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1. INTRODUCTION

Many parents are uncertain about how to toilet train their children. They hear conflicting messages from well meaning grand-parents, friends and neighbours about the best age to start the most successful method to use. Sometimes they allow the process to become too important and get caught up in power struggles, and then unintentionally teach the child that he can control them with his performance. On the other hand the child gets very confused when adults give so much attention to toilet training, when it gets to be the most talked about subject of the day, and when they receive inconsistent attention for their bed-wetting. Such confusion is a hinderance to the child for learning age appropriate ways.

2. BEHAVIOUR MANAGEMENT OF TOILET TRAINING

Whereas psychopathology rarely causes elimination disorders, parental reaction to enuresis can contribute to the development of emotional and behavioral problems in children.
When to Toilet Train

Most professionals familiar with child development consider it unwise to initiate toilet training before the child is both physiologically and psychologically ready for the training process. Physiologic readiness involves the muscular development necessary for bowel and bladder control. Psychological readiness for toilet training includes both cognitive development and motivation. The child must possess the cognitive ability to follow instructions as well as learn and recall the component skills necessary for independent toileting behaviour. In addition the child must be willing to use the toileting skills he or she has learned.

How to train

Brazelton has given a CHILD-ORIENTED APPROACH thirty years ago, which still has much merit.

1. After the child reaches 18 months of age, a "potty chair" on the floor is introduced as the child's own chair. A verbal association is made between the chair and the parents toilet seat. The parent takes the child to sit on the chair for a few minutes at a routine time each day for one week. It is important
that the child be completely clothed when he or she sits on the chair. Otherwise, the unfamiliar feeling of a cold seat can interfere with further cooperation. While the child is sitting on the potty seat, the parent can sit with and read to the child or give the child a snack to eat. Because the child's chair is on the floor, the child is free to leave any time. There should never be any pressure to remain seated.

2. During the second week, the child is asked to sit on the potty chair with his or her diapers off. No attempt to "catch" the stool or urine is made. "Catching" the stool at this point can frighten the child and result in "holding back" for a longer period thereafter. The routine is introduced gradually to avoid setting up fears of strangeness and of loss of "part of the child".

3. As the child becomes interested in sitting on and eliminating into the pot, he or she is taken to the pot a second time during the day when his or her diapers are soiled. The child is changed on the potty seat, and the dirty diaper is dropped into the pot. The parent points out that this is the eventual function of the chair. If the child is willing, the child is taken to the chair several times a day to "catch" the urine or stool.
4. During the next phase of training, the toilet chair is placed in the child's room or play area. All diapers and pants are removed for brief period of time, and the child's ability to urinate or defecate by himself or herself is pointed out. The child is encouraged periodically to go alone to the pot if he or she so desires. The ability to perform alone becomes an exciting accomplishment, and many children take over the function entirely at this point. Training pants are introduced at this time.

5. After bowel training is complete, boys can be taught to stand for urination. This skill is easily taught by having the child watch and imitate other men.

6. Night training is postponed until the child develops the ability to control bowel and bladder function during the day. When the child expresses an interest in night training, the parents can awaken the child in the early morning and offer him or her the opportunity to go to the toilet. It is often useful to place a pot painted with luminous paint by the child's bed. The child can be encouraged to use the toilet chair in the early morning as well as at night.
The child oriented approach is geared towards minimizing conflict and anxiety and it stress the importance of flexibility. The training should be conducted in a relatively low key, matter-of-fact manner with an underlay in expression of confidence that the child will learn independent toileting skills when the time is right. Although the readiness tests described earlier can provide a general guideline as to when the training process should begin, training should be discontinued if the child does not make progress. Training can then be resumed after a period of 2 or 3 months. Children generally learn rather quickly when they are ready. Most children have learned proper toileting habits by the age of 5 or 6.

3. PREVENTION

The key issue for parents to understand is that toilet training should be an educational and not a disciplinary process. It is preferable if the parents, rather than other adults, can be the ones who work with the child in this process because they are likely to be the most important adults in the child's life and the people he or she is most likely to want to please. Wanting to please his or her parents is powerful motivation for the child in
achieving most, if not all, developmental progress. In this case the parental role should be first to help the child understand the goal and then to achieve it. In our society the goal is acceptance of the standard toilet (or special child-oriented) facilities in bathroom as the appropriate and sole place for elimination. It is inherently obvious, but sometimes often overlooked, that the child is really the only person who can control the muscles and impulses of elimination. It is therefore obvious that the best approach would be to help the child to exercise that control and manage those impulses. The children who most quickly and easily become toilet trained are those whose parents put most of their efforts into helping the child develop motivation towards assuming that control. This makes praise and parental approval for progress and success much more than punishment or parental disapproval for failure. It helps if the parents understood the premonitory signs of elimination in the child, or failing this, encourage the child to let the parent know when elimination is imminent. The parent can then assist the child in assuming the proper position on or at the proper apparatus. This is best achieved calmly and matter-of-factly rather than with stress and anxiety. The child should be allowed to sit or stand, at the toilet for a reasonable, but not long period. There should
be praise either for success or for trying. Over a period of time it is likely that the child will achieve occasional and then increasingly frequent successes especially if the parents are warm in their approach. Eventually the child will become reliably consistent, and he or she should then be given entire control over the process.

4. SUMMARY AND CONCLUSIONS OF THE STUDY

a. INTRODUCTION:

All the children in the course of growing up encounter minor stresses: a change of house or school, the birth of a new baby etc. Such stresses demands for increasing maturity on the part of child. Most children at some time or the other react to these stresses with temporary behaviour disorders such as temper tantrums, nightmares, bed-wetting etc. Till the age of five years bed wetting is considered as a normal developmental process of the child. While some children cross this developmental milestones quite early, others cannot achieve bladder control even after five chronological years.
Diagnostic features of Enuresis as per DSM III R is: the essential feature of Enuresis is repeated voiding of urine during the day or at night into bed or clothes (Criterion A). Most often this is involuntary but occasionally may be intentional. To qualify for a diagnosis of Enuresis, the voiding of urine must occur at least twice per week for at least 3 months or else must cause clinically significant distress of impairment in social, academic or other important areas of functioning (Criterion B). The individual must have reached an age at which continence is expected (i.e. the chronological age of the child must be at least five years) (Criterion C). The urinary incontinence is not due exclusively to the direct psychological effects of a substance (e.g. diuretics) or a general medical condition (e.g. diabetes, spina bifida, a seizure disorder) (Criterion D).

b. RELATED RESEARCH:

(i). STUDIES ON BIOLOGICAL CAUSATIVE FACTORS:

(ii). Family / Genetic Influences

Enuresis runs in families. Approximately 70% of clinically referred enuretics have a first degree relative who was enuretic as a child (Bakwin, 1961) Familiality is not an artefact of
clinical referral because it is also found in non-referred samples. In their study of a New Zealand birth cohort (n = 1265), Fergusson et al (1986) found that a family history of enuresis was the most important predictor of delayed bladder control and in a Finnish community study Jarvelin et al (1988) calculated a relative risk for enuresis of 7.1 among offspring of male and 5.2 among offspring of female enuretics. In a twin study in unreferred subjects that verified zygosity by blood studies Bakwin (1973) showed that concordance for enuresis was significantly higher in monovular than in binovular twins (68 versus 36%).

(ii). Bladder Size & Function

A number of studies (Starfield, 1967; Esperanca & Gerrard, 1969; Jarvelin et al., 1990, 1991) have found lower maximum urinary voided volumes in enuretics than controls, although with considerable overlap between both groups. Using age & weight-standardized norms, Gardner & Schaffer (1984) and Schaffer et al (1984) found that 55% of a population of self-referred enuretics in a school clinic had a functional bladder volume greater than normal.
(iii). Other Developmental Delays

Two large prospective birth cohort studies (Essen & Peckham, 1976; Fergusson et al., 1986) and a large retrospective clinical study (Steinhausen & Gobel, 1989) have noted a relationship between enuresis and early delay in motor, language and social milestones. These were not confirmed in a third prospective cohort study that used somewhat more limited measures (McGee et al., 1984). Clinical studies suggest that psychiatric symptoms are more common in enuretics with a history of motor and speech delay (Hailgren, 1957; Mikkelsen et al., 1980; Schaffer et al., 1984). Community studies by Miller (1973) and Essen and Peckham (1976) found that enuretics were shorter than non-enuretics and Douglas (1973) reported an association between bed-wetting in the mid-teens and delayed puberty.

(iv). Minor Neurological Abnormalities

Among referred clinical enuretics, psychiatric disturbance is more prevalent in those with minor neurological signs (Mikkelsen et al., 1980; Schaffer et al., 1984). In a longitudinal study of an unselected birth cohort, enuresis was
significantly more common in females in whom abnormal motor
signs (poor coordination etc.) had persisted through middle
childhood (Lunsing et al., 1991).

(v). Intelligence

Many studies have investigated the cognitive function of
enuretic population by standard IQ testing. Barbour et al, 1965
reports a tendency for adolescents with persistent enuresis to
have lower IQ score. IQ differences in Oppel’s Series was found
only for low birth-weight groups. In an unselected population,
enuretics did not differ from non-enuretics with respect to IQ
(McGee et al., 1984). However in a study that over-sampled for
handicapped and retarded children, enuresis was several times
more prevalent in those groups than in the general population
(Jarvelin et al., 1988).

(vi). Sleep Abnormalities

In a prospective longitudinal study, Fergusson et al. (1986)
noticed that toddlers aged 1 & 2 who slept more than 15 hours a
day were likely to develop bladder control at a latter age than
those who slept for shorter periods. It is not known whether the pattern of excess sleep quantity continues as the child gets older. Mikkelsen and Rapoport (1980) studied enuresis and sleep architecture and noted that enuresis wet at all stages on a seemingly random basis, the frequency of events within one sleep stage being proportional to the amount of the time spent by the individual in that sleep stage.

(vii). EEG & Sleep Abnormalities

EEG abnormalities were reported in enuretics by Takayasu (1963). He suggested that enuresis may represent an "Epileptic Equivalent". Paussant (1967) compared 138 enuretics and found EEG abnormalities in 10% which is the same as the general population. EEG-Oloffson et al.(1971) studying a enuretic - normal population found EEG abnormalities in a enuretic group.

(viii). Urinary Tract Infection

Five percent of clinically referred enuretics have evidence of a Urinary Tract Infection (UTI, Kunin et al, 1962; Schaffer et al, 1968) five times the rate found in general population (Savage
et al, 1969). Conversely, the prevalence of enuresis in infected girls is five times greater than that found in the general population. (Dodge et al, 1970) Infection is most common in female enuretics, in those who wet frequently and in day-wetters (Kunin et al, 1962; Schaffer et al, 1968; Dodge et al, 1970; Halliday et al, 1987; Jarvelin et al, 1990). There is some evidence that enuresis may facilitate ascending infection. Infected enuretic girls who continue to wet are more likely to become re-infected than enuretic girls who become dry (Dodge et al, 1970). Effective anti-biotic treatment in infected enuretics cannot be relied upon to cure the enuresis (Jones et al, 1972).

(II) STUDIES ON PSYCHOLOGICAL CAUSATIVE FACTORS

a. Toilet Training

Prospective studies in New Zealand (Fergusson et al., 1986) and Israel (Kaffmann & Elizur, 1977) suggest that enuresis is more likely among children who start toilet training after age 18 months. The rate of enuresis at 6 - 8 years old among children reared in a Kibbutz where training was started before 20 months was 5% compared with nearly 20% among those who started training later. This is likely to be because parents who
experience difficulty training their infants defer the process, for in the Israeli study the onset of training varied as a function of kibbutz rule rather than the individual characteristics of the child.

b. Stress Experiences

There is conflicting evidence on the relationship between early stress events and later enuresis. In an early longitudinal study, Douglas (1973) found that children who had more stressful life events at 3 - 4 years of age had a twofold increase in the risk of enuresis. There seems to be a clearer relationship between stressful events and the onset of enuresis which include birth of a younger sibling (Werry & Cohrsen, 1965), severe head injury (Chadwick, 1985) and natural disaster (Durkin et al., pers. comm.).

c. Gender

For several decades it has been reported in nearly all studies that boys are more likely than girls to suffer enuresis. An often cited statistic is that boys are twice as likely to be enuretic.
Reasons for this difference have been ascribed to social attitudes in child rearing, whereby girls are not permitted to be untidy, hence they are trained to greater fastidiousness. Other reasons ascribe the known decreased incidence in girls to easier submission to training and the fact that female enuretics have relatively few problems in other areas of their lives, so that they are not brought to medical attention. Some argue that the incidence ratio reflects genetic considerations. On those occasions when male and females enuretics have been followed, it seems that boys cease their wetting latter than females. Further, at all ages boys are more wet than girls. This raises the issue of differential maturational between boys and girls (Fergusson et al, 1986).

d. Resistance to Change

Dimson and Umphress et al, (1982) found a correlation between amount of resistance to change. There are many psychodynamic speculations deemed to be causative significance of enuresis. It is viewed as a desire for regression, a bid for attention, an active plea for help, a stated resentment to parents, a masturbatory equivalent, a clinging to infancy and the
expression of anger and resentment. Still other theories suggest that the enuretic is upset over sibling rivalry or feelings that he is an unwanted child. Thus enuresis is thought to be an demonstrate for an unwillingness to grow up.

**e. Family Social Background**

Socioeconomic factors may influence the development and persistence of bed wetting behaviour. The disorder is most prevalent among children of manual labourers and occurs least frequently among children of prosperous professionals. The discrepancy is attributed in part to the fact that toilet training is begun later in poorer, less educated groups. (Blomfield JM, Douglas, Essen J Peckham).

**f. Psychiatric Disorder**

Symptoms that have been thought to be specifically related to enuresis have included tics, temper tantrums, nail-biting, fire-setting and cruelty to animals (Felthous & Bernard, 1978; Jacobson, 1985). However systematic studies have failed to show a consistent or specific pattern for associated psychiatric
symptoms (Lickorish, 1964; Rutter et al., 1973; Mikkelsen et al., 1980), or a specific association with deviant personality profiles, including passive-aggression, emotional immaturity or passivity (Achenbach & Lewis, 1971).

There is evidence of a dynamic link between psychiatric disorder and enuresis. Essen & Peckham (1976) found that 7-year-old children who would become dry by age 11 years had an intermediate level of problems compared to children who had never been wet and those who would remain wet. In the Isle of Wight longitudinal study (Rutter et al., 1973), children who were both wet and disturbed at the age of 10 years were more likely to have stopped wetting by age 14 if they were no longer psychologically disturbed. Such findings would be compatible with enuresis being either a cause or a consequence of psychiatric disorder.

**g. Enuresis as a Symptom of Underlying Disturbance**

Many enuretics who wet frequently at home are dry when they sleep with relatives or on a holiday (Molling et al., 1962; Stein et al., 1965). Relatives point to these phenomena as an example of bed wetting being a purposeful and hostile act. However such
children often admit to anxiety about wetting when in an unusual setting and their dryness may be bought at the expense of fitful sleep. Bed wetting is a distressing and, in some cases, stigmatizing condition. A number of studies have shown that enuretics who have been successfully treated with the night alarm become more assertive, independent and happy and that they gain in self-confidence (Behrle et al., 1956; Lovibond, 1964; Baker, 1969; Moffatt et al., 1987).

(III) STUDIES ON TREATMENT MODALITIES

a Enuretic Alarm / Bell & Pad

The enuretic alarm or bell and pad method of treating enuresis utilizes a urine-sensitive pad placed in the child's bed, which is connected to a bell / buzzer or light. The electrolytic effect of urine completes a circuit, activating an alarm that continues to sound until manually turned off. Newer models of the alarm involve smaller, credit-card size pads attached directly to the child's underwear. In the literature from 1960 to 1975, Doleys found that across all studies using the urine alarm, 75% of 628 patients were successfully treated in 5 to 12 weeks.
b. Dry Bed Training

Axrin et al, (1982) developed a multidimensional approach to enuresis known as "Dry Bed Training". This approach uses operant conditioning principles to teach the child the responses necessary for remaining dry at night. Positive reinforcement for inhibiting urination, retention control training, positive practice, nighttime awakening, mild punishment, and a urine alarm are all incorporated in this procedure while dry bed training was initially described.

Several modifications were subsequently made, including possible omission of the urine and use of increased office based training for the parents and the child in place of the technician. In the initial evaluation of dry bed training 100% of the 24 children achieved the 14 day dryness criterion. Set by the authors, and none were reported to have relapsed at the 6 month follow-up.
c. Method to Increase Bladder Capacity

For a long time it has been known that Enuretics have small functional bladder capacity. This fact led urologists to promote the treatment method of bladder training. In this therapy, the patient is asked to quantify his ability to drink measured volume of fluid and to withhold increasingly larger in accommodating greater quantities of urine. At night the patients heightened threshold for retention eliminates the problem of bed-wetting.

d. Psychotherapy Or Counselling

Varying success has been reported with psychotherapy but it probably does not play a major role in the patients who do not have underlying psychopathology. It may be undertaken as an isolated mode of management or as an adjunct to other specific regimens. The goals of counselling include:

1. Parental understanding of the multifactorial nature of enuresis.

2. Parental acceptance of the child and his symptoms to provide maximum emotional support through positive interaction.
3. Instilling in the child and his family the same optimism projected by the clinician.

4. Development of an appreciation on the part of the child that he and not his parents, is responsible for and can have control over enuresis.

5. Enhancement of the social maturity of the children who demonstrate immaturity in social interactions.

e. Motivational Counselling

Through motivational counselling, the child learns to assume responsibility and become an active participant in the management program. He or she should be informed about the therapeutic options, and agree to and understand each step in the treatment plan. Verbal praise from parents is appropriate for all children.

The success of motivational counselling remains controversial. Result from one study indicate that 70% of children experience "marked improvement" in achieving dryness with this method; another study documented a 25% success rate. Combined with other modalities, motivational counselling may provide a format for educating the child and the parent, as well as contribute to nighttime continence.
f. Drugs

The use of Imipramine, a tricyclic antidepressant, has become increasingly popular in research and clinical settings. Blackwell and Currah (1973), Lovibond and Coste (1970), O'Leary and Wilson (1975), and Stewart (1975) have reviewed much of the literature in this area. Studies by Forsythe and Merrat (1969), Kardash, Hillman and Werry (1968), McConghy (1969), Schaffer, Costello and Hill (1968) have shown imipramine to be significantly more effective than placebo in reducing wetting frequency.

g. Hypnosis

Researchers have explored the use of hypnotherapy in the treatment of enuresis for decades. Trance induction, heightened suggestibility without trance induction, enhanced by antecedent counselling regarding positive attitude, expectations and motivations and self hypnosis are three paradigms in hypnotherapy.


h. Elimination Diets

It has been proposed that there is a relationship between food allergy and enuresis, however, hypoallergenic diets have produced remission in some children. Similarly eliminating milk products, citrus and chocolate, among other foods to which children are commonly allergic, may benefit some children.

i. Acupuncture

Acupuncture emerged as a possible therapy for enuresis in 1986. In a placebo-controlled study, conducted in Italy, examined the value of three modalities in the treatment of enuresis; administration of desmopressin acetate (DDAVP); acupuncture; and a combination of DDAVP and acupuncture. Therapeutic efficacy was defined by percentage of dry nights. Children who received DDAVP or acupuncture alone experienced success in terms of achieving dryness; however the combination of DDAVP and acupuncture demonstrated the greatest effectiveness.
c. METHODOLOGY:

TOPIC: "Study of some Psycho-Social Correlates of Functional Enuresis"

(i). Objectives:

The magnitude and severity of the problem of enuresis has already been discussed. Yet, very little attention has been paid to study enuresis and its psycho-social correlates in Indian context. Hence, the researcher thought of working on this problem as she hoped that elimination of this problem would help the child, parents and their family at large.

The objectives of this study are:

1. To study the differential impact of intervention on the frequency of bed-wetting.

2. To study the differences between girls and boys on the impact of the intervention technique.
3. To study the differences between primary and secondary enuretic children.

4. To assess the differential impact of the intervention technique with respect to:
   (a) Family Environment Scale (FES)
   (b) Interview Schedule for children & Adolescent (ISCA)
   (c) Self Esteem (SE)
   (d) Behaviour Checklist (BCL)

(ii). Hypothesis

1. There will be an impact of the therapeutic treatment intervention on the enuretic boys and girls leading to significant change on family environment dimensions; namely (a) on relationship (b) on personal growth (c) and on system maintenance.

2. There will be an impact of the therapeutic treatment intervention on the primary type and secondary type of enuretic children, leading to significant change on family Environment dimensions, namely (a) on relationship (b) on personal growth (c) and on system maintenance.
3. There will be an impact of the therapeutic intervention on the total sample of Enuretics leading to significant change on family environment dimensions; namely (a) on relationship (b) on personal growth (c) and on system maintenance.

4. There will be an impact of therapeutic treatment intervention on the enuretic boys leading to significant change on family environment dimensions namely (a) on relationship (b) on personal growth (c) and on system maintenance.

5. There will be an impact of therapeutic treatment intervention on the enuretic girls leading to significant change on family environment dimensions namely (a) on relationship (b) on personal growth (c) and on system maintenance.

6. There will be an impact of therapeutic treatment intervention on the primary type leading to significant change on family environment dimensions namely (a) on relationship (b) on personal growth (c) and on system maintenance dimension.
7. There will be an impact of therapeutic treatment intervention on the secondary type leading to significant change on family environment dimensions namely (a) on relationship (b) on personal growth (c) on system maintenance.

8. There will be an impact of the therapeutic treatment intervention on the boys and girls leading to significant reduction in the psychological symptoms.

9. There will be an impact of the therapeutic treatment intervention on the primary type and secondary type of Enuretic children leading to significant reduction in the psychological symptoms.

10. There will be an impact of the therapeutic treatment intervention on the total sample of Enuretics leading to significant reduction in the psychological symptoms.

11. There will be an impact of the therapeutic treatment intervention on the Enuretic boys leading to significant reduction in the psychological symptoms.
12. There will be an impact of the therapeutic treatment intervention on the Enuretic girls leading to significant reduction in the psychological symptoms.

13. There will be an impact of the therapeutic treatment intervention on the Primary type leading to significant reduction in the psychological symptoms.

14. There will be an impact of the therapeutic treatment intervention on the Secondary type leading to significant reduction in the psychological symptoms.

15. There will be an impact of the therapeutic treatment intervention on the boys and girls leading to significant increase in the Self-Esteem.

16. There will be an impact of the therapeutic treatment intervention on the Primary type and Secondary type of Enuretic children leading to significant increase in the Self Esteem.
17. There will be an impact of the therapeutic treatment intervention on the total sample of Enuretics leading to significant increase in the Self Esteem.

18. There will be an impact of the therapeutic treatment intervention on the enuretic boys leading to significant increase in the Self Esteem.

19. There will be an impact of the therapeutic treatment intervention on the Enuretic girls leading to significant increase in the Self Esteem.

20. There will be an impact of the therapeutic treatment intervention on the Primary type leading to significant increase in the Self Esteem.

21. There will be an impact of the therapeutic treatment intervention on the Secondary type leading to significant increase in the Self Esteem.
22. There will be an impact of the therapeutic treatment intervention on the total sample of enuretics leading to significant reduction in behaviour characteristics.

23. There will be an impact of the therapeutic treatment intervention on the enuretic boys leading to significant reduction in behaviour characteristics.

24. There will be an impact of the therapeutic treatment intervention on the Enuretic girls leading to significant reduction in behaviour characteristics.

25. There will be an impact of the therapeutic treatment intervention on the Primary type leading to significant reduction in behaviour characteristics.

26. There will be an impact of the therapeutic treatment intervention on the Secondary type leading to significant reduction in behaviour characteristics.

27. There will be an impact of the therapeutic treatment intervention on the sample of enuretics leading to continence or decrease in frequency of bed-wetting.
iii. Sample:

Out of the total number of 52 cases, 40 were considered for this study. There were 12 drop outs. (When a child failed to come for four consecutive times it was considered as drop out). Hence the study sample was forty consecutive enuretic children between the age of 5 and 13 years who attended the clinic from March '95 to March '97. The children had been brought by their parents to the clinic with a complain of bed wetting or at times the parents came with a different problem but bed wetting was discovered during the course of the interview. The total sample of 40 enuretic children consists of 17 girls and 23 boys.

iv. Instruments used for Data Collection:

For the purpose of collecting data the following instruments were used.

a. Family Environmental Scale (Moos and Moos, 1976)

b. Interview schedule for children and adolescents (Modified version from Maria Kovacs & Shobha Srinath NIMHANS).
v. Variables:

As in all experimental studies the present study too consisted of independent and dependent variables.

Independent Variable:

It is one which is manipulated by the investigator or experimentor. Therefore the independent variable of the present study were psycho-social variables which were: (1) Family Environment, (2) Psychological Symptoms, (3) Self Esteem, and (4) Behavioural Characteristics.

Dependent Variable:

It is the one which is dependent on the other variables and consists of what is measured in an experiment. The dependent variable of the present study, therefore, was the symptom i.e. enuresis or bed wetting.
vi. Statistical Analysis:

The data collected was quantitative in nature and hence it was subjected to statistical analysis. The statistical analysis used were the following:

a. Analysis of Covariance (ANCOVA)
b. t-test for repeated measures
c. Sign test

viii. Conclusions:

Therapeutic treatment technique intervention was found to be effective as it helped 32 enuretic children in achieving continence. The eight children who could not achieve continence had certainly decreased their frequency of bed-wetting from the base line frequency.

Of the three dimensions of FES, Cohesion subscale of Relationship dimension, Achievement Orientation subscale of Personal growth and Organization subscale of System Maintenance have significant relation with functional enuresis.
It can be concluded from this study that some enuretic children do suffer from certain psychological symptoms. With the continence of enuresis, psychological symptoms were also eliminated. From the findings of this study it can also be concluded that enuretic children have low self esteem. Enuresis and self esteem have shown high significant relation in this research.

Lastly, certain behaviour characteristics are found to be present in enuretic children.

5. LIMITATIONS OF THE PRESENT STUDY

1. The data collection for this study was done at a Child Guidance Clinic. Therefore the clinical picture is very specific and does not include children from the general public.

2. The sample size is also limited. Therefore, for an in-depth analysis to draw very profound conclusion, there is a need for a larger sample size.
Some of the children had undertaken previous treatment.

Data was collected from the mothers only since it was not possible for the fathers to be involved for various reasons.

Follow-up was conducted immediately after three months therapeutic treatment was over. A subsequent follow-up after a period of six months could not be performed because of lack of parents' and children's cooperation.

6. SUGGESTIONS FOR FURTHER RESEARCH

Keeping the above mentioned limitations in mind, following suggestions if taken into consideration can add new dimensions to the results with greater degree of certainty.

1. Sample size can be increased and more variables can be added such as stress, maternal tolerance etc. in future research.
2. Future research if possible should be such which can include enuretic children from general public, Paediatric Clinic etc to get an over all picture.

3. A research becomes more meaningful when there is no previous exposure to the technique. If it is possible to have children without any previous treatment the results will show greater degree of certainty.

4. The position of a father cannot be over-looked in any family. Hence it becomes important to have fathers' cooperation and involvement.