm program which I use is suitable for a child of at least five years of age. Older children are given as much encouragement as possible to be independently responsible for managing the alarm. Weekly reports of progress are extremely important in order to maintain the child's and parents' motivation, and monitor the reliable use of the instrument. Reports can easily be managed by telephone.

There are a range of alarms available through chemists. I have repeatedly found that parents come to me for assistance after having bought a cheap alarm from the chemist and found that either the child did not awaken to the alarm, or the alarm would

sound inconsistently. Parents have been woken during the night to alarm sounds which had been simply triggered by the child's perspiration. Disappointed parents and children have woken in the morning to a flooded bed when the alarm did not sound.

**The Boss of the Bladder Program**, established in Melbourne, uses the most efficient and reliable alarms available on the market today. These alarms are only available from professionals; usually nurses, social workers, psychologists, doctors and special teachers. The important aspects of conditioning with an alarm are that the child awakens as fully as possible, and makes a trip to the toilet (whether there has been minimal or full wetting).

The most commonly used alarm is the bell and pad. The urine sensitive rubber pad is put on the mattress and connected to a buzzer/bell alarm box near the bed. When a wet occurs, the alarm sound wakes the child, who is encouraged to finish the urinating on the toilet.

Problems with the bell and pad are rare. The exception is where the child is a very deep sleeper. With persistent parental encouragement and practice, however, the child can usually be taught to arouse to the bell. Personally worn alarms are typically used for toilet training during the day and can be used for night training. The device has a small alarm which is pinned to night clothes and connected to a small sensor that is worn in the pants. These alarms have advantages in ease of transport and cost, but reliability may need to be tested.

Parents have reported to me that 'There is nothing more frustrating than an alarm that goes off when it shouldn't and doesn't go off when it should.'

In most cases, alarms are successful within six to eight weeks. There is extreme variation for individuals, however, with permanent dry nights being gained after two nights in one instance in my practice, but not after sixteen weeks in another.

Extra drinks may be included in an alarm program. Research evidence and practical experience have indicated that children

who have a series of dry nights can then be encouraged to drink more (thereby overloading the system). If they can **still** persist with dryness, they may be more likely to remain dry indefinitely.

With the introduction of extra drinks, wetting may resume for a short period, until the bladder learns to hold that amount of urine or the bladder muscle wakes the brain. In my practice, recommend extra drinks in most instances. A few exceptions are with young children who can't understand the concept of extra practice and with extremely anxious children who once dry, are horrified at the thought of wetting again.

## DAY-RETENTION TRAINING

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Children with day wetting problems can be encouraged to play games with bladder *'holding on'*.

An intense program involves increasingly longer intervals of holding on between the passing of urine. The child is asked to tell the parent when he wants to go to the toilet. The parent encourages the child to hold on. The time is gradually increased – four minutes, ten minutes, fifteen minutes, up to forty-five minutes. A kitchen timer may be used to assist the game. Ask the child 'Can you beat the buzzer?' A piece of a jellybean (one jellybean can be cut in four or even eight) can be a reward for successfully prolonging the length of the delay.

### **HOLDING ON GAMES AIM AT INCREASING BLADDER CAPACITY**

Retention training may work in forty per cent of cases, but even when this procedure does not cure wetting, it should make other approaches easier to carry out due to increased bladder capacity. Some children can cheat by telling you they want to go before

they really have the urge. They do this to make sure they will get the reward. Ongoing measurement of capacity, by having the child actually wee into a bucket or a jug, may provide a check on this attempt at manipulation. The reward would only be given if capacity showed an increase, therefore proving that the child had been holding on for some time.

**Caution: Children with recurrent infections should NOT be asked to ‘hold on’.**

## PROGRESSIVE WAKENING

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Progressive awakening is not the same as lifting the child. In lifting, or ‘*waking and taking*’, the parent wakes the child once a night, typically prior to the parent retiring to bed. Section 1 of this book discussed how waking and taking is really doing nothing in teaching the child to take control, and indeed may simply perpetuate low bladder capacity by having the child keep his bladder empty.

A regular waking program is much more systematic, and involves the parent waking the child up on the hour during the night. When the child is woken, it is expected that if the child is wet, he or she go to the toilet and change the bedding.

There are two types of waking programs. In the regular waking program the parent wakes the child at consecutive time periods, for instance every hour. In the variable waking program the child is woken at a wide variety of times during the night. There is no regular pattern.

Waking programs are very demanding on the parent and there is no guarantee that the child’s brain will link the wakening with his or her own body urges to urinate during the night. Similar comment could be made for the next treatment method which is to be discussed: dry bed training.

## DRY BED TRAINING

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There has been some controversy over the ethical application of dry bed training. This procedure involves the child practising correct toileting procedures a large number of times before going to bed, and then lying in bed reciting a statement such as:

*'I feel nice and dry in bed.'*

In addition to the massed practices (usually 20 times) before going to bed, the child is woken on the hour during the night. Should the child be wet, he or she is to take full responsibility for changing and then to practise again possibly twenty times before returning to sleep.

A study reported by Fincham (1984) reported that parents who had actually implemented a urine alarm program and dry bed training **evaluated the urine alarm procedure as being much more favourable** than the dry bed training. In my experience, dry bed training can be an extremely negative and distressing procedure. Parents can be very grumpy about hourly waking and children can be hysterically upset!



## ROLE OF A CONTINENCE PHYSIOTHERAPIST

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Some physiotherapists have a special interest in the treatment of bowel and bladder problems in children and adults.

Such a professional working with a child who wets will assess the child's day and night bladder function to determine any physiological basis for the lack of bladder control.

Treatment aims to normalise bladder function. This is done by teaching the child techniques to 'retrain' the bladder both to store urine optimally and empty to completion.

In working towards dryness, a therapist also promotes the child's self-esteem and confidence.

Appropriate physiotherapists may be found by contacting *The Continence Foundation of Australia*, or the *Australian Physiotherapy Association*.

## CHIROPRACTIC

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Chiropractic manipulation has been shown to be effective in some cases of bedwetting. The chiropractor does a careful history and examination before deciding that manipulation is appropriate. The usual form of manipulation is very light and usually applied to the low back area.

Children who have chiropractic manipulation do not experience any discomfort or pain.



## HYPNOSIS

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Since children under the age of twelve are usually very good hypnotic subjects, it would seem useful to consider the possibility of hypnosis for assisting a child in learning dryness. In my experience, hypnosis is especially useful with older children – children above the age of eight, who are secondary enuretics or who have found their wetting problem to become an increasing source of embarrassment and cause for concern.

Parents are cautioned to seek a therapist who is a qualified and registered hypnotist. I am a member of the Australian Society of Hypnosis. Membership is restricted to medical practitioners, psychiatrists, psychologists and dentists.

I will often make a personalised audiotape, with direct suggestions for the child to integrate mind and body well-being and comfort. Suggestions are also made for increased confidence and positive feelings of self-esteem. In some cases a story might be told on the tape about another child who managed to learn to stay dry or overcame an obstacle that was interfering with their achieving a specific goal. The hypnosis tape may not necessarily be aimed at specific reduction in wetting. A main goal is to assist the child in having calming and confident thoughts prior to sleep and in focussing on achieving any worthwhile aim that they set. Details for arranging for personalised tapes are at the back of this book.



## PSYCHOTHERAPY

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Long-term psychotherapeutic counselling is not commonly used for treatment of wetting problems. In my experience, children are usually responsive over just a few sessions which concentrate on building self-esteem and boost a sense of personal power over **all** their problems. For ideas to help your child with problem solving and self-esteem, I strongly recommend you read my book ***Fear-free Kids*** and listen to my audio tape *How to Super-boost Your Child's Self-Esteem*.

## BOOKS AND AUDIO TAPES

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Some children have become dry simply by reading the children's section of this book! They also enjoy and learn from the ***How You Can Be Boss of the Bladder*** two audio-tape set. The child tape has a story for younger children on one side and on the other a positive suggestion tape for being dry which is suitable for older children and adults. The tape for parents has information on wetting and becoming dry on side one, and a **BONUS** on side two – a relaxation tape to acknowledge their positive parenting skills and offer a chance to wind down and relax after the busy day (and difficult time fixing up wet beds!).



## PROBLEMS AND RELAPSE

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Once a child has been reliably dry for two consecutive weeks, continued dryness can be expected. A few children who have cured themselves of wetting with enuresis alarms start wetting again some months later. Usually another training week or two on the alarm will be sufficient to reinstate dryness.

Very, very occasionally, another recurrence of wetting will occur. It may be that there are some changes in the child's life which are not being adjusted to. At this stage it is recommended that the child see a professional for counselling.

Some children relapse during times of stress such as a death in the family, severe sickness, new experiences and changes like transition from primary to secondary school, and a new baby at home. For some children who relapse, it seems as if their brains just forget the recently learned skill of staying dry. Perhaps the brain and body are too busy integrating new things which have been learned. These children respond best to the alarm program and can usually become dry quickly.

## FINAL RECOMMENDATIONS

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In the light of the necessity for all treatment methods to be positive and not stressful for the children, parents are initially counselled to use minimally intrusive and maximally positive treatment procedures in order to help their children learn dryness.

Children under the age of five may respond to rewards and a motivation sticker program. **Caution:** Remember, those with primary enuresis (that is, have never had a dry night) may find the reward

system frustrating. How can you boss your bladder if your brain and bladder 'won't talk'? Their neurological system is just not ready.

Children over the age of five are ready for a supervised program which typically combines a bell and pad alarm, a motivational scheme, regular weekly telephone calls, and extra drinks after seven consecutive dry nights until fourteen consecutive dry nights are reached. This is the program recommended by **The Boss of the Bladder Program**. If results for an alarm program with back-up reward scheme are slow to be achieved, progressive awakening and a relaxation tape are often useful additions.

Regular counselling may be appropriate for children on the above programs if there are additional problems such as difficulties with learning, social skills, or self-esteem.

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